Alliance
for Health Policy
and Systems Research

External evaluation 2020

Alliance for Health Policy and Systems Research

February 2021

Response of the Alliance Board

The Alliance Board is very grateful for the External Evaluation of the Alliance for Health Policy and Systems Research conducted by Hera, and its collaboration with the Evaluation Sub-Committee (ESC) of the Alliance in preparing the evaluation. The Hera team met several times with the ESC as well as the Board, beginning at its November 2019 Board meeting, and various times during January to July 2020. We also appreciate the presentation of the Draft Report at the Alliance Board Meeting on 5 June 2020 and submission of the Final Report on 8 July 2020. The Board Evaluation Sub-Committee provided a detailed set of comments on drafts of the report, and appreciate that the Hera team systematically documented their responses. The Alliance Board has reviewed the findings and key recommendations in depth and has begun to implement key recommendations during 2020, as well as carrying them into the forthcoming strategic plan.

The Evaluation is comprehensive and systematic, and in addition to describing the Alliance achievements and shortcomings, provided relevant recommendations for preparation of the Alliance's next Strategic Plan (2021-25). The Board agrees that given the many changes that have occurred in the arena of health systems around the world, it is important for the Alliance to refresh its vision as it develops its new Strategic Plan. The Board and Secretariat has discussed the vision and priorities of the Alliance in meetings on 31 July 2020 and 9 October 2020 and continue to incorporate these issues in developing Strategic Plan. The Evaluation provided a useful input into those discussion, as did inputs from an extensive survey and interviews conducted by the Secretariat of both current and potential stakeholders of the Alliance. The latter inputs were not included in the external evaluation, but during discussions of the evaluation report were recognized as critical for developing the future strategy.

Board members also agree with the recommendation around the need to address matters related to the role of the Board, including issues around power of different stakeholders on the Board. As the Alliance broadens its stakeholder base, it will also increase the number of board members, particularly to include representation from low- and middle-income countries, and to more actively engage board members in board functions between regular meetings.

The Board has also followed up on the Report's recommendations to enhance support to the Secretariat, particularly as it has a small technical staff with a large mandate and manages a sizeable work programme. The Alliance has initiated a consultancy to help it to examine issues around its size and skills composition that was prompted by the Evaluation. Furthermore, a management coach has been hired to improve team functioning within the Secretariat, who will provide ongoing support for the Alliance Secretariat. Finally, monitoring and evaluation (M&E) was recognized as an important area that will require particular attention in the next plan period. Renewed effort will be put on developing its M&E systems in a way that recognizes how assessing research outcomes is an evolving area of study.

The external evaluation has helped the Alliance to identify ways to continue to improve its functioning and performance, and reinforced the critical roles played by the Alliance in the development and use of health policy and systems research to strengthen health systems around the world.

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EXTERNAL EVALUATION OF THE ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH

Final Report

July 8th, 2020

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ACKNOWLEDGMENTS

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EXECUTIVE SUMMARY

CONTEXT AND METHODOLOGY

The Alliance for Health Policy and Systems Research (the Alliance) was founded in 1999 as an initiative of the Global Forum for Health Research and, within its first five years, formalised its institutional structure as a partnership hosted by WHO. Since inception, it commissioned four external reviews or evaluations. The fourth evaluation which is the subject of this report covers the performance and achievements of the Alliance under its third strategic plan (2016 – 2020). It was conducted between November 2019 and May 2020 and therefore focused on the Alliance performance during the first two biennia of programme implementation in this strategy period, i.e. 2016/17 and 2018/19.

The terms of reference for the evaluation list 11 evaluation questions that were grouped by the evaluation team into three main areas of enquiry:

- The relevance of the Alliance's mission, its added value and the achievement of its objectives
- The governance and the hosting arrangement of the Alliance
- The efficiency and effectiveness of management by the Alliance Secretariat

The evidence for answering the questions in each of the three areas was generated by collecting and analysing data from an on-line survey of Alliance stakeholders, key informant interviews with a sample of stakeholders, document and literature reviews and a scan of the Alliance footprint on internet and social media platforms.

A list of stakeholders invited to participate in the on-line survey and sampled for interviews was obtained from the Alliance Secretariat and expanded with additional contacts obtained from Health Systems Global (HSG) as well as through snowballing by following suggested contacts from those already interviewed. For sampling key informants, and for the analysis of survey responses, the list was disaggregated into six main stakeholder groups while acknowledging overlaps, with many stakeholders belonging to two or sometimes three groups.

Invitations to the on-line survey were sent successfully to 386 stakeholders and the survey had a valid response rate of 32 percent. Key informant interviews were conducted with 55 stakeholders in the following groups:

- Current or former Alliance Secretariat staff (18)
- Current or former Alliance Board or STAC members (13)
- Staff of WHO HQ, Regional Offices or Country Offices (9)
- Alliance grantees since 2016 including researchers, policy- and decisionmakers (8)
- Other stakeholders including staff of international organisations active in health systems support or research and members of the Board of HSG (7)

Secretariat staff and Alliance Board and STAC members were oversampled because they were the main sources of information for answering questions on management and governance.

The evaluation had the limitation that almost all data were collected from internal Alliance documents and from survey responses and interviews with key informants who were, or who had been engaged with the Alliance as staff, partners, donors or grantees. Data reflecting an external perspective of the role and work of the Alliance were therefore limited. No feasible methodology

could be developed in the time and with the resources available to the evaluation team to reach a representative sample of individuals who had not had any engagement with the Alliance and, at the same time, would have had sufficient knowledge to inform any of the evaluation questions.

EVALUATION FINDINGS AND CONCLUSIONS

Relevance and added value

There was broad consensus among stakeholders that the Alliance fills a major gap in health policy and systems research (HPSR). Its ability to engage with policymakers, its thought leadership in HPSR and its focus on health systems in low and middle-income countries were perceived as its main added values. Interviewed stakeholders were divided on their views about the demands placed on the Alliance today.

- On the one hand, there is the demand to continue exercising thought leadership in the theory and science of health policy and systems. With the expansion of the HPSR field since the creation of the Alliance both in terms of the research community and in thematic terms through developments in technology and the increased demand for understanding systems across sectors, the resource requirement for exercising effective leadership has increased. Furthermore, the global landscape of institutions supporting health systems development has changed since the Alliance was created, weakening its initial leadership role in driving the generation of evidence in this field.
- On the other hand, there is an increased demand for applied science in health policy and systems, i.e. the translation of knowledge into policy- and decision-making practice. This role requires a presence or at least an influence in the places were policies are formulated and decisions are made. The Alliance has evolved into this direction during the last two strategic periods in close association with the WHO country- and regional infrastructure, but it is still a long way from effectively filling this role.

These two demands are, of course, interrelated, but there is a tension between them. The Alliance made efforts to negotiate this tension and has thereby been confronted even more acutely by its own limitations in terms of human and financial resources.

Achievement of strategic objectives

The Alliance achieved (and often over-achieved) the output targets of the performance framework used for the period from 2016 to 2019. However, the cumulative targets were set low and never adjusted during the four-year implementation period. The weak link between performance indicators and workplans, the lack of formal indicator definitions and the absence of a consolidated performance monitoring database were additional weaknesses limiting the usefulness of reported performance data for inferences on the achievement of strategic objectives.

The grant-making process of the Alliance was transparent and fair. Criteria of equity and gender equality were applied. Eligibility criteria were adapted to the purpose of each proposal call. A trend towards commissioning low budget research grants was observed during the strategy period. Small grants may serve the objectives of building the capacity of young researchers and of 'priming the pump' for the development of HPSR infrastructures in low- and middle-income countries (L/MICs). The trend was, however, primarily justified by the aim to meet or surpass the output targets of number of publications in scientific journals. While this was successful, it also increased the work

stress of Secretariat staff and its contribution to building or maintaining theoretical leadership in HPSR is doubtful.

Governance and institutional arrangements

In the on-line survey and in interviews with key informants, the current governance arrangements received mixed reviews. The STAC was considered an essential body for assuring the scientific and technical legitimacy and credibility of the Alliance; the Board was considered efficient because of its small size but its ability to provide effective oversight was not considered strong and the dominance of the voices of donor representatives on the Board was perceived to be problematic by many stakeholders.

The question about the effectiveness of the current governance arrangement is, however, closely linked to the question about the institutional arrangement, and specifically about the Alliance's relationship with WHO. There was no consensus among stakeholder about which institutional model the Alliance should pursue, except for the need to maintain a close association with WHO. However, a strong message emerged from the evaluation that can be summarised in the statement that '*form should follow function*'. Organisational and governance changes are necessary, but they should be preceded by a clear definition of strategic direction and, equally important, the proof of the financial and organisational capacity to implement this direction.

Management effectiveness and efficiency

In the past two biennia, the Alliance executed between two-thirds and three-quarters of its available programme budget for activities and operations. There are plausible links between the low performance in budget execution, the widespread perception by informed stakeholders that the Alliance Secretariat was under-staffed, the reports of a high level of work pressure by interviewed Secretariat staff, and the high level of staff mobility, especially in the 2018/19 biennium. A high level of work stress and a non-supportive work environment were cited by several current and former staff members as underlying reasons for the high mobility.

The biennial workplan, the quarterly reports and the operational workplan were the main planning and monitoring instruments used by the Alliance. The three instruments were poorly aligned and lacked specific information essential for management control, such as implementation targets and timelines. The assessment of the efficiency of programme delivery was constrained by modifications of activities without explanation and justification, as well as by changes in reporting formats. Efforts to improve the alignment of planning and monitoring instruments with strategic objectives were on-going at the time of the evaluation but had not yet been implemented.

During the last two biennia, the Alliance enhanced its visibility by developing and implementing a coherent communications strategy. However, little is known about the profile of the Alliance audience. The social media footprint of the Alliance increased steadily and by the end of 2019, the Alliance was on a good trajectory of building an audience of Twitter followers, including in L/MICs.

RECOMMENDATIONS

The evaluation team formulated six recommendations that flow directly from the conclusions drawn on the basis of evidence generated by the findings of the evaluation. In abridged form, the recommendations are:

1. In the process of developing the 2021-25 Strategic Plan, the Board should consider the human and financial resources that are required to meet the strategic objectives, estimate the resource requirements for meeting them and include a strategy for raising them.
2. In order to achieve the vision of the Alliance, the Board in consultation with external partners should invest in renewing the platform of cooperation among global institutions that are active in health systems support in order to advance evidence-based health policies at global, regional and country-level.
3. For the 2021-25 Strategic Plan, the Alliance Board should develop a performance monitoring framework with clearly defined measurable indicators, sources of information and targets, managed by dedicated Secretariat staff qualified in M&E and supported with improved monitoring tools.
4. The Alliance Board should address issues of weak oversight and uneven power distribution in the governance of the Alliance, as well as its institutional structure and relationship to WHO. However it should only do so after a clear vision and strategy has been developed and adopted, applying the principle that form should follow function.
5. The Board should commission a thorough management review of the Alliance Secretariat by specialists in this field with a particular focus on organisational structure and culture and on planning, monitoring and reporting processes. The outcome of this review should be clear recommendations for improving the management structure and processes of the Secretariat.
6. The Secretariat should implement a plan to better define, segment and expand the audience for Alliance communication outputs within its 2020/21 workplan.

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ABBREVIATIONS

AHPSR	Alliance for Health Policy and Systems Research
APW	Agreement for Performance of Work
CO	Country Office (WHO)
DFID	Department for International Development (UK)
ERC	Ethical Review Committee (WHO)
ESC	Evaluation Sub-Committee (of the Alliance Board)
GPW	General Programme of Work (WHO)
HEART	Health & Education Advice & Resource Team (DFID)
HPSR	Health Policy and Systems Research
HR	Human Resources
HRP	Special Programme of Research, Development and Research Training in Human Reproduction
HSG	Health Systems Global
HSS	Health Systems Strengthening
IRP	Implementation Research Platform
KII	Key Informant Interview
L/MIC	Low- and middle-income country
LOA	Letter of Agreement
MDG	Millennium Development Goal
PAHO	Pan American Health Organization
PHC	Primary Health Care
PI	Principal Investigator
RFP	Request for Proposals
RO	Regional Office (WHO)
SDG	Sustainable Development Goal
STAC	Scientific and Technical Advisory Committee (AHPSR)
TDR	Special Programme for Research and Training in Tropical Diseases
TOC	Theory of Change
TSA	Technical Service Agreement
TSC	Technical Service Centre
UHC	Universal Health Care
VfM	Value for Money
VOIP	Voice over Internet Protocol

1 INTRODUCTION

1.1 THE ALLIANCE FOR HEALTH POLICY AND SYSTEMS RESEARCH

In 2017, the Alliance for Health Policy and Systems Research (AHPSR or 'Alliance') marked its 20th anniversary. Major milestones of the **early years** of the Alliance were:

- In 1996, the WHO *Ad Hoc Committee on Health Research Relating to Future Intervention Options* released its summary report *Investing in Health Research and Development* including Chapter 6, '*Research to inform health policy*'. [1] The chapter summarised a large volume of technical papers on methodological and substantive issues of health policy and systems research (HPSR) that were published under separate cover. [2]
- In 1997, an international consultative meeting in Lejondal, Sweden agreed to create the Alliance of Health Policy/Systems Research and '*requested the Norwegian and Swedish sponsoring agencies to establish and provide support for an Interim Board*'. [3]
- In 1999, the *10/90 Report on Health Research* by the *Global Forum for Health Research* listed the Alliance as one of its supported fora, with capacity building as its main area of interest. [4]
- In November 1999, the Alliance was formally constituted as an initiative of the Global Forum with the aim of '*contributing to health development and the efficiency and equity of health systems through research on and for policy*'. [5]
- In 2000, the World Health Report '*Health Systems: Improving Performance*' introduced a ranking of national health systems that, although controversial, raised international interest in health systems without, however, referring to health policy and systems research. [6]
- In 2004, the WHO *Task Force on Health Systems Research* to support the attainment of the Millennium Development Goals (MDGs) published its report in the Lancet. [7] It included a table of suggested topics for health-systems research potentially affecting the attainment of the MDG targets.
- In 2005, the Alliance underwent its first external evaluation. Structural issues were raised because of the planned separation of the Alliance from the Global Forum. The Secretariat was already housed in WHO, but it now transitioned to a 'Hosted Partnership', a transfer of the legal entity responsible for the Alliance from the Global Forum to WHO. The option of transforming the Alliance into a WHO Special Programme was raised but not further pursued. [5] Generic 'Hosting Terms' were developed and adopted by WHO in 2013. [8]

Throughout this early period and the subsequent years, the **aims of the Alliance** remained essentially unaltered although there are nuanced differences between the statement adopted in 1999 *'to contribute to health development and the efficiency and equity of health systems through research on and for policy'*, [5] and the formulation in the current 2016-20 strategic plan, '*to promote the generation and use of health systems research as a means to strengthen the health systems of low- and middle-income countries'*. [9]

1.1.1 THE CONTEXT OF THE ALLIANCE'S WORK

The context of health policy and systems research evolved significantly throughout the 20-year history of the Alliance. Health systems strengthening (HSS) became an increasingly explicit programmatic objective of international agencies and global health initiatives. The 2008 World Health Report renewed the attention to Primary Health Care (PHC) principles, particularly the *'recognition of the social value of health systems'*. [10] With the transition from the MDGs to the Sustainable Development Goals (SDGs) by the UN General Assembly in 2015, [11] the goal of Universal Health Coverage (UHC) became an overriding theme of national and international health policies.

In response to these changes, the scope of HPSR gradually expanded from an initial focus on health service management and service delivery to include the social dimensions of health. Even more importantly, the realisation that global solutions were not equally applicable across varying contexts raised the importance of contextualised HPSR that brought it closer to policy- and decisionmakers and programme managers who needed evidence-based solutions for the issues they were confronted with. [12] With the growing demand for evidence, the number of institutions and agencies conducting or supporting health systems research expanded rapidly.

