EVALUATION OF

THE ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH

An initiative of the Global Forum for Health Research

conducted over the period June – December 2004

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1.0 INTRODUCTION

The enormity of the challenge facing health, health systems and human development generally is now being realised. It is reflected in the deterioration in life expectancy occurring in many developing settings; in new international initiatives established to address HIV & AIDS, TB and malaria, and maternal mortality; in the setting of Millennium Development Goals and fears of their not being met; and equally in the inappropriately low output of health policy and systems research (HPSR) from low and middle income countries – a 5:95 gap relative to industrialised nations attesting to the absolute deficit that has accumulated over decades.[1] However this situation is also provoking an uncommon consensus on the need to turn the tide[2] and is, indeed, setting the scene for the next phase of Alliance development.

The Alliance for Health Policy & Systems Research, following 5 years of activity (2000-2004), is at a crossroads; it is expected to 'graduate' as an initiative of the Global Forum for Health Research by the end of 2005. In establishing itself as a body independent of the Forum, and ensuring its longer-term security, it is critical that any future organisational option be realistic and sustainable, as well as take account of profound changes in the external environment and important changes underway in the United Nations and particularly in the World Health Organisation.

The Alliance track-record is of an intense 5-year period, involving considerable activity, some notable achievements and important lessons. These should form the basis for planning the next major phase of the Alliance and, indeed, can inform other initiatives in the field. With little exception, those interviewed for this report acknowledge the serious contribution of the Alliance to promoting HPSR in low and middle-income countries, and in creating further 'space' for its practice. Equally, the Alliance's strong commitment to supporting and strengthening the work of southern researchers is well recognised.

1.1 Origins and aims

Alliance origins lie in a succession of initiatives and expert reviews extending back some 20 years to the mid-1980s. The Commission on Health Research for Development recognized the need to 'invest in long-term development of the research capacity of individuals and institutions, especially in neglected fields such as … the policy sciences and management research' and to 'develop reliable and continuing links between researchers and research users';[3] the Ad Hoc Committee on Health Research Relating to Future Intervention Options noted that 'the most striking deficit of all appears to be in the fields of behavioural research and health policy research'.[4] The Ad Hoc Review (1996) catalysed a period of consultations that culminated in a 'meeting of interested parties' in Lejondal, Sweden, in 1997. Following an interim, start-up period, the Alliance was formally constituted in November 1999 with the aim of: 'contributing to health development and the efficiency and equity of health systems through research on and for policy'.

The prolonged interim phase of the Alliance, preceding its formal constitution, reflected in part contending perspectives between the different constituencies responsible for establishing the Alliance. It took time to reconcile these perspectives and achieve sufficient consensus on Alliance aims and objectives. This extended phase was also the consequence of an unexpected combination of events. While efforts to bring the Alliance into being – and finance it – were underway, a new Director-General took office in WHO.

Dr Gro-Harlem Brundtland's intention to establish an Evidence and Information for Policy (EIP) cluster, with a talented leadership, met with widespread approval. Indeed all associated with the field, including prospective investors involved in establishing the Alliance, were concerned to demonstrate support for this WHO initiative. Thus the lengthy interim phase as Alliance founders grappled with the need to reconcile and align these potentially parallel efforts.

In 2002 the original aim was revised, the Alliance's aim now being 'to promote the generation, dissemination and use of knowledge for enhancing health system performance'.

As laid out in the terms of reference for this evaluation (Appendix 4), we have

- **'critically examined the extent to which the Alliance is achieving its aim and specified objectives, and the extent to which it has positioned itself for the future' and will make recommendations on**
- **'the future aims and objectives of the Alliance, the adequacy of the human and financial means needed to achieve (this), and the governance of the Alliance'.** [5]

1.2 Organization

Although discussed in 5.0 below, it is useful to outline what currently constitutes 'The Alliance'. Strategic direction, financial oversight and overall accountability are provided by a Board of some 15 persons including leading scientists/academics in the field, respected policymakers and practitioners, senior members of the Alliance's primary funders, and a representative(s) of the Global Forum. The WHO has a permanent observer while a representative of COHRED[d] has observer status. The Alliance 'engine-room', answerable to the Board and its Chair, is a small, Geneva-based Secretariat, located in the EIP cluster[e] of the WHO, and led by a Manager with two support staff (additional professional capacity is obtained through short-term contract and consultancy services). The Secretariat is the executive arm of the Board; in addition, the Board Chair devotes a month or so of dedicated time[f] to Alliance activity each year.

The Alliance has contact with several regional networks, four of which have received modest but regular support and contribute to extending the Alliance's outreach capability. Likewise, considerable effort has been directed towards building a worldwide 'Partnership' of a few hundred institutions, a majority of which are academic/research groups, viewed as key generators of HPSR.

1.3 Resources

The Alliance has been fortunate to enjoy significant core funding, since inception, from the Norwegian Ministry of Foreign Affairs, the Swedish Agency for Research Cooperation and Development (Sida/SAREC)and the World Bank. Recently, key project funds were contributed by the International Development Research Centre (IDRC) Canada, and the Department for International Development (DfID), UK, as well as some WHO departments.

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[d] COHRED: Council on Health Research for Development
[e] EIP: Evidence and Information for Policy Cluster
[f] contracted by the Alliance Board

This said, it should be recognised that further funders, and hence resources at a scale initially anticipated, have not materialised. **Average annual expenditures have amounted to some USD 1,5 million per year, considerably lower than the USD 3-4 million initially hoped for/anticipated**. Moreover, it was some time before the persisting nature of this situation was fully grasped by Alliance leadership. Over the past 5 years, Board and Secretariat have thus faced a major challenge: **how to modify and target an ambitious programme, at a time of high expectation and when needs appeared extreme**. This has proved a difficult and continuing challenge; the mismatch between plans and available resources has been considerable – indeed, average annual resources available have been *lower* than the minimum budget scenario described in the 1999 report of the Interim Board.[6]

1.4 Evaluation methods

This evaluation of the Alliance's first 5 years was conducted over the period June-December, 2004. We have gathered information through:

1. Extensive face-to-face and telephonic *'key informant'* interviews with members of the Alliance Board and Secretariat, their WHO hosts in the EIP Cluster, staff of the Global Forum for Health Research, members of international and regional networks and country researchers (listing in Appendix 1)
2. A comprehensive review of *Alliance-linked documentation* (illustrative listing in Appendix 3) *and website* including Founding documents, Board minutes, Financial records, Strategic frameworks and Workplans, Calls for proposals and peer-review assessments, published 'outputs' and 'products' including newsletters, journal submissions, working papers and the Biennial Review
3. Rapid *regional network assessments* through multiple interviews with network leadership and appraisal of network outputs
4. A *self-answering survey* distributed electronically to all past and current Alliance grantees, ie those receiving 'young researcher' and 'research to policy' grants between 1999 and 2004 (Appendix 2). The survey contained a mix of closed and open questions addressing involvement of stakeholders in the research, dissemination of research and policy impact at international, national and local levels, whether and how the Alliance improved the policy impact of their work, capacity needs and whether the Alliance addressed these, suggestions on how grant funding by the Alliance might be improved.
5. *In-depth discussion* with the Alliance Board at its November 2004 Board meeting held in Mexico City.

2.0 STRATEGIES AND FINANCIAL ALLOCATIONS

Alliance priorities and strategies are captured in the two strategic frameworks developed for the periods 2000-2002 and 2003-2005 (Table 2.1).

Table 2.1 Alliance strategic themes and relation to strategic frameworks

Strategic themes	2000-02 strategic framework	2003-05 strategic framework
A. Monitoring and publicising HPSR	A. HPSR Review	A. Monitoring and publicising the global progress of HPSR.
B. Development of research, methods and tools	D. Development of HPS Research, Methods and Tools	B. Synthesising, disseminating and funding research on priority areas.
C. Attainment of a critical mass of researchers	B. Capacity assessment C. Capacity strengthening	C. Encouraging the attainment of a critical mass of researchers
D. Strengthening demand		D. Promoting policy relevant research and evidence-based decision making
E. Ensuring access to HPSR knowledge	E. Dissemination and systematisation	E. Ensuring widespread access to HPSR knowledge
F. Developing the Alliance and evaluation	F. Partnership development	F. Monitoring and evaluating progress in the Alliance partnership and secretariat.

The proportion of monies allocated to the major strategic themes is indicated in Figure 2.1 with trend lines shown in Fig 2.2. The 2003 Strategic Review saw some shift in priorities, not fully reflected in expenditure trends but evident in adjustments to Secretariat focus and time use, the decision not to proceed with a fourth round of research to policy grants, and in recent outputs such as the Biennial Review and strategic research initiatives. This said, the Alliance programme of work is characterised by considerable continuity in activity, in part because essentially all projects and related infrastructure had to be established 'from scratch', and the Alliance's implementation capacity has remained limited over the 2000-2004 period. **While efforts were made to focus limited resources on a few key initiatives, Board and Secretariat found it difficult to select from a range of strategic priorities and ensure follow-through.**

