AUSTRALIAN GLOBAL HEALTH ALLIANCE

Stronger together

Mapping the Australian Global Health Community

A report commissioned by the Australian Global Health Alliance
2023

Contents

Foreword

As a paediatrician and long-term advocate for health equity and global health in our region, I am always delighted to engage with and support the important work of the diverse and excellent organisations and institutions that make up the global health community of Australia.

I have joined Australian delegations to Myanmar and Papua New Guinea, and witnessed myself the huge challenges individuals and local communities face accessing healthcare in resource-poor settings or in precarious situations such as natural disasters or conflict. We can be proud of Australia's history of supporting our region and continuing the long-standing technical exchanges and capacity building work in medical, health and community-based institutions.

Now more than ever, in the relative aftermath of the worst of a global pandemic and facing critical challenges such as climate change and its terrible impacts on health, we need to empower, use, and support our local global health talent. Through strengthening our cross-sector collaboration and working in partnership with countries and institutions in the Indo-Pacific region we can really make a difference.

All communities are different, and we need to look at local networks to build resilience and deal with the health issues that we are facing in the developing world. There are wonderful health initiatives that have flourished because of the wonderful support of the Australian Global Health Alliance. It has been my very great privilege to support their work around the globe.

I truly welcome this new report initiated by the Australian Global Health Alliance to map the diversity of the functions and local and global connections of the global health community in Australia. This report will both further their own important work in strengthening the global health sector for future generations, but also provide a better understanding of where gaps, risks, and opportunities lie for those interested to understand how best to support global health.

There will increasingly be new diseases, pandemics, or existentialist threats to human health. But it is the strength, solidarity and leadership of the health and scientific community, and their long standing partnerships and relationships to important others – including with political leaders – that will determine the outcomes.

We must continue to work together, share, and find new and creative solutions to all current and future health challenges.

Dr Mike Freelander MP

Executive Summary

This report presents the findings from a recent study commissioned by the Australian Global Health Alliance into the landscape of global health actors and activities in our region. The study sought to explore two key domains: firstly, who is part of the global health community, and secondly, how are these actors working together? The study involved a network survey as well as key informant interviews, and included both members and non-members of the Australian Global Health Alliance.

Key Findings:

- DIVERSITY: The global health community is made up of large and small organisations, operating across research, policy and practice settings, and focused on a variety of thematic areas, including health equity, women and health, and the health workforce. There is strength and opportunity in this diversity.
- EXCHANGE: Opportunities to come together, to get to know each other's strengths and interests, and to share collective wisdom is an important and necessary endeavour, and one that requires time and energy.
- COLLABORATION: Those working in global health seek opportunities for meaningful and purpose-driven collaborations, including with those working in and beyond our region. Identifying clear and shared drivers for collaboration, and building mutually beneficial collaborative actions, is key.
- COLLECTIVE VOICE: The global health community is seeking opportunities to elevate the visibility of global health, to increase recognition of global health as valuable to both domestic and international audiences, and to enable more efficient access to greater funding for global health work.

Findings from this study point to areas of activity for the Australian Global Health Alliance, and others working in global health, in particular:

- Coordinate advocacy: seek opportunities to build a shared and powerful voice for global health that is respected and heard by decision-makers.
- Facilitated connections: support community members in connecting with others in meaningful, purpose-oriented ways.
- Diversify community membership: enable and encourage other voices to be included in global health efforts, including those working in different sectors and settings.
- Consider implementation partners: global health is more than global health research, and there are powerful roles for those who deliver and implement global health programs and services.
- Consider the broader global health community: recognise and celebrate the global connections that actors in this community enjoy and draw from. Continue to find ways that support relationship building within and across geographical, sectoral and institutional boundaries.

This study is an early effort to better understand the global health community working in our region, and the opportunities that exist for strengthening their ongoing, collaborative efforts. The findings confirm and inform the direction of our current strategy with its overall objective to strengthen the global health ecosystem (please see About the Australian Global Health Alliance). We encourage readers to share this report widely, and to continue finding ways to create strong, meaningful and value-focused collaborations that advance health and wellbeing for all.

Acknowledgments

We acknowledge the Wurundjeri people of the Kulin Nation as the Traditional Custodians of the Country upon which we have conducted this project. We recognise their continuing connection to the land and waters, and thank them for protecting this country and its ecosystems since time immemorial. We acknowledge the Elders – past, present and emerging of all the land we work and live on and their Ancestral Spirits with gratitude and respect.

We would also like to acknowledge the Steering Committee of this project, Associate Professor Seye Abimbola, Marion Stanton, Professor Barbara McPake, Professor Jane Fisher and Mark Sullivan AO, as well as the Alliance Executive Committee and Secretariat for their contributions and time: Professor Brendan Crabb AC, Professor Jane Fisher, Associate Professor Helen Evans AO, Matthew Ralston, Dr Selina Namchee Lo, Abbie Minter, Piyali Somaia, Prabhleen Kaur and Georgina Wawryk.

Finally, but most importantly, we would like to acknowledge and thank all those who took part in this study. Your time, insights and contributions are greatly valued.

Knowledge and empowerment for good.

This report was prepared by Dr Nic Vogelpoel, Dr Cameron Willis and Dr Daniel Chamberlain, of Day Four Projects. Day Four Projects focuses on connecting strategy, implementation and impact evaluation, so that pathways from vision to action are clear, meaningful and fit for purpose.

We partner with NGOs, multi-stakeholder groups, charities, research institutions, governments and businesses to scale-up their social impact.

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Introduction

Good collaboration is a foundational element in global efforts to reduce health inequities and promote health and wellbeing of for all. [1,2,3,4] Such collaborative efforts embrace those working across all of society, from public, private and civil society; research, policy and practice; and those working in low, middle and high-income country settings. [5,6] The scope of global health work is therefore immense, growing and interdependent, creating a terrain that is difficult to navigate and challenging to work within. Making visible the key actors who are active in global health, and how they are collaborating with each other, is one way to make this terrain a little less challenging, and to support more joined-up efforts to tackle shared global health priorities.

This report was commissioned by the Australian Global Health Alliance, and provides an initial snapshot of a sub-set of self-identifying global health stakeholders with active programs of work in Australia and/or Oceania. The report outlines an anonymised version of who these stakeholders are, along with their core areas of expertise: areas in which each is equipped with resources (potentially including financial and non-financial resources) that are of value to the global health community.

