

## **Researching people-centred health systems: the reward and challenge of co-production for HPSR**

Authors:

Uta Lehmann, MA, PhD  
School of Public Health, University of the Western Cape

Lucy Gilson, BA, MA, PhD  
School of Public Health and Family Medicine, University of Cape Town and Dept Global  
Health and Development, London School of Hygiene and Tropical Medicine

Corresponding author:

Uta Lehmann, School of Public Health, UWC, Private Bag X 17, Bellville 7535, South Africa.  
Tel: +27-21-9592633; Fax: +27-21-9592872; Email: ulehmann@uwc.ac.za

Running title: Co-production in HPSR

Key words: HPSR, methodology, action learning, reflective practice, governance

Key messages:

- Co-production is an essential dimension of HPSR, as an applied and embedded research field concerned with people and health systems
- Co-producing knowledge demands approaches to engagement that allow real understanding of both practitioner and researchers' worlds
- Co-production needs time for relationship- and trust-building and flexibility to determine form, shape and deliverables
- There is an learning opportunity in making use of and weaving into each other different forms of data

Acknowledgements:

We thank all those collaborating in the DIALHS project in Mitchells' Plain, Cape Town. Our particular thanks go to: the late James Claasens, Patti Olckers, and Keith Cloete from the Metro District Health System, Western Cape provincial Department of Health; Soraya Ellokori, Ivan Bromfield and Zandile Mahlangu from the health department, City of Cape Town; Nikki Schaay, Helen Schneider and Vera Scott, of the University of the Western Cape and Sue Cleary and Judy Daire of the University of Cape Town. The DIALHS project is funded by the Atlantic Philanthropies.

Word count: 3598

## Abstract

Health Policy and Systems Research is centrally concerned with people, their relationships and the actions and practices they can implement towards better health systems. These concerns suggest that HPS researchers must work in direct engagement with the practitioners and practice central to the inquiry, acknowledging their tacit knowledge and drawing it into generating new insights into health system functioning. Social science perspectives are of particular importance in this field because health policies and health systems are themselves social and political constructs. However, how can social science methodologies such as action research and narrative and appreciative enquiry enable such research, and how can methodologies from different disciplines be woven together to construct and make meaning of evidence for this field?

This paper seeks to present 'methodological musings' on these points, to prompt wider discussion on the practice of HPSR. It draws on one long-term collaborative action learning research project being undertaken in Cape Town, South Africa. The DIALHS project, District Innovation and Action Learning for Health System Development, is an action-research partnership between two South African academic institutions and two health authorities focussed, ultimately, on strengthening governance in primary health care.

Drawing on this experience, the paper considers three inter-related issues:

- The diversity and complexities of practitioner and research actors in co-producing HPSR;
- The nature of co-production, and central role of providing space to grapple across different systems of meaning;
- The character of evidence and data in co-production.

There is much to be learnt from research traditions from outside the health sector, but HPSR must work out its own practices – through collaboration and innovation among researchers and practitioners. In this paper, we provide one set of experiences to prompt wider reflection and stimulate engagement on the practice of HPSR for people-centred health systems.

## Introduction

*“Health policy and systems research (HPSR) is an emerging field that seeks to understand and improve how societies organize themselves in achieving collective health goals, and how different actors interact in the policy and implementation processes to contribute to policy outcomes. It covers a wide range of questions (...) – including the role, interests and values of key actors at local, national and global levels”* (<http://www.who.int/alliance-hpsr/about/hpsr/en/index.html>. Accessed 13/11/2013).

This widely accepted definition of HPSR makes two important points: that this research field is centrally concerned with people and their relationships; and that it is concerned with actions and practices towards better health systems. By definition, almost, these concerns suggest that HPS researchers must work in direct interface with the constituency they serve; not remote and distant from the ‘object’ of their study, but “embedded in the ecosystem in which the decision-makers operate” (WHO 2012, p.19).