The institutional context of the Alliance's operations also evolved.

- In the organisational restructuring of WHO Headquarters in 2007, the Alliance Secretariat moved from the Evidence, Information and Policy Cluster to the Health Systems and Services Cluster, reporting directly to the responsible Assistant Director General. The proximity within the cluster to WHO health systems departments such as the Department for Health Systems Governance and Financing provided opportunities to coordinate and complement the Alliance research mandate with the work on norms, standards and policy advice of WHO. [13] In March 2019, WHO was again restructured, and the Alliance Secretariat moved to the Science Division reporting to the Chief Scientist. As of January 2020, this division includes the Special Programme for Research and Training in Tropical Diseases (TDR). The Special Programme of Research, Development and Research Training in Human Reproduction (HRP) is formally located in the UHC/Life Course Division but also reports to the Chief Scientist. This co-location of research programmes in WHO offers new opportunities for collaboration and complementarity.
- Since 2006, the Alliance has implemented its programmes under three successive WHO General Programmes of Work (GPW): 2006-2015, 2014-2019, and 2019-2023. Throughout this period, the aims of the Alliance were always fully aligned with those of WHO. Each GPW, however, set new accents that affected this alignment, whereby these accents may also have been influenced by the Alliance. The promotion of health systems research is mentioned in all three GPWs, albeit only in sub-sentences. Entire sections, on the other hand, are dedicated to health systems strengthening. The differences are that in the 11th GPW (2006-2015) and the 12th GPW (2014-2019), strengthening health systems was primarily presented in terms of efforts to improve health service delivery. [14,15] While this focus is not lost in the current GPW (2019-2023), the term people-centred health systems is introduced, community involvement is mentioned as a critical systems component, and there is explicit reference to social, environmental and economic determinants of health and to multisectoral approaches anchored in a human rights perspective. [16]

- Following a statement issued by the first Global Symposium on Health Systems Research in Montreux, Health Systems Global (HSG) was created in 2012 with assistance of the Alliance. HSG is an international membership society with the mission to *'convene researchers, policymakers and implementers from around the world to develop the field of health systems research and unleash their collective capacity to create, share and apply knowledge to strengthen health systems'.* [17] There are complementarities between the work of HSG and the Alliance. To avoid duplications and overlaps of the mandates, a Memorandum of Understanding was signed by the Board Chairs of the two organisations in 2015 and renewed in 2019. [18] The Executive Directors of the two organisations have observer status on each other's Boards.

1.1.2 The AHPSR Strategic Plan 2016-2020

The implementation of the '*AHPSR Strategic Plan 2016-2020: Investing in knowledge for resilient health systems*' [9] is the primary focus of the evaluation. It is a concise document that, on few pages, lays out the objectives and planned strategies of the Alliance over the five-year period.

Table 1. Alliance Objectives and Strategies 2016-2020

Objectives	Strategies
1. Provide a unique forum for the health policy and systems research community	Bring together key actors, especially national policymakers, to establish research priorities for health policy and systems research particularly related to the SDGs and other health goals
	Facilitate greater sharing, coordination and alignment of approaches among global and country actors
	Convene meetings of interested partners to discuss challenges facing the field and the role of the Alliance in addressing these
2. Support institutional capacity for the conduct and uptake of health policy and systems research	Work with selected research and policy institutions to develop and test effective models and mechanisms to support capacity development
	Increase the uptake of research practices and evidence by decisionmakers through active engagement, leveraging existing and new health policy and systems research networks and partnerships
	Strengthen the capacity of women, early-career researchers, and policymakers as future leaders in the generation and uptake of knowledge by prioritising their inclusion in training opportunities and programmes
3. Stimulate the generation of knowledge and innovations to nurture learning and resilience in health systems	Increase production and publication of high quality, relevant research and syntheses on health policy and systems research
	Develop new models, methods and approaches for the generation, synthesis and use of health policy and systems research
	Create an open repository of knowledge products aimed at health systems strengthening
4. Increase the demand for and use of knowledge for strengthening health systems	Build and support a network of policy- and decisionmakers to strengthen the demand for health policy and system research
	Engage decisionmakers and researchers at local and regional levels and implement mechanisms to identify and use available knowledge to improve health systems performance
	Launch policy-information platforms in selected countries to provide a space for policy- and decisionmakers to share and use local and global knowledge on priority topics.

Despite its condensed format compared to previous strategic plans,[1] the scope of strategies outlined in the 2016-2020 strategic plan has expanded. Strategic shifts reflect an increasing

[1] The 2016-2020 strategic plan has 13 pages compared to 21 and 42 pages of the preceding two strategic plans

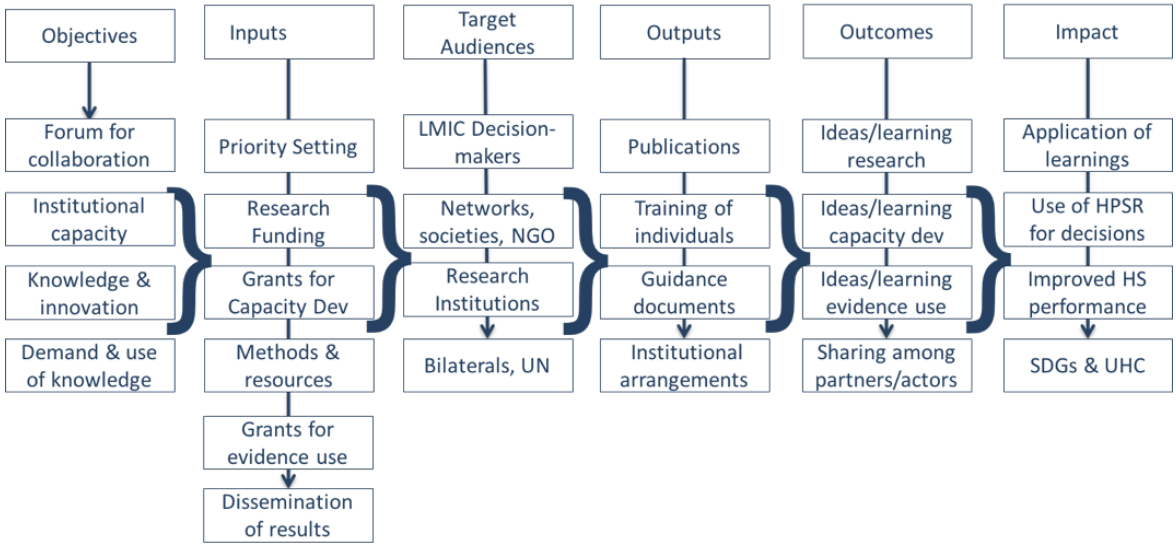
maturity of the field of HPSR. Most noticeable is the increased importance of the convening role of the Alliance and the support of partnerships and networks. This is evident when mapping the strategies against those of the previous strategic plan.

Table 2. Mapping 2016-2020 Strategies against 2010-2015 Strategies

Strategic Plan 2010-2015	Strategic Plan 2016-2020
Contribution to global health policy and systems networks and partnerships	
• Support network of policy research institutes	• Build and support a network of policy- and decisionmakers to strengthen the demand for health policy and system research • Increase the uptake of research practices and evidence by decisionmakers through active engagement, leveraging existing and new health policy and systems research networks and partnerships • Convene meetings of interested partners to discuss challenges facing the field and the role of the Alliance in addressing these • Facilitate greater sharing, coordination and alignment of approaches among global and country actors • Bring together key actors, especially national policymakers, to establish research priorities for health policy and systems research particularly related to the SDGs and other health goals
Contribution to national evidence-to-policy processes	
• Support select countries, in an integrated fashion, from knowledge generation to synthesis, evidence use and capacity development • Continue to support national evidence-to-policy processes	• Engage decisionmakers and researchers at local and regional levels and implement mechanisms to identify and use available knowledge to improve health systems performance • Launch policy-information platforms in selected countries to provide a space for policy- and decisionmakers to share and use local and global knowledge on priority topics.
Contribution to increasing the capacity for HPSR and knowledge translation	
• Provide a facilitator and coordinator role to scale up HPSR training and mentorship • Review options and determine best strategy to support policy-maker capacity development	• Work with selected research and policy institutions to develop and test effective models and mechanisms to support capacity development • Strengthen the capacity of women, early-career researchers, and policymakers as future leaders in the generation and uptake of knowledge by prioritising their inclusion in training opportunities and programmes
Contribution to increasing the increasing global knowledge on health systems	
• Support primary research and syntheses through catalytic seed funding and collaboration with other funders • Review and document lessons learnt from investments to date in national evidence-to-policy processes • Document and develop consensus around standards/norms for methods and tools; and their application • Support development of methods for HPSR synthesis	• Increase production and publication of high quality, relevant research and syntheses on health policy and systems research • Create an open repository of knowledge products aimed at health systems strengthening • Develop new models, methods and approaches for the generation, synthesis and use of health policy and systems research

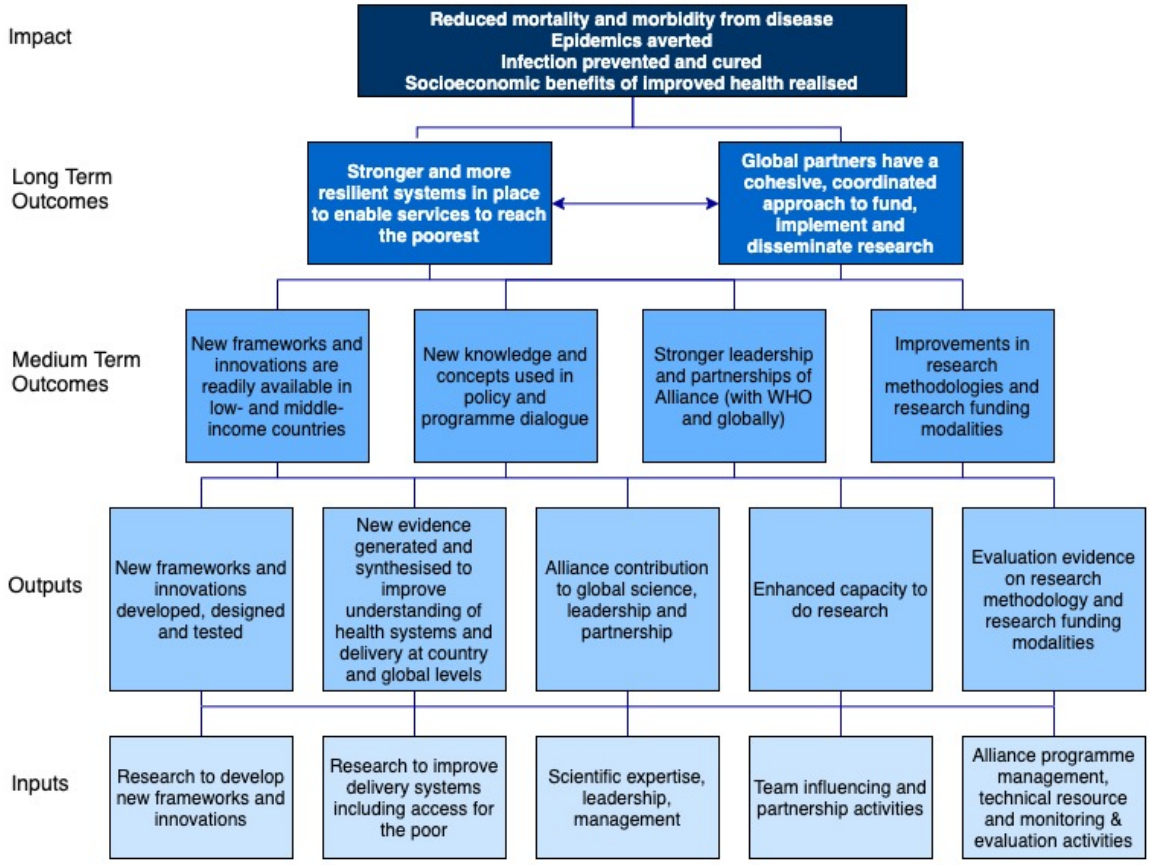
Logical or Theory of Change (TOC) frameworks were not included in any of the three strategic plans, however the biennial workplans for 2016/17 and 2018/19 include iterations of a TOC that is currently being further developed for the 2020/21 workplan. One of the challenges that contributes to the somewhat unusual structure of the TOC frameworks is the conceptualisation by the Alliance of the non-linearity of the evidence-to-practice process. Knowledge generation and evidence-based decision-making are understood as integrated processes within a health systems learning cycle that do not lend themselves to be presented in a framework based on linear logic. This integrated knowledge-to-policy paradigm is, however, not reflected in the TOC frameworks that are still structured according to a linear logic, even though the chain of causal logic is difficult to follow and does not lend itself to a TOC-based evaluation.

Figure 1. Theory of Change Framework (2016/17 Workplan)



Note: The Alliance uses the term 'Theory of Contribution to Change'. However, since all Theory of Change Frameworks are frameworks of contribution, we have used the term Theory of Change throughout.

Figure 2. Theory of Change Framework (2018/19 Workplan)



1.1.3 The 2014 External Review

Since its foundation in 1999, the Alliance underwent three external reviews or evaluations. The latest was an external review conducted by the Health & Education Advice & Resource Team (HEART), a consortium contracted by the UK Department for International Development (DFID) for technical assistance in 2014. [19] It was based on document reviews and interviews with 37 Alliance Secretariat staff and stakeholders. In interviews with the evaluation team, the two authors of the review stated that it was conducted over a short time period with limited time for data collection.

The review team issued 21 *'strategic'* recommendations primarily focused on the development and implementation of the 2016-2020 strategic plan most of them supported by 15 *'tactical'* recommendations where *'relatively minor actions could have significant impact'* based on the same review findings. The Alliance Board responded to the review that for the development of the 2016-2020 strategic plan, it will '*take these recommendations into account, weighing them in the context of other preparatory work including mapping exercises, expert consultations and an internal review.*' [19] The Executive Director reported on the responses and status of implementation to the Board in October 2015. A document summarising this report in the form of a table was provided by the Secretariat to the evaluation team. **(see Volume 2)**

The terms of reference of the evaluation include a follow-up of the recommendations of the 2014 external review.

2 EVALUATION APPROACH AND METHODOLOGY

The Evaluation Sub-Committee (ESC) of the Alliance Board established the terms of reference (TOR), guided the evaluation, reviewed the methodology, provided comments and approved the inception report. The draft evaluation report was submitted to the ESC and discussed prior to presentation to the Board.

Data collection for the evaluation was conducted between December 16th, 2019 and March 30th, 2020. The findings, conclusions and recommendations of the evaluation are based on evidence generated with data collected through document reviews, key informant interviews (KIIs) and an on-line survey of a broad range of stakeholders. Documents were obtained from the Alliance Secretariat and through targeted internet searches using standard search engines. Most documents were provided by the Secretariat, including internal documents such as minutes of Board and Scientific and Technical Advisory Committee (STAC) meetings, budget and expenditure reports, communications related to research grants and statistics of social network activities.

For the on-line survey and for sampling informants for KIIs, a database of Alliance stakeholders was established that included a total of 401 names and contact addresses categorised by stakeholder groups as presented in **Figure 3.**

Figure 3. Alliance Stakeholder Map

As indicated in the figure, there were many overlaps among these categories of stakeholders. Several individuals belonged to two, some even to three stakeholder groups. This was taken into consideration when sampling respondents for KIIs.

All stakeholders were invited to complete an on-line survey. After removing duplication and those who had no email addresses, 386 invitations were sent by email from the server of the Alliance and the HSG Secretariats, 34 were returned as not deliverable, and 111 completed the survey for a response rate of 32 percent. For KIIs, 55 stakeholders were sampled. Six did not respond or were not available but were replaced during data collection. A detailed description of the methodology for sampling, data collection and analysis is provided in **Volume 2**.