In doing so, the report provides an initial inventory of actors and the beginnings of a marketplace of services and supports for those working in global health.

At the same time, the report provides an estimate of how these stakeholders are connected to each other – the collaborative 'muscle' that exists in the global health community. While it is the first time such a study has been done, and it remains an estimate, it also provides a starting point for understanding the relationships that exist – and those that do not – among global health actors in this region. These relationships may be many and varied, including joint research initiatives, collaborative efforts to inform policy and/or practice, or shared approaches to designing and delivering global health programs and services to and with communities. They are inherently dynamic and evolving, and yet reflective of the underlying collaborative foundations of global health in the region: foundations that are critical for enabling change, progress and impact.

Together, these insights into who is part of the global health community, and how they are connected to each other, provide valuable inputs into ongoing efforts to deliver better health outcomes for all.

1 Jenkins C, Hien HT, Chi BL, et al What works in global health partnerships? Reflections on a collaboration between researchers from Vietnam and Northern Ireland BMJ Global Health 2021;6:e005535.
2 John CC, Ayodo G, Musoke P. Successful Global Health Research Partnerships: What Makes Them Work? Am J Trop Med Hyg. 2016 Jan;94(1):5-7. doi: 10.4269ajtmh.15-0611.Epub 2015 Oct 19. PMID: 26483123; PMCID: PMC4710444.
3 Meslin, Eric & Garba, Ibrahim. (2016). International Collaboration for Global Public Health. 10.1007/978-3-319-23847-0_8.
4 Jakab Z, Selbie D, Squires N, et al Building the evidence base for global health policy: the need to strengthen institutional networks, geographical representation and global collaboration BMJ Global Health 2021;6:e006852
5 Kuruvilla S et al. Business not as usual: how multisectoral collaboration can promote transformative change for health and sustainable development. BMJ 2018;363:k4771
6 Wiggins B, Anastasiou K, Cox DN. A Systematic Review of Key Factors in the Effectiveness of Multisector Alliances in the Public Health Domain. American Journal of Health Promotion. 2021;35(1):93-105. doi:10.1177/0890117120928789

Aims and Objectives

This study aimed to address the following key research questions:

1. **What are the key Australian entities - organisations, institutions, networks and other groups - that contribute to Global Health?**

2. **What activities do these Australian entities undertake that contribute to Global Health?**

3. **What are the relationships that exist among these entities?**

The study aimed to conduct an initial exploration into the above questions, with a view that future studies will help to understand how the community of global health actors changes and evolves over time.

Approach

This study adopted a network lens to better understand and define the set of actors active in global health in the region. This involved two related methods: completion of an online survey, and participation in 1:1 interviews with key stakeholders within the network.

Survey

Data for the network survey was collected through blending a 'whole network' survey with snowball sampling, using SurveyMonkey as a platform. The survey used a list of network actor organisations identified by the Australian Global Health Alliance, which formed the basis of the roster, and the first round of people invited to participate. Multiple people from the same organisation on the roster were able to respond. In those cases where that occurred the responses were conflated to a single response, taking the maximum response in each case.

The first section of the survey asked respondents to identify details about their organisation and their department/section: the organisation type, their approximate size in full time equivalent staff, their core activities, their areas of specialty, and the regions they worked in. The analysis of the responses uses standard quantitative methods, and the presentation of this data is the first section of the results.

The second section of the survey asked respondents to identify the nature of their relationship with the listed actors across five different domains:

1. engaging in joint or collaborative research projects ("Research Projects"),

2. engaging in advocacy ("Advocacy")

3. engaging in policy development ("Policy Development")

4. collaborating on non-research global health programs or services ("Programs and Services")

5. collaborating on knowledge exchange, mobilisation or exchange initiatives related to global health ("Knowledge Exchange").

These domains are considered here as 'sub-communities', and responses have been analysed within these communities to examine the overall structure of the network and the individual position of actors in the network. Standard social network analysis measures were computed, including those that describe the overall structure of the community, as well as the centrality of actors within sub-communities. Visualisations of the relationships among community members have been developed as sociograms and are presented throughout the report. The Appendix provides a full set of definitions for metrics computed as part of this study).

Interviews

To better understand the structure, motivations, collaborative initiatives and ambitions of community members, a set of 1:1 interviews were conducted. 10 interviews were held with key stakeholders within the global health community. These stakeholders were sampled to provide maximum variation, and included representatives from academia, government, non-government organisations (national and international), and research institutes; and those who appeared to occupy central positions in the community, intermediate positions, as well as those who were at the periphery of the community. Interview transcripts were analysed thematically to provide additional insights into the structure and relationships of the network analysis.

Results are presented in response to the key questions guiding this review, and feature quantitative analyses of community members and their interrelationships, as well as qualitative insights from key informant interviews.

Findings

Who is part of this community?

Thirty-nine organisations responded to the survey, which included responses from 18 academic institutions, 3 research institutions, 4 government departments, and 17 non-government organisations (with 10 organisations preferring to self-describe). Many of these organisations were large and complex entities with more than 100 employees (Figure 1) and working in a range of activity domains (Figure 2).

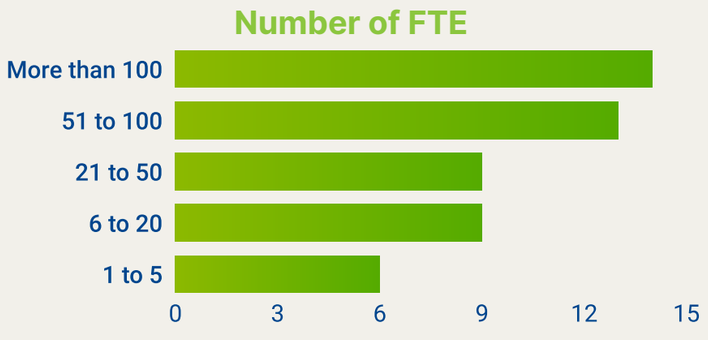


Figure 1: Number of FTE in each organisation

Knowledge translation, mobilisation and exchange, along with research, were most commonly reported as core areas of activities among those participating in this study (note: organisations were able to nominate multiple activity areas and core areas of speciality).