In other words, as an applied field of research, seeking to be useful for policy-making and management, it is necessary for researchers to engage with all those “who share a stake in improving policies, such as programme managers, implementers, or citizens and civil society.” (WHO 2012:18). However, this engagement is not just to ensure that research is directed towards policy-maker needs or that research results are disseminated, but more fundamentally - to draw the tacit knowledge and experience of health system actors into the research endeavour (Rose 2005; Flyvbjerg 2007). As the 2012 WHO HPSR strategy notes:

*“While transforming the results of relevant research into policy and practice, HPSR also benefits by drawing on lessons generated from existing practices, which add to the knowledge obtained from designed research studies and also help generate fresh research questions, which need to be answered. Knowledge generation and knowledge translation are, therefore, not unidirectional in HPSR. They are bidirectional, with the decision-makers, as well as the researchers, teaching each other and learning from one another”* (WHO 2012, pp.14–15).

Beyond application and embeddedness, an additional widely accepted central tenet of HPSR is inter-disciplinarity (Adam & de Savigny 2012; Bennett et al. 2011; Hoffman & Rottingen 2012). Social science perspectives are of particular importance because health policies and health systems are themselves social and political constructs, as is evident from the WHO strategy and other articles and documents published in the last few years (Adam & de

Savigny 2012; Sheikh et al. 2011; Gilson et al. 2011; Bennett et al. 2011), They are neither naturally occurring phenomena, nor simply a collection of technologies. They are fundamentally shaped by political decision-making, and their everyday operations are underpinned by social relationships among the actors involved in managing, delivering and accessing health care and engaged in wider action to promote health. Indeed, their complexity is a reflection of the influence of actors over problem definition, what new interventions or policies comprise, how health systems work, and how interventions or policies play out through these systems (De Savigny & Adam 2009; Ssengooba et al. 2007). As an applied field, concerned with influencing policy and practice, HPS researchers are, moreover, themselves embedded in the complexity they research, and have to address the double hurdles of scholarly quality and relevance (Pettigrew 2001).

While many of the principles of this evolving field have now been established, it is much less clear how HPS researchers give expression to these principles in their daily practices. How to engage social science methodologies such as action research and narrative and appreciative enquiry that enable embedded research, how to weave together methodologies from different disciplines and how to construct and make meaning of evidence for this field are not well documented.

This paper aims to illuminate some of the methodological opportunities and challenges that arise from breathing life into HPSR principles, drawing on experiences from a long-term action-research partnership between two South African academic institutions and two health authorities, the (*District Innovation, Action and Learning for Health System Development* or DIALHS project). It specifically offers some 'methodological musings' on three inter-related issues:

- Realising, recognising and working with the diversity and complexities of practitioner and research actors in co-producing HPSR;
- Understanding and theorizing co-production – with interest in the form and quality of the relationship between researcher and managers, as well as the uncertainties experienced when both actor groups give up control to respond, at least partly, to the rules of the other and to work with other systems of making meaning, which may be poorly understood and legitimized in their own context;
- The character of evidence and data in co-production - thinking about what constitutes evidence and data when working in partnership and at the interface between action, reflection and research; and the value of moving beyond a uni-dimensional view of knowledge as data which is collected and then analysed, to building layers of knowledge in conversation.

### **The DIALHS project**

In 2010 two academic institutions and two government health departments in Cape Town, South Africa embarked on a partnership to support the emerging district health system by working closely with managers and staff in one of the City's sub-districts around governance issues.

Developing from a series of conversations between senior managers/policy makers and academics we conceptualized this partnership as an *'action research'* project aiming to:

- develop and test strategies for strengthening the district system through improved implementation of existing policies and programmatic innovation;
- identify both key restrainers and enablers of district health system development, and appropriate actions to, respectively, overcome or enhance these;
- guide the development and distil practical examples of the leadership and management strategies needed across levels to support effective policy implementation and strengthen the district health system;
- provide support for post graduate public health and health management training programmes that draws on such experience.