2.1 LIMITATIONS

The main limitations of the evaluation were potential omission and inclusion biases due to the sampling frame of stakeholders and the purposive sampling of key informants. Especially policy- and decisionmakers as well as health systems programme managers who had no prior engagement with the Alliance were not included in the sampling frame despite requests by the ESC. A feasible methodology to include a representative group of such individuals could not be found, nor does it, in the view of the evaluation team, exist. Furthermore, it is doubtful that such individuals would have offered information contributing to answers to the evaluation questions, except maybe a statement of whether they did or did not know the Alliance and its products.

Oversampling of current and former Alliance staff, Board and STAC members for KIIs could also have introduced an inclusion bias. Answering evaluation questions on Alliance governance and management required a large representative sample from these groups and oversampling was therefore justified. The initial sample was, in fact, expanded by snowballing on the basis of suggestions and recommendations provided by key informants during interviews.

Over the four-year period from 2016 to 2019, the Alliance supported 111 research projects generating 210 peer-reviewed publications. A formal assessment of the quality of research outputs was not done, primarily because of time and resource limitations. This was already indicated in the inception report and approved by the ESC.

3 EVALUATION FINDINGS

3.1 EVALUATION QUESTION 1

Is the mission and aim of the Alliance still relevant and to what extent are the objectives being achieved?

3.1.1 RELEVANCE OF THE ALLIANCE STRATEGY 2016-2020

The majority of survey respondents and interviewed key informants considered that '*increasing demand for and use of knowledge*' (Objective 4) and '*supporting institutional (and individual) capacity building*' (Objective 2) as the two most relevant objectives of the Alliance. Views on the relevance of '*providing a unique forum for the HPSR community*' (Objective 1) tended to be split. Alliance staff, STAC and Board members considered it relevant while others were less convinced of its importance for the Alliance strategy. Views also differed on the relevance of Objective 3, '*generation of knowledge and innovations'*. Overall, it received the lowest relevance rating both in the survey and in interviews, but researchers and policymakers generally considered it important to continue to advance the field of HPSR. This objective received proportionally the largest budget allocations during the 2016-20 strategy period.

Surveyed policymakers stated that research supported by the Alliance was relevant for meeting the priorities of low- and middle-income countries (L/MICs). These views may, however, be biased as all of them had at one time been recipients of Alliance grants. The processes for setting the research priorities by the Alliance, including for the flagship reports, were generally considered appropriate and thorough. Many respondents were unable to rank these processes on a scale of weak to strong, and several key informants from different stakeholder groups noted that the process should be better documented.

The relevance of the Alliance strategy was assessed according to three criteria: (i) the extent to which stakeholders considered the strategic objectives relevant for meeting the HPSR priorities of low and middle-income countries; (ii) the extent to which policymakers considered the research areas relevant for meeting the HPSR priorities of L/MICs; and (iii) the extent to which the Alliance approach to research priority-setting contributed to a research portfolio that served health policy priorities in L/MICs.

Relevance of strategic objectives

Respondents to the on-line survey were asked to rank actual or potential areas of work of the Alliance by order of importance in relation to its mission to '*promote the generation and use of health policy and systems research as a means to strengthen the health systems in low- and middle-income countries*' (see **Annex 2**). Four areas of work were ranked among the top three priorities by around half of the respondents (ranging from 49 to 54 percent). They broadly aligned with objectives one, two and four of the Alliance 2016-20 Strategy.

Table 3. Ranking of priority areas of work by survey respondents

Activity	Ranked among top 3 by % of respondents	Linked to Strategic Objective (Table 1)
Support the institutional capacity development of research and policy institutions in low- and middle-income countries	54%	Objective 2
Support the capacity-building of researchers and policymakers in conducting health policy and systems research, particularly women and early career researchers	51%	Objective 2
Bring together key actors, especially national policymakers, to establish research priorities for health policy and systems research	49%	Objective 1
Engage with researchers and policymakers at national, regional and global levels with the aim to promote evidence-based health policies and programmes	49%	Objective 4
Develop and publish methodological guidelines for health policy and systems research, as well as normative guidelines, for instance for the ethical review of research proposals	35%	Objective 3
Develop new models, methods and approaches for the generation, synthesis and use of health policy and systems research	28%	Objective 3
Facilitate greater sharing, coordination and alignment of approaches among global and country actors	24%	Objective 1
Increase production and publication of high quality, relevant research and syntheses on health policy and systems research	20%	Objective 3
Launch policy-information platforms in selected countries to provide a space for policy- and decisionmakers to share and use local and global knowledge	19%	Objective 4

Interviewed key informants disagreed on the role the Alliance should play in realising each of the four objectives. The majority of Board and STAC members stated that the Alliance should move into the position of global leadership through its convening role rather than by acting as a research funding institution. A majority rated **Objective 1** as the highest priority, emphasising the ability of the Alliance to convene policy- and decisionmakers because of its link to WHO. Key informants in the stakeholder group of 'Other Partners' (Figure 3) were less convinced of the organisation's effectiveness in '*providing a unique forum*'. Several considered the objective too vague. One respondent stated that this activity was '*poor use of money*' and others felt that HSG was a more effective convenor because of its membership structure.

For many key informants, **Objective 2** on institutional capacity building was closely linked to Objective 4, with Objective 4 being more the '*advocacy role*' and Objective 2 the '*practical support*'. The objective was considered relevant, but several respondents stated that, given its limited size and budget, the Alliance should be more strategic and selective in how and where it strengthens and builds capacity. The approaches to capacity building that are currently being tested by the Alliance were generally only known by interviewed Secretariat staff, Board and STAC members. Those who were aware, thought that more learning should happen to better understand the value and impact of different approaches. This is being pursued by the Alliance.

The focus on institutional capacity building was generally appreciated and endorsed by interviewed key informants as a way to increase the demand and use of evidence. However, many informants also stressed the continued need for individual capacity building, especially in countries where the field of HPSR is not highly developed, for instance in many francophone countries in Africa, and for early-career researchers.

There was more disagreement among key informant about activities under **Objective 3**. While most stakeholders acknowledged that the Alliance could not exist without supporting the generation and synthesis of knowledge, opinions differed on the extent to which it should fund research. For some, including most Board members, some staff members and WHO staff, this objective should be approached strategically, focusing on synthesising evidence and making it easily available, as well as mobilising others to invest in health systems research. The generation of knowledge should be used as a tool for building capacity of researchers and, furthermore, linked to Objective 4 to ensure knowledge generation leads to knowledge uptake and use.

Interviewed staff stated that research funded by the Alliance focused on niche areas, meeting a need to demonstrate proof of concept and advance the development of methodologies and guidelines for HPSR. They did not consider the Alliance to be the main funding agency for grants to advance the knowledge on health policies and systems, however, over 40 percent of the activity budget in 2016-2017 and over 30 percent in 2018-2019 were allocated to the objective of knowledge generation.

Recipients of grants, including researchers and policymakers, on the other hand, considered the knowledge generation objective relevant and important, although they acknowledged that the number of agencies funding HPSR has increased, and that there are now more alternatives for research fund applications. The focus of the Alliance on health systems in L/MICs was appreciated as well as the fact that the Alliance was simultaneously building the capacity of researchers. They felt that a programme that focused purely on capacity building without a component of generating knowledge would have difficulties attracting funds from donors.

Some key informants at country level, including WHO CO and RO staff, stated that the Alliance should more proactively look at how existing health systems knowledge in countries could be better managed and shared. They linked this to the WHO transformation process which aims to make better use of existing resources at country level, and the creation of a repository of knowledge products. Although the readers on health policy and health systems commissioned and published by the Alliance presented extensive information on country experiences, they are rather academic products that are not very accessible to decisionmakers who are seeking information on what worked where and how.

Objective 4 was considered relevant by all stakeholder groups and seen by some even as the 'mission' of the Alliance. However, most acknowledged that this was not an easy objective and that there was still a long way to go. Several informants mentioned that this objective should be better linked to Objective 2 (capacity building) and 3 (knowledge generation) to ensure the knowledge generated by the Alliance is the right type of evidence for decisionmakers and more capacity is built in policy and implementing institutions. Others stated that this objective required a stronger engagement with country governments through the WHO Country Offices (COs). This was pursued by the Alliance during the period under evaluation, however only in a limited number of countries.

One concern, however, expressed by some informants, was that the Alliance should not only focus on knowledge transfer to policymakers, but also include decisionmakers such as health service personnel and institutions and organisations working more widely on the improvement of health systems.

Several informants also pointed out that there are challenges of working with both researchers and policymakers because of misaligned incentive. Publications drive researchers and allow them to progress in their careers, whereas the interest of policymakers in scientific publications is limited. Information to drive evidence-informed policies is not always publishable in peer reviewed papers and often has to be available in shorter timeframes than the publication process allows. The Alliance, as an institution hosted by the Science Division in the WHO, however, is in a position that allows it to reach all stakeholder groups and overcome this dichotomy.

A minority of informants were more sceptical and felt that the Alliance, with a small Secretariat, could not be expected to have a major influence on policymaking at country level. Instead, it should collaborate with others who are already directly working with governments and support existing initiatives.

Policymakers views on the relevance of priority research areas

Eleven policymakers from three WHO regions (AFRO, AMRO and SEARO) participated in the on-line survey, all from L/MICs. All replied that the Alliance-supported research was either relevant or very relevant to meeting the health system and policy priorities in L/MICs. Respondents appreciated that the Alliance targeted decisionmakers while collaborating with academia and research institutions. This approach helped build synergies for sustainable outcomes at a lower cost, which is much welcomed in under-resourced settings. The research addressed real-time operational challenges and helped in the understanding and improvement of health systems in the country context. Furthermore, funds for training at the national level were also considered important to ensure the generated evidence supported decision making. All of the respondent policymakers were, however, also beneficiaries of Alliance grants and may therefore have had a biased perspective. This was an acknowledged limitation of the evaluation methodology. (**Section 2.1**)

Interviewed decisionmakers generally agreed that the Alliance's focus on creating links between policymakers and researchers was important. Some found that embedding research stronger in implementing institutions was necessary, whereas others stated that research should maintain some independence and should therefore stay outside of government agencies. Several informants, including a policymaker, believed that the research focus areas did not necessarily respond to the health systems needs of L/MICs and encouraged the Alliance to engage more with countries to establish their needs and the potential contribution of research to meet them. One informant encouraged the Alliance to '*think out of the box*' and to try to forecast how health systems needed to change in order to achieve UHC, including looking at innovations and technology. This was also echoed in the on-line survey where narrative responses to the question about other areas of priority in which the Alliance was not operating included '*future health systems and innovations*' as well as '*innovative digital tools for generation, synthesis and use of HPSR*'.

Priority setting processes

The Alliance uses a two-step approach for identifying its research priorities. In the first instance, the priorities in terms of research portfolios are identified for each biennium through a process led by the Secretariat. This process compiles inputs received through their engagements with WHO departments, grantees, policymakers as well as events organised and meetings attended. Based on this input – which is not a formal process, but rather a collection of information from different sources – the Secretariat prepares a programme of work which is presented to the STAC. Following discussion and feedback from the STAC, the programme is reviewed and presented to the Board for approval. The decision on topics for flagship report follows a similar process, usually also involving an external Advisory Board. Once the broad research portfolios are defined, the Alliance engages in a more formal priority setting process which involves the wider HPSR community. Six prioritisation exercises were realised and published in peer-reviewed journals. [e.g.25] The exercises were comprehensive and involved local, regional and global stakeholders. Detailed priority setting exercises with inputs from local and regional stakeholders were also organised for some calls for research grant proposals.

Feedback from survey participants and key informants generally referred to the priority setting processes in which they were involved. STAC and Board members commented mostly on priority setting for research portfolios, whereas grantees generally focused on priority setting for their specific grants. Several respondents to the survey (28) and in interviews (5) stated that they were not aware of how the Alliance defined its priorities.

The opinion of key informants on the identification of research portfolios varied. For some the process was adequate and the Secretariat together with the STAC should be responsible for identifying priorities. As the STAC also includes representatives of L/MICs, policymakers and research institutions, they felt that input was provided from a sufficiently broad range of stakeholders. Many others, however, stated that the current process could and should be improved by more formally involving a wider group of stakeholders, including WHO departments, Regional Offices (ROs) and Country Offices (COs).

The on-line survey asked whether research institutions and policymakers in L/MICs influence priority setting by the Alliance. Among the grantees (researchers and policymakers), 48 answered this question, all but one located in a L/MIC. Less than half (22) considered the influence strong while 11 considered it weak and 15 stated that it was neither weak nor strong.

While a wider consultation of L/MIC stakeholders may be desired, some informants acknowledged that this may be difficult considering the human resource capacity of the Secretariat. However, several informants, from different stakeholder groups, believed that the process for setting research priorities should be better documented.

In relation to selecting topics for the flagship reports, most key informants stated that the current process was appropriate. According to them, the Secretariat was best placed to identify the topic and work with the STAC and an external Advisory Board to finetune the concept. Donor representatives on the Board felt that the Board should be more consulted, while other Board members considered it a technical issue that should be primarily discussed at the level of the STAC.

The issue of earmarked funding was also raised by several stakeholders as a factor influencing research priorities. Two (current or past) Board members also expressed a somewhat critical view

of the influence of donor representatives on the Board: *'The Alliance has a very narrow funding basis and very few donors. If one of the key donors pushes a certain theme or issue as a top priority, then the other Board members have a choice to either support it and ensure that the Alliance continues to receive the necessary funds or block it and risk that the donor withdraws. It is not a level playing field and this is no different from other global health initiatives.*'

3.1.2 ADDED VALUE

There was consensus among on-line respondents and interviewed key informants that the Alliance fills a major gap in health policies and systems research. The positioning within WHO legitimises its role as a convenor of policy- and decisionmakers and is the main unique characteristic of the Alliance. The engagement with policymakers, thought leadership in HPSR and the focus on L/MICs are the main added values of the Alliance. Collaboration with WHO departments and hosted research programmes increased during the strategic period 2016-2020. Constraints were, however, also mentioned, most often the limited capacity of the Alliance to exercise leadership and coordination in the field of HPSR that had greatly expanded over the past two decades.

Unique characteristic of the Alliance

Respondents to the on-line survey were asked to select one of five options to complete the statement '*if the Alliance did not exist as a partnership hosted by WHO …*'. Two-thirds (66%) of the 109 respondents who answered the question selected the option *'… we would need to create the Alliance to fill a major gap in HPSR'*. Less than one fifth (18%) believed that important gaps in HPSR could be filled by other existing networks and organisations. Similar responses were obtained in interviews with key informants. Most stated that if the Alliance did not exist, it would need to be created. The responses were, however, more nuanced. Many noted that the field of HPSR had evolved considerably since the creation of the Alliance and credited the Alliance for being the main, or at least a major, driver of this change. Several stated that it was time for the Alliance to reflect on how to continue positioning itself as a leader in a more crowded space.

A large majority of interviewed key informants considered the close association with WHO the main characteristic that made the Alliance unique. It provided access and convening power for policy- and decision-makers and thereby the ability to link policy and systems research to decision-making, strengthening the evidence-base of programmes, policies and guidelines at local, national, regional and global levels. Interviewed WHO staff provided examples of where the Alliance executed this role during the evaluation period, but also mentioned that the scope and reach of Alliance activities were limited because of its small size in terms of budget and human resources.

Added value of the Alliance

Three attributes of the added value of the Alliance were mentioned most frequently by key informants:

- **Engagement with policy- and decisionmakers**: This is identical to the 'unique characteristic'. In addition to the limitations in reach discussed above, limitations in scope were also mentioned, for instance by one STAC member: *'The Alliance needs to identify issues that can help countries. For example, some countries are using digital technologies in ways that will leapfrog their health systems. The Alliance should engage and generate evidence that can guide these initiatives.'*

- **Global thought leadership and steering of the agenda on HPSR:** Through its flagship reports and methods readers, the Alliance innovated, experimented and pushed forward new ideas, and, in the words of one key informant, maintained '*unquestionable global technical leadership*'. The most frequently cited examples were the World Report on Health Policy and Systems Research published in 2017 [28] and the Health Policy Analysis Reader published in 2018 [29]. Current work on a flagship report on Learning Health Systems has the ambition to continue in this tradition.