Figure 2: Core activities of organisations

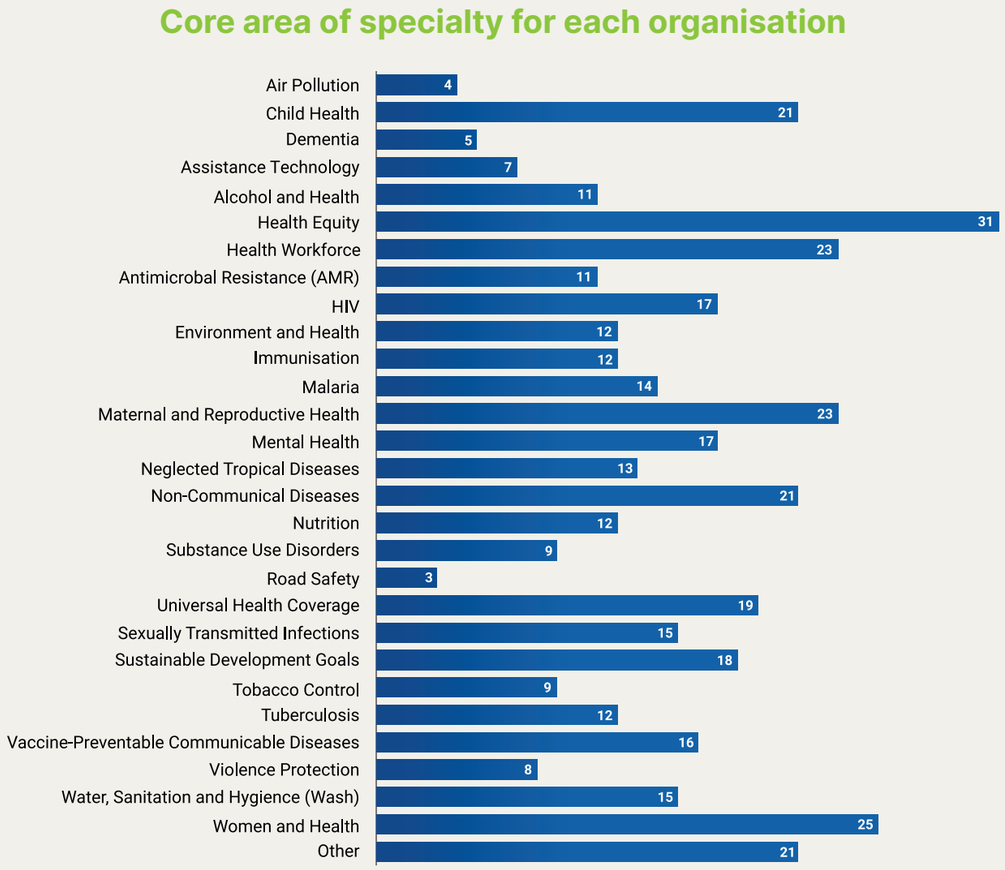


Figure 3: Core areas of specialties for each organisation

Figure 3 above lists the areas of specialty for the organisations that participated in this study, noting organisations could work across multiple specialities. Health equity, women and health, maternal and reproductive health, and health workforce were the most commonly nominated areas of speciality for those participating. Most often, organisations reported active programs of work in Oceania and Asia, with a large proportion also referencing work in Africa (Figure 4).

Figure 4: Regions worked in by organisations

How are they connected?

A large and loosely connected community

The results of this study are reflective of a large and relatively loosely connected global health community operating in the region (noting that organisations in this study are likely to have relationships with others beyond the regional scope of this analysis). Density is a measure of the proportion of connections that exist in the network (see Table 1, and the Glossary of Terms in the Appendix). Most connections were reported within the Research focused community, where on average, organisations reported just under 5 connections with others in the community (Average Degree), with 7% of all possible connections present in this community (Density - see Table 1). In contrast, when focused on Programs and Services, organisations reported just under 2 connections on average with others in this community (Average Degree): with 2.9% of all possible connections present (Density).

Measure	Research Projects	Advocacy	Policy Development	Programs and Services	Knowledge Exchange
Density	0.07	0.04	0.029	0.029	0.037
Average Degree	4.75	2.73	2	1.96	2.52
Indegree Centralisation	0.17	0.2	0.1	0.11	0.13
Diameter	5	6	3	4	5

Table 1: Measures of network cohesion for the five sub-communities

The differences in density are further described in Figure 5 below, which provides a visual representation of the relationships that exist among those collaborating on global health research (Panel 1), and those collaborating on global health programs and services (Panel 2). As can be seen, the Research community (Panel 1) includes a denser set of relationships, centred around Research Institutions (purple nodes), Academic Institutions (blue nodes) and Government Departments (red nodes). Moving out from these denser set of relationships, it is possible to see nodes that are less connected to others in this community, including national NGOs (light green) and international NGOs (dark green). In contrast, the Programs and Services community (Panel 2) may be described as a more sparsely populated community, with one actor (the central purple node) providing a connection point for many others to access a sub-group of stakeholders actively collaborating in programs and services. As can be seen from Panel 2, a sub-group of national NGOs (the light green nodes in the lower right of the figure) appear to be more connected in this community, and more heavily involved in program and service delivery.