Straddling concepts of action learning and action research, we also agreed on three fundamental rules of engagement, as noted in the workplan included with the formal Memorandum of Understanding (MOU) that underpinned the partnership:

“1. As we will adopt an action learning approach, an integral feature of the collaboration will also be regular review of activities within the learning sites with the relevant sets of colleagues to adapt and revise activities as necessary. The research team will, therefore, also play an important supportive role in encouraging cycles of planning, implementation/ practice, reflection and evaluation, learning and revision.

2. The specific areas of action research to be implemented in each site will be identified by working closely with the local health managers and staff, first, to consider local needs and opportunities, and second, to identify key entry points through which to strengthen the district health system and programme implementation within it.

3. Every agreed activity will be led and managed by local health officials, and implemented by them in conjunction with their staff. The research team will help develop each activity and support its implementation”.

In contrast to other action research projects, the DIALHS project does not aim to “research” an intervention but instead, to better understand, intervene in and research routine system practices – learning with rather than about health systems actors in cycles of action and reflection over a prolonged period of time. Together we are exploring, implementing and reviewing a range of issues and actions linked, ultimately, to strengthening governance in primary health care and strengthening practices of leadership. Our cycles of action learning, structured sub-studies and reflection are summarised in Table 1, with the data they have generated<sup>1</sup>.

---

<sup>1</sup> It is impossible to do justice to the complexity and richness of all learning activities here. We have already reported on aspects of the project (Elloker et al. 2013) and other papers are presently being generated and submitted.

Table 1: Summary of DIALHS activities and data			
Activities and engagements which generated data		Data generated	
Situational analysis		<ul style="list-style-type: none"> <li>• Review of x policy documents and minutes of statutory meetings</li> <li>• Stakeholder interviews</li> <li>• Observations of meetings</li> </ul>	
Cycles of	Planning of interventions <ul style="list-style-type: none"> <li>• Community profiling and Local Area Groups</li> <li>• Support for Environmental Health Practitioners</li> <li>• Support for PHC facility managers</li> <li>• HIV/AIDS &amp; TB programme roles</li> </ul>	Presentations and meeting/workshop notes (can we quantify? For each activity maybe?); document reviews	Composite reports of interventions (Community Profiling, HAST, Facility manager support, KPAs)
	Implementation of interventions	Presentations, notes of meetings, field notes and reports	
	Review and reflection	<ul style="list-style-type: none"> <li>• Notes of meetings with teams involved in intervention</li> <li>• Presentations and reports to meetings of health service partners</li> </ul>	
Research sub-studies <ul style="list-style-type: none"> <li>• The transition process from nurse to facility manager</li> <li>• The information used by facility managers in routine decision-making</li> </ul>		<ul style="list-style-type: none"> <li>• Interviews</li> <li>• Observations</li> </ul>	
Meetings and reflections of research team		<ul style="list-style-type: none"> <li>• Transcriptions and notes of x reflective meetings of research team</li> </ul>	
Interviews and reflective conversations with sub-district and district managers		<ul style="list-style-type: none"> <li>• Notes of meetings with district managers</li> <li>• Notes of meetings with sub-district managers</li> </ul>	

The journey on which we have embarked is by no means complete and has brought both expected and unexpected opportunities and challenges. In particular, we have been challenged to think about how to support health policy and system change through a research-service partnership, including how to address “the thorny issue of the boundary between researcher and advocate” (Gilson et al. 2011, p.4), i.e. the challenges arising from embeddedness.

### Knowledge production and action at the interface between research and practice

Action research, narrative inquiry and action learning are well established and well theorized concepts and approaches outside the HPSR field, encompassing “a collective process in specific contexts for inquiring into and taking action on projects and practices within their

complex, multi-agent contexts” (Rigg 2011, p.15). They hold the promise of better “connectedness” between researchers and practitioners in applied fields of study as they “can readily break down the roles that are typically assigned to practitioners and researchers” (Ospina & Dodge 2005, p.410).