  The Alliance, furthermore, has ambitions to expand the current scope of HPSR. According to the Executive Director, it focuses primarily on policies and systems for health services rather than policies and systems for health. He advocated a more holistic systemic concept of health and its determinants. This was widely supported by on-line survey respondents among whom 78/105 (74%) stated that the interrelationship of health and non-health issues addressed by the SDGs should be a high priority for the HPSR agenda of the Alliance.

- **The focus on low- and middle-income countries:** Informants primarily referred to the contribution of the Alliance in building capacity for HPSR and implementation research in L/MICs. The concept of '*priming the pump'* was mentioned by one respondent.

The three attributes of added value align with the four objectives of the 2016-20 Strategy. They are linked, but nevertheless encompass a very large and diverse field of work that would even be a challenge for a much larger organisation.

During the evaluation period, the collaboration of the Alliance with WHO Departments such as the Department on Health Systems Governance and Financing and the Health Workforce Department increased in volume and effectiveness as reported by WHO staff. The Alliance Executive Director noted, however, that there is still much work to be done before the Alliance would become the reference in WHO for generating and translating evidence for health policies and systems.

Collaboration with the other two research programmes hosted by WHO, TDR and HRP also increased. It was much in focus during the evaluation period and was actively promoted by donor agencies, including through joint funding. A status report was provided to the Joint Coordinating Board of TDR in June 2019. [30] It mentioned the AHPSR/HRP/TDR joint Theory of Change framework for strengthening capacity in implementation research as well as a number of initiatives for joint research activities in Latin America, Nepal, India and Ethiopia, also involving the Pan-American Health Organization (PAHO) and/or WHO COs. According to interviews with TDR and HRP staff, the collaboration with the Alliance has, however, not been optimal. Conceptual differences in the approach to priority setting and limited availability of Alliance staff for collaborative planning activities were cited. In fact, both HRP and TDR have a much larger staff complement. HRP already has a unit focusing on health systems research for sexual and reproductive health, while TDR supports by far the largest volume of capacity-building initiatives in implementation research. For the research collaboration on health and mass migration in Latin America, a partnership initiative of PAHO, HRP, TDR, the Alliance and two Latin American research organisations, the call for research proposals issued by PAHO in September 2019 did not even list the Alliance among the programme partners. [31]

3.1.3 ACHIEVEMENT OF STRATEGIC OBJECTIVES

The Alliance achieved (and often over-achieved) the output and outcome targets of the reporting framework used for the period from 2016 to 2019. Although cumulative performance targets are, according to interviewed staff, established annually, nine of 16 targets were already achieved in the preceding year indicating an issue with the target-setting process. The weak link of performance indicators to workplans, the lack of formal indicator definitions and the absence of a consolidated performance monitoring database were additional weaknesses limiting the strength of performance data for inferences on the achievement of strategic objectives. A new performance monitoring framework to be implemented from 2020 onwards was under development during the evaluation period. Although not yet completed, there is evidence that it will correct some of these weaknesses.

From 2016 to 2019, the four objectives of the Strategic Plan 2016-20 were tracked by the Alliance Secretariat with the aid of a results framework that included one impact statement with three indicators, one outcome statement also with three indicators, and three output statements with 16 indicators. The impact indicators were considered out of scope for performance monitoring. The three outcome indicators map against Objectives 2 and 4 of the Strategic Plan. The three output statements roughly map against Objectives 2, 3 and 4, although two indicators under Output 3 also tracked performance under Objective 1.

The Alliance did not maintain a performance monitoring database but transcribed information from different sources and databases each year into an annual 'logframe' that did, however, not list targets. These are available in separate 'logframe-targets' documents. Since the Secretariat uses the term 'milestones' interchangeably for both achievements and targets, gaining an overview of achievements was a time-consuming exercise.

The unavailability of a comprehensive performance database affects the awareness of both the Secretariat and the Board about the performance of the Alliance. Most key informants reported that the performance of the Alliance was good, often mentioning that there were areas of lower and higher performance, but never being able to cite evidence or even to specify what these areas were. Some key informants also stated that the performance had improved since 2018, a perception which is, however, not reflected in the performance data. When asked about the Alliance's performance, interviewed staff mostly referred to the staff member who acts as the focal point for logframe reporting, indicating that they were not aware of the extent to which objectives were achieved. Several staff members stated that they had difficulties relating their work to the performance framework.

A consolidated table of cumulative performance targets and achievements over the strategy period was assembled by the evaluation team and is presented in **Volume 2** and summarised in **Table 4.**

Table 4. Reported achievements against targets 2016-2019

	Indicators	Achievements against targets 2016	2017	2018	2019
Outcome Increased generation and use of health policy and systems research (HPSR) resulting in improved maternal and child health services, reduction of the burden of HIV/AIDS, malaria and other diseases in select countries.	Number of Alliance- funded research projects being conducted	111%	111%	110%	109%
	Number of Alliance- supported publications cited five or more times by others	108%	117%	116%	180%
	Number of countries in which Alliance supports active engagement of all stakeholders in policy dialogues and other knowledge translation platforms	**	98%	**	100%
Output 1 Increased production and publication of high quality, relevant research and syntheses on health policy and systems research LMICs, particularly focusing on the poor	Number of publications on HPSR in L/MICs published in peer-reviewed journals	**	111%	**	121%
	Number of HPSR peer-reviewed publications on L/MICs where the lead author is from an LIC	**	148%	**	177%
	Number of products from Alliance-funded projects	104%	108%	109%	104%
	Number of oral presentations made at national and international forums based on Alliance funded projects	98%	100%	100%	98%
	Number of Alliance-funded projects aimed at developing HPSR methodologies	108%	107%	106%	100%
Output 2 Increased number and capacity of institutions, particularly in LMICs, able to undertake and use high quality, health policy and systems research.	Number of researchers undertaking Alliance-funded HPSR studies in L/MICs.	123%	120%	118%	129%
	Percent of researchers undertaking Alliance-funded HPSR studies in L/MICs that are women	98%	98%	118%	124%
	Number of decisionmakers in L/MICs sensitised to use of evidence in health systems decision making through Alliance- supported activities	**	119%	**	148%
	Number of researchers in L/MICs trained in Alliance-funded short-term training and fellowship programmes	**	144%	**	133%
	Number of young researchers in L/MICs trained in Alliance funded short- term training and fellowship programmes	**	142%	**	147%
	Number of decisionmakers in L/MICs trained in Alliance-funded short- term training and fellowship programmes	**	142%	**	150%
Output 3 Increased number of countries and instances where HPSR is promoted and/or used as an element of policy formulation and decision-making processes.	Number of Alliance-funded policy dialogues at global, national and sub-national levels bringing together decision-makers and researchers.	**	101%	**	93%
	Number of policymakers engaged through these dialogues	**	97%	**	89%
	Number of products demanded by and designed for decision makers and made available to them	**	108%	**	109%
	Number of new/revised policies, programmes or practices informed by Alliance supported initiatives	**	103%	**	115%

*Source: Alliance HPSR Logframes 2016-2019 and Alliance Target Logframe; ** reported biennially*

The table, which consolidates information received by the evaluation team from the Secretariat in several separate documents, shows that the Alliance consistently achieved or over-achieved its

targets for all indicators in 2016, 2017 and 2018, and for all but two indicators in 2019. These two targets for Output 3 that map against both Objective 1 and Objective 4 of the Strategic Plan were nevertheless achieved at 89 and 93 percent respectively. The Alliance thus demonstrated a very high level of achievement.

Repeated over-achievements on several indicators, however, raises questions about target-setting. In 2019, for example, six indicator targets were achieved at more than 130 percent, two of them at 177 and 180 percent respectively. According to Alliance staff, targets for indicators were set on an annual basis. If this is the case, then the performance of the previous year was not considered. and targets were set too low. As the detailed table in **Volume 2** shows, cumulative 2019 targets for nine of 16 indicators had already been achieved in the preceding annual or biennial period automatically resulting in a report of over-achievement even if activities would have come to a complete halt. This limits the utility of the performance framework for understanding the annual achievements of the Alliance. Other weaknesses that potentially limited the usefulness of the 2016-19 performance monitoring data as evidence for achievements included:

- Operational definitions or calculation methods for the indicators are not available. This is problematic for 10 of the 19 indicators. For the output indicator *'number of decisionmakers in L/MICs sensitised to use evidence in health systems decision making through Alliance-supported activities*', for instance, neither the term 'decisionmaker' nor the term 'sensitised' are defined. The achievement could therefore be counted in multiple ways. It could, for example, include the number of people receiving the newsletter. In the absence of definitions of terms, the counting of outputs and interpretation of terms is subjective and does not allow consistency, especially if there has been turn-over of staff.
- Sources for the reported results were not available. The annual 'logframe' documents refer to the Alliance monitoring database and the grantee survey. However, when we asked for a copy of the database, we were informed that there were different data sets from which the reports were generated. Which data source was used for which indicator was, however, not documented.
- The results framework was not linked to the operational workplans, defining which activity was implemented to contribute to which output or outcome. This made it challenging for staff to understand how their work contributed to the achievement of strategic results and to comprehend whether or not sufficient and the right activities were implemented to achieve defined outputs. This was also reflected in staff interviews.

Challenges of performance reporting were discussed by the Board in their meetings in Fall 2017 and 2018. In 2017, the Board meeting minutes stated that activities and products should be presented in a way that they could be linked to strategic objectives. Another requested action was to create operational plans showing each activity and that '*a link should be made between 7 strategies and 4 strategic objectives*'. In response, the Secretariat reviewed the portfolio of activities and carried out an exercise to align activities and strategies with the strategic plan objectives. The Board meeting minutes from November 2018 highlighted again that there was a need to establish links between the workplan, the strategy, the reporting framework and the TOC framework. Board members also expressed that the reporting framework was not using the right indicators to reflect the outcomes of the Alliance's work. The Secretariat was requested to develop a new and simpler reporting framework responding to the requirements of all funders. The new

reporting framework was requested to be rolled out in 2019 to enable one cycle of reporting prior to the external evaluation. The delivery of the new reporting framework, however, was delayed. A draft was presented to the Board in Fall 2019. The Board commented that '*there was a need for all indicators to be measurable and [to] reduce potential ambiguities in the wording of indicators*'. It was referred to a subcommittee for a final decision in 2020. At the time of the evaluation it was in the process of being finalised.

The new reporting framework will be used from 2020 forward. It includes outcome and output statements and indicators; the impact level was deleted. It lists three outcomes measured with five indicators and seven outputs measured with 16 indicators. The number of indicators has slightly increased, and numerous indicators were changed compared to the 2016-19 framework. The new framework addresses several weaknesses of the former logframe. It is planned to link activities of the workplan with outputs and strategic objectives. The quantitative indicator results will be complemented by short narratives with the aim to add descriptive qualitative information. It also includes a column of explanations on how to interpret the indicator data. For some indicators, the explanations are comparable to operational definitions; for others, however, the explanations are either missing or are not yet sufficiently detailed to serve as operational definitions. For the new indicator 5.1 ('*Number of researchers based in LMIC institutions gaining skills in the generation of HPSR'*), for example, it is not defined how '*gaining skills*' will be measured. The data sources for the indicators are also not (yet) included. The final draft of the new results framework was not yet available for review. It is, however, noteworthy that in the process of its development, existing shortcomings of current monitoring and accountability processes are being addressed.

3.1.4 Effectiveness of the granting process

The grant-making process of the Alliance was considered transparent and fair by on-line survey respondents and interviewed key informants. Criteria of equity and gender equality were applied. Eligibility criteria were adapted to the purpose of each proposal call. Informants were critical about the small budgets ceilings of research grants, a practice that increased during the evaluation period and according to Alliance management was more efficient in generating results, i.e. publications that could be reported to donors. It did, however, also increase the transaction costs for the Secretariat and raised questions about sustainability.

Requests for proposals were widely disseminated by the Alliance and accessed by institutions, including governments, research institutions, NGOs and private sector entities globally. Two thirds of awards (62%) were made to institutions in low- and lower middle-income countries. While the budgets of winning proposals from low-income countries were on average much smaller than those from richer countries, the difference can be explained by differences in research infrastructure and capacity, as well as by awards to mentoring institutions and Technical Support Centres that tended to be larger but that implemented much of their work in L/MICs.

Grant-making practice

Eighty-five respondents to the on-line survey had either applied for an Alliance grant or were involved in grant adjudication. Among them, 87 percent found that funding decisions were made and communicated within the timelines stated in the call for proposals and 85 percent that fair criteria of quality and equity were applied in a transparent manner during grant adjudication. Key informants interviewed generally concurred with this view. The grant-making process was

considered transparent, however, several grantees mentioned that they would have liked to receive feedback when their application had been rejected, so that they could learn and improve.

The selection process was also considered adequate. The Secretariat, usually with support of external reviewers, prepares a shortlist based on specific eligibility criteria. This shortlist is presented and approved by the STAC. Those involved in peer reviews considered the process effective, transparent and equitable. The review process usually included two reviewers and a final meeting chaired by the Secretariat. Criteria of equity and gender were applied, and different eligibility criteria were used depending on the type of the grant. For example, grants on knowledge generation would focus more on the technical quality of the proposal and the track record of the institution or researcher, while geographical distribution was also considered. If four of the five shortlisted proposals were from the same country, other proposals would be considered to ensure more equity in the distribution. Selection of capacity building grants focused on the ability of the applicants who would potentially benefit from the project.

The focus on gender balance in the research teams increased during the period under evaluation. In recent years, the gender balance among principal investigators improved. In 2018, 22 of the institutional grants adjudicated were female-led compared to 12 grants that were male-led. In 2019, there was an almost equal distribution among female-led (17) and male-led (18) projects.

Several grantees, however, observed that the same institutions received grants year after year because they had already established a relationship with the Alliance. Ten organisations or institutions received almost half (43%) of the $10.7 million disbursed by the Alliance through Agreements for Performance of Work (APWs), Technical Service Agreements (TSAs) or Letters of Agreement (LOAs) between 2016 and 2019. In addition to HSG, these included institutions in L/MICs in the EMRO, SEARO and AFRO regions and institutions in the USA.

Table 5. Location of the top ten recipients of Alliance grants 2016-2019

LOCATION	APW	TSA	LOA	# CONTRACTS	FUNDING VOLUME
HSG (global)			3	**3**	$1,111,783.00
Lebanon	3	3	1	**7**	$ 939,099.00
South Africa	3	2	3	**8**	$ 842,135.00
USA	5	1		**6**	$ 498,758.00
India		2		**2**	$ 278,954.00
Ethiopia	2	1		**3**	$ 220,000.00
Uganda	2	2		**4**	$ 204,987.20
South Africa		1		**1**	$ 180,000.00
South Africa		1		**1**	$ 149,975.00
Kenya	1	1		**2**	$ 144,786.00
TOTAL	**16**	**14**	**7**	**37**	**$ 4,570,477.20**

Source: Alliance grant database (internal document)

Several key informants commented on the small size of Alliance research grants. '*Grants have been too small. The Alliance is putting the burden on the researchers to get work done and are asking too much for the funding available'*. The Executive Director acknowledged that the Alliance issued many small grants, a practice that increased the transaction costs, but it also increased the results that the Alliance was able to report to its donors: '*If you invest $30,000, you may get one publication, if you invest $100,000, you may still get one publication. With three grants of $30,000,*

you may get three publications, but it is a headache to manage all these grants.' The budgets of research grants, according to another informant, decreased over time as it was found that smaller grants generated results faster and more efficiently. While there is sufficient evidence to support this, the respondent questioned the relevance of this achievement for the Alliance which should be '*an innovation hub and not a small grant making institution*'.