Figure 2.1 Allocations (%) to major strategic themes, 2000-2004

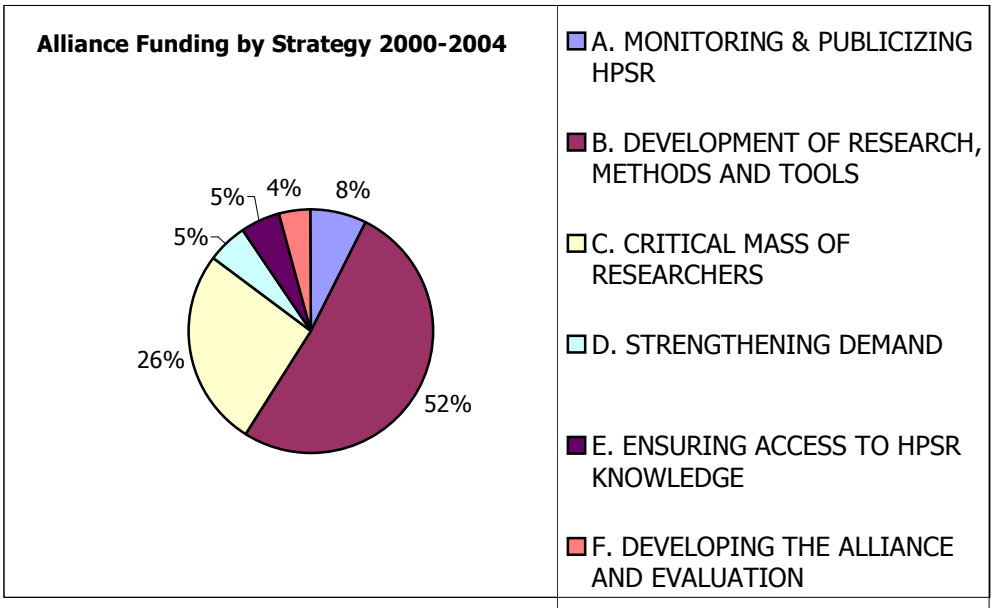
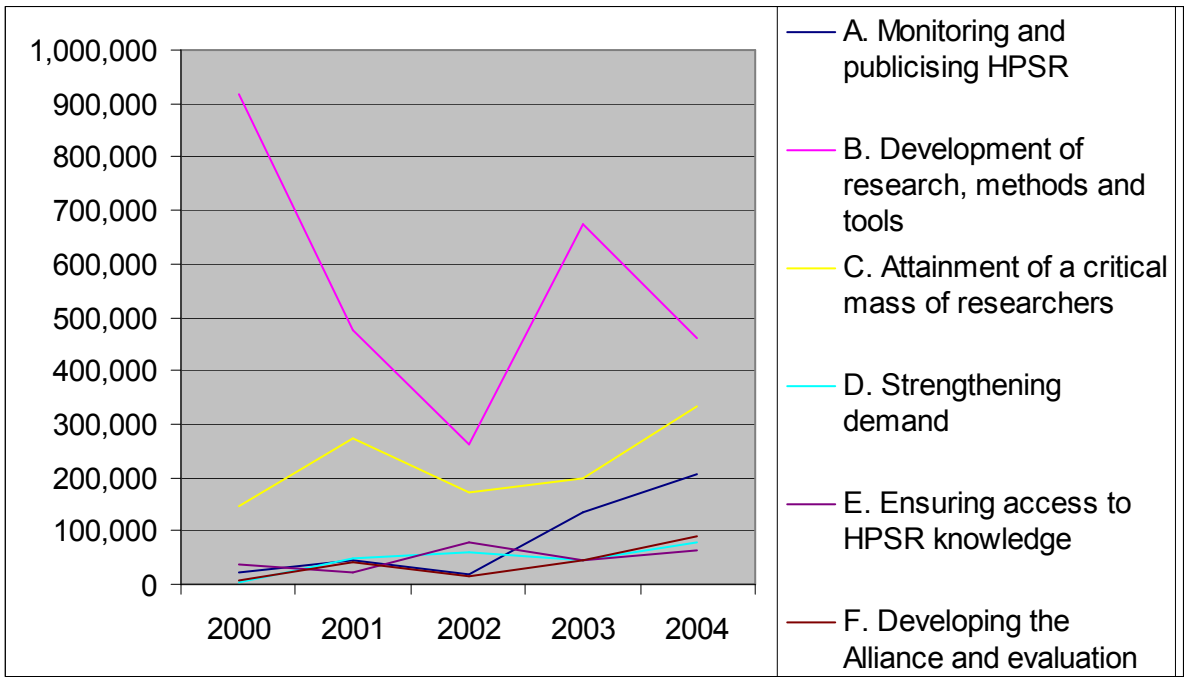
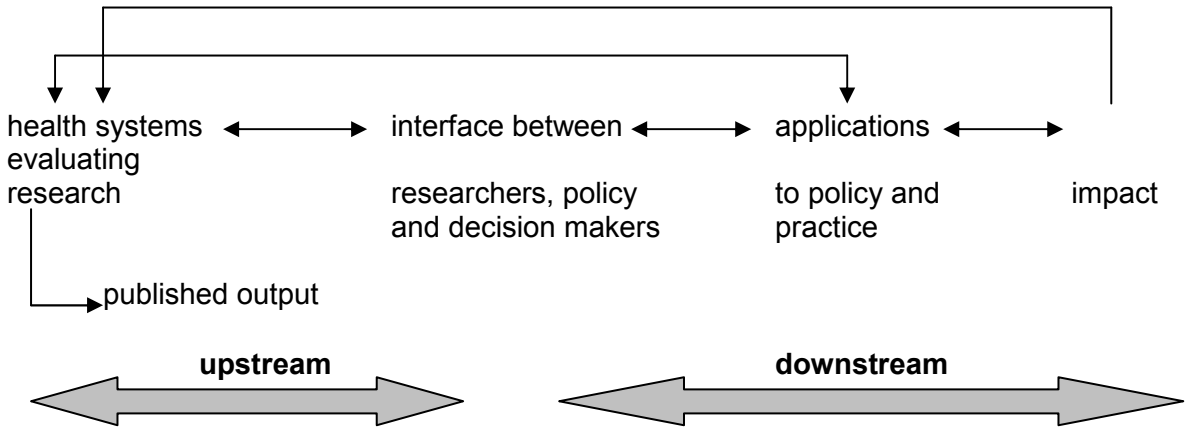


Figure 2.2 Trends in expenditures: major strategic themes, 2000-2004



2.1 Strategic focus
Figure 2.3 shows a simplified schema to represent health policy and systems research activities and outputs:

Figure 2.3



It is clear that Alliance efforts have targeted largely the 'upstream' end of this continuum, focusing particularly on country-level research generation and related efforts at capacity development. This entailed a major effort on the part of the Alliance Secretariat and Board, and required the establishment of an effective 'small grants' management infrastructure, complemented by a range of capacity strengthening supports (protocol development and writing workshops, for example). Repeated and widely disseminated calls for proposals / letters of intent – taking advantage of Alliance partner institutions – helped create a southern presence which, Alliance leadership argued, served to publicise and build the profile of the Alliance among a primary constituency, namely the community of southern HPSR researchers and students affiliated largely with universities and research groups.

Although acknowledged in planning and discussion documents, far fewer resources – reflected in financial allocations[g] over the period – were focused on the more downstream components of HPSR, the 'interface' between researchers and decision-makers (locus for the uptake, adaptation and application of evidence), and efforts to monitor implementation or evaluate the impacts of research/evidence-based applications.

Further analysis of financials (Table 2.5) makes clear the major commitment of the Alliance to supporting Southern-based researchers and assisting with capacity-building efforts (detail in sections 3.0 and 4.0 below). This was highly valued by southern HPSR leaders such as coordinators of the regional networks.

[g] and, in some instances, donor specifications

2.2 Financial allocations

Approach and methods

The Alliance evaluation team requested the Manager of the Alliance to analyse trends in expenditure and allocation in the evaluation period 2000-2004. This section and section 5.2 present that analysis, along with additional work by the evaluation team.

Analysis of expenditure trends across activities used the audited expenditure reports submitted to the Board for 2000 to 2003, and the budgeted expenditures for 2004. Expenditures were considered by the year in which they were made and not necessarily for the year that the Board approved the budget. All expenditures on activities included a proportion of Alliance professional salaries according to the time spent on them.

- Expenditures were allocated following the two strategic frameworks under which the Alliance operated during the period, one from 2000 to 2002, the other for 2003 and 2004. Expenditures across these two periods were reconciled under the current (2003-2005) framework as can be seen in table 2.1.
- Expenditures were broken down geographically in two ways. First, geographical allocations were analysed for all expenditure that had a clear country focus. This included expenditures on research grants, training and country case studies. The funding included in this analysis totals US$ 2.2 million, 41% of funding on activities. Secondly expenditures were broken down by region and country for research grants only.
- The final analysis (section 5.2) looks at the stability of funding and disbursement. For this section, several key donors were interviewed to understand their perspectives on the future funding of the Alliance.

2.3 Key Findings

- **Expenditure by strategy**

Total expenditure of the Alliance for the period 2000-2004 amounted to US$ 6.91 million, (Table 2.2). Of this, 72% was devoted to activities and the remainder to governance and administration. Emphasis on task B. Development of Research, Methods and Tools was high throughout the period although it reduced over time; while Task D. Strengthening Demand and Task A. Monitoring and Publicising HPSR both gained ground. Administrative costs remained roughly constant, aside from 2002 when overall expenditure fell.

Table 2.2 - Expenditure by strategy 2000-2004 (US$)

	2000		2001		2002		2003		2004		Total	
	$	%	$	%	$	%	$	%	$	%	$	%
A. Monitoring and publicising HPSR	23,213	2%	46,067	5%	20,187	3%	133,428	12%	205,664	17%	428,560	9%
B. Development of research, methods and tools	918,065	81%	475,335	52%	260,960	43%	672,907	59%	460,225	37%	2,787,493	56%
C. Attainment of a critical mass of researchers	147,694	13%	271,984	30%	171,754	28%	199,008	17%	333,896	27%	1,124,336	22%
D. Strengthening demand	4,243	0%	49,988	6%	60,314	10%	44,917	4%	76,978	6%	236,440	5%
E. Ensuring access to HPSR knowledge	36,017	3%	21,781	2%	77,328	13%	46,652	4%	62,819	5%	244,597	5%
F. Developing the Alliance and evaluation	8,485	1%	41,843	5%	13,904	2%	43,232	4%	88,173	7%	195,637	4%
Sub total activities	**1,137,717**	**100 %**	**906,998**	**100 %**	**604,447**	**100 %**	**1,140,146**	**100 %**	**1,227,755**	**100 %**	**5,017,062**	**100 %**
Sub-total: Secretariat, Board & Administration	247,156	18%	232,888	20%	327,364	35%	265,675	19%	819,517*	40%	1,892,601	27%
Total expenditure	**1,384,873**		**1,139,887**		**931,811**		**1,405,821**		**2,047,272**		**6,909,663**	

* Relatively high secretariat/administrative expenditures in 2004 were budgeted for, and included hiring of P5 communications officer.

Table 2.3 describes the foci of research awards, providing a clear indication that the highest proportion of funding was for policy and systems level research, key topics being equity and social policy, health sector financing, public/private mix and the policy process. Substantial funding, however, went to work that combined policy, systems or services with important disease/health conditions. Here the conditions receiving highest funding were malaria and tuberculosis.

Table 2.3 Young Researcher and Research to Policy Grants by Topic, 2000-2004

Main Topic	**Disease/ Health Area**											
	Not disease specific	Comple-mentary medicine	HIV/AIDS	Hyper-tension	Injury	Malaria	MCH	STI	TB	Violence	**Grand Total**	**%**
Demand, access and utilisation of health services	11000	16000	27200			21000	23000	22000			120200	**8%**
Epidemiology				24000	37900						61900	**4%**
Equity/ social policy	268025										268025	**18%**
Finance	224722					22300					247022	**17%**
Global trade	44400					8800					53200	**4%**
Health Research	20000										20000	**1%**
Hospital	8690	7000									15690	**1%**
Human Resources	72610		17000								89610	**6%**
NHA	58850				23400						82250	**6%**
Organisation: Decentralisation/ integration of health services	31200					20560					51760	**4%**
Policy process	134009				5000		20000				159009	**11%**
PPM	10500					24450	24000		960 00		154950	**11%**
Service needs assessment						43000					43000	**3%**
Service performance	22300		9000			23500	25000			11000	90800	**6%**
Total	906306	23000	53200	24000	66300	163610	92000	22000	960 00	11000	**145741 6**	**100%**
%	**62%**	**2%**	**4%**	**2%**	**5%**	**11%**	**6%**	**2%**	**7%**	**1%**	**100%**	

- **Expenditure by region and country**

A total of 42 countries benefited from country focused Alliance funding for both research and other activities throughout the period (Table 2.4). Africa had the greatest number of countries funded, with 15, and received 41% of the grants. Asia and Latin America and the Caribbean (LAC), each had 13 countries funded, receiving 41% and 27% of the grants respectively. Only one grant went to a European country (Georgia).

Table 2.4 – Total research and non–research grants by region, 2000-2004

Income Group	All Grants		Countries		Investment		Grants to Population Ratio*
	No.	%	No.	%	US$	%	
Upper Middle Income	46	24	8	19	**548,414**	**25**	1,072
Lower Middle Income	59	31	11	26	**574,978**	**26**	3,267
Low Income	88	46	23	55	**1,097,542**	**49**	2,228
TOTAL	**193**	**100**	**42**	**100**	**2,220,934**	**100**	

* Population number per dollar of Alliance investment

Table 2.4 shows that 45% of total grants made were to middle income countries and 55% to low income countries. The Alliance spent twice as much per head of population in upper middle-income countries than lower income ones. A corresponding picture is provided when Young Researcher and Research to Policy funding (Table 2.5) is examined. This shows that most research funding went to Asia and Africa, with China, India, Uganda, Nigeria, Mexico and Argentina being the countries receiving the highest levels of grants. A relatively low proportion of young researcher grants were awarded in the Africa region, with China receiving the most grants.

The figures suggest the influence of both higher numbers and quality of applications from middle income countries, reflecting their greater institutional capacity (confirmed in an assessment of research capacity undertaken by the Alliance). The figures probably also reflect the higher input costs of middle income countries. Nevertheless, they draw attention to the general requirement to find ways to further enhance support to low-income country researchers. It may be useful to analyse why so few young researcher grants were made to the African region.