The challenge and the opportunity of these approaches lie in the collective ownership and the emergent nature of the process of inquiry, research *with* practitioners, rather than *about* practice (Bradbury-Huang 2010, p.93), which demands flexibility, responsiveness and trust among research partners.

Amongst the DIALHS researchers, several had previously worked in health services, several had prior experience with action research and action learning (AR/AL), and all of us had long histories of working in close collaboration with colleagues from the health system. AR/AL thus felt like neither a foreign nor a particularly intimidating prospect. Our service partners, however, generally had experience with more ‘conventional’ forms of health research. Some had only experienced research as a largely extractive process, whilst others were used to being able to determine and influence research agendas with little direct engagement with the research process itself. Action learning was a fairly novel concept for all, although some had a little past experience with collaboration in service improvement interventions.

Whatever our starting points, as the project unfolded, we all, both researchers and practitioners, found ourselves grappling with the implications of our own well-considered and -intentioned terms of engagement (as cited above). We found that neither the well established distinction between practitioners and researchers, nor the traditional conceptualizations of AR and AL did justice to the complexity of collaborative action, planning and knowledge generation processes that seek to be fully equitable, mutually constitutive, and transcend hierarchies of knowledge and hierarchies of action.

#### Who are the people in health systems? Dealing with actor complexity

From very early on in the project the question of who the project partners are has played a significant role as a foundation for the co-production of knowledge. Formally the Universities were partnering with the City of Cape Town (CoCT) and Western Cape provincial government health departments. As we conceptualized the project and submitted it for funding the initial engagements were primarily between two senior academics and key health policy makers in the provincial government and to a lesser extent the CoCT, and more specifically the two district managers. As discussions about the specific site of work became more concrete the two sub-district managers for the two health authorities were drawn into these engagements. As the project unfolded and we entered the initial cycle of assessment, analysis, feedback, and agreement on activities, the actor map became more complex. The partnership was not between one service partner and one research partner, each with one set of roles, action imperatives, values and mind sets, but with a complex, multi-layered, dynamic and inter-dependent set of relations and learning processes.

Firstly, it became clear that the service ‘partner’ was not a homogenous entity with just one set of priorities and views. While the research team had recognised and expected that we would work with different levels of the health services, from facility to district managers,

plus communities, as appropriate, we had not considered the implications and complexity of engaging with different actors with different roles, positions, understandings, agendas and values. As the researchers, we had committed to negotiating and agreeing all actions and interventions with local actors, but had to think much harder about with whom to negotiate and agree as we developed our activities: the sub-district managers? their superiors in the district office, with whom we had after all signed the MOU? the sub-district management team? What about the programme and facility managers, who work closer to the frontline of service delivery? And what about community-level actors? The research team realised it was not a question one could answer once given that activities unfolded over time, and only in the evolving practice did we begin to understand the complexity of partnership.

The 'research partner' is, secondly, also made up of a diverse group of people, including social scientists with a background in health policy research, and nurses and doctors who had worked as clinicians in the public health services in the country and the district. They therefore brought different experiences, different perspectives, and different academic understandings to discussions of both focus and method in the evolving work. Developing a collective understanding and making meaning of this research endeavour, which did not come with a fixed protocol and predetermined tools and methods but rather with a broad framing and a commitment to joint ownership and co-production, thus became a critical part of the project – not only for the research team, but also for the collective of the research and services team.

Both the character of the partnership and well as the terms of engagement are therefore under continuous discussion, both “mutually constituting and uplifting but also at times disturbing and debilitating” (Orr & Bennett 2012a, p.1).

#### Approaches to co-production

Although the AR/AL literature discusses the collaborative and iterative nature of developing research questions and making sense of data, the research processes within AR/AL cycles usually retain their traditional character of researchers collecting data through interviews and observations from practitioners. Research and action themselves remain fairly separate as domains of researchers and practitioners, respectively (Koshy et al. 2011; Khresheh & Barclay 2007; Reason & Bradbury 2008; Bradbury-Huang 2010).