Two key informants questioned whether the small funding volumes, short timeframes and demands for product-based deliverables of research grants issued by the Alliance contributed to building sustainable institutions and longer-term partnerships. According to them, the Alliance focused too much on expectations that grants generate publications and not sufficiently on providing technical support in addressing institutional or country needs.

Reach of Alliance proposal calls and grants

Most survey respondents (88%) stated that calls for proposals were widely disseminated and easily accessible. This is, however, subject to an inclusion bias because the sampling frame included only institutions that had received grants from the Alliance.

According to current practice, the Alliance publishes its requests for proposals (RFPs) on its website and shares them through its mailing list and social media channels. Several sites cross-post the Alliance calls.[2] The evaluation team had access to a database of grant applications for 2018 and 2019. During this period the Alliance issued 21 RFPs to institutions, three of them for Technical Support Centres (TSCs) to support country-level teams of researchers and decisionmakers in systems thinking and health policy research. A total of 916 institutions or organisations from 89 countries applied for funds, some of them in joint bids. The total number of bids was therefore only 572. The average number of bids per RFP was 27. When the RFP for 'Embedding Research for SDG in the Americas' was removed from the analysis because it was jointly issued with PAHO, HRP and TDR, the average number of applications dropped to 19. In total, 69 bids submitted by 78 institutions or organisations in 41 countries were successful.

Table 6. Institutions responding to Alliance RFPs in 2018/19 by Region

Region	Institutions	Countries	Successful	Countries	Success rate
AFRO	348	24	33	13	9%
AMRO	288	23	19	13	7%
EMRO	58	11	3	3	5%
EURO	68	19	4	4	7%
SEARO	126	7	13	5	10%
WPRO	28	5	6	3	22%
Total	**916**	**89**	**78**	**41**	**9%**

Source: Alliance tender database (internal document)- our calculation

Most bidding institutions were government departments or agencies (39%), followed by academic institutions (36%), NGOs (11%), the private sector (8%) and individual consultants (6%). Almost half of the awards, however, were made to academic institutions (48%), representing 65 percent of total funding. Government institutions were awarded one third of the grants, however this

[2] Such as for example: https://www.publichealthupdate.com/?s=Alliance+HPSR or https://www2.fundsforngos.org/health/

represented only 15 percent of total funding. NGOs were awarded eight percent, while the private sector and individuals each received four percent of awards.

The majority of successful bids (41%) were submitted by institutions in lower middle-income countries followed by upper middle-income countries (28%). Institutions in low income countries submitted 22 percent of successful bids, however, the value of these bids was only nine percent of the total value of all successful tenders.

Table 7. Successful bids by economic level of countries of origin

Economy	Countries	Successful bids	Total value of bids	Average value
High Income	5	7	$1,103,314	157,616
Upper-middle Income	15	22	$1,870,271	85,012
Lower-middle Income	13	32	$3,128,666	97,771
Low Income	8	17	562,213	33,071
Total	**41**	**78**	**6,664,284**	**85,440**

Source: Alliance tender database (internal document)- our calculation

Overall, these data suggest that the RFPs for institutional grants issued by the Alliance reached a wide range of institutions in a large number of countries. Most awards were made to institutions in L/MICs. The higher value of awards to high- and middle-income countries compared to low income countries was partially due to grants for TSCs and mentoring institutions that supported health systems research, training and knowledge translation in low-income countries, and partially due to the differences in HPSR implementing capacity between countries according to their economic basis.

3.1.5 Follow-up of strategic recommendations of the 2010-14 external review

The Alliance Secretariat and Board accepted the majority of recommendations of the 2014 External Review and integrated the response in the formulation of the 2016-20 Strategic Plan and the biennial workplans of the strategy period. While there is evidence that progress has been made in several areas covered by the recommendations, key informants acknowledged that many of them continue to be valid with room for further progress.

The 21 strategic recommendations of the external review report as well as the response from the Secretariat and Board are presented in **Volume 2**. No management response was provided to the 15 tactical recommendations. They were, however, closely linked to the strategic recommendations. An initial plan to discuss them in a separate section of the evaluation report (under Question 3) was therefore abandoned. The recommendations were structured in five groups:

- Development of the Strategic Plan 2016-20
- Future structure of the Secretariat
- Future major workstreams
- Partnerships with WHO and HSG
- Dissemination and Advocacy

Recommendations for the development of the Strategic Plan 2016-20

Ten recommendations were formulated under this heading. The management response rejected Recommendation 3 on institutional structure because it was based on an incomplete

understanding of the nature of the hosting arrangement between the Alliance and WHO. Recommendation 6 on the alignment of the STAC with the Alliance Strategy was contested by STAC members who stated that they were misquoted during the presentation of the draft report. This was confirmed by the evaluation in interviews with former STAC members.

The remaining eight recommendations are reflected in the 2016-20 Strategic Plan and in the two biennial work plans that were developed during the evaluation period. The extent to which recommendations on issues such as strategic consultations, research priority setting, institutional capacity building, profiling of the Alliance, balance among strategic objectives, dissemination and knowledge translation were implemented is discussed in **Sections 3.1.1 to 3.1.3**.

The Board, STAC and staff members interviewed by the evaluation team generally considered that the recommendations continue to be valid. All respondents acknowledged that the Alliance made impressive progress in profiling itself and disseminating its results although there continues to be room for further improvement. The relatively small size of the Alliance was acknowledged as a limitation in the focal shift from individual to institutional capacity-building.

Views on priority setting processes differed among key informants. Some expressed concerns about the influence of financial donors; others felt that the needs of national policymakers did not receive sufficient attention; and others were of the opinion that the Alliance should not compromise its role as a thought-leader in HPSR, and that notable advances in HPSR would not have happened if the Alliance had only focused on the immediate needs of health service practitioners and decisionmakers. It is unlikely that these tensions can be completely resolved. There is, however, evidence that the Alliance implemented some rigorous consultative priority-setting processes, most recently on HPSR for the attainment of the SDGs. [20] Respondents to the on-line survey rated the priority-setting processes of the Alliance as strong but were less convinced that researchers and policymakers in programme countries had a major influence.

Recommendation for the future structure of the Secretariat

The review issued one recommendation to align the role and the staffing structure of the Secretariat. According to the Executive Director's response, changes were made in the staffing of the Secretariat and three new high-level posts were created.

Changes in the staff complement and structure, however, continued throughout the evaluation period, with 14 new staff members joining the Secretariat, most of them on time-limited contracts, and 15 staff members leaving, including eight who had started within that period. This is a rather high level of staff mobility in a unit that, according to the organigram of January 8th, 2020 had only 17 staff positions of which seven were vacant or under recruitment. The issue is further discussed in **Section 3.3.3**.

Recommendations on future major workstreams

The Review issued four recommendations on future workstreams, namely on flagship reports, systemic review centres, the Implementation Research Platform (IRP) and Nodal Institutes. Work with Nodal Institutes was discontinued, and the support of Systemic Review Centres continued during the strategy period as recommended.

The Board disagreed with the recommendation to make the selection of flagship reports more transparent and responsive to global priorities. Themes for flagship reports, according to

interviews with key informants, are proposed by Advisory Boards with members from outside and inside the Alliance and final decisions are made by the STAC and Board, sometimes after protracted discussions.

For the IRP, the review recommended steps to consolidate and expand the range of activities. The Alliance initiated this platform in 2010 and was a major contributor to establishing implementation research in the global health research landscape. However, at the time of the 2014 review, IRP activities were nearing their end and the platform soon became inactive. This may explain why the Secretariat did not respond to the recommendation. Methodology development, training and grant programmes for implementation research were firmly established in the portfolios of the main IRP partners (the Alliance, TDR and HRP) throughout theevaluation period and are continuing. Key informants, including TDR and HRP staff, confirmed their commitment to promoting and supporting implementation research but saw little use in continuing the IRP.

Recommendations on partnerships with WHO and HSG

The review recommended that the Alliance and HSG should sign a memorandum of understanding to '*secure a complementary and collaborative relationship*'. This was implemented in 2015 and extended in 2019. Key informants confirmed that the relationship between the two organisations was indeed collaborative.

Three recommendations on the partnership of the Alliance with WHO were issued. The management response was somewhat perfunctory, pointing to the close institutional ties of the Alliance with WHO. Interviews with WHO staff confirmed that the collaboration of the Alliance with WHO HQ Departments strengthened during the evaluation period. One respondent, however, expressed concerns that the relocation of the Alliance during the latest structural reform of WHO from the former Health Systems Cluster to the Science Division may weaken the links to WHO programme departments. The respondent suggested that a location in the UHC/Life Course Division in close cooperation with the newly created Special Programme on Primary Health Care would have provided greater assurance of the use of Alliance results in the support provided by WHO to countries.

The work of the Alliance with WHO COs was seen more critically by many key informants. Almost all considered this an important entry-point for the Alliance to meet its objective of increasing the demand and use of knowledge by national decisionmakers. Although this is explicit in the Strategic Plan, it was only achieved in a limited number of countries, primarily in Ethiopia, India, Nepal and Pakistan. Especially in countries with very weak health systems who could potentially benefit most from Alliance support to HPSR, the work of the Alliance is not well known by the WHO COs. Limited human and financial resources were mentioned as a constraining factor by several respondents.

Dissemination and communication

A recommendation on communication was largely implemented and key informants were unanimous in stating that the communication style and reach of the Alliance improved during the evaluation period although many also stated that there was still room to grow. This is further discussed in **Section 3.3.5**.

The review also recommended that the Alliance should study '*the preferred communication medium of policymakers*'. Engagement with policymakers was pursued by the Alliance during the evaluation period but the evaluation team is not aware that such a study was undertaken.

The tactical recommendations

The 15 tactical recommendations did not appear in the report's summary list of recommendations and there was no response by the Secretariat or the Board. Most of them recommended operational steps to support the implementation of the related strategic recommendation. For instance the strategic recommendation on increased communication with policymakers was supported by the tactical recommendation to work with the WHO COs to facilitate the access to national policymakers.

Less clearly linked to a strategic recommendation and not supported by any findings was a recommendation for the Alliance to develop guidelines for the ethical review of HPSR. This was taken up by the Alliance, a meeting of experts was organised in 2015, and a guideline document on ethical considerations for health policy and systems research was published in 2019. [22]

The strategic recommendation on the future structure of the Secretariat was further supported by a tactical recommendation for a review of management style and organisational culture. An analysis of organisational culture was conducted by a human resource management coach in 2017 and followed by a staff retreat. This is further discussed in **Section 3.3.3**.

3.2 Evaluation Question 2

Do the governance and the hosting arrangement of the Alliance contribute optimally to the achievement of the organisation's objectives?

3.2.1 Governance structures and mechanisms

The governance of the Alliance is provided by the Board which has an overall oversight function and the STAC overseeing the technical quality of the Alliance programme of work. The remits of the two bodies are well defined. On-line survey respondents and interviewed key informants rated their composition and functioning as somewhat appropriate and effective. Asymmetries of power and the dominance of the voices of donor representatives on the Board were acknowledged while there were doubts about feasible solutions for improvement. The Board was considered to function efficiently although some Board members expressed frustration about insufficient information and deliberation for effective oversight. The creation of permanent sub-committees was suggested as a step towards improvement.

The governance structure of the Alliance is made up of two committees.

- The Board has 11 members including three representatives of the core financial donor agencies, a representative of WHO (the administrative line manager of the Alliance Executive Director), the Executive Director of HSG (non-voting), the Chair of the STAC, and five members selected by the Board from respondents to a call for candidature and nominated for three-year terms with the option of one renewal. In November 2019, 5/11 members were female and 6/11 resident in a L/MIC. The candidates are presented to the Board by the Secretariat highlighting their potential strengths in four areas: (i) being a recognised global leader in HPSR; (ii) having the ability to raise funds; (iii) lending creditability and visibility to the work of the Alliance; and (iv) having senior operations management expertise and experience. [27]

- The Scientific and Technical Advisory Committee (STAC) has seven members with scientific or policy-making expertise selected by the Board for three-year terms. In November 2019, 5/7 members were female and 4/7 resident in a L/MIC. The same process as for the selection of Board members is applied.

The remits of the two governing bodies are defined as follows:

Table 8. Board and STAC roles and functions

BOARD	STAC
• Review / decide on strategic direction and focus • Select the members of the STAC • Approve the workplan and budget • Monitor and evaluate progress • Lead in ensuring contributions of complementary health policy and systems research initiatives • Contribute to fundraising	• Provide scientific and technical advice to the Board and Secretariat • Provide technical input to the work plan and its implementation • Participate in the evaluation of competitive calls for proposals • Identify potential collaborators and act as ambassadors for the Alliance

Source: www.who.int/alliance-hpsr/about/en/

While key informants noted that in the past the division of roles between the two governing bodies was not always clear, it improved considerably during the evaluation period although there were still occasions when the Board engaged in technical discussions that should more appropriately be considered the remit of the STAC. The fact that the STAC rather than the Board reviewed and commented the quarterly programme implementation reports, which is a rather unusual division of responsibility, was not commented by key informants.

On-line survey respondents who were or had been a member of the Board or STAC or who were otherwise well informed about their function were asked about their views on the governance structure, the composition of Board and STAC membership, and the effectiveness of the two bodies for providing oversight over the work of the Alliance (Board) or its technical quality (STAC). Not all 40 respondents who accessed these questions were able to answer all of them. Those who did generally agreed that the structure, composition and functions of the governance bodies were appropriate and effective. There were three negative responses to each of the four questions. While one of them was consistently provided by the same respondent, the other two differed from question to question.

Table 9. Appropriateness and effectiveness of governance

	STRONGLY DISAGREE	DISAGREE	NEUTRAL	AGREE	STRONGLY AGREE
The governance structure is appropriate	1	2	4	19	13
The composition of the Board is appropriate	2	1	4	23	6
The Board provides effective oversight	1	2	5	17	8
The composition of the STAC is appropriate	2	1	3	15	13
The STAC provides effective technical guidance	2	1	4	15	12

See Volume 2

Interviewed key informants confirmed the tendency of a general satisfaction with the composition and effectiveness of the STAC. As one Board member expressed: *'The STAC is a critical body giving value to the Alliance. This structure must be there and should be strengthened. That is where the scientific credibility of the Alliance is generated. It allows the Alliance to fill a norm-setting role.'*

This view is also shared by Alliance staff, but some staff members mentioned that the relationship between the Secretariat and the STAC is sometimes tense: *'Presenting a concept paper to the STAC is like defending a thesis. The relationship could be more collegial.'*

Views expressed by interviewed key informants about the composition and function of the Board were more critical. Most appreciated that the Board was leaner and less political than the large governance structures of other global health partnerships, and therefore more efficient. On the other hand, two Board members felt that this apparent efficiency was often due to the Board only fulfilling *'a rubberstamping function'*. A published review of the governance of global partnership characterises this tension as the trade-off between inclusiveness and effectiveness. [32]

The composition of the Board elicited most comments. Board members, like members of any governing board of a non-profit organisation, should act in the interest of all stakeholders. The Alliance Board comprises members from three distinct stakeholder groups:

- Three permanent members are nominated by the core financial donors. Although they are meant to serve in a personal capacity, they cannot avoid representing the shareholder interests of their national government agencies to whom they are accountable; and they do so with varying intensity.
- Two permanent members are nominated by WHO and HSG. One of them, the representative of WHO, is also the line manager of the Executive Director and de facto the administrative head of the Alliance.
- The remaining six members are appointed for limited periods on the basis of personal characteristics from a loose network of policymakers and scientists knowledgeable in HPSR. The selection has a positive bias towards candidates from L/MICs. This group could be considered as representing the beneficiaries or potential beneficiaries of Alliance activities.

In theory, the three main groups of stakeholders are represented on the Board in reasonably appropriate proportions, but while the five permanent members have a delegated authority from powerful institutions, the six appointed members derive their authority only from their personal skills and reputations. This creates asymmetries of power as pointed out by one Board member already quoted in Section 3.1.1 who described the Board as an *'uneven playing field'*.