Panel 1: Research Community

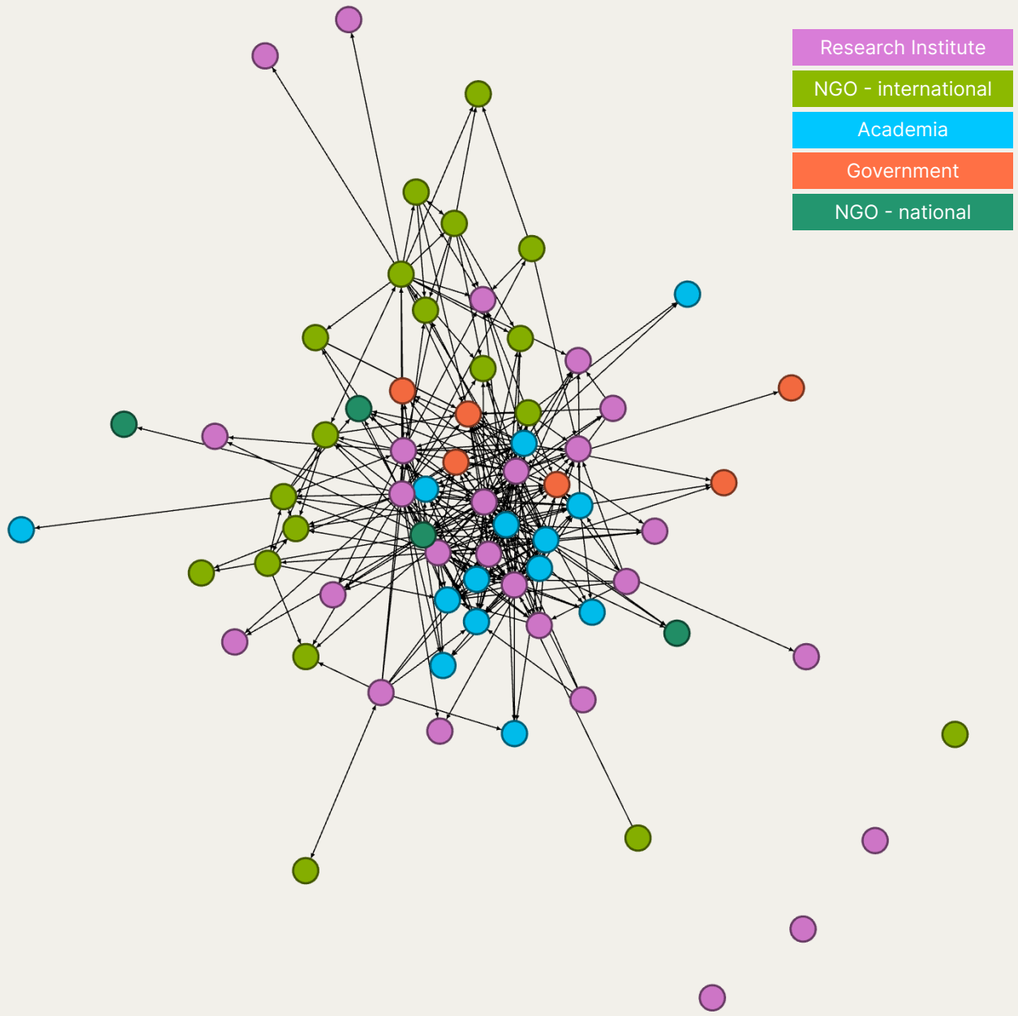


Figure 5: Sociograms for Research, and Programs and Services Communities

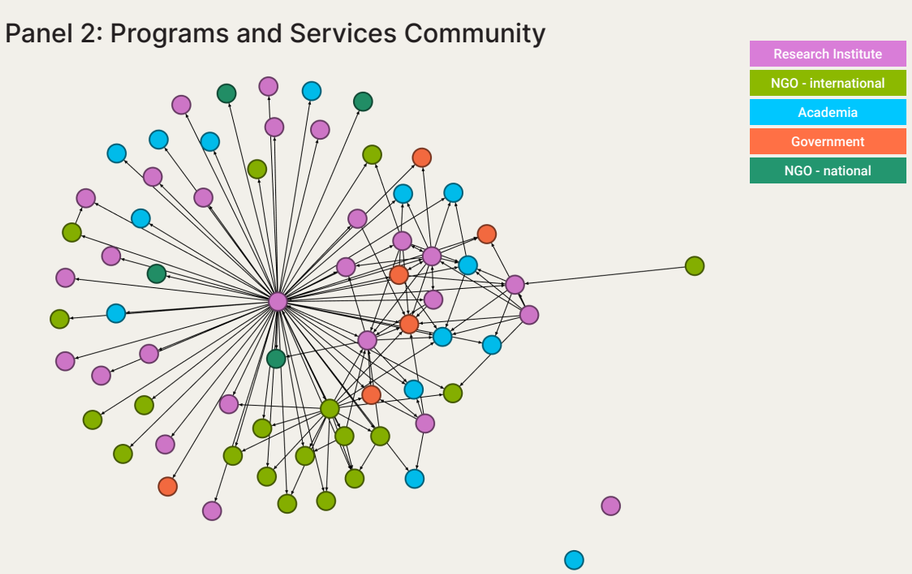


Figure 5: Sociograms for Research, and Programs and Services Communities

The measures in Table 1 and the images in Figure 5, suggest that the overall density of the community is low, particularly for non-research-based relationships. The present results suggests that those included in this study (across all sub-communities) tend to focus on cultivating targeted and tailored relationships with others working in global health. Insights from key informants help to understand the potential factors driving these more intentional collaborative behaviours, noted to relate to three broad factors:

- **Complementary resources:** For many working in resource-constrained environments, a key driver for collaboration was noted to be access to complementary resources. While such resources may be financial, more often, they are specific non-financial resources such as particular skills, areas of expertise or reach/access to particular groups or communities. Seeking these more specific complementary resources is likely to generate fewer, but more targeted collaborations.
- **An aligned philosophy:** Members of this community report seeking partners who share similar values and commitments, such as commitments to decolonisation, excellence, or local-level impact.
- **Positioned to drive impact:** Inter-organisational collaborations were viewed as mechanisms to contribute to impact, particularly in the context of specific communities:

> "Partnering in communities means working with consumers, policy makers, and clinicians. We view partnerships in terms of what is needed to deliver a good project: is it other universities, policy makers, community organisations?"
>
> – Global Health Researcher

These data suggest that members of this community approach connections and collaborative opportunities with an intentionality – seeking specific opportunities with specific partners that will contribute to shared and individual goals.

A strong focus on global health research

Research was noted as a core area of expertise for many of the organisations included in this study, as well as a central focus for their collaborations with others in the global health community. Nearly twice as many 'research' connections existed among those surveyed when compared to advocacy or knowledge exchange activities. These results are unsurprising, given the dominance of research focused organisations within the surveyed community (82% of respondents reported having some focus on research). And while reported areas of research were diverse, themes of equity, gender and inclusion were the focus for many: with health equity, women and health, and maternal and reproductive health occupying the top three areas of speciality for included organisations (see Figure 3).

Collaboration within and across these equity-centric research domains is critical, as evidenced by the example in Box 1 of a collaboration reported by a study participant to test and scale inhaled oxytocin.