In the DIALHS project, we have sought to bring the two closer together, co-producing insights and knowledge by bringing conceptual and theoretical questions and debates into conversations between researchers and practitioners, collectively developing action plans and collaboratively theorizing and presenting insights. This approach has presented new challenges for understanding and practicing co-production and partnership. We have found insights from the public administration literature helpful, as the field has historically worked with quite fluid boundaries between academia and practice – including the concepts of co-production and of 'pracademics' (Orr & Bennett 2012b; Ospina & Dodge 2005).

But even in this traditionally inclusive field, co-production of knowledge between practitioners and researchers has been a much debated terrain, raising questions of “who produces knowledge, for whom and for what purposes” (Orr & Bennett 2012b, p.3). While



there is widespread agreement on the desirability, importance and promise of well articulated research-practice interfaces, the practice is often fraught with complexity and “politics”, as it involves “cooperative interactions between members of two communities that have distinct interests, expectations, and priorities” (Orr & Bennett 2012b, p.1). Within the DIALHS project we have, for example, grappled with research concerns about academic rigour, having to provide detailed protocols for ethics clearance and uncertainties about the nature of our data, and with some practitioners’ concerns about the researchers’ prolonged presence in the sub-district without clear tools, ‘results’, and action recommendations.

We found that connectedness, rather than forming naturally, needed to be ‘worked’ to provide the basis for mutual learning, and we have, over the years, explored a number of concepts and activities aimed at nurturing the construction of an ethical, co-producing project.

Perhaps the most important concept, permeating all layers and dimensions of the project, is that of ‘reflection’, drawing from Schon (1983). Virtually every member of the DIALHS team, researchers and practitioners, has commented on the value and importance of reflection in different aspects of their professional practice, both in project meetings and interviews, but also more publicly in reports to senior managers in the health system and in various public venues. Other concepts, which have become part both of the DIALHS discourse and of the discourses of practice in the sub-district are: distributed leadership, appreciation, time-to-think, problem-solving and inclusiveness. Team members have reported that they have changed their personal engagement with colleagues above, below and alongside them, and introduced changes to their routine activities (such as meetings) as a result of discussion or role-modeling within DIALHS.

Three other activities have also helped us get to know each other’s professional contexts and rationalities. These are: joint reading and discussion of relevant academic literature (e.g. on reflective practice, theory of change, governance, leadership development); collaborative writing (see, for example, (Elloker et al. 2013)); and joint presentations at local and international conferences, including the 2<sup>nd</sup> Global Forum on Health Systems Research in Beijing in 2012. These became particularly important because while researchers developed increasingly rich insights into health system functioning through DIALHS activities we found that practitioners had little opportunity to see academic life or talk about our collective engagement within academic contexts. Gaining insight into the expectations and discourses of the research community not only facilitated understanding and appreciation, but also built trust among the DIALHS team. We all acknowledge the value and importance of getting to know and appreciate our respective professional communities’ rationales and priorities, and the richness of knowledge co-produced in this fashion.

### Creating evidence and making meaning

As we grappled with ways of connecting and reframing the question of ‘who produces knowledge for whom and for what purpose?’, we have also interrogated the nature of evidence in this research.

Questions such as ‘how do we understand what we are doing?’ (how do we make sense?), ‘how can we show what we are doing?’ (what is our evidence?), and ‘how do we talk about what we are doing?’ (how do we theorize?) have been central DIAHLS pre-occupations over time. Working without the traditional tools and scaffolding devices of research (fixed protocols, pre-determined schedules of data collection, analysis, and feedback) meant that we struggled to justify ourselves to our respective communities (‘professional tribes’). We spent an awful lot of time in meetings, formal and informal, big and small, in cycles of conversations to plan and implement strands of work, reflect on their outcomes and re-plan.

Our methodological starting points were the cycles of action and reflection familiar from action research methodology, comfortable in the knowledge that data generated by action learning and action research can take many forms, and that their criteria for validity and rigour are the same as for other forms of research: that they be systematically collected, analysed and interpreted (Zuber-Skerritt 2001). However, we found action research methodology again falling short of our experience, in that data generation generally remains restricted to primary data, e.g. interviews or observations.