Table 2.5 – Young Researcher and Research to Policy grants by country, 2000-2004

Region	Country	Research to Policy		Young		Total		Percentage
		Grants	Funding	Grants	Funding	Grants	Funding	
Africa	Benin	1	6900	1	8000	2	14900	1.0%
	Cameroon	2	40000			2	40000	2.7%
	Cote d'Ivoire			1	7000	1	7000	0.5%
	Eygpt	1	31850			1	31850	2.2%
	Ghana	2	33700	2	17000	4	50700	3.5%
	Ghana, India & South Africa							0.0%
	Kenya	1	16000			1	16000	1.1%
	Mali	1	20000			1	20000	1.4%
	Mozambique			1	8800	1	8800	0.6%
	Nigeria	4	79500			4	79500	5.5%
	South Africa	2	49000	1	8000	3	57000	3.9%
	Tanzania	2	40500			2	40500	2.8%
	Uganda	3	65010	1	8000	4	73010	5.0%
	Zimbabwe	2	38000			2	38000	2.6%
Africa Total		**21**	**420460**	**7**	**56800**	**28**	**477260**	**32.7%**
Asia	China	7	151410	8	85972	15	237382	16.3%
	India	6	109000	2	13300	8	122300	8.4%
	Indonesia	1	28000			1	28000	1.9%
	Myanmar	1	21000			1	21000	1.4%
	Pakistan	1	20000	1	9500	2	29500	2.0%
	Philippines	1	22000			1	22000	1.5%
	Sri Lanka	1	21390			1	21390	1.5%
	Thailand	2	31000	2	15890	4	46890	3.2%
	Viet Nam	2	27000			2	27000	1.9%
	Vietnam			1	7300	1	7300	0.5%
Asia Total		**22**	**430800**	**14**	**131962**	**36**	**562762**	**38.6%**
Europe	Georgia	1	23000			1	23000	1.6%
Europe Total		**1**	**23000**			**1**	**23000**	**1.6%**
LAC	Argentina	3	72550	2	13000	5	85550	5.9%
	Brazil	1	21335	3	21909	4	43244	3.0%
	Chile	1	30000	1	11000	2	41000	2.8%
	Colombia	3	41800	2	21000	5	62800	4.3%
	Costa Rica			1	11000	1	11000	0.8%
	Jamaica			1	6000	1	6000	0.4%
	Mexico	3	73000	3	25400	6	98400	6.8%
	Peru	1	23000			1	23000	1.6%
	Uraguay	1	23400			1	23400	1.6%
LAC Total		**13**	**285085**	**13**	**109309**	**26**	**394394**	**27.1%**
Grand Total		**57**	**1159345**	**34**	**298071**	**91**	**1457416**	**100.0%**

2.4 Strategic critique

The approach and programme of the Alliance is vulnerable to a strong critique mounted by a cross-section of key informants. They argue that, in focusing up-stream, **Alliance efforts were largely supply-oriented and thus insufficiently emphasised critical aspects of HPSR practice – specifically the demand for health systems research among policymakers, decision makers and providers, and the interface between this group and researchers.** As a result, important domains of HPSR practice, essential to health systems development, remain to be adequately addressed. This would include such areas as:

- The interface between researchers and policymakers – including what facilitates or hinders productive interaction, and mechanisms to support effective engagement
- Processes by which research findings can be made accessible, policy relevant and actionable
- Research syntheses addressing some of the major, long-standing or more complex health system challenges.

Clearly this critique has a basis, notwithstanding the need for choice that Alliance leadership would have exercised – indeed, it highlights some of the strategic choices that continue to confront the Alliance. It also bears on the high (but differential forms of) demand for evidence in two overlapping but distinct communities – that which is more internationally oriented (and stresses the need for synthetic understanding), the other which is more nationally focused (and stresses the need to support country-level research and researchers). Further, it reflects the high expectations of the Alliance, which should be tempered by appreciation of the time needed to produce good research and build the requisite capacities, as well as foster access to various policymaking communities.

3.0 STIMULATING HEALTH POLICY AND SYSTEMS RESEARCH

In this section, stimulating health policy and systems research and research capacity development were analysed together.

3.1 The Alliance's strategy for stimulating research and capacity building

The main Alliance strategy in this area consisted of offering competitive research grants, with an array of targets and objectives, namely Research to Policy grants, Young Researcher grants and calls for Strategic Research. The proportion of Alliance funding for this area was considerable (52%) supporting the strategic priority of 'ensuring access to HPSR knowledge' (and which is taken to include stimulating HPSR). Main areas/grants funded included:

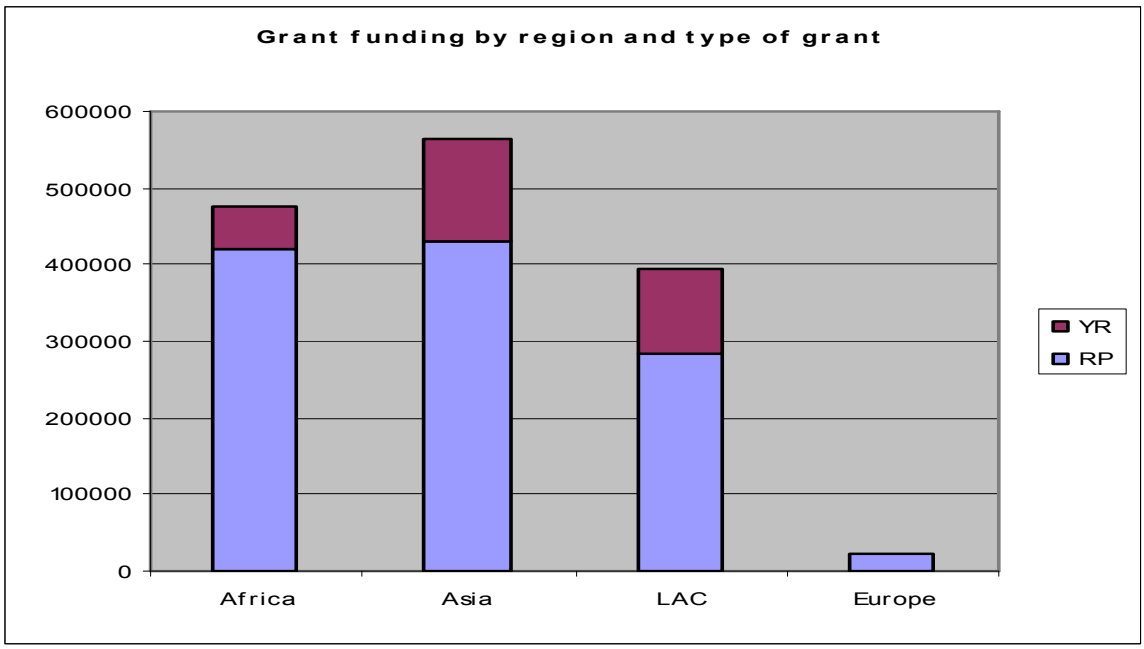
3.1.1 Needs Assessment When the Alliance was constituted in 1999/2000, one of the first tasks identified in its initial work plan and budget was a cross-continent mapping and monitoring of HPSR efforts. The intended outcome was a report on existing capacity, with the identification of major gaps at country level. A concurrent review of country level research priorities was likewise planned. With this information as baseline, the Alliance Board envisaged the ongoing monitoring of new HPSR initiatives at country level during the second and third year of Alliance operations. Originally, US$ 100,000 was budgeted for this task for the first year only, to be included in Secretariat costs. Actual expenditures covered three years for a total of some US$ 145,165.00.

In 2000, the Alliance leveraged resources with WHO to co-organize a high level conference on capacity strengthening. A special conference session and parallel meeting laid the basis for collaboration with regional networks, including networks in sub-Saharan Africa, Latin America and the Asia-Pacific region and a further one located in China. A special consultation, involving 60 Alliance partners, was held in October 2000 during the tenth anniversary conference on essential national health research (ENHR) in Bangkok, Thailand. This led to a plan of action on capacity strengthening for the Alliance.

Plans for capacity assessment over the period 2001-2002 included i) Identification of research expertise and strengths of partner institutions on the basis of the web-based Alliance information system; ii) Assessment of research management capacity in order to identify funding and human resource constraints and solutions; iii) Undertaking of country case studies on research-to-evidence processes that were planned and prepared in 2000.

3.1.2 Capacity building for HPSR was one of the key strategies that the Alliance focused on, garnering some 27 % of total expenditures from 2000 to 2004 (Figure 3.1).

Figure 3.1 Grant funding by region and type of grant



**YR = young researcher grant; RP = research-to-policy grant*

Young Researcher grants aimed to provide incentives for the entry of younger researchers into the HPSR field with a focus on research that could support health policy development. Further, the grants aimed to promote the generation of information for policy making, and to strengthen the capacity of teaching programmes in HPSR.

3.1.3 Research stimulation took two forms: **Research to Policy grants** were expected to support the generation of knowledge in high priority areas within a demand-response framework, thereby a) to feed into country policy and b) through comparative analysis and synthesis to contribute to international knowledge. Secondarily, these grants were designed to provide incentives for institutional development and an accompanying culture conducive to strengthening the impact of research on policy. It was expected that this process would lead to regional-level capacity able to support research-to-policy methodologies and approaches.

To render the research-to-policy grants effective, Alliance management anticipated that they would respond to demand for research by institutions from developing countries. Research priorities would be identified through various mechanisms, including past applications, partner profile information and consultations with collaborating networks and agencies. Knowledge synthesis on specific HPSR topics would be encouraged and supported through methods development; technical support for proposal writing would be provided.

Strategic Research was meant to contribute to 'international knowledge' in high priority but neglected or innovative areas, thereby encouraging new policy thinking. Projects were commissioned on a competitive basis from experts or institutions, following consultations at international and country levels, and with 3-year cycles.

3.1.4 Support to HSPR Networks. Efforts at regional level aimed to promote a regional capacity for policy relevant research and, particularly, a capacity to utilise research results and enhance the value of research for policy makers. This strategy aimed to strengthen the capacity of regional networks to advocate for HPSR, support such work and its dissemination, and facilitate the research to policy process. In addition, the approach aimed to strengthen the capacity of regional networks to themselves identify and implement training strategies for enhancing the value of research for policy makers. Support for 3-5 workshops per year was envisioned to train up to 75 suitably qualified persons each year, some of whom could then themselves act as trainers. Other objectives included strengthening the managerial capacity of network secretariats, and obtaining support for the implementation of Alliance activities.

3.2 Evaluation Methods

This aspect of the evaluation focused on key questions related to the three approaches adopted by the Alliance:

- *Did the Alliance identify and focus on appropriate gaps/ needs for capacity building and research stimulation?*
- *Was the Alliance successful in stimulating research?*
- *Did the Alliance help to 'build capacity'?*

These questions were addressed using information derived from grantee survey responses (n=26), reviews of records and reports, and interviews conducted with key informants. Analysis focused on describing the scale of capacity building efforts, resources allocated to developing health policy and health systems research capabilities, areas of capacity building covered and an assessment of outcomes.

3.3 Key Findings

Did the Alliance adequately assess and define gaps/needs for capacity building and research stimulation?

- **The Alliance was successful in identifying needs using a process that involved key stakeholders.** Research capacity was comprehensively assessed at institutional, country and regional levels in collaboration with WHO/RPC[h]. Review of existing research capacity, with emphasis on countries with least capacity, was accomplished by conducting Alliance partner surveys, case studies on 7 developing countries, and capacity-strengthening meetings with 7 networks. The process also created opportunities to develop partnerships between the Alliance and countries and institutions, and to undertake informal consultations.

- **The Alliance however did not sufficiently link these findings to its own capacity strengthening and research stimulation activities.** Although the

[h] RPC = Research and policy coordination

Alliance conducted a broad and in-depth assessment of capacity needs, its own capacity building efforts were narrowly defined. While the Alliance paid due attention to ensuring regional spread in its investments, in many key areas there may have been insufficient attention given to balancing technical skills development with the range of non-technical qualities that are vital in effective HPSR. In addition, although support opportunities were created for both emerging and established researchers, there was little focus on the critical area of leadership development for more senior researchers.