> "Post-partum bleeding is the largest cause of maternal deaths the world over, and nearly all these deaths occur in low and middle income countries. Until now, oxytocin – what women receive immediately after childbirth to ensure they don't bleed excessively - has only been available as an injection, and that requires a range of things to deliver it safely and effectively, such as refrigeration, skilled workers, and clean syringes. All these can be lacking in a resource poor setting.
>
> Through this collaboration, we've reformulated oxytocin as a powder which can withstand any ambient temperature, and which can be delivered through an inhaler. We've been able to take it from the academic work to prove the concept, all the way through to partnering with pharma companies and philanthropic donors, to take that project to phase 2 clinical trials. And hopefully to go through to a final product. We have partnered with pharmaceutical companies, gained philanthropic support, as well as public support from governments in Australia and overseas – and delivered it entirely as a collaborative effort."
>
> – Global Health Researcher

Box 1: Research Collaboration Example

A small number of actors that occupy central positions

Table 2 outlines the most nominated organisations in each of the sub-communities. The more nominations an organisation received from others within the network, the higher it's nomination rank. For example, Government Agency 1 was the most nominated organisation in the Research Projects community, Academia 1 was the second most nominated organisation in Research Projects community etc. As can be seen from Table 2, government agencies (red), research institutes (purple), and academic institutions (blue) were most frequently nominated by others, suggesting they occupy central

positions. Of note, one Government Agency (Government Agency 1) was the most frequently nominated organisation across all sub-networks (except the Advocacy network, where it was the second most nominated organization).

Rank	Research Projects	Advocacy	Policy Development	Programs and Services	Knowledge Exchange
1:	Government Agency 1	Government Agency 2	Government Agency 1	Government Agency 1	Government Agency 1
2:	Academia 1	Government Agency 1	Government Agency 2	Research Institute 2	Research Institute 1
3:	Research Institute 1	Research Institute 1	Academia 1	Academia 1	Government Agency 2
4:	Research Institute 2	Research Institute 3	Research Institute 4	Research Institute 3	Research Institute 3
5:	Academia 2	Research Institute 2	Research Institute 1	Academia 3	Academia 3
Average	5.28	2.75	2.04	1.96	2.59
Range (min-max)	0-22	0-16	0-10	0-9	0-13
Standard deviation	4.76	2.6	1.82	1.65	2.16

Table 2: Most nominated organisations in each sub-community

Funding for global health is a primary lever activated by Government Agency 1, which many others within the community seek to access. This Agency distributes this funding to multilateral agencies, global health product development partners, implementation partnerships (including capacity building initiatives with research intensive institutions), and support for other large public sector agencies working to strengthen global health in the region. Of note, the Agency recognises its central position, and the value it can play in strengthening relationships among members of the global health community:

> "We've been working with **a medical research institute** who have strong links with the Government of Timor Leste. We were able to fund an expansion of their support for the Timor-Leste health system. It really came into its own – the people from **the institute** provided massive support to the government of Timor-Leste, to do testing, make policy decisions, and roll out training. It's had a nation-wide impact in Timor-Leste. It's also a good example of what we try to do in general: look for strong and sensible pre existing relationships that can be expanded and built upon."
>
> – Senior Government Agency Official

Other centrally located stakeholders included Academic institutions and Research institutes, particularly in relation to policy development and knowledge exchange communities.

The importance of convening and brokering

> "There's a fragmentation of activities, funding, and limited private sector engagement in global health: all of which are the brakes that are on the development of global health. Not just in Australia, but elsewhere too. Trying to navigate that is a challenge that we all face, and anything that the Alliance can do, and is doing, to change that, is valuable."
>
> – Global Health Researcher

> "We need to be joining-up and collaborating more effectively, and deepening the understanding of the importance of global health as opposed to individual streams of things"
>
> – NGO Representative

Despite instances and examples of strong collaborative practice among those included in this study, the above quotes reflect an alternate view of the state of global health in the region, particularly the challenges imposed by stakeholder disconnection, fragmentation, and siloed action.

Brokers within networks and communities play important roles in facilitating the flow of information (and other resources), helping to connect diverse and sometimes disconnected groups. Table 3 summarises betweenness centrality rankings for the organisations in each of the sub-communities. Organisations with high betweenness rankings may be considered as conduits for network activity, and can influence the network, such as by selectively editing or withholding information that passes through them. Organisations with higher betweenness centrality scores (and therefore, higher rankings) are therefore important for fostering network connectivity.

Rank	Research Projects	Advocacy	Policy Development	Programs and Services	Knowledge Exchange
1:	Research Institute 5	Research Institute 1	Research Institute 1	Research Institute 1	Research Institute 1
2:	Research Institute 2	Research Institute 2	NGO International 1	Research Institute 2	Research Institute 2
3:	Academia 3	NGO National 1	Government Agency 3	Research Institute 3	Research Institute 3
4:	NGO National 2	Government Agency 3	Academia 4	Government Agency 3	Government Agency 3
5:	Institute 3	Research Institute 3	Academia 3	Research Institute 6	Academia 3

Table 3: organisations with the highest 'betweenness scores' across sub-communities

As can be seen in Table 3, Research Institutes occupy many of the top rankings for betweenness scores across the sub-communities, and therefore appear to occupy important brokering roles. Some of these entities, such as the Australian Global Health Alliance, have convening and connecting as core areas of activity, including helping to connect sometimes hard to reach groups. For those included in this analysis, this connection-focused role is an important and valued one, as illustrated by the following:

> "It's more in its role as a convenor of technical exchanges and as a secretariat for the parliamentary group that we see value in relating to the Australian Global Health Alliance."
>
> – Government Official

> "I think the real benefit is the engagement with others that are not providing the same service or offer that we are, but are aligned and are trying to achieve the same outcomes for different cohorts or different areas."
>
> – Global Health Researcher

Specialist brokering roles that play a 'match making' and navigation function may therefore be of significant value to the community, and point to areas of future investment and effort by members, including the Australian Global Health Alliance.

The role and value of a collective voice

> "We haven't had a coordinated voice in global health in this country before the Alliance. It has provided a point where we all come together - through events, that's been one of the key forums that I've got to know what is going on in global health around Australia. There hasn't been that before."
>
> – Global Health Researcher

Those interviewed as part of this project repeatedly referenced the importance and value of a collective voice in global health. Such a voice was seen by community members as a vehicle for building a shared understanding of global health efforts, for advocating (particularly to government) around key needs for the sector, and for communicating the value of global health work – both locally and globally. As described by one interviewee:

> "We haven't had a lot of recognition of global health at the federal level of government. With the new government, that's changing. The Alliance team have been at the forefront of pushing for that. The Parliamentary Friends of Global Health is a great forum for us to get into Canberra and make them aware of the value of this sector to Australia and get that better supported."
>
> – Global Health Researcher

The above quote speaks to the importance of a collective voice from the global health community to government stakeholders: helping to coordinate shared and agreed messages that can speak to what global health is, and its value to the region. In the words of one Global Health Researcher, the desired result of this is *"greater recognition of the value of global health work – so that it's not seen as philanthropic, but that it has an inherent value to Australia" (Global Health Researcher)*.