As we have begun to write and theorize, we have started to recognize the opportunity of treating the emerging layers and dimensions of documentation we have collected as data and evidence themselves, alongside more traditional forms. Partly to understand better the emerging project process and partly to have a language to speak about our work, we have, over time, systematically documented all engagements between DIAHLS actors in various project-related activities. Our evidence, therefore, includes not only “classic” formal data, such as interviews, which are recorded, transcribed and analysed, and observations recorded in field notes; but also notes from joint planning meetings, workshops, conversations, report-backs, which were shared between researchers and service partners, and a mix of detailed transcriptions and notes from the research team’s own planning and, more importantly, regular and systematic reflection meetings (see Table 1).

Through our data collection, documentation and reflection practices we are, thus, creating multiple and inter-dependent cycles of increasingly rich data, analysis and learning (Figure 1; see also Argyris & Schon 1978; Argyris 2008).

Figure 1: Schematic representation of data generation and sources in DIAHLS project



Because the AR/AL literature remains silent on such layered and inter-connected data, we have drawn on the concept of “bricolage” in our approach to collecting and interpreting

data. First introduced into the literature on qualitative research methods, particularly educational research, by Denzin and Lincoln (1999), the term was used to signify “eclectic multi-theoretical and multi-methodological approaches to meaning-making in research” (Rogers, 2012: 3). Most important for us was the insight that “empirical data viewed from another perspective or questioned by one from a different background can elicit fundamentally different interpretations” (Kincheloe 2004, p.7). This stimulated us to create opportunities to bring DIALHS actors into various conversations with each other (creating connectedness), surfacing and sharing tacit knowledge (values, mindsets, experiences) to better understand each other. We have done this in formal data collection processes by adopting styles of in-depth qualitative inquiry together with cycles of feedback and reflection, but also in collectively planning and deliberating on particular interventions as well as in preparing presentations and writing papers as shared activities. All these processes combine engagement and reflection, and provide opportunities for individuals’ to bring their tacit and personal knowledge into conversation with each other, to make meaning together and so generate new knowledge (Nonaka 1994; Ospina & Dodge 2005; Rynes et al. 2001).

## **Conclusions**

In considering how to do research for people-centred health systems, we have used the experience of one action-learning project to highlight some of the opportunities and challenges of co-producing knowledge. Co-production is vital within a research field, HPSR, that focuses on health system actors and their roles in strengthening health systems. HPSR strives to value and brings to bear the expertise, mindsets and experiences of all health systems players, in creating knowledge at the interface between research and practice to stimulate action.

The challenge and the opportunity of a knowledge co-production project lie in the diversity and richness of actors involved, their mindsets, values and experiences, in the rich moments of alterity as they do from any sense that co-production entails unification” (Orr & Bennett 2012a, p.3). This requires attention and time to build relationships and trust.

Another opportunity for innovative knowledge production in the field lies in using evidence beyond conventional data sources and treating emerging layers and dimensions of documentation as data to create richer learning and knowledge production opportunities.