The situation is not different from the governing structures of other multi-partner health programmes where the voices of financial donors tend to dominate the Board discussions. However, because core operations of the Alliance are financially dependent on only three donor agencies, the asymmetry of power is amplified because the withdrawal of any one of them could generate irreparable harm to the organisation.

Several suggestions on how to decrease this asymmetry were offered by key informants. These included:

- Increasing the number of appointed Board members which would have cost implications and is unlikely to reduce the imbalance because the origin is not their number but their power.
- Changing to a system where non-institutional Board members would be appointed by the Regional Committees of WHO which theoretically would increase the power of their voice. But the experience of this system in the governing bodies of other programmes such as HRP has not been very positive.

- Reducing the number of donor representatives by instituting a system of rotation and mutual delegation among them which is unlikely to be accepted by the core donors.
- Increasing the number and diversity of core donors and institutional members of the Alliance, bringing them into the Board and thereby balancing the weight of single donor voices. This would likely reduce the imbalances, but it is a solution that would have to be pursued through fund-raising rather than through a reform of Board composition.
- Abolishing the Board and strengthening the technical oversight mandate of the STAC which would, in fact, only be possible if the Alliance were fully integrated into WHO and come under the governance of the World Health Assembly. This option was only supported by two interviewed key informants. (**Section 3.2.2**)

The feasibility or functionality of all these options was questioned by key informants. As one senior WHO staff commented, that *'if it is not broke, don't spend too much time on the governance, but rather spend this time with the functions, and how they can create more impact.'*

The ability of the Board to provide effective oversight was also questioned by some informants. The Board only meets once a year with a second remote meeting by teleconferencing that, according to some Board members, was generally too short to allow in-depth discussions. All acknowledged that the Board Chair had frequent contacts with the Executive Director and exercised a key oversight function, shared to some extent with the WHO administrative head, the Chief Scientist and formerly the Assistant Director General.

Board members acknowledged that the Secretariat implemented Board decisions, however several expressed frustration that these decisions were often based on limited information and insufficient time for discussion and deliberation. This could be solved, according to one respondent, by establishing permanent sub-committees on issues such as monitoring and evaluation or finance. While this would likely improve the oversight capacity of the Board, it is somewhat constrained by its overall small size.

3.2.2 Organisational arrangement

There was a broad consensus among key informants that the close association of the Alliance with the WHO was its main source of strength. The administrative reorganisation of the Alliance in the WHO Science Division was also supported by many. Most key informants expressed reservations, doubts or insufficient knowledge about future options of the Alliance to fully integrate into WHO, to continue as a hosted partnership or to be transformed into a special programme with or without co-sponsorship by other international agencies working in health systems strengthening. Several key informants warned that 'form should follow function' and that the future role of the Alliance should be agreed prior to initiating a discussion on organisational change.

Throughout 2019, the Alliance Board discussed the organisational and hosting arrangements of the Alliance Secretariat. During the Board meeting of June 2019, the Executive Director explained that it was not the task of the evaluation to explore organisational options for the Alliance. [23] In November 2019, the Secretariat presented a paper to the Board discussing three options for future organisational arrangements: (i) continue business as usual; (ii) phase out the Alliance and create a new department of WHO; and (iii) transform the Alliance into a special programme for health

policy and systems research. [24] The Secretariat recommended to pursue the third option. The Board asked the Secretariat to further explore the implications of such a change.

The evaluation terms of reference (TOR) ask for an assessment on whether the '*current organisation and hosting arrangements of the Secretariat are fit for purpose*'. (**Volume 2**) Keeping in mind the statement of the Executive Director, the evaluation team did not examine or recommend future organisational options, but questions on whether current arrangements are fit for purpose unavoidably led to discussions with key informants about counterfactuals.

The organisation and hosting arrangement of the Secretariat was discussed with 32 key informants, including all Board and STAC members, WHO staff and representatives of potential funding partners. All of them affirmed that the close association of the Alliance with WHO was its main source of strength. One informant went as far as stating that *'the Alliance would be replaceable if it were not for its particular location and network within the WHO framework'*. Most grantees, including researchers and decisionmakers, thought that the Alliance was an integral part of WHO. As one key informant at country level stated: '*Anybody in the countries who knows about the Alliance refers to it as 'WHO'. Nobody understands or is interested in the implications of a 'hosted partnership'. WHO gives the Alliance the legitimacy to work with governments, and governments are used to work with the WHO Country Offices.'*

There were no clear tendencies in KII responses on questions about the current institutional structure of the Alliance as a hosted programme or other future options.

- Some level of **independence of the Alliance from WHO,** assured by its own Board and STAC, was considered desirable by all but two key informants. Two reasons were cited with about equal frequency: The ability to independently raise funds; and the ability to pick-up, explore and lead research on health policy and systems themes that are not (yet) recognised as being within scope of WHO. The few informants who were less convinced stated that WHO departments could and are receiving designated donor funds just like hosted programmes, and that the so-called financial independence of the Alliance currently meant a dependence on three European government agencies. The ability to break new ground and establish leadership in systems research, could, according to two respondents also be achieved by an integration of the Alliance in the WHO Academy, which, however, would be a rather long-term perspective.
- The administrative reorganisation of the Alliance in the **WHO Science Division** was generally welcomed by key informants, primarily because this would facilitate the collaboration among the Alliance, TDR and HRP. Only one respondent thought that it would be more advantageous for the Alliance to be housed in the UHC/Life Course Division of WHO, preferably linked to the Special Programme on Primary Health Care. This, according to the informant, would promote the translation of systems knowledge into WHO guidelines and into the health policies of Member States.
- The institutional structure of a **hosted partnership** raised questions among some key informants about the partners in this partnership. This was clear in 1997 when the Alliance was formed at the meeting in Lejondal attended by a large number of multilateral agencies, government departments, research institutions and networks. It was expected that they join as members in an alliance, '*capitalising on each other's comparative advantage and avoiding*

irrational duplication' in the promotion and support of HPSR. [3] As noted by several key respondents, the field of HPSR has grown enormously since this early meeting. Health systems strengthening is now a major focus of international cooperation. New actors with large funding bases such as the Global Fund to Fight AIDS, Tuberculosis and Malaria, the Gavi Alliance and the Bill and Melinda Gates Foundation have emerged. Research on systems and maybe to a lesser extent policy is being conducted or supported by new institutions and by many of the original participants in the Lejondal meeting.
In 2019 a Master student at the Karolinska Institute conducted a study of partnerships in HPSR using the Alliance's database of more than 350 'partners' as a sampling frame. [26] Technical support, training and funding were the most cited partnership activities. These are not different from the 'partnerships' between research institutions and their donors, reflecting a concept that differs from that of a partnership among organisations 'capitalising on each other's comparative advantage'. The only clearly identifiable Alliance partners that meet the criteria proposed in Lejondal are the three core funding agencies that are pooling resources in the Alliance to reduce duplication in the support to HPSR channelled through their governments' international cooperation budgets, WHO as a contributor of its brand and infrastructure and HSG as a contributor of its network of HPSR scientists. Other relevant institutional partners are engaging with the Alliance only sporadically by contracting the Secretariat for the implementation of activities funded with designated contributions, and, most importantly, the largest global health initiatives active in the support of health systems are not engaged.

- Transforming the Alliance into a **Special Programme for HPSR** is an option favoured by the Secretariat. The implications, however, were not clear to interviewed key informants. Those who were familiar with the two co-sponsored special research programmes housed at WHO were clear that the Alliance lacked co-sponsorship and also the size that could accommodate the heavy governance structure of HRP and TDR. A Special Programme on PHC without co-sponsorship was recently created by WHO but following this model would not be distinct from a full integration of the Alliance into the WHO structure, something that was not favoured by most (see above). Two options were mentioned by key informants, albeit with some doubts about their feasibility. (i) A special programme co-sponsored by multilateral partners focusing on health systems support and willing to co-fund a joint research programme. The WHO, the Global Fund and Gavi were mentioned in this context. The feasibility of this option should, according to key informants, be explored by the Alliance Board rather than the Secretariat. And (ii) a 'hybrid' WHO special programme without co-sponsorship, fully integrated as a department in WHO but maintaining its own STAC. The advantages cited were greater visibility, the disadvantages were the perceived difficulties in raising funds.

In general, key informants expressed reservations, doubts or insufficient knowledge about an institutional reorganisation of the Alliance, with some stating that this would amount primarily to a rebranding with uncertain implications. Several were of the opinion that '*form should follow function*'. A member of the Board noted that '*before you get into the discussion if the Alliance should be a hosted partnership or a special programme or a department of WHO you need to first of all develop a long-term vision of what you expect the Alliance to achieve in the future*'. Another key informant, a senior WHO staff, stated that the Alliance should *'first of all think on how it could*

expand its programme. If it hits the limit of what can be done with the current structure and governance, it will have to think on how to change its structure. Changing the structure first may create a space that it then will not be able to fill.'

3.3 Evaluation Question 3

Is the work of the Alliance managed and monitored effectively and efficiently?

3.3.1 Management efficiency

Most key informants and survey respondents rated the management of the Alliance Secretariat as efficient and effective, however a majority also believed that the Secretariat was under-staffed. The execution of budgets for programme activities and operations was 73 percent in 2016/17 and 66 percent in 2018/19. This relatively low execution rate was primarily responsible for the large carry-over of uncommitted funds into the following biennium. Human resource budgets were executed at 80 in 2016/17 and at 83 percent in 2018/19. While the Alliance budgeted staff expenditures at about 40 percent of anticipated income, the funds carried forward from the previous biennium decreased the ratio of human resource expenditure to programmable resources to only 18 and 19 percent respectively. It is highly plausible that this low ratio contributed substantially to bottlenecks in programme implementation.

Perception of management effectiveness and efficiency

The on-line survey asked all respondents who stated that they were familiar with the work of the Secretariat about perceptions of management efficiency. The question was answered by 39 respondents, among them 15 staff members, eight Board or STAC members, six WHO staff and ten others who, however, may have previously been staff, STAC or Board members. Most survey respondents agreed that the management of the Alliance is effective and efficient, only a few were non-committal while one current or former staff member strongly disagreed. The number of respondents was too small for a disaggregated analysis.

Table 10. Survey response on management efficiency

The Secretariat implements the Alliance Strategy 2016-20 effectively and efficiently					
	Staff	Board/STAC	WHO	Others	Total
1. Strongly disagree	1				**1**
2. Disagree					**0**
3. Neither agree nor disagree	3	1	1		**5**
4. Agree	8	5	5	8	**26**
5. Strongly agree	3	2		2	**7**
Total	**15**	**8**	**6**	**10**	**39**

Among the six respondents who did not agree, three explained their response with a narrative that referred to staffing issues, including insufficient high-level staff and high staff attrition that, in the view of two of the respondents, was related to management style. This is further discussed in **Section 3.3.3**.

In KIIs, the question of management efficiency was discussed with 24 informants, including 12 current and former staff members, seven current and former Board and STAC members, three WHO staff and two staff of external agencies that had provided funds to the Alliance during the evaluation period. Almost all of them stated that workplans were generally implemented, although

frequently with delays that were often due to factors not under the Secretariat's control. These include lengthy ethical approval processes by the WHO Ethical Review Committee (ERC) and at times lengthy exchanges with the STAC for revisions and final approval of concept notes. Two former staff members commented that operational planning by the Secretariat usually did not integrate the risk of such delays in the planning process and the planned implementation periods were therefore often too short.

Almost all informants commented on human resource issues, most frequently mentioning the large number of work streams managed by the Secretariat with a small staff complement. In addition, several staff members also stated that planned work schedules were often interrupted by demands to draft concept notes or develop responses to health systems research questions that were not planned and that had to be delivered on very short notice. The Executive Director stated that such demands often came from WHO and were not unusual in a large institution with a global mandate. This may therefore be an issue of clarity of roles and responsibilities of staff which was also signalled in the report of the human resource management coach of 2017 as an area needing improvement. [21] This is further discussed in the section on Secretariat staffing (**Section 3.3.3**).

Analysis of budgets, revenues and expenditures for the biennia 2016/17 and 2018/19

WHO-certified statements of accounts for the Alliance were available for the years 2016 to 2019, covering both biennia. They show that 57 percent of the financial resources available to the Alliance in 2016/17 were carried forward from the previous biennium; for 2018/19 it was 52 percent.

Table 11. Income and expenditures 2016/17 and 2018/19

	2016/2017	Source	2018/2019	Source
Income 2016/17	12,040,029	Certified Statement 2017	13,102,777	Certified Statement 2019
Carried forward	15,845,787	Certified Statement 2016/17	14,040,167	Certified Statement 2019
Total resources	27,885,816	Certified Statement 2016/17	27,142,945	Certified Statement 2019
% from carry-over	**57%**		**52%**	

In each biennium, the carry-over included a reserve fund for salaries and administrative expenditures as well as committed funds for ongoing activities. The salary reserve was increased in 2018 from $1.5 million to $2.6 million as per WHO recommendation. The carry-over of uncommitted funds into the next biennium is presented in **Table 12**.

Table 12. Carry-over of uncommitted funds into the next biennium

	2016/2017	Source	2018/2019	Source
A. Available funds	27,885,816	Certified Statement 2017	27,142,945	Certified Statement 2019
B. Unspent balance	14,040,168	Certified Statement 2017	15,741,528	Certified Statement 2019
C. Salary reserve	1,550,000	Workplan 2018/19	2,716,500	Workplan 2020/21
D. Planned activities	3,200,369	Workplan 2018/19	4,513,891	Workplan 2020/21
E. Encumbrances	486,988	Secretariat information	1,612,486	Secretariat information
E. Uncommitted	**8,802,811**	**=B-C-D-E**	**6,898,651**	**=B-C-D-E**
% uncommitted funds	**32%**	**=E/A**	**25%**	**=E/A**

We treated encumbrances reported by the Secretariat for the two biennia like funds carried forward for activities planned in the next biennium. The WHO certified financial statements do not recognise encumbrances and report expenditures at the time that service or goods are delivery,

irrespective of when payments are made.[3] Any reported encumbrances can therefore only be treated as financial commitments for activities yet to be delivered.

We further analysed the budget execution by focusing on the execution of **activity budgets**. Budgets and expenditures under the category of **operations** are included although they include budget lines for fundraising, reporting, governance and administrative costs that are not direct programme costs. Expenditure reports under this category are, however, not disaggregated and it is not possible to separate programme expenditures from expenditures on programme support and administration within the operations category.

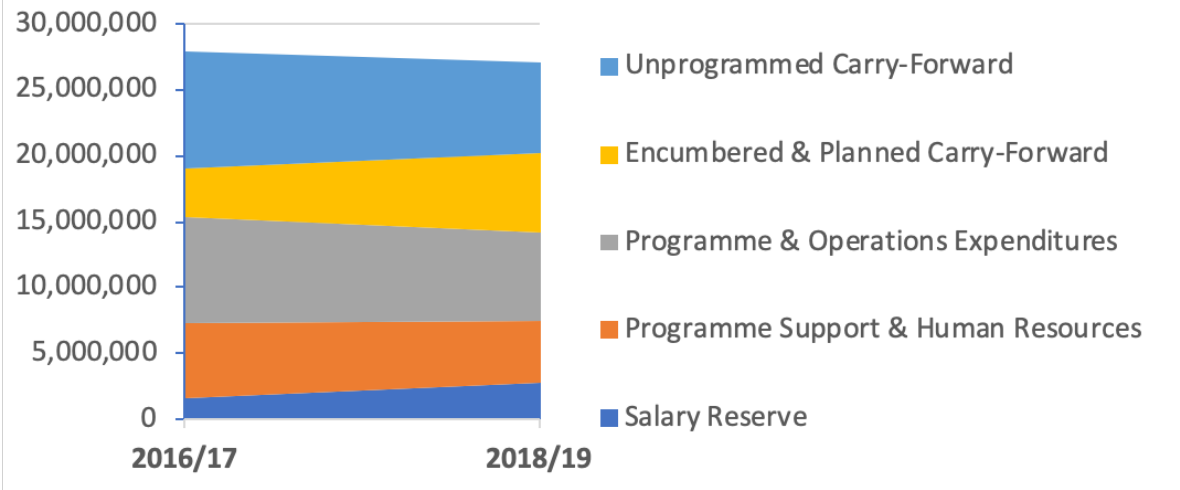
Table 13. Execution of biennial programme and human resource budgets

	2016/17	2018/19
A. Planned expenditures (for activities and operations)	14,772,500	16,129,281
B. Encumbrances at end of biennium	486,988	1,612,486
C. Funds for planned activities in the next biennium	3,200,369	4,513,891
D. Programmable funds in current biennium (A-B-C)	11,085,143	10,002,904
E. Expenditures (for activities and operations)	8,040,172	6,577,586
Execution of programme budget (E/D)	**73%**	**66%**
F. Human resource budgets	6,196,125	5,136,590
G. Human resource expenditures	4,958,964	4,266,636
Execution of human resource budget (G/F)	**80%**	**83%**

Sources: WP 2016/17, 2018/19 & 2020/21; Certified Financial Statements 2017 & 2019; information on encumbrances provided by Secretariat

The low biennial execution of funds for programme implementation and operations of 73 and 66 percent were primarily responsible for generating the uncommitted funds that were carried forward by the Alliance at the end of the 2016/17 and 2018/19 biennia. The information is summarised in Figure 4.