Was the Alliance successful in stimulating research?

- **The Alliance was successful in setting up a sound grant funding process and overall completion rates were high.** Calls have been well publicised and over-subscribed, a review process defined, funding mechanism established and a support programme for grantees developed. Three rounds of research to policy grant calls were conducted and 92 awards provided. While most grants awarded in the second round have been completed, several are still in progress. Not all proposals approved for grants in round 3 have as yet received their funding via WHO[i]. Selected papers have been identified for publication and are in process of peer review.

- **Research completion and turnaround times were largely appropriate**. There were annual research to policy calls for applications, and it took about 2 years from identification and approval of research projects to publication. Strategic research calls were disseminated every year; the full process took up to 3 years to complete. Although longer time frames may well be appropriate for in-depth strategic work, for research to meet immediate policy needs, shorter time frames will at times be necessary.

- **Efforts do not appear to have generated a visible body of work in key health systems areas.**
  Although a range of topics received funding (Table 3.1), the amounts awarded to each research area were too limited to generate a substantial body of work in any one area. Key informants, active in the international arena, reflected on the apparent lack of a comprehensive body of work addressing prevailing priorities. Many argued that the Alliance had not made a sufficient impact on international health policy. However a minority of informants saw this as a positive sign, noting that the diversity of work reflected the felt needs of researchers rather than the wishes of international agencies. Several key informants commented positively about the recent move towards strategic grants. This has resulted in two strategic research efforts underway in Africa and Asia that are focused on health workforce performance. Additional grants will be funded through a recent call addressing governance, equity and health in Eastern and Southern Africa.

[i] While Round 1 was managed through the Global Forum, subsequent rounds have depended on the prolonged and at times cumbersome WHO review and administrative procedures.

Table 3.1 Grant funding by research area

Topic	Number of studies
Health Systems	**85**
Policy Process	12
Public-Private Mix	8
Decentralisation	7
Equity/ social policy	17
Finance	30
Global trade	2
Health Sector Reform	3
Health Systems Research	1
Human Resources	5
Health Services	**19**
Service Performance	9
Demand, access, utilisation of health services	7
Hospitals	3
Related to areas of health	**30**
HIV/AIDS	4
Complementary Medicine	2
Injuries and violence	5
Malaria	8
Maternal & Child Health	3
TB	5
Hypertension	1
Reproductive Health	2

- **The Alliance had limited success with both leveraging of grant funds and co-funding of projects; it has not, to-date, played a brokerage role.** In a number of instances, notably with WHO departments, the Alliance was able to foster co-funding of research to policy grants. It was also able to leverage funds from, for example, WHO as well as the IDRC, leading to their investment in strategic research areas. Possibilities for playing a significant brokering role (where monies would not necessarily pass through the Alliance) have, however, not been explored. Given the limited direct funding of the Alliance, it was unlikely to achieve its core aims without substantial co-funding of HPSR by other organisations.

Did the Alliance build capacity?

- **Respondents could identify and appreciated the Alliance's efforts in capacity building; many needs however remained unmet.** A range of workshops (protocol development, proposal writing, writing for publication etc) were provided. This was among the most commonly cited benefits by grantees, and the need for additional workshops was clearly articulated. Nevertheless a number of key respondents emphasised that workshops should allow more time to discuss and develop proposals adequately, and avoid a narrow or overly rigid concern with proposal format. Short courses - on data analysis and methods training particularly – were also identified as a means to address capacity development needs. However the needs identified were substantial and many grantees reflected that, despite the usefulness of the funding, they still required significant further support to become successful career researchers.

- **The Alliance was insufficiently financed to build a critical mass.** Building a critical mass of researchers in any field is a major and long-term undertaking. Despite stated Alliance objectives, and support to regional networks, it is difficult to judge whether the pattern of grant investments has contributed to major additional capacity in the HPSR field – though some limited impact should be discerned.

- **The Alliance focused on the skills development of individuals rather than building capacity in institutions.** Given limited funding, several key respondents felt that the Alliance's impact was weakened by scarce funds being spread too thinly amongst too many institutions; further, that once-off grants were sometimes awarded without considering support to the surrounding research environment. Reinforcing this, several responses from grantees reflected a sense of isolation and the need to develop/participate in supportive research teams and a conducive institutional environment.

- **Regional networks have been constructively supported although the potential gains have not been fully realised.** Four regional HPSR networks, covering several countries and institutions, have been supported since 2000. These are the Asia-Pacific Health Economics Network (APHEN), the Health Economics and Policy Network in Sub-Saharan Africa (HEPNet), the Southern Cone Network of Latin America and the China Health Economics Network (CHEN). Although these are the major networks supported by the Alliance, others are being nurtured. One of the regional networks (APHEN) did not receive a third round of funding due to problematic performance and is currently restructuring itself.
    - HEPNet leadership confirmed that Alliance investments have added considerable value to the network's ongoing activities. Modest resources have strengthened the network secretariat, while interactions with the Alliance secretariat have assisted HEPNet in supporting country-based scientists to successfully seek grant funds from the various Alliance calls. Network leadership have been quite willing to provide regional support for Alliance efforts (workshops, mentoring of grantees, advice on research-policy engagement etc) but requested that, in future, they play a more active and 'partner' role in the Alliance's regional planning and decision-making.

- As with HEPNET, the Network for Health Systems and Services Research in the Southern Cone of Latin America reported that the Alliance has added value to their activities and, despite the modest sums contributed, has supported their secretariat and facilitated interactions and exchange between researchers of different countries in the region. However, the Southern Cone Network also seeks to become more of a 'real partner' and has on occasions felt it was expected simply 'to carry out tasks for the Alliance'. In addition, the network reported that there has been some duplication of effort when the Alliance has contacted researchers directly, but also asked the network to contact them - suggesting that care should be taken to avoid this.
- The Chinese Network for Training and Research in Health Economics and Financing is based on a growing collaboration involving over 20 institutions – largely schools of public health but with meaningful participation by the Ministry of Health. Training, and to an extent research, activities reflect this dual focus on public health / medical schools and service-providers / policy-makers at both city and provincial levels. Despite challenges in coordinating the network, it has clearly contributed to much-needed policy and systems research awareness. Partnership with the Alliance has supported translation and dissemination of the Alliance Newsletter and facilitated several successful grant applications (including publication support).
- Over time, leadership and organisational difficulties led to non-renewal of Alliance support for the APHEN. However the elements for effective regional networking can be discerned and network leadership readily specify areas of progress. As with the other networks, APHEN leadership expressed their concern for a more balanced and effective partnership with the Alliance.

❖ **The networks that have interacted with the Alliance are diverse and there is substantial scope for strengthening their capacity.**[j] Some networks are more developed than others with greater depth of health policy researchers, more experience in health systems research and greater publication output. A number of grantees reported that they were part of stand-alone organisations that lacked any link with research networks, while others noted participation in networks that were not supported by the Alliance.

❖ **The Alliance has provided limited support to teaching programmes; this could prove an effective approach to building capacity.** Alliance management planned to contract, through a competitive process, teaching programmes or networks of programmes with regional or international coverage that are based in middle and low-income countries. Proposals needed to demonstrate capacity to provide supervision at masters and doctoral levels. Grants were to provide funds for the fieldwork component of student research projects as well as ensure technical support to students and development of staff and syllabi. Calls for teaching programme proposals were launched late in 2003, for a one-year period renewable; 10 grants were recently awarded.

[j] See detailed report by Daniel Morales-Gomez, Assessment of Support to Networks and Future Prospects, October 2004

3.4 Further comment and recommendations

- The Alliance approach was to stimulate research within the constraints of its available budget. Greater impact may be possible if the Alliance took on the role of advocate and broker and not only that of primary or co-financier.

- HPSR Networks can be valuable contributors and extend the reach of Alliance efforts; greater involvement, stronger partnerships and more sustained contributions should be considered.

- The strategic involvement of training institutions – such as Schools of Public Health – is a necessary feature of efforts that seek to build long term and advanced HPSR capability. Creative and mutually beneficial academic links with northern institutions may carry substantial benefits for graduate training bases (national and regional) in the south.

- Additional approaches to capacity development could be considered and tested - for example, fostering different forms of south/south learning partnerships could prove innovative and productive.

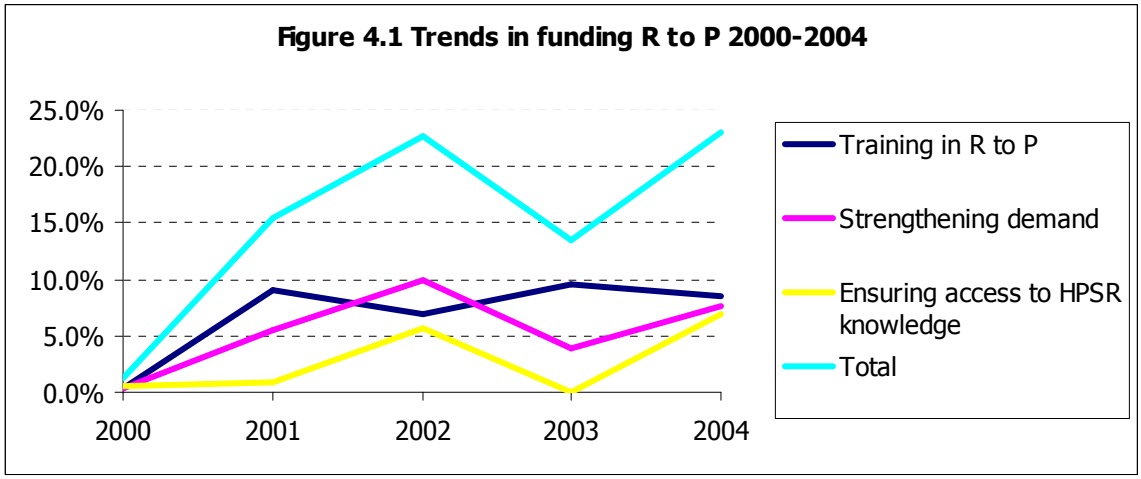
4.0 LINKING RESEARCH TO POLICY AND PRACTICE

A central goal of the Alliance is to bridge the divide between health systems research and health policy. This was expressed in one of its initial aims, 'to develop essential information for policy decisions in the health sector', and thereafter in its revised strategic framework, 'to promote the dissemination and use of knowledge to improve the performance of health systems'. Reflecting the importance that the Alliance placed on this area, the external evaluation was asked to assess the contribution that the Alliance has made to the increased utilisation of health systems research results in health sector policy and practice at local, national and international levels. This section summarises our findings and recommendations.

4.1 The Alliance's Research to Policy Strategy

The starting point was to define the Alliance's key strategies to improve the use of research in policy making. The Alliance spent around 18% of its funding, excluding overheads, on research to policy activities. Figure 4.1 shows that this varied slightly over the years with high points in 2002 and 2004 and a dip in funding in 2003.

Figure 4.1 Trends in funding Research to Policy 2000-2004



The Alliance funded three main activities, each for approximately $300,000 over five years. The first activity was the development of training materials in research to policy. The second was aimed at strengthening the demand for health policy and systems research. This included several working papers that discussed case studies on research to policy and a workshop on the utilisation of research and guidelines on getting research into policy (GRIPP), outlined in the Alliance's flagship publication 'Strengthening Health Systems: The Role and Promise of Policy and Systems Research'. The third activity was to promote access to health policy and systems research. This included production of a newsletter and a web-based search engine. In addition, a collation of Alliance funded research will be published in a special issue of Health Policy and Planning.

However, perhaps the most important activity of the Alliance's work that could indeed impact policy was to stimulate policy-oriented research. As described in the previous section, the funding of 'research to policy' grants, and the accompanying support to grantees to build their capacities in this area, claimed 35% of Alliance funding excluding overheads. Support was provided to researchers in several ways, from designing a

research approval process that emphasised impact on health policy and practice, to the provision of training on the research to policy process.