At the same time, a mechanism that allows for a collective voice to speak with and sometimes for a community of global health actors, was seen as an efficient way for connecting knowledge with policy action: *"We can all talk individually but the collective voice is the important part – the Alliance provides government with a go-to body if they want advice around a particular or broad global health issue" (NGO Stakeholder)*. Elevating the visibility and value of the global health community, while providing a mechanism to inform government decision-making, is therefore an important role to be played by brokering organisations such as the Alliance.

Opportunities for strengthening the community of global health

Insights from this study point to a range of opportunities for strengthening global health in the region, noting the importance of: nurturing good collaboration, advocating for global health, and supporting good global health practice.

- Nurturing good collaboration: *"we've had lots of potential conversations about partnerships but then it just stops" (Private sector stakeholder)*. While collaboration and partnerships are recognised as critical to the work of global health, they are also considered to be difficult to form and sustain. Results from this study confirm that there is appetite for meaningful and effective collaborative opportunities: *"We need to identify, create and bolster a community and provide support for global health researchers. We need to create a community, support it, and try to enhance the opportunities for research, including into policy and practice." – (Global Health Researcher)*

Investing in strategic 'match making' efforts, and nurturing good collaborative practices over time, is a valued and important function for growing and strengthening global health efforts in the region.

- *Advocating for global health work:* there is an ongoing need for domestic advocacy efforts to continue demonstrating the importance and value of global health work. Challenges in articulating and communicating the benefits of global health work to domestic agencies has limited investment opportunities in the field. Through a clear and shared voice to decision-makers (including funders), the field of global health will be better positioned to attract investment, and translate findings into lasting impact in domestic and international settings.

Supporting good global health practice:

> "The global health community is overdue for reform. Focusing on what global health is and how to do it well, and then promulgating that approach to others is critically important. Making sure that the research community is aware of what good global health research is and sharing guidelines for good practice, would be great."
>
> – Global Health Researcher

Those in this study have called for practical steps to support improved global health practice in the region. Some have suggested a leading role for a convening body (such as the Australian Global Health Alliance) for supporting this practice change, which may include publishing *"policy guidelines, what a research partnership looks like in global health, what does authorship look like, or guidelines for capacity building in global health" (Global Health Researcher)*. Engaging the community in developing these materials would serve the dual goals of enhancing global health practice (and its impacts upon people and populations), as well as strengthening the quality of relationships that exist among global health actors.

Implications

The results of this project provide important insights into key regional actors working in global health, their various skills and expertise, and how they are currently connected to each other to advance shared and individual priorities.

Findings from this work suggest that the global health community involves a set of actors who are not deeply connected to the breadth and depth of work that is taking place across research, advocacy, knowledge translation, programs and services, and policy development in the region. In contrast, members of this community have established working relationships with smaller and more targeted sets of stakeholders, that are chosen as they deliver value for themselves as well as contribute to broader global health goals. Adding to this picture, are a small number of relatively well-connected organisations who occupy central positions within this community: some of whom play brokering roles in connecting more peripheral actors.

These results point to a set of considerations for those working in the global health community, as well as organisations such as Australian Global Health Alliance who occupy important convening and connecting responsibilities. These are outlined below:

Coordinated advocacy:

The value of coordinated advocacy for both individual organisations, and their shared global health priorities was recognised and reaffirmed by participants in this project. Through a more coordinated advocacy function, members of the community were seeking several outcomes, related to elevating the visibility of global health, changing perceptions of global health from a philanthropic endeavour to one that also delivers domestic value, and facilitating more efficient access to greater funding for global health work. There is therefore a significant role for Australian Global Health Alliance and others to support this advocacy work, which has recently progressed through the launch of the Parliamentary Friends initiative. Identifying further targets and opportunities for coordinated advocacy is an area of significant value.

Facilitating connections:

There appears to be an ongoing 'match-making' role for Australian Global Health Alliance and others to support members of this community in developing targeted and tailored relationships. These relationships require time, resources and ongoing negotiation as they are formed, implemented, reviewed and refined. Supporting those working in global health to build trusted, mutually reinforcing and valued relationships, and to navigate the challenges that come with partnering, would be of real value to those working in this community. Beginning with those organisations who have been found to have high betweenness scores is likely a sensible place to start and progress this work.

Diversifying community membership:

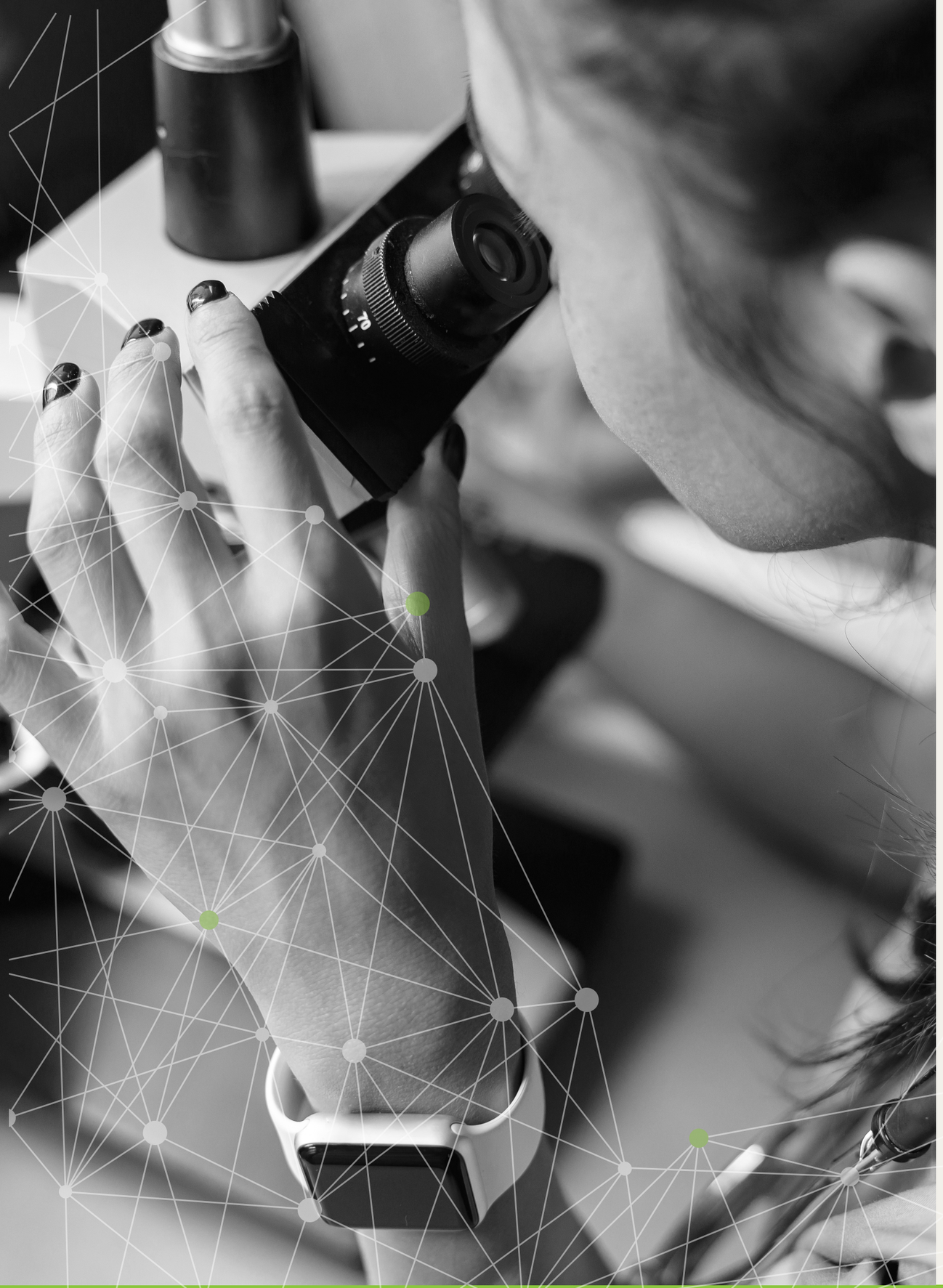
This study suggests that many of those involved in regional global health efforts are heavily focused on global health research and knowledge translation, which reflects the comparatively large number of Academic Institutions and Research Institutes in this sample. Future opportunities exist to expand who is part of this community, particularly those working in private and public sectors, and at multiple levels and jurisdictions. Increasing the engagement of these stakeholders will lead to a greater diversity of perspectives, needs, collaborative opportunities, and a chance to progress shared global health priorities that cross sectoral boundaries. Identifying and communicating the value of this community to those not currently engaged will be key.

Consider implementation partners:

NGOs and other global health delivery partners do not feature strongly within the current membership of the community. Consistent with the above, these stakeholders bring different and diverse perspectives on what is needed to address global health priorities, particularly those needs that are operating at local, national and regional levels. Intentional efforts to include these perspectives in the work of the community, and to provide a platform for their contexts and needs to be shared, will likely support shared advocacy and connectivity goals outlined above.

Consider the broader global health community:

This study focused on those stakeholders who are actively involved in global health work in Australia and Oceania. Many of these stakeholders are part of broader communities, networks and other collaborative initiatives that span a variety of geographical boundaries. Building on these connections and considering how knowledge, insights and experiences can be shared and translated across these boundaries will likely yield new connections, and new ways of working that deliver greater impact. Finding or building shared network-to-network opportunities (such as co-hosting events, or co-sponsoring initiatives) may be tangible steps for supporting greater exchange of knowledge.



Conclusions

Good collaboration is central to reducing health inequalities and promoting health and wellbeing for all. In focusing on a sub-set of global health actors who are operating in Australia and Oceania, this project has helped to identify who these actors are, and how they are working together.

Opportunities exist for organisations such as Australian Global Health Alliance to continue facilitating strong and meaningful connections, advocating for shared global health priorities, and elevating the visibility and value of global health work – internationally and domestically. More is not always better, and this study testifies to the importance of selective and purposeful relationships that meet stakeholder needs, while broadening the membership of this community to include those from different sectors, and in different settings. Ongoing work to co-create a mutually reinforcing community for all its members is an important and valued area of work, for Australian Global Health Alliance and others committed to good global health.

Appendix

Glossary of Terms

The following glossary provides a list of commonly used network terms referred to in this report.

A **node** is a point in a network, representing an actor, such as a person or organisation. Nodes are also referred to as vertices or a vertex.

A **tie** connects two nodes in a network, and indicates a relationship between the two. It can be symmetric (where the relationship is undirected) or asymmetric (where the relationship is measured as going from A to B).

A **network** is the structure formed by the nodes and ties, and includes all nodes regardless of whether they are connected together or not. A node that is not connected to any other nodes is called an **isolate**. Nodes are a part of the same **component** if there is a direct or indirect connection between them.

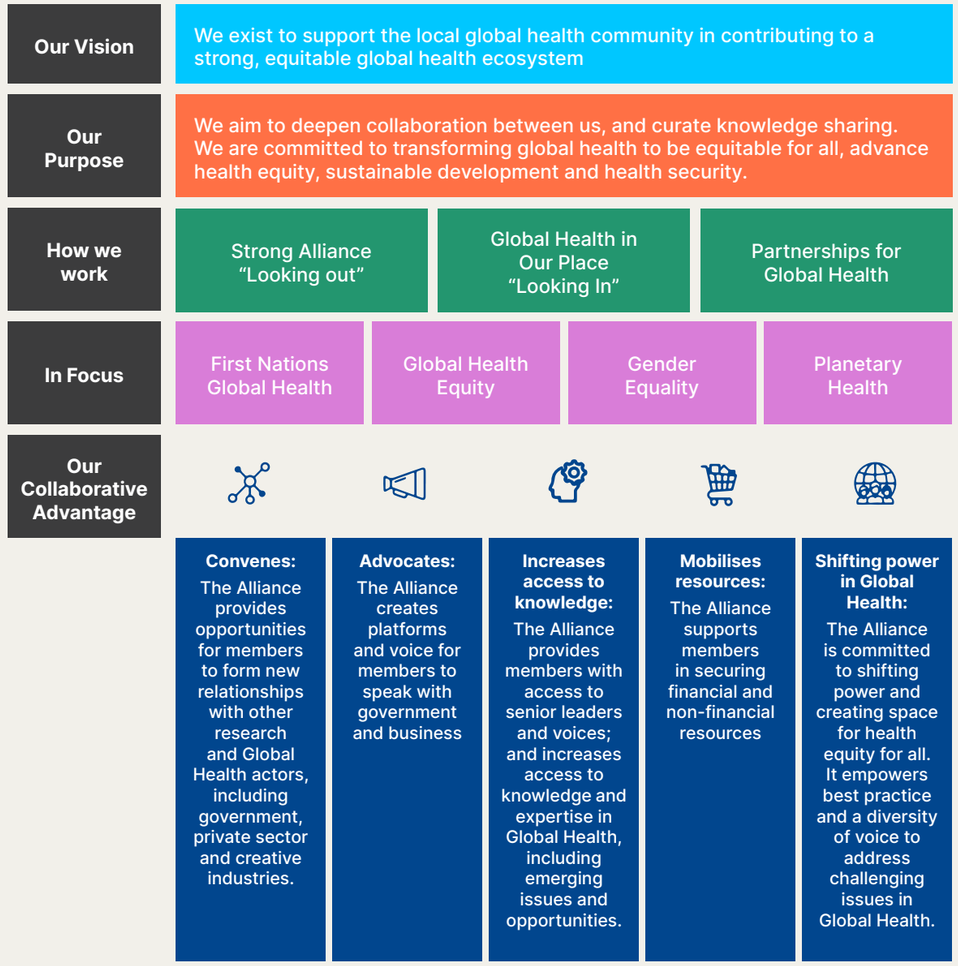
A **cluster** is a set of nodes that are connected to each other. Three nodes that are connected to each other is called a **triad**, and four nodes are called a **clique**.