Figure 4. Expenditures 2016/17 and 2018/19



The human resource budgets were executed at 80 and 83 percent which is reasonable given the long WHO recruitment processes and resulting temporary vacancies. Of the biennial revenues of $12.0 million in 2016/17 and $11.4 million in 2018/19, the Alliance spent 41 and 37 percent on

[3] "WHO recognises expenses at the point where goods have been received or services rendered and not when cash or its equivalent is paid" (WHO Certified Financial Statements 2017 and 2019)

human resources. This ratio compares to other large research support programmes. Total financial resources available to the Alliance were, however, considerably larger because of the carry-over of funds from past biennia. Against total programmable resources (not including reserve funds and programme support costs) the ratio of expenditures on human resources was only 19 percent in 2016/17 and 18 percent in 2018/19.

The low level of staff expenditures in relation to available funds was a likely contributing factor to the low execution level of the programme budget, perpetuating itself in successive biennia by again generating large carry-overs of unallocated programme funds. This triangulates with perceptions of under-staffing of the Secretariat expressed by key informants and respondents to the on-line survey. Several key informants cited staff shortages as the main reason for the Alliance's efficiency losses. The Executive Director stated in interviews that he aimed at maintaining a ceiling on HR expenditures of 40 percent of biennial income. Planning personnel expenditures according to anticipated revenue is prudent fiscal management. However, sufficient staff is also required to gradually decrease the overhang of unspent funds that is carried forward in each biennium.

3.3.2 Monitoring implementation processes and results

During the 2016-20 strategy period, the Alliance used ten methods or instruments to monitor implementation process and results. In addition to the logframe performance monitoring framework, the biennial workplan, the quarterly reports and the operational workplan were the main planning and monitoring instruments. The three instruments were, however, poorly aligned and lacked specific information essential for management control, such as implementation targets and timelines. Repeated modifications of activities without explanation and justification, as well as changes in the reporting format may have contributed to general inability of key informants to provide specific information about where the Alliance had done well or less well, although most were under the impression that the Alliance had achieved its strategic objectives.

The evaluation question under this heading explored the institutional mechanisms that are in place to assure tracking of the implementation processes and results. We identified ten mechanisms or tools that were used by the Alliance between 2016 and 2019 to monitor programme implementation for management control and accountability.

Table 14. Management control and accountability mechanisms or tools

Accountability tool / mechanism	Purpose & Content	Frequency	Approval	Data sources
1. Biennial workplans and budget (also called operational plans)	Planning documents with short descriptions of working areas (called 'activities') and high-level budget estimates. The 'activities' are, with some exceptions, not quantified and they are formulated at the strategic and not the operational level	biennially	Board	Team retreat, internal documents, input from STAC
2. Quarterly reports	Quarterly implementation progress reports that are loosely connected to the biennial workplans	quarterly	STAC	Input from technical officers
3. Operational Plan (since 2019)	Developed to facilitate detailed workplan tracking; updated every quarter after the quarterly team planning meeting	biennially	Executive Director	Internal planning documents (not formalised)
4. Logframes	Tables of indicators and achieved results of outputs and outcomes (see Section 3.1.3). Also serves as reporting framework for core donors of the Alliance	annually	Board	Grantee survey and several data bases

Accountability tool / mechanism	Purpose & Content	Frequency	Approval	Data sources
5. Secretariat Reports (since 2018)	Internal activity, progress and management reports delivered to the annual physical meeting of the Board	annually	Board	Grantee survey, several data bases and internal documents
6. Annual Executive Director's Performance Matrix (since 2018)	Annual confidential review by the Board of the Executive Director's performance in seven areas of responsibility against established benchmarks (either annual or for the remaining strategy period)	annually	Board	Data collected by Board from multiple sources
7. Annual reports	Reports on key activities and results for accountability to external stakeholders and for advocacy. Linked to the logframes and the biennial workplans but not systematically	annually	Board	Grantee survey, several databases and internal documents
8. Grantee surveys	Annual on-line surveys to collect information from grantees on publications and achievements. Response rates around 30%	annually	Secretariat	Grantees
9. Grantee reports	Grantee reports as per grant contract terms	Project dependent	Technical Officers	Grantees
10. Donor reports	Reports to donors on projects funded with designated contributions	Project dependent	Technical Officers	Internal and external documents of the Secretariat

The tools most relevant for monitoring implementation processes are the biennial workplans and the quarterly reports. In 2019, the operational workplan was added. The annual Executive Director's performance matrix was added in 2018 as an accountability instrument that summarised the status of programmatic achievements in addition to other benchmarked performance indices. The results monitoring framework is discussed in **Section 3.1.3**.

Biennial workplans 2016/17 and 2018/19

The biennial workplans for the two biennia were approved by the Board. According to the interviewed Board members, they were largely implemented as planned. *'The workplans are done in such a way that they are achievable … [and] the Alliance met its workplan targets. When it does not, there is usually a reason often beyond its influence.'* This was also confirmed by the Board's Executive Director's Performance Reports which stated that the key result for completion of workplan activities in 2018 was '*accomplished for finances (111%) and activities*' and in 2019 with '*almost 100% implementation*'.

Activity 4.3. Strengthening capacity for embedded research
The Alliance will further strengthen the capacity for embedded research in Latin America, targeting priority countries of PAHO including fragile states. The Alliance will focus on investing on strengthening the capacity of decisionmakers, especially programme managers, to identify health system barriers and overcome these barriers by learning and undertaking systems or implementation research.

The statement that 'targets are being met' raised questions on how this could have been assessed by the Board. The biennial workplans contained short narratives labelled 'activities' that were, in fact, descriptions of working areas leaving much room for interpretation. They were rarely quantified and mostly not explicit about their scope. This is illustrated by an example of 'capacity strengthening' from the 2018/19 workplan (see textbox). It does not include information on how many decisionmakers are targeted nor how their capacity will be strengthened. It would therefore not have been possible to assess whether the activity was implemented as planned. Budget

estimates were provided for each activity, but without details on how the budget would be spent. The workplan activities were, furthermore, not linked to the performance monitoring framework 2016-2019 which would have allowed some tracking of achievements.

Several key informants mentioned that the biennial work plans were often developed in haste and not sufficiently connected to the workplan of the preceding period. In its current form they provide a strategic overview for operational planning, but not sufficient information for monitoring implementation processes and results.

Quarterly reports

According to the Secretariat, the purpose of the quarterly reports was to provide an update of progress on workplan implementation. The evaluation team received eleven of the 16 quarterly reports for the two biennia one of them covering two quarters. The information on the status of activities presented in these reports is extracted in **Table 16**.

Table 15. Quarterly reports - status of activities

Status / Quarter	2016/17								2018/19						
	1	2	3	4	5	6	7	8	1	2	3/4	5	6	7	8
Not yet initiated	10	10	Not received	8	8	Not received	Not received	5	Not received	0	0	0	0	0	0
On track	24	25		28	29			18		26	25	33	27	22	25
Completed	0	0		0	2			7		2	3	0	0	1	0
Slightly delayed	2	4		2	1			6		2	8	5	12	8	5
Missing data	4	1		0	0			1		0	0	0	0	0	0
# activities removed	n/a	0		2	0			1		n/a	n/a	n/a	n/a	8	1
Total # activities in QR	40	40		38	40			37		30	36	38	39	31	30
Comments	Limited alignment with workplan			Two activities removed				Five activities not implemented		Activities not aligned with workplan	Activities modified / reorganised	Activities modified / reorganised	Activities modified / reorganised	Some modifications of activities	Some modifications of activities
% delayed activities	5%	10%		5%	3%			16%		7%	22%	13%	31%	26%	17%

Source: Quarterly reports 2016-2019

In terms of accountability, the quarterly reports were presented and approved by the STAC which is quite unusual as they are not strictly technical but rather management reports. There is limited information about the approval process. Only two of the STAC minutes included a reference to the reports: In April 2016, the STAC requested '*to add more information/clarity into the quarterly report, especially when activities were delayed*', and asked to include another column for STAC input. In April 2018, the STAC noted '*that updates should include information on challenges and how the Secretariat seeks to overcome them rather than only focusing on informing that all is on track'*. A page for STAC comments was included in most reports but did not contain any text in the versions received by the evaluation.

The quarterly reports in 2016/17 were in the form of a five-column table.

- The first column listed activities that were not numbered and not in the same sequences as in the biennial workplan. They could be matched but had to be traced one at a time. There were also activities not listed in the workplan.

- The second column, entitled 'products/ deliverables' was not consistently filled out. It provided information on achievements of deliverables in the quarter but did not include an update on the achievement of cumulative results nor information on planned activities for the next quarter.
- The status of implementation was listed in the third column in categories of 'not yet initiated', 'on track', 'slight delay', 'delay' and 'completed'. Target completion dates were not listed, and the category 'completed' was used inconsistently.
- The fourth column listed the initials of the responsible officer, and space for comments was provided in the fifth column.

In 2018/19 the structure of the quarterly reports changed and the alignment with the biennial workplan was challenging to discern for an external reviewer. In addition, the order of activities changed from one quarterly report to the next which made tracking of progress time-consuming. Generally, the modifications, additions or removals of activities were neither documented nor justified. In the first quarter of 2018, the column of 'products/deliverables' was replaced by a column for 'timeframes'. It was, however, not filled out and it was removed in subsequent reports.

Table 15 also shows that the proportion of delayed activities increased significantly in 2018/19 compared to 2016/17. At the end of the first biennium, only seven of 37 activities were listed as completed, while implementation for five had never started. On the basis of the number of planned activities, this is a completion rate of 19 percent. At the end of the second biennium, all of the 30 activities had started but none was listed as completed. [34] A considerable number of programme activities are planned and implemented over several years or biennia which will affect project completion rates. Furthermore, in a response to a previous draft of this report, the Secretariat stated that completed projects are not included in the quarterly reports. This may be true for some, but not for all projects as can be seen in **Table 15**.

Other observed internal inconsistencies are that activities labelled as completed in one quarter, appeared again in the next with the label of being 'on track', and that activities in each quarter of the second biennium were reorganised and often modified. Several key informant mentioned frequent changes of planned activities, one of them referring to activity planning by the Secretariat as a '*moving target*'. The analysis of the quarterly reports substantiated these statements.

On the basis of available information, the evaluation could therefore not confirm the perception of the majority of key informants who stated that the timeliness of programme delivery improved in the second biennium without, however, being able to provide details to support this perception. It was also not possible to confirm the Executive Director's annual performance reports that listed rates for workplan implementation of 111 percent in 2018 and at almost 100 percent in 2019. It is, however, not clear whether these percentages refer to the overall activity completion rate or to the performance benchmark of at least 75 percent completion.

The 2018 audit of the Alliance recommended to '*conduct robust monitoring of all awards especially those nearing their end dates to ensure that planned activities are completed before the said dates and ensure the achievement of planned outputs*' and to '*conduct periodic monitoring of workplans to avoid possible mismatches or misalignments of award balances*'. [33] In a follow-up email of March 2020, the Director of External Audit asked for '*additional evidence of actions taken in order to be able to close the recommendation on award monitoring*'. These audit findings align with our

evaluation findings. A fundamental weakness of implementation monitoring by the Alliance during the 2016-20 strategic period was that the planning and monitoring instruments and methods were not linked, and that frequent modifications, deletions or additions of activities were neither sufficiently explained nor justified.

Operational workplan

The operational workplans were introduced in early 2019 to facilitate the monitoring of operational activities. They were considered living documents and, according to management staff, updated quarterly during internal quarterly team meetings. The operational workplan has the form of an excel spreadsheet that lists ongoing projects, their budget, and the responsible technical officer. It used mostly the same activities as the quarterly reports for 2019 however not structured or numbered in the same way. Better alignment with the quarterly reports would have greatly facilitated the tracking of implementation targets, however this would also have required a listing of the targets and timelines which were absent in the operational plan. Introduced as a tool to improve management control of programme implementation, it did not live up to its promise.

3.3.3 SECRETARIAT STAFFING

Most key informants who were knowledgeable about the Alliance Secretariat operations agreed that the Secretariat was under-staffed. One reason for this were long recruitment processes for WHO staff that were, however, largely mitigated by frequent recourse to the recruitment of staff under temporary contract terms. A high level of employee mobility was also cited by many. An analysis of team management was done by a human resource coach in 2017 followed by a team-building workshop. Some issues that were identified by the consultant as needing improvement have since been addressed, but others were again mentioned as factors depressing staff morale and team spirit by key informants who were on staff after 2017.

Staffing levels and structure

Among the respondents to the on-line survey, 15 stated that they were current or past staff members of the Secretariat, and 25 that they had knowledge of the Secretariat's functioning. More than two thirds believed that the Secretariat was under-staffed. Comments by survey respondents included, that the Secretariat did not have enough senior level staff with long-standing experience in the field to drive the dialogue with the Alliance partners; that because of the turnover and loss of institutional knowledge, there was limited opportunity for growth or innovation among staff; and that the Secretariat lacked expertise in systems thinking, digital health and innovations. One respondent commented that under-staffing was mostly related to the fact that the Secretariat had not been able to fill all approved positions.