The Alliance did not fund major efforts to build the capacity of policy makers to use research, produce syntheses or policy briefs (this was an expectation of Alliance-funded researchers), or develop national level research to policy interfaces, and as such its strategy can be characterised as supply or researcher driven. With its limited funds it primarily supported researchers, providing them with the means, knowledge and tools to develop policy relevant research and bring their results to policy makers.

Examining the Alliance's main strategic documents,[k] and through interviews with key informants, it is clear that this approach developed through the lifetime of the Alliance. Early documents clearly place the Alliance in the role of catalyst, both for the increased supply and demand of health systems and policy research. They state the importance of *advocating and collaborating* in activities such as capacity building and suggest that over time the Alliance could act as a broker between funders and research. Later documents, such as the strategic framework 2003-5, clearly recognise the importance of increasing the demand and utilisation of health systems research. The 2003-5 framework identifies clear aims such as ' C1, Development of capacity to use evidence for policy', and 'D, Promoting Policy Relevant Research and Evidence–based Decision Making, including approaches that achieve effective interaction between key actors'. However, in practice, the activities under these areas were confined to the production of training materials and web-based tools, rather than expanded to an advocacy or brokering role between key actors in the research to policy process.

4.2 Evaluation Methods Specific to Research to Policy

The ideal way to evaluate the impact of the Alliance's research to policy strategies would be to assess the knowledge and use of research results as reported by policy makers. However this evaluation was not set up to conduct the type of indepth survey that would be required and, given the Alliance's modest scale, it is unlikely that a survey of national policy makers would provide useful information. We focused, therefore, on an assessment of the processes used to support researchers, a review of the policy relevance of grants awarded and training materials, interviews with key informants, and a survey of grantees. For the research to policy assessment we used these methods to address the following key questions:

- *Did the process for assessing research grants sufficiently emphasise the policy impact of the research?*
- *Did the training and support given in the area of research to policy improve the capacity of researchers and policy makers?*
- *Were the research results produced relevant to national and international policy issues?*
- *Were research results adequately disseminated to policy-makers?*

[k] Report and recommendations of the Interim Board, Workplan 2001-3, Strategic Framework 2003-5.

- *Is there any evidence of use of research results by policy makers?*

In answering these questions we used no single prior conceptual model of the path from research to policy. Whilst accepting that elements of several of these questions can be debated (for example the definition of policy relevant results), for simplicity we concentrated on those elements that have been identified in prior assessments of successful research to policy experience. These included:

- The importance of prioritising research topics in consultation with key stakeholders, potential policy impact being a key criteria

- The desirability of involving stakeholders throughout the implementation of the research

- The importance of providing high quality, timely and credible evidence to policy makers, that places results in the context of policy, rather than policy in the context of results

- The need to strategically communicate evidence to policy makers. This should reflect an understanding of the policy process and the capacities of policy makers to absorb research results.

It is acknowledged that, even where research demonstrates all these elements, there is no guarantee of it having an impact on health policy. Finally, we placed no prior emphasis on the relative importance of influencing local, national or international policy but focused on the Alliance's achievements in each of these. We took this approach as it was clear that different stakeholders placed quite different value on policy impact at different levels, and to take one perspective as a starting point would lead to an incomplete evaluation. When making recommendations, we took the view that efforts to change health policy are primarily targeted at the national level, but can be influenced by evidence from both local and international sources.

4.3 Key Findings

Did the process for assessing research grants sufficiently emphasise the policy impact of the research?

- **The proposal format developed by the Alliance adequately emphasised policy impact.** In order to have a policy impact, proposals need to be designed to address policy questions by providing robust evidence. The Alliance proposal forms encourage researchers to do this, clearly demanding the identification of aims, objectives and justifications in terms of policy, using the conceptual framework and project design sections to outline scientific principles. In addition, Alliance proposals require a letter of support from policy partners, a description of policy and decision relevant outputs anticipated, and an outline of strategies to enhance the dissemination and utilisation of results. Although this is not unique and appears straightforward, the Alliance can be congratulated on its approach of encouraging policy impact to be at the forefront of proposal development. Some key respondents felt that the proposal format was too rigid and 'impossible to write a clear and comprehensive research proposal within it'; the Alliance may

still have work to do to ensure that the format is flexible enough to meet the range of health systems and policy research questions possible.

- **A review of proposals showed that there is still some way to go before proposals fully reflect an understanding of policy impact.** Determining policy impact is complex and requires an understanding of health systems constraints, the decisions and processes that affect them, and the political environment. While the format provides ample opportunity to describe the health systems problems, this evaluation found that in many proposals the central policy decision to be supported/affirmed or refuted was ill defined. In addition, most proposals lack a clear description of the key policy actors, decision-makers to whom the proposal is targeted, and a considered strategy of how to disseminate results. This finding, however, only serves to highlight the need to build capacity in this area which the Alliance is attempting to address with the finalisation of its research to policy training tools.

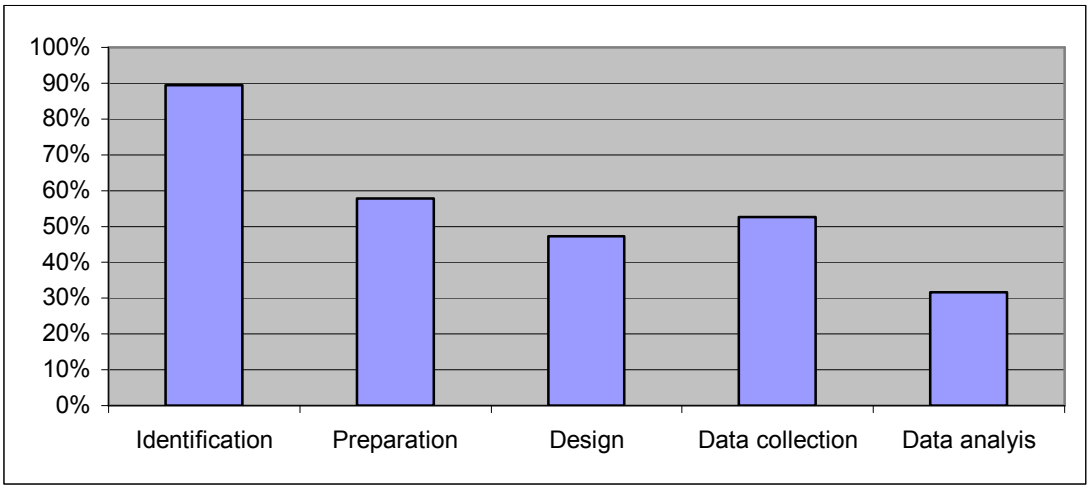
- **Further, the Alliance did not establish a sufficient process to ensure that research was of the scientific quality required to ensure findings were credible to policy makers.** Several key respondents highlighted that a key determinant of policy impact is scientific robustness and that the Alliance process did not adequately ensure this. An in-depth review of a sample of proposals from the LAC region found that only 2 of the 9 proposals sampled used a methodology that was robust enough to ensure policy impact[1]. In addition, the evaluation team found that the Alliance did not develop a process to assess the quality of final reports and/or publications. An ad hoc process was used whereby final reports were sent to Alliance partners for assessment, but with no obligation to do so. Often there was no assessment. The quality of final reports and abstracts, as assessed by the evaluation team, was mixed.

- **In terms of involving policy makers in the development of proposals, the Alliance had mixed success.** The attachment of a letter from policy makers, although a starting point, is not sufficient evidence of policy maker involvement. Involving them can be difficult and may provide too high a hurdle particularly for new researchers. However, recognising this, it remains clear that the attendance of policy makers at key Alliance events, such as protocol development workshops, was not considered a necessity, and therefore efforts had varying success.

- **Grantees, however, reported significant involvement of decision makers during their research projects.** Although this finding is based on information that is self reported and therefore may be biased, Figure 4.2 suggests that Alliance grantees did have some success in involving policy makers throughout their research, particularly in the identification of research questions. An in-depth examination of survey responses shows that proposals aimed at answering operational questions were more likely to involve those providing health services. For studies with results aimed at the national policy level, involvement was weaker, however there were very few examples where there was no stakeholder involvement during the implementation of the research.

[1] Ricardo Bitran, overall qualitative assessment of proposal

Figure 4.2 - Policymaker involvement in implementation of research (n=26)



- **The quality of dissemination strategies presented in proposals was mixed.** If results are to be brought to policy makers, then the plan for dissemination has to be strategic, reflecting an understanding of the policy process and key actors. However, only around half of the studies have a clear strategy for dissemination to policy makers with corresponding budgets. In addition, many of the grantees responding to the survey recommended that the Alliance provide funding for dissemination. Since funding was provided in some cases, it is unclear why other grantees were not aware that they could request funds for these activities.

- **Grantees felt that they were not adequately supported in international dissemination.** Many grantees surveyed felt that they did not receive adequate support to improve their skills in international dissemination. Most felt that the Alliance was in a good position - as a body with international links - to assist, but had not done so. Several grantees had cooperated with the Alliance to submit articles to Health Policy and Planning, but were frustrated that articles were not yet published; this said, the long-anticipated special issue will materialise during 2005. Discussion with the Alliance manager revealed that the lack of progress was largely due to an approach that relied on external resource people - when those with the real motivation are the researchers/writers themselves.

Did the training and support given in the area of research to policy improve the capacity of researchers and policy makers?

- **The set of research to policy resource modules is clearly a useful and innovative product of the Alliance.** The Alliance is to be congratulated in its production of resource materials to support research to policy training; this clearly fills a gap in the current training available for health systems researchers and policy makers. As stated above, this evaluation found clear evidence of the continuing need to build capacity in the research to policy knowledge and skills of researchers; in addition it is clear that there is a corresponding need to build the capacity of policy makers to process and apply research findings. The Alliance recognised this early on and used its limited funds to high impact by producing this useful training tool. Key respondents who had attended the workshops

regarded the experience as fruitful, due as much to the participatory nature of the workshops as to the materials themselves. The materials have since been further developed and several participants commented on the need to be context specific and less formulaic as well as a need to supplement the training with courses that provide specific skills. Examples of skills mentioned were techniques for communication and dialogue, writing of policy briefs and, more generally, writing for the press and presenting recommendations.

- **The Alliance had mixed success in involving policy makers in training.** A key audience for the research to policy materials is policy makers. However the involvement of policy makers in research to policy training varied by region. This gap was noticed by a few of the grantees surveyed, one recommending that the Alliance only invite researchers who bring policy makers with them.

- **The Alliance did not adequately follow-up on training.** This was partly because the main purpose of the initial research to policy courses was to develop training materials. However, although the training ends with the development of a research to policy strategy, little follow up support or funding was given to participants to implement the strategies developed.

Were the research results produced relevant to local, national and international policy issues?

- **In broad terms most of the research funded was either locally or nationally relevant.** The grantee survey demonstrates that grantees can clearly describe the policy relevance of their work. A broad assessment by the evaluation team of all the main research topics found that most of these address important policy concerns. The in-depth review of a sample of proposals from the LAC region also found that the broad research questions were highly relevant to national public health policies. Relevance for other countries in the region was also considered reasonably high.

- **However, it was more difficult to demonstrate the direct relevance of the research to national policy debates, agendas and actors at the time of the research.** In the few cases where the evaluation team had direct policy experience of the issue or country concerned, or were able to speak with policy makers,[m] it found that - although most proposals addressed useful areas in broad terms - direct links to policy processes or key policy actors at the time could not be made.

[m] Health financing in Ghana and Egypt, Tuberculosis Control in South Africa, Vietnam

- There is little evidence that the Alliance adequately linked calls for proposals to national/regional priority setting processes**.** This interaction can be organised in several ways; one approach being to determine the national and local relevance of research through a process involving researchers and policy makers. The Alliance is now beginning to make efforts in this area. However, other international NGOs, such as COHRED[n] are working on priority setting at the country level. Although this evaluation found evidence of collaboration with COHRED at the international level, this did not appear to extend to the national level. In addition, the Alliance's call process is not explicitly linked with its own network-based priority setting process.