Term	Technical Definition	Definition	Importance
Density	The density of a network is the total number of ties divided by the total number of possible ties.	Density is a measure of the proportion of connections that exist in the network.	Density is a simple and widely used measure, often used as a proxy for connectivity of the network. It has issues but it would be expected to be reported. The density is presented as a proportion between 0 and 1, or as a percentage.
Degree (Freeman 1979).	The number of vertices adjacent to a given vertex in a symmetric graph is the degree of that vertex.	Degree is a count of the number of connections for any particular node.	The degree is simply a measure of the number of connections for each person in the network, the larger the number the more people they are connected with. The degree is presented as a whole number.
Indegree/ Outdegree (Freeman 1979).	For non-symmetric data the in-degree of a vertex u is the number of ties received by u and the out-degree is the number of ties initiated by u.	Indegree is the count of the number of nodes that have nominated a connection with a particular node. Outdegree is the number of connections nominated by a particular node.	Indegree and outdegree are useful measures where relationships are not symmetric or equally reciprocated. Indegree is also useful when there are missing respondents, as there is a certain level of randomness to who actually responds and indegree scores are averaged out across the network. This means that we can estimate how connected an organisation is, regardless of whether they responded. Indegree and outdegree are presented as whole numbers.
Average Degree (Freeman 1979).	The average number of adjacent vertices in a network.	Average degree is the average number of connections for nodes in the network.	Like density, in that it provides a measure of connectivity in the network, but is more useful when comparing networks of different sizes. Average degree is presented as a real number.
Degree Centralisation (Freeman 1979).	The normalized degree centrality is the degree divided by the maximum possible degree expressed as a percentage.	Degree centralisation is a measure of the extent to which connections are concentrated towards a small proportion of the network. A higher degree centralisation score indicates that the network is 'centralised' through a small number of nodes in the network.	Centralisation in networks can be an indication of a lack of connectivity, or a single or small number of very important or dominating organisations. It suggests a set of unequal relationships within the network. This may be by design (where one or more organisations are performing a coordinative role), or due to disparate size and capacity of individual organisations. Centralisation is presented as a proportion between 0 and 1, or as a percentage.
Clustering Coefficient (Watts 1999).	The clustering coefficient of an actor is the density of its open neighbourhood. The overall clustering coefficient is the mean of the clustering coefficient of all the actors.	Clustering is a measure of how many of the nodes that are connected to a particular node are also connected to each other, which is expressed as a proportion of the total possible connections. The overall clustering coefficient is the average across the network.	Where density tells you how connected the network is, the clustering coefficient tells you how well connected the various bits of the network are. A high clustering coefficient can be an indication of lots of small groups, loosely connected. The clustering coefficient is presented as a proportion between 0 and 1.

Term	Technical Definition	Definition	Importance
Geodesic Distance (Burt 1976, Doreian 1974).	The length of a path is the number of edges it contains. The distance between two nodes is the length of the shortest path.	The length of a path is the number of steps it takes to get from one node to another. The geodesic distance is the shortest path of all possible paths between two nodes in the network.	The number of steps it takes to get across a network is a useful measure of how quickly information can be disseminated to the entire network. Geodesic distance is presented as an average of the all geodesic distances, as a real number.
Betweenness Centrality (Freeman 1979)		A measure of the number of times a vertex occurs on a geodesic. The normalized betweenness centrality is the betweenness divided by the maximum possible betweenness expressed as a percentage	The shortest path between every pair of nodes is calculated, and a score is given to the nodes on the paths. Nodes that appear on many paths will have higher scores, indicating that they are frequently found "between" pairs of nodes.
Diameter	The diameter is the longest geodesic distance in the network.	The diameter of the network is the 'longest short path' between nodes, and indicates the maximum number of steps it would take to get from one node to the node furthest away from it in the network.	The diameter gives a useful indication of how broad the network is. A short diameter indicates that information can be quickly disseminated, a long diameter indicates that, for small networks, the network is likely broken up into small groups that are poorly connected. The diameter is presented as a whole number.

About the Australian Global Heath Alliance

The Alliance is the member-based peak body for Australian global health organisations, with a mandate to strengthen the global health ecosystem through national and global connections, partnerships, research, and innovation, promoting best practices in global health, and advocacy (see figure below). Our membership is diverse, ranging from universities and research institutes to international and national non-government organisations or peak bodies, to government entities and public private partnerships. The Alliance also hosts the secretariats of the Australian Network of WHO Collaborating Centres and Pacific Friends of Global Health. Founded in 2016 by a number of Australian global health organisations and leaders, the Alliance is currently the only OECD country global health alliance with a commitment to First Nations global health equity as part of its foundational mandate. The current strategic focus of the Alliance includes Planetary Health (with a specific focus on Climate Change and Health Security and Sustainable Development), Gender Equality, First Nations Global Health and Health Equity.



The Australian Global Health Alliance's 2023 Strategy

Day Four Projects

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