## Bibliography

- Adam, T. & de Savigny, D., 2012. Systems thinking for strengthening health systems in LMICs: need for a paradigm shift. *Health Policy and Planning*, 27 (suppl 4), pp.iv1–iv3.
- Argyris, C., 2008. Single-Loop and Double-Loop Models in Research on Decision Making. , 21(3), pp.363–375.
- Argyris, C. & Schon, D., 1978. *Organizational Learning: A Theory of Action Perspective*, Reading MA: Addison-Wesley.
- Bennett, S. et al., 2011. Building the Field of Health Policy and Systems Research<sup>2</sup> : An Agenda for Action. , 8(8), pp.1–5.
- Bradbury-Huang, H., 2010. What is good action research?: Why the resurgent interest? *Action Research*, 8(1), pp.93–109.
- Denzin, N.K. & Lincoln, Y.S. (EDS. ., 1999. *The SAGE handbook of qualitative research (3rd ed.)*, Thousand Oaks, CA: Sage Publications.
- Elloker, S. et al., 2013. Crises, Routines and Innovations: The complexities and possibilities of sub-district management. In A. Padarath & R. English, eds. *South African Health Review 2012/13*. Durban: Health Systems Trust, pp. 161–173.
- Flyvbjerg, B., 2007. *Making Social Science Matter: Why Social Inquiry Fails and How It can Succeed Again (2nd Edition)*, Cambridge, UK: Cambridge University Press.
- Gilson, L. et al., 2011. Building the Field of Health Policy and Systems Research<sup>2</sup> : Social Science Matters. , 8(8).
- Hoffman, S. & Rottingen, J.-A., 2012. Assessing implementation mechanisms for an international agreement on research and development for health products. *Bulletin of the World Health Organization*, 90(11), pp.854–863.
- Khresheh, R. & Barclay, L., 2007. Practice--research engagement (PRE): Jordanian experience in three Ministry of Health hospitals. *Action Research*, 5(2), pp.123–138.
- Kincheloe, J., 2004. Introduction: the power of the bricolage: expanding research methods. In ... *in educational research. Conceptualizing the bricolage*. pp. 1–22.
- Koshy, E., Koshy, V. & Waterman, H., 2011. *Action research in healthcare*, Thousand Oaks, CA: Sage Publications.
- Nonaka, I., 1994. A dynamic theory of organizational knowledge creation. *Organization Science*, 5(1), pp.14–37.
- Orr, K. & Bennett, M., 2012a. Down and out at the British Library and other dens of co-production. *Management Learning*, 0(0), pp.1–16.
- Orr, K. & Bennett, M., 2012b. Public Administration Scholarship and the Politics of Coproducing Academic–Practitioner Research. *Public Admin*, xx, pp.1–10.

- Ospina, S.M. & Dodge, J., 2005. Narrative Inquiry and the Search for Connectedness<sup>2</sup> : Practitioners and Academics Developing Public Administration Scholarship. *Public Administration Review*, 65(4), pp.409–423.
- Pettigrew, A.M., 2001. Management Research After Modernism. *British Journal of Management*, 12(s1), pp.S61–S70.
- Reason, P. & Bradbury, H. (eds. ), 2008. *The SAGE Handbook of Action Research: Participative Inquiry and Practice (2nd edition)*, London: SAGE Publications Ltd.
- Rigg, C., 2011. Systemic action and learning in public services. , 8(1), pp.15–26.
- Rogers, M., 2012. Contextualizing Theories and Practices of Bricolage Research. , 17, pp.1–17.
- Rose, R., 2005. *Learning from comparative public policy: A practical guide*, Abingdon: Routledge.
- Rynes, S.L., Bartunek, J.M. & Daft, R.L., 2001. Across the great divider: knowledge creation and transfer between practitioners and academics. *Academic Management Journal*, 44(2), pp.340–355.
- De Savigny, D. & Adam, T., 2009. *Systems thinking for health systems strengthening* D. De Savigny & T. Adam, eds., World Health Organization.
- Schon, D., 1983. *The reflective practitioner*, London: Temple Smith.
- Sheikh, K. et al., 2011. Building the Field of Health Policy and Systems Research<sup>2</sup> : Framing the Questions. , 8(8), pp.1–6.
- Ssengooba, F. et al., 2007. Health sector reforms and human resources for health in Uganda and Bangladesh: mechanisms of effect. *Human resources for health*, 5(1), p.3.
- WHO, 2012. *Changing mindsets. Strategy on Health Policy and Systems Research*, Geneva.
- Zuber-Skerritt, O., 2001. Action Learning and Action Research<sup>2</sup> : Paradigm , Praxis and Programs. In S. Sankara, B. Dick, & R. Passfield, eds. *Effective change management through action learning: concepts, perspectives, processes and applications*. Lismore, Australia: Southern Cross University Press, pp. 1–20.