Box 4.3 Grantee views on Alliance support to dissemination

"The Alliance's international prestige has contributed to contact with professionals from the Ministry of Health, to publish the research's results by an international journal, to disseminate them by an international conference, and to capitalise my dual professional roles, academic and in the health public administration."

"Policy makers from provincial level showed tremendous interest in a workshop. Two provincial health officials were research members; 5 high rank provincial health officials attended a focus discussion/workshop to help analysing data. Five articles were published in a national journal "Chinese Primary Health Care". But we still need help to publish the results internationally".

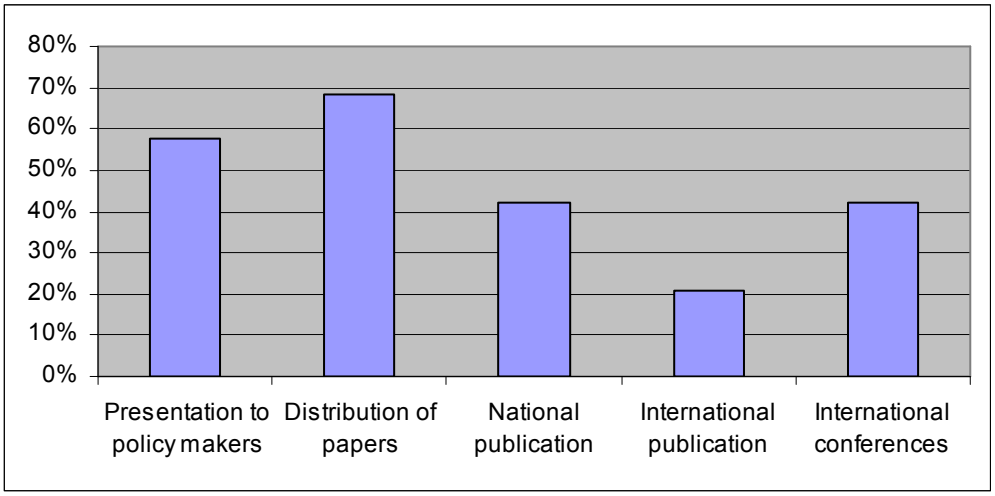
- **Aside from instances where calls were directly supported by groups within WHO, international relevance appeared limited.** A clear message from several key informants was that the Alliance did not fund the type of research that was internationally relevant. Similarly, there were few examples where several studies examined a common policy issue, building cumulatively upon each other to provide either a systematic base or evaluation of a policy, or where cross-country comparisons were made. Nevertheless it is clear that, over the years, the Alliance moved towards a more strategic approach in its funding of research. In earlier years the evaluation found examples where research was linked to international priorities such as the public-private mix in tuberculosis control. In later years the Alliance announced two strategic research calls that were also supported by WHO programmes. In areas involving such collaboration, the evaluation found that key informants acknowledged the usefulness of the Alliance's work.

Were research results adequately disseminated to policy-makers?

- **Research results were disseminated nationally, but there was limited international dissemination.** Reviewing Figure 4.3 it can be seen that just under half of the proposals covered by the grantee survey produced results in national publications, but only 4 out of 19 in international journals, although somewhat more were presented at conferences. Some 60-70% of grantees distributed results through presentations and/or provided papers to policy makers, something feasible for all proposals as it does not require peer review.

[n] COHRED: Council on Health Research for Development

Figure 4.3 – Reported dissemination by grantees (n=19, completed research)



- **The Alliance has produced many valuable dissemination products and distributed them widely.** The Alliance invested considerable time in distributing its products. CDs were distributed in 2003 and 2004. The Alliance has produced many working papers and two books, and has a well established website which includes a useful search engine. The website is being widely accessed. In the three month period August to October 2004, the website had around 4,400 unique visitors. Of these 55% were from Europe or North America, the remainder assumed to be from developing countries. It is estimated that around half of site visitors use the evidence-based search engine, and there have been around 500 document downloads.[o]

- **However, most of the Alliance's dissemination products were not primarily targeted at policy makers.** Policy makers generally require a short accessible accurate summary of the evidence base relevant to a decision. Although effort was made to remove technical language from the search engine, most policy makers and technocrats are unlikely to use search engines without an intermediary and, however well designed, it cannot be a tool primarily for policy makers. Policy makers are more likely to rely on expert presentations, syntheses and policy briefs as information sources, and it is the producers of these who are likely to find the search engine most useful. Although the Alliance has produced useful books and working papers, there is a risk that these formats are too long to appeal to policy makers. The Alliance is, however, beginning to address this issue and work to identify areas for syntheses began in 2004. Areas currently identified are largely based on opportunities within WHO and are not linked to priority setting processes within the regional networks.

[o] Analysis of the performance of the Alliance website. Paper presented for discussion at the 8th Meeting of the Alliance Board.

Table 4.1 Modes of information dissemination used by the Alliance

Books	Strengthening Health Systems Research The Public Private Mix in Health
Training	Collaborative Training Programme Modules in Research to Policy on Advocacy, Priority Setting and Knowledge Management
Newsletters	9 newsletters
Case studies	Case studies in HPSR capacity, priority setting, capacity building, support of research, institutional support, utilisation of HSPR
Working papers	10 papers on capacity assessment and strengthening 9 papers on research management and enabling environments
Research abstracts	Research abstracts of all Alliance funded grants

Is there evidence of use of research results by policy makers?

- **Research results of the Alliance are likely to have been used to a limited extent in local and national policy making.** Although self reported, the grantee survey provides clear examples of where research results have been used in national health policy (see boxes), as well as where research has influenced the way in which local health services have been provided. However, these sorts of changes tend to be simpler to influence with research, unlike some of the wider policy issues that require reallocations of resources and affect larger interest groups. There is less evidence that the work of the Alliance on these types of issues has influenced policy makers.

Box 4.2 Grantees reporting the impact of their work on policy

" We identified risk zones for reproductive tract infections (RTI) in urban areas. The study was then used as the basis for further research to design services preventing RTI in young people"

"Policy makers and HIV/AIDS NGOs utilised the publication of the research HIV/AIDS' voices to define policies for HIV/AIDS care. They used the story as evidence of what HIV/AIDS sufferers demand in terms of quality and equity of care and the coverage of antiretroviral drugs for HIV/AIDS"

- **Research funded by the Alliance has been used internationally, but only when supported by international programmes at the WHO.** Most of the key informants interviewed at international level were unfamiliar with the research produced by the Alliance. This is unsurprising given the limited international publication of research funded by the Alliance. However there were exceptions. Where the Alliance has worked in collaboration with WHO international programmes, with the Global Programme to Stop TB or the Human Resources Section in Evidence, Information and Policy for example, then the Alliance was seen as having made a useful contribution to international policy. Where this was

not done, for example in health care financing, those interviewed at international level had not drawn on the Alliance's work.

4.4 Discussion and recommendations

In summary, evaluation of this sphere of Alliance activity reflected many of the deeper issues at play when encouraging applications of health policy and systems research in policy-making from a researcher driven perspective. Key issues are the limited capacity of researchers to assess the policy environment, the lack of functioning interfaces between researchers and policy makers at local and national levels, difficulties of involving policy makers in research activities, and difficulties in disseminating research in a form that is accessible to policy makers.

The Alliance has addressed each of these concerns, though with mixed success. Although the capacity of grantees remains low, the Alliance has now produced innovative resource/training tools in research to policy that have the potential to contribute substantially to this area. The Alliance has been less successful in directly supporting researchers to navigate and further develop researcher-policy maker interfaces. It also had mixed success in involving policy makers in research activities, although the grantees themselves have made considerable efforts towards this. Finally probably the weakest area, in the sense that it is one of the simplest to address, is the gap in facilitating the dissemination of results to both national and international policy makers.

However, these findings have to be considered in the context of a limited budget and a relatively short period of operation. Other parts of this evaluation show that the Alliance had fair success in stimulating research through establishing its grants programme and infrastructure, its networks and its main channels of communications. With these the main emphases between 2000 and 2004, it is not surprising that it is only at the end of the evaluation period that the main research to policy activities are beginning to take shape.

Drawing on past experience, the discussion below focuses on how these beginnings could best be developed building from this solid base. Three key areas could be further developed to improve the research to policy activities of the Alliance in the future.

- **Focus research funding on quality not quantity.** A key finding is that the Alliance is spreading its scarce resources too thinly to achieve the quality of research that may impact policy decisions. Although the amounts of funding for each grant are comparable to sums awarded by similar funding streams, the support of the Alliance to each grantee needs to ensure that the Alliance really adds value. The aim should be that a grant from the Alliance has the reputation of providing an opportunity for researchers not just for funding, but also to significantly improve their skills, at both junior and senior levels. In addition, it may be better to prioritise a limited number of topics, although this should be based on regional/ national consultation to ensure that issues selected reflect the identified needs of national policy makers (further discussion below). There are two kinds of resources that grantees should be provided with routinely:

    - **Research to Policy training, with follow-up.** This should be linked with other capacity building activities such as the protocol development workshops. Where a need is clearly identified, follow-up activities could

be supported with small grants. One possibility is to run research to policy training and follow this up with a targeted call for grants and further training on protocol development. All these activities could include funding for policy maker/provider participation in the workshops as a part of the research team.

- **Assistance with both national and international dissemination.** A pre-requisite for funding grants should be a plan and budget for dissemination. In addition, the Alliance should continue to develop grantee skills, perhaps by developing the research to policy tools further in the areas of communication and dissemination. The Alliance could also provide examples of what types of products and messages best reach policy makers. Perhaps most importantly, the Alliance should support researchers achieve international dissemination, with funding for translation and the write-up of results.

❖ **Raise the profile of the Alliance by developing specific dissemination strategies for national and international policy makers.** The Alliance needs to urgently identify one or two information products for policy makers. Work on syntheses has started and should be continued and expanded. Policy briefs on key findings from Alliance work, or the state of the art in areas of health systems research, may also be of value. This could profile the Alliance internationally as a key player in mapping the terrain of health systems and policy research. It could also provide a unique opportunity for health systems researchers in southern countries to gain international access through producing this work, potentially with support of authorities from international or northern institutions. This should enjoy higher priority than further development of the web-based search engine.

❖ **Profile the Alliance as a key stakeholder in health systems and policy research, and an organisation that can represent researchers and bring their perspectives to the attention of policy makers.** The Alliance is well established as a network of researchers. It now needs to take advantage of this position to link these researchers to policy makers at international and national levels. Priority should be given to strengthening relationships at the international level, and advocating and seeking co-financing for activities at the national level. In addition to capacity building and research stimulation, these links should have the aim of bridging the research to policy divide, allowing the Alliance to offer its members the opportunity to be involved in defining common research agendas and advocating for health systems and policy research. Key steps towards this aim could be:

- **Decentralise calls to the networks over time.** As an organisation that represents regional networks and national research institutions, the Alliance has significant potential to become more regionally and country oriented. This is a prerequisite if the Alliance is to position itself as an organisation that 'represents' its members. At present, priorities for research calls and issues for synthesis etc tend to be decided in an ad hoc or entrepreneurial way, based on relationships within WHO. In keeping

with the network evaluation carried out in 2004[p], this evaluation supports the view that the networks become more active when deciding priorities for research calls, and over time take on a more substantial role in managing the calls[q].

- **Strengthen links with international stakeholders.** The Alliance could then use the priorities set and its broad representation of the regional networks as a basis to interact with international policy makers, for example in WHO programmes. Aside from improving the Alliance's profile in the activities of other agencies, the Alliance could seek co-financing to organise one or two high profile events at the international level, to provide its networks and members with a space to meet international policy and northern research institutions. This could open channels of communication more commonly accessed by researchers based in northern institutions.

- **Increase direct funding to involve national policy makers in Alliance events and activities, and advocate for co-financing.** The Alliance should continue to improve efforts to actively involve policy makers in its activities. Support for policy-makers or service providers should be standard for Alliance events. Researchers should be informed that, unless they attend with a policy-maker or health service practitioner, they will not receive training. In addition, the Alliance should seek co-financing to expand and involve national policy makers in its research to policy training. Finally it should strengthen collaboration with other agencies and NGOs involved in similar activity to link Alliance efforts to others at national level.

- **Fund activities that explore how best to support research to policy.** The Alliance should further develop its working paper series and policy briefs, to look more closely at how to support research to policy interfaces, and navigate the changing financing architecture for health systems research funding. Although there are other international efforts underway to improve the financing for health policy and systems research, international financing for health systems is increasingly being channelled to national governments according to broad national plans. The Alliance could thus examine how national researchers and international agencies can advocate to policy makers to allocate funds to health systems research in national health sector plans.

[p] Morales-Gomez, 2004

[q] Note: In December 2003, the Alliance Board resolved to discontinue its small grants programme – on grounds that, in fact, significantly increased funds are required to render such a programme worthwhile.

5.0 GOVERNANCE, ORGANISATION AND MANAGEMENT OF THE ALLIANCE

Early evolution of the Alliance occurred in parallel with the setting up of the Global Forum for Health Research. These processes converged, with the Alliance being formally established as an 'initiative' of the Global Forum (one of a number of such initiatives established under the umbrella of the Forum), accountable, finally, to the Forum's Foundation Council, legally constituted under Forum statutes, and with the Forum providing an avenue for the Alliance to both receive donor monies and provide assurances regarding the necessary financial controls.

Careful discussion of a range of organisational options,[7] within and outside of the UN, resulted in a partnership with the Evidence and Information Cluster of the WHO, key to which was locating the Alliance Secretariat within the cluster (initially in the Financing, Expenditure and Resource Allocation Group, more recently with Research Policy and Cooperation). This arrangement offered both an administrative infrastructure and the necessary checks, balances and accountabilities needed for day-to-day secretariat operations. Despite a need for familiarity over somewhat cumbersome operating procedures, the arrangement has functioned reasonably. It was expected that the Alliance Manager would take the lead in collaborating closely with WHO staff – within and beyond the cluster – realising the potential for a range of joint or complementary efforts.

Providing a sound legal and institutional basis for new or unconventional structures is not straightforward and considerable time and effort was needed, during the start-up phase, to establish this. The Alliance's institutional arrangements are complex and so, although quite workable, there are frustrations associated with multiple lines of reporting, accountability and responsibility on the part of both secretariat and officers of EIP/WHO. The Secretariat of the Global Forum continues to provide support and advice to the Alliance on a range of organisational, financial and strategic issues.

5.1 Governance bodies and relationships

5.1.1 The Alliance Board

Board membership has clearly been considered from a range of relevant perspectives: gender, north-south, professional balance, founding funders, stakeholders and observers. However reviewing its composition over the years, and taking into account the full span of HPSR activities, there are **grounds to consider stronger participation from the users of evidence, whether from ministries of health (policy makers or senior managers) or other government groups**. Similarly, when considering succession, it may be that a leading former minister or well-recognised ministry official should be considered for the position of Alliance Chair; indeed, it may be worth considering a co-chair formulation involving both outstanding research and health service leadership.

The range of Alliance activities were ambitious, required effort over many fronts, and a complex of executing skills in an environment of constrained resources. Clearly the Board has been successful in establishing a viable and productive organisation. Nevertheless, while giving due acknowledgement to these efforts, we consider that the Board

- had difficulty in following through on its strategic choices

- could have deployed its limited resources towards more targeted and strategically selected goals
- had expectations of its Manager and Secretariat not fully congruent with their constrained capacity or skill mix
- was right to attempt to expand the professional capacity of the Secretariat (and that the inability to achieve this led to some compromise in fulfilling the work programme)
- does not appear to have fully explored potential international funding sources with a view to broadening the Alliance resource base.

To some degree, this may have resulted from the inexperience of Board members; equally from the demanding challenge of putting in place a well-functioning networked organisation. But there is a sense, expressed by some Board members, that they should have been more assertive in fulfilling their strategic and oversight roles.

5.1.2 The Secretariat

In providing a permanent focus for the Alliance, its Manager and Secretariat have worked hard and the range of activities and outputs is impressive. Accepting the Alliance Strategic Framework, and carrying responsibility for its implementation through successive workplans, was onerous and called on a spectrum of skills and abilities not generally found in any single person. From this perspective, our view is that **overall Secretariat professional capability was insufficient to deliver fully on Board expectations, and that the skill mix required extended beyond that of a single professional staff member.**

The relationship between Secretariat and Board, and the leader of each, is pivotal in any organisation. Despite some difficulty, a workable and professional relationship was sustained over the years. An important area of interaction relates to the degree of independence or autonomy of Secretariat from Board. A sound balance needs to be achieved and it appears that the Manager was at times seen as exceeding his brief, assuming a degree of leeway/independence in initiatives that the Board did not intend. This provoked some frustration, and concern regarding the direction of projects; both parties, however, would need to reflect on this and how to avoid it in future.

5.1.3 Relationship of Board/Secretariat with WHO/EIP, and interactions with other divisions/groups/programmes in the Organisation

It is understandable that expectations of the relationship between the Alliance and WHO, mediated particularly through the Alliance Secretariat, would be high – as indeed they should be. Thus WHO/EIP concerns of acting simply as an administrative 'sleeping partner', expected to confirm all Secretariat activity but play little role in its oversight, need to be recognised.

Some gains have been made and a few useful, low-key collaborations undertaken; particularly worthwhile was a 'strategic research' effort with Human Resources for Health. Other joint efforts, involving some combination of grant and/or technical support, have involved Stop-TB, Violence and Injuries Prevention, the National Health Accounts team, Roll Back Malaria and Sustainable Development; taken together some 14 research-to-policy grants were co-funded on issues of mutual interest. In addition, there have been useful contacts with WHO regional offices (AFRO, PAHO, EURO).

Clearly, much of the justification for locating the Alliance Secretariat in WHO/EIP was to encourage productive partnerships – with groups within the Evidence & Information for Policy cluster in the first instance, but similarly with other WHO groups or clusters; a particular opportunity lies in forging collaborations with disease or condition-focused 'scientific and technical programmes'. **Achieving this at some scale will require a strategic aligning of Alliance objectives with the motive forces influencing WHO's prevailing mission, priorities and strategic plans** ('3x5', decentralisation to regions and countries, country-based action etc). In addition to scientific, research and policy credibility, necessary secretariat skills include an ability to identify opportunities and their policy/systems research dimensions, establish common purpose and build rewarding coalitions, and an element of 'flexible entrepeneurialism' in support of this.

5.1.4 Alliance partners

The Alliance Manager has been innovative and skilful in developing effective communication connections with a few hundred policy & systems research groups across the world (see website for detailed listing[r]), and considerable effort – particularly in the early years of the Alliance – was directed towards this. Numbers have fluctuated over the years and currently involve some 300 groups, about 60% of which are academic and research groups, the balance including Ministries of Health and/or their component sections. This is the basis for a virtual 'pre-network', linked to the Alliance secretariat and providing a conduit for proposal calls, surveys and general information distribution; 'Alliance members' have at times been asked to respond to questionnaires and queries. **Although the members have not played a role in Alliance governance, and could not be said to collectively form a network, some in-depth appraisal of the future utility of this 'membership' resource – whether simply as an efficient conduit for information and dissemination, or as the basis for more formal networking and collaboration – should be considered.**

5.1.5 Relationship to complementary international networks

The Alliance shares with COHRED, INCLEN[s] and INDEPTH[t] (and potentially others) strong interests in strengthening southern research capacity, more effectively integrating southern scientists into regional and global research efforts, and an explicitly country/regional orientation; in several countries these four networks collaborate with similar groups. Further, they demonstrate a partial overlap in core funding sources, Sida (Sweden) and the World Bank being notable examples. While a more effective partnership would not necessarily result, there is certainly potential for up-scaled collaborative efforts. In addition it is possible that, in some low-income settings, the networks compete for scarce scientific capacity. **There are, therefore, ample grounds to recommend that the networks' leaderships be more active in reviewing each others' programmes and seeking constructive partnership.**

5.2 Funding and Financial Management

Table 5.1, reviewed together with background reports, demonstrates that the Alliance was relatively well managed from a financial perspective. Expenditure stayed within budget for all but the first year, and although there were roll-overs year by year, these have been reduced over the years. The overhead costs of the Alliance were within reasonable levels

[r] www.alliance-hpsr.org
[s] INCLEN – International Clinical Epidemiology Network
[t] INDEPTH – International Network for the Demographic Evaluation of Populations and Their Health

considering that this was a start-up period (Table 2.2 above). Financial reporting was complex given the different accountability channels to both WHO and the Global Forum. There were some initial problems, but this improved significantly over the years although the current structure does incur some duplication of effort.

Reviewing funding sources (Table 5.1) it can be seen that funding has been relatively stable over the period 2000-2004 (falls during 2001 and 2002 were largely exchange rate related). Clearly NORAD (Norway), SIDA (Sweden) and the World Bank have consistently provided the substantial core and institutional resources that are imperative for an initiative such as the Alliance to thrive. The IDRC became a more significant contributor in 2004; DFID funded the Alliance for the development of research to policy materials in 2003.

Interviews with key donors suggested that these funding levels may be difficult to maintain. Visibility at international level is viewed as a high priority. A number of current donors stressed the importance of the Alliance being seen to contribute to some of the key health systems issues and constraints faced by their (ie donors') recipient countries. Perspectives regarding the institutional framework for the Alliance were mixed, with several donors stressing the importance of links with WHO whilst others would find it difficult to support the Alliance if it became solely a WHO entity and lost its independence.

Table 5.1 Alliance income, budgets and expenditure, 2000-2004

	2000	2001	2002	2003	2004	Total
	Actual					
Income						
NORAD	494,944	454,174	502,572	538,778	550,000	**2,540,468**
SIDA	350,160	281,037	300,000	368,634	393,489	**1,693,320**
World Bank	400,000	400,000	400,000	400,000	400,000	**2,000,000**
IDRC	86,178	14,672	50,750	83,325	272,329	**507,254**
WHO		25,400		20,567	23,000	**68,967**
COHRED			35,000			**35,000**
Global Forum			20,000			**20,000**
DFID				159,598		**159,598**
Other *	874,537		10,000	181	796	**885,514**
Total	**2,205,819**	**1,175,283**	**1,318,322**	**1,571,083**	**1,639,614**	**7,910,121**
Budget	1,300,000	1,713,144	1,576,649	1,693,571	2,106,946	**8,390,310**
Expenditure	**1,380,873**	**1,139,887**	**931,811**	**1,405,821**	**2,047,272**	**6,909,663**
Income- Expenditure	820,946	35,396	386,511	165,262	-407,658	1,000,458
Budget - Expenditure	-84,873	573,257	644,838	287,750	59,674	1,480,647

* balances carried forward

- **Conclusions**

The financing base of the Alliance has been stable and financial management on the whole good. However, the Alliance is now at a crucial stage and needs to increase its visibility if funding levels are to be maintained. After five years this is, however, a modest aim with meaningful financial growth the far preferable option.

6.0 GENERAL CONCLUSIONS AND RECOMMENDATIONS

The role and contributions of the Alliance over the past 5 years can be appraised in terms of their scale, balance, and 'synergy' with complementary efforts:

- With respect to scale of activity, resources were modest and ambitions high. The case for substantially upscaling the Alliance endeavour remains as strong as ever. Every effort to generate the necessary resources should be expended. Albeit hardworking and achievement-oriented, the Secretariat – for much of the time but one stable professional – was simply too limited in size and capability to address adequately the full Alliance portfolio. Experience to-date should provide a keener sense of the capacity required and complex of skills necessary to fulfilling Alliance aims.
- In regard to balance, the Alliance can justify its primary focus on the 'upstream' end of HPSR activities. Yet responding to growing international demand (and, in all likelihood, regional and national / sub-national expectations) some re-orientation towards the more 'downstream' and interface spheres of HPSR is vital and offers major opportunities to better articulate and engage with the field.
- In terms of 'synergy', while some collaborations have indeed proved fruitful, there is great potential to expand the scope of partnership, and in the process build and extend the field of HPSR. Possibilities include:
    - within WHO/EIP
    - across WHO (Geneva and regionally) and particularly with the disease or condition-oriented scientific and technical programmes
    - new but cognate groups such EPOC – the Effective Practice and Organisation of Care Group of the Cochrane Collaboration[u]
    - other networks and international NGOs, for example COHRED, INCLEN and INDEPTH all of which have a strong country-level orientation and commitment to southern scientists.

There is some need for the Alliance to reconceptualise its role. Emerging clearly is a rapidly expanding desire for greater HPSR understanding among key academic, 'translational', international and advocacy constituencies; current and pending efforts in Mexico (the 2004 Ministerial Summit) and elsewhere[8] should encourage the demand from health ministries in many middle and low-income countries. **The Alliance could begin to respond to this demand by more explicitly, visibly and systematically mapping out key HPSR terrains (discussed below) as indeed has now been embarked upon through the just-launched and impressive publication "Strengthening Health Systems".** It may also be useful for the Alliance to characterise the nature of differences in HPSR demand at international and country levels to inform its strategic approach.

6.1 The Alliance 2000-2004: A balance sheet

Table 6.1 takes a simple 'balance sheet' approach to assessing the Alliance endeavour over the past 5 years. While the sheet could be extended or further detail added, the intention is not to fill all the gaps but rather to characterise, if incompletely, work to-date and provide some idea of needs, demands and opportunities to inform future HPSR directions.

[u] www.epoc.uottawa.ca

Table 6.1 A balance sheet addressing selected areas of Alliance endeavour, 2000 – 2004

ACTIVITY / THEME	ACHIEVEMENT	GAPS / POTENTIAL FUTURE FOCUS
Upstream		
Research grants (individual)	high completion rate; country focus with national application	limited international visibility or collective impact; uncertain policy application
Strategic research	targeted with clearer focus on priority issues; opportunity for funding partnerships	recently introduced; await potential impacts; could prove fruitful
Syntheses	limited; recent biennial publication an excellent basis	limited emphasis but major demand internationally; likely growth in demand regionally and nationally
Capacity development	stimulated applications; many grants to young researchers; recent, non-specific links to training institutions	collective impact uncertain; contribution to institutional capacity unclear but warrants assessment
Workshops, tools and methods	considerable research support via workshops; HPSR search engine regularly used; short-course curricula and masters level contributions	limited exploration of HPSR field, especially methodologically
Interface		
Researcher-policymaker interactions	expected in research applications; a few case-studies	limited collective understanding; major field requiring articulation and development
Building the evidence on effective researcher-policymaker interactions		field requires thorough articulation and development
Downstream		
Applications of research/evidence and what facilitates or hinders		major field requiring articulation and development
Alternate forms of learning, non-experimental evidence, 'learning by doing'		major field requiring articulation and development
Evaluation of range of evidence-based interventions		major field requiring articulation and development

ACTIVITY / THEME	ACHIEVEMENT	GAPS / POTENTIAL FUTURE FOCUS
Networking and <u>dissemination</u>		
Website and e-distribution	high functioning informative website; excellent distribution to academic and research partners	website a valuable resource deserving review and possible extension including greater cross links (eg to Cochrane and other sites); distribution to policy-makers less developed
Newsletter	distinctive, informative, wide distribution	

6.2 Extending Alliance-HPSR 'domains' – Notes on future directions

These notes, reflecting potential future work of the Alliance, draw on the balance sheet above and the more general findings of this evaluation. They could contribute to a thorough re-consideration of the aims, objectives and expected outputs of the Alliance in its next phase of work. Indeed, **we recommend that a series of well-framed and carefully constructed discussions / mini-workshops over the near term (some 6 - 8 months) be used to carefully consider these and related domains** – to articulate the scope and dimensions of the field and to help establish the basis for targeted strategic planning and corresponding workplans.[9]

- <u>Substantive issues</u>
  - clarify and articulate the research agenda as this is currently understood; differentiate between immediate priorities, near-term foci, and critical issues requiring a longer research horizon and more sustained investment
  - help frame the scope and define the essence of new and emerging issues (such as chronic care)
  - appraise contrasts/differences in priorities (international vs national for example).

- <u>Methods and methodologies</u>
  - draw attention to methods and tools central to HPSR analyses and what constitutes their effective use (how much evidence constitutes a case for action?; is there some threshold of evidence needed before launching an intervention?; whether/how pilot studies can inform system-wide reforms?)
  - consider the use and applications of systematic reviews, the areas and issues that might be fruitfully addressed, and explore ways to adequately incorporate qualitative or quasi-experimental forms of evidence into such reviews
  - address 'interdisciplinarity' in systems and policy research, and the need/opportunities to draw on both quantitative and qualitative methods in addressing complex questions

- advance the field of study including intervention-evaluation designs – for example, as part of efforts to 'roll-out' prototype approaches or 'scale up' health reforms or particular interventions.

- Researcher-policymaker 'interfaces'
  - what processes are more/less effective in facilitating productive interactions
  - what constitutes 'productive interaction'
  - whether, and if so how, to build an evidence base on factors likely to enhance or hinder productive interactions (does this differ by level of interaction, local vs national, for example)
  - what skills, and forms of research / policy leadership, are necessary.

- Capacity development
  - based on Alliance and other experience, what forms of capacity building initiatives might prove most fruitful
  - what forms of institution strengthening might prove productive? what role for public health and other graduate training institutions? how to support interdisciplinary training and effective training across disciplines?
  - on what basis can institutions be assessed and selected? how to support a regional role for promising national institutions?
  - consider articulating an approach to strategic institutional development; consider new models of S-N-S collaboration.

- Funding and brokering
  - approach systematically and actively the full range of funders with potential interest in supporting HPSR
  - consider reframing the 'investment' role of the Alliance – as a resource able to advise/guide/comment on critically needed or 'good-buy' investments – whether for research (including implementation-evaluation) or for training/capacity development
  - assess whether the Alliance is suited to an 'informed brokering' role
  - how to access / facilitate access to apparently available but little tapped resources for HPSR – such as country-level loans/grants from bilateral or multilateral institutions (regional and international), the Global Fund[10] etc.

6.3 Future organisational possibilities for the Alliance

While a range of organisational options could be put forward, it is necessary to put recommendations into context ie to take funder concerns and institutional developments in the external environment into account, at the same time as appraising realistically the current organisational state of the Alliance, current and likely future trends in its funding support, and preferences expressed by members of the Board. While the Global Forum could potentially be prevailed upon to provide a further grace period, the expectation that the Alliance will 'graduate' from the Forum has been made clear and, indeed, this has always been the understanding between Alliance and Forum leadership.

In essence, there appear to be three broad organisational possibilities for the Alliance:

1. As a free-standing, independent international NGO, with the requisite legal status and a resource base / funding horizon sufficient to support this option
2. Continuing along current lines, but outside of the WHO ie with an independent Board and with the Alliance secretariat hosted either by another UN agency or by some other host institution
3. In strengthened partnership with the WHO, including any organisational restructuring that may be desired/indicated.

Option 1 does not appear to be viable. Its annual cost would be substantial, secretariat staffing would need to be increased and, given Alliance experience over the past several years, there is little likelihood of generating the serious support and resources necessary to such an option. Option 2 is theoretically possible, however none of the key informants approached in this evaluation have recommended it, and no other institution, to our knowledge, has offered itself as a potential host. Unless there is as yet unrecognised, serious interest in the Board to explore this possibility, it should be set aside.

Option 3, then, requires very serious consideration by the Board – since there are various configurations possible and, once direction is charted, major change is unlikely. While the leadership regime within WHO will certainly change over time, current leadership, including that of the Evidence and Information for Policy cluster, is committed to a substantially up-scaled, major thrust in health systems and policy development. A strengthened relationship with the Organisation may thus offer the opportunity for an exceptional alignment between Alliance priorities and evolving WHO directions. Certain reciprocal benefits could be fostered, among them:

- mutual gains from the search for additional HPSR resources
- (for the Alliance) more effective access to government, health ministries and policymakers, as well as gains from WHO's convening capability
- (for WHO) effective connections with research networks and academic institutions, NGOs and civil society; every possibility to strengthen these should be pursued.

It is the case that, unlike most other established or emerging research initiatives, ready access to decision-makers in the public sector in low and middle-income countries is vital for progress in Alliance projects and programmes – the more so if the 'downstream' aspects of HPSR are to feature prominently in the Alliance portfolio. For WHO/EIP, there is every reason to seek close partnership with a recognised systems and policy research body, which has a respected and growing track record, is well-networked with the policy research community, and can be expected to bring a sharp analytic edge to critical issues.

In configuring the future shape of a reformatted Alliance-WHO partnership, several pertinent considerations arise:

- Governance: The great majority of key informants expressed the concern that some form of **independent oversight** of Alliance activities was necessary, whether through a Board or Steering Committee or some equivalent entity – partly to preserve an independent scientific position, partly to facilitate appropriate ring-fencing and accounting for research monies contributed, and also to enable research and working partnerships with bodies outside of governments. In addition, there was a persisting concern that likely future arrangements could lead to a distancing from

southern scientists and institutions. It was however acknowledged that the preferred configuration needed to be the outcome of Alliance-WHO discussions, advised by their sponsors.

- Secretariat: While alternatives exist, this would in all likelihood continue to be based within – or closely linked with – EIP in its Research Policy and Cooperation Division (RPC). As emphasised in this review, **attention must be given to a strengthened professional capability in the Alliance secretariat, as well as to the complex of skills required to successfully manage its mission**; without this, progress may well prove disappointing.
- Regional networks and secretariat location:
  - It is by no means clear that the Alliance secretariat should remain solely Geneva based; increasingly, absence of a southern-based secretariat presence is a handicap and serves to reinforce 'centre-periphery' stereotypes. The point can be strongly argued – that **a Geneva-based secretariat alone will have difficulty fulfilling the Alliance mandate**.
  - The Alliance has invested modestly in four regional networks. Recognising some variation in their performance and stability, there are nevertheless good grounds to appraise the suitability of one or more of these networks taking on a secretariat-type role (whether regionally or more broadly). This would require careful discussion between Alliance-WHO and network leadership, recognising that a more involved partnership role for network leadership would be expected.
- Organisational set-up: A revised arrangement with WHO/EIP should build on experience to-date. Given Alliance independence from the Forum, and a closer alignment between Alliance and WHO in governance structures, it should be possible to construct a somewhat **simpler organisational configuration** than has obtained up to now. Clearly though, administrative accountability and responsibility, and overall decision making authority, needs to be properly considered and agreed on including mechanisms for dispute resolution.

WHO Special Programme

Among the WHO configurations possible, there are grounds to retain the possibility of a suitably sized Special Programme in Health Policy and Systems Research. This option was repeatedly mentioned in key informant discussions and, acknowledging the ambivalence that some expressed regarding its appropriateness, **we recommend that the possibility of a Special Programme be kept alive, potentially for more serious consideration some time in the future**.

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[10] Feachem RGA. Fighting AIDS, TB and malaria – the research imperative. In: Matlin S (ed.) Global Forum Update on Research for Health 2005. Health Research to Achieve the Millennium Development Goals. 2004. London: Pro-Brook. ISBN 2-940286-30-2.