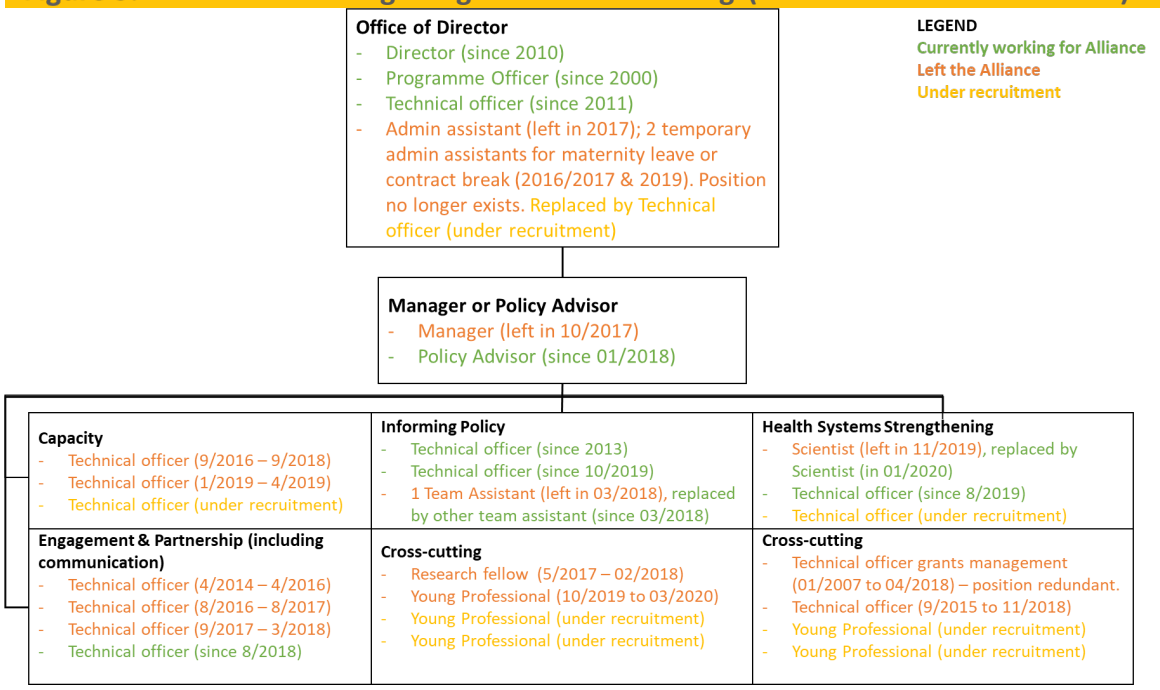
The most recent organogram provided by the Secretariat lists 17 staff positions of which 10 were filled by February 2020 (4 female and 6 male). Among them, four were in position prior to the period under evaluation and six joined the Secretariat between January 2016 and February 2020. Recruitment for the seven vacant positions (3 technical officers and 4 young professionals) was underway.

Fifteen staff members had left the Alliance between January 2016 and March 2020 (13 female and two male):

- Eight had started to work with the Alliance prior to 2016, one of them retired, one left to pursue academic studies, five moved to other positions in WHO, and one was engaged on a temporary contract for a two-year project that ended in 2016.
- Seven joined and left the Secretariat during the period. One of them was on a permanent contract and requested redeployment in WHO after 10 months, the remaining seven were engaged with time-limited contracts ranging from a 60-days to six months, or with temporary / short-term contracts of one to two years that were not renewed.

The staff movements are illustrated in **Figure 5**.[4]

Figure 5. Alliance Organogram and Staffing (Jan 2016 – March 2020)



While staff movements in WHO and its hosted programmes are not unusual, the employee turnover in 2018 was exceptionally high. Calculated on the denominator of 17 approved positions in 2019 it was 35 percent which is actually an underestimate because the denominator should be the filled positions each year, which were probably in the range of 10 to 12 although we did not have the exact information. The high level of turnover in 2018 likely contributed to the low levels of budget execution of the 2018/2019 workplan **(see section 3.3.1).**

Table 16. Annual staff turnover (2016 – 2019)

Year	Number of staff leaving	Staff turnover rate*
2016	1	6%
2017	4	24%
2018	6	35%
2019	3	18%
	Average	21

** Calculated on the denominator of 17 approved positions*

[4] One additional Young Professional on a six-month contract included in a list provided by the Secretariat at the time of reviewing the draft evaluation report is not included in the organogram

Gaps between staff replacements were short with an average of two to three months except for the technical officer position for capacity strengthening which has been vacant for almost a year. In 2019, the Executive Director reported to the Board that the WHO transformation process had delayed the recruitment of new staff. [23]

In accordance with the Generic Hosting Terms for WHO Hosted Partnerships, [8] Alliance Secretariat staff are WHO staff members and are selected on a competitive basis in accordance with WHO rules. These foresee three types of personnel contracts: fixed term contracts, short-term contracts of one to two years, and temporary contracts of up to six months. Temporary contracts can be awarded without competition and require the least time and administrative effort. They are frequently issued by WHO and also by the Alliance. As stated by the Executive Director, '*we have to find someone who is appropriate and find out if we can work together, whether the profile matches*'. However, one senior WHO informant noted that many professionals enter into temporary staff contracts with WHO in the hope of future renewal. They are therefore in a vulnerable position and tend to try to conform which can be stifling in a programme striving to be a thought leader in its field.

Staffing profiles were generally considered adequate, however, several key informants felt that the Secretariat recruited too many junior staff members. Concurrently, some junior staff felt that they were asked to perform significantly above their paygrade.

Staff management and development opportunities

To review whether the Secretariat staff felt supported and had enough development opportunities, interviews were held with 18 of the 25 staff members (72%) who worked for the Secretariat during the period under review (11 female and 7 male). They included ten current staff members including the Executive Director and eight who had left the Alliance between 2016 and 2019.

In September 2017, on an initiative of the former Assistant Director General of WHO and the Executive Director, the Secretariat contracted a human resource management coach to identify management issues and propose solutions for improvements. The consultant interviewed all Secretariat staff members, prepared a summary report, and facilitated a team retreat with the aim of improving teamwork in the Secretariat. [21] The summary report provided an overview of what worked well, what needed to be improved, how the Executive Director was perceived by the team and what should be done going forward. The evaluation used the findings reported by the consultant under the heading '*what needs to be improved*' to assess whether there has, in fact, been improvement:

- **Need for more clarity on roles, responsibilities and structure**: In 2018 a review of the Secretariat team functions was done to ensure alignment of the team with the strategic directions and to maximise team performance and efficiency. Positions and terms of references were reviewed, and necessary team competencies were identified. The organogram and management structure were revised, ensuring technical leads for cross-cutting priorities. The Policy Advisor and Executive Director form the senior management team and co-manage the staff. The Policy Advisor is the de facto Deputy Director and the direct line manager for most of the technical officers. While this double management structure is appreciated by some, others find it ineffective as it seems to double up some of

the technical work. Furthermore, this structure has centralised all decision-making and made some staff members feel disempowered.

- **Less silo mentality, competition and accountability at the individual level:** Former and current staff members still find that there are too many silos. Individuals are responsible for their portfolios and there are few opportunities for collaboration among technical officers. While there is collaboration with supporting functions, such as administration, contracting and communication, the lack of team work on projects also feeds a culture of competition. People interviewed felt that the Secretariat is a competitive environment where they are solely responsible for their projects and '*if anything goes wrong, it's you on the line*'.
- **More communication and feedback among the team:** Staff reported some improvement in this area. The weekly staff meetings encouraged staff to present an update on their work, including activities, planned travel, contracts, etc. Some staff also felt that feedback can be provided and is taken on board. Others felt their contributions were not listened to, either because they tried to innovate, or because they ranked lower in the hierarchy of the WHO professional grade system.
- **Planning in advance and proactive versus reactive engagement**: New processes were started in 2018, including the development of an operational plan which has helped with streamlining work and planning processes. However, several staff complained about ad hoc requests, coming from WHO or donors or in preparation of STAC meetings, that need to be responded to on short notice. These requests created additional pressure on a small team with an already considerable workload.
- **Low level of trust and micromanagement**: Some staff members felt these were still issues and that they were interrelated. Low level of trust combined with high expectations means that documents and presentations often undergo several iterations. This affects the morale of staff. Some (female) staff members mentioned that their inputs were often not appreciated during team meetings and felt unsupported by management when making presentations to the STAC. Other (male) staff stated that they had no problems discussing their issues with the team and the Executive Director and they did not complain about micro-management. As one informant put it: '*Personality matters on how you can make it work for you. If you are determined, you can find every resource at the Alliance to grow, however you need to be self-motivated. People that are more timid or self-conscious face a more difficult time and they could benefit from more support*.'

When asked about whether the Alliance provides opportunities for professional development, the reactions ranged from '*it was a very stimulating and challenging environment*' to '*there are opportunities for development but not enough time*' to '*it was a process of immense personal growth through suffering, tremendous suffering*'. Technical officers are recruited as researchers but are expected to manage and commission research instead of conducting research. This is stated clearly in their terms of reference. They are, however, also encouraged to publish at least two scientific papers each year. One technical officer assessed the workload to be 60 percent technical and 40 percent administrative and noted that the position provided technical staff with access to a lot of interesting information, but that more time was needed to analyse this information. Several interviewed staff members stated that they found the process of preparing and presenting concept notes to the STAC caused significant distress and anxiety.

3.3.4 VALUE FOR MONEY (VFM)

The Alliance programme from 2016 to 2019 was economical in terms of generating planned outputs and outcomes at low costs. Secretariat staff, however, reported that this significantly increased the workload and pressure. Issues of efficiency in terms of planning and implementing programmes in time were identified by the evaluation and also mentioned in the 2018 external audit report. Equity in terms of supporting institutions in low and lower-middle income countries as well as promoting gender equality by positive discrimination of female-led research teams were successfully pursued by the Alliance during the strategy period under evaluation.

Economy

The 2014 external review report stated that '*the review team felt that further (cost) efficiency gains could be achieved by reducing transaction costs and tackling duplication, particularly in regard to monitoring, management accounts, and some HR functions*.' [19] Specifically, the report only referred to performance monitoring metrics which, according to the reviewers, focused on processes (e.g. number of meetings) and not sufficiently on outcomes (e.g. number of publications). Performance monitoring during the 2016-20 period is discussed in **Section 3.1.3**. Although some areas of indicator definitions and data sources are raised that require further improvements, primarily outcomes and outputs were monitored, including the number of publications produced with Alliance support. There is, however, no standard benchmark for the cost of a research publication against which the Alliance could be evaluated. Arguably, the Secretariat pushed the economy of funding research and capacity building far during the period under evaluation by launching many RFPs for small-budget research grants while keeping its staff complement at a low level. This is discussed in **Sections 3.1.4, 3.3.1 and 3.3.3**. Although the evaluation team has no comparators, it is plausible that this has resulted in a very positive balance or outcomes against costs. However, it generated considerable work stress among staff.

In any research, research support or research development programme that does not require extensive investments in laboratories, human resource costs are the main cost drivers. The Alliance was able to keep these costs low while meeting or even surpassing its performance targets. On the basis of a simple outcomes for inputs calculation, the operations of the Alliance were economical, even highly economical. Only two interviewed key informants, both among the stakeholder group of former and current Secretariat staff, suggested that the quality of the publications and the overall impact of the Alliance's work could be improved, including by reducing the product-focus of grant management, by increasing the budget ceilings of research grants, and by increased investment in a stable high-quality workforce. A formal assessment of the quality of Alliance-supported research outputs was out of scope of the evaluation as noted in **Section 2.1**.

Efficiency

Financial management, contracting and procurement of the Alliance are subject to WHO rules and regulations as defined in the hosting terms. [8] Several grantees mentioned initial difficulties with adapting to the WHO contracting system, but this was outside the Alliance controls. Not within its control were also delays in the approval of research contracts due to lengthy processes of the WHO Ethics Review Committee. Since these are well-known and long-standing issues, they could be better factored into programme planning by extending planned implementation periods at the outset, thereby avoiding the frequent reports of delayed implementation.

In 2019, the Office of the External Auditor of WHO conducted an audit of Alliance operations in 2018 focusing, among others on the *'efficiency, effectiveness and economy of operations and on compliance with WHO regulations'*. [33] The auditors observed '*awards that are near their end dates with low percentage of implementation*', confirming the findings of delays in implementation. The auditors also commented that the Alliance had not prepared an annual procurement plan for contracts and services in 2018. Such a plan is, in fact, a management tool for planning and monitoring the timely delivery of contracted services or products and for managing the risks of delayed delivery.

Overall, the audit found that financial controls were in place and functioned as intended, but that there were opportunities to enhance existing controls, policies and procedures in other areas, including procurement. By March 2020, the Office of the Comptroller confirmed that eight of the 12 audit recommendations were closed. In terms of the evaluation question about the efficiency of procurement systems and financial management processes, this indicates progress although some issues still remain to be addressed.

Equity

As discussed in Section 3.1.4, the Alliance applied criteria of equity and gender equality in its grant awards decisions. In 2018 and 2019, 39 institutional grants were awarded to teams with a female principal investigator (PI) compared to 30 that were led by a male PI. In the same year, institutions in the WHO Africa Region received, together with institutions in AMRO, the largest number of grants. Institutions in low-income and lower middle-income countries were awarded two thirds of all grants and more than half (55%) of funds.

These statistics indicate that the Alliance applied criteria of equity in the geographic orientation of its programme activities. They do not answer the evaluation question on whether '*vulnerable, marginalised and hard-to-reach groups*' were reached. This would have required a systematic review of all funded research plans and protocols and could only have been done in the context of a research quality evaluation. This was, however, out of scope for the evaluation.

3.3.5 COMMUNICATIONS

On-line survey respondents agreed that communications and advocacy of the Alliance were effective or at least somewhat effective. Key informants noted that this area of work improved considerably since 2018. Key products such as the flagship reports and the readers are widely known and used by researchers. The extent to which policy- and decision makers know about the Alliance and use its products is, however, not known. The social media footprint of the Alliance increased steadily, particularly in the second biennium. By the end of 2019, the Alliance was on a good trajectory of building an audience of Twitter followers, including in L/MICs.

Recognition of and knowledge about the Alliance by external stakeholders

The 2014 external review recommended that the Alliance improve and scale up its external communication, a recommendation that was also endorsed by the Board in its 2015 meeting. Funding for advocacy and communication was increased in the 2016/17 workplan and endorsed by the Board in its December 2015 meeting. The main channels used by the Alliance to communicate its work in 2016/17 included its website, Twitter, an e-newsletter, publications and events, in particular the biennial HSR Symposia.

Three staff changes of technical officers responsible for the communications portfolio occurred between April 2016 and August 2018. Since then, the position appeared to have stabilised. The new technical officer developed a communications strategy with the objectives to enhance the visibility, accessibility and coherence of the Alliance's communication. Some interviewed key informants commented that the strategy did not sufficiently differentiate the approaches necessary to reach distinct target groups, but there was general agreement that communications of the Alliance had improved considerably. Improvements were highlighted in the areas of branding, the presentation of the website and the Alliance's social media presence on Twitter. '*Communications used to be hopelessly underdeveloped. This was an impossible situation. But with [the new technical officer] this has improved considerably. If you ask me about the main changes in the Alliance over the last two years, I would say that it has been in communications.'* And another quote from a key informant: *'The communication of the Alliance has significantly improved. Historically, the visibility and reach of the Alliance was very low. Today, there has been a significant increase.'*

Among the 105 respondents to the on-line survey who answered the question about the effectiveness of the Alliance's communication, 41 percent agreed that it was effective and 45 percent that it was somewhat effective, largely supporting the views expressed by interviewed key informants. However, it should be kept in mind that our sampling frame of stakeholders was highly biased towards individuals who knew about the Alliance, many of them with strong links to the programme. A methodology to collect information about knowledge and use of Alliance communication products from policy- and decisionmakers who had never cooperated with the Alliance was not feasible within the scope of the evaluation. (**Section 2.1**)

Interviewed external stakeholders, including grantees, WHO staff and those in the 'other' category, mentioned the Alliance website as their key source of information. They reported that documents could be easily found and that they searched it regularly for new publications. Web searches on HPSR bring up the Alliance website as one of the top results. Several stakeholders questioned, however, to what extent the website was used as a resource by policymakers.

The Alliance used Twitter as a social media tool to reach a global audience. Some key informants commented the increased presence of the Alliance on Twitter, but others stated that the social media presence of the Alliance was still weak and required more investments.

The e-newsletter was used by the Alliance to provide regular updates on its work to subscribers. A sign-up form for the newsletter is available on the website. The number of subscribers increased in 2018/19 reaching over 2,000 by the end of the biennium. Not all interviewed external stakeholders were, however, aware of its existence. One grantee commented: *'I don't think the communications of the Alliance is effective. They could have a newsletter; they could have a more targeted approach to communications. They have a website, but they could do more.'*

Many key informants mentioned the publications of the Alliance, primarily papers in peer reviewed journals, the flagship reports, the readers and the annual reports. The flagship reports and readers were highlighted by most interviewees as innovative and important publications that were very useful for their work. While interviewees considered that the readers and flagship reports would be of equal relevance to researchers and policymakers, some questioned the extent to which they were accessed by the latter.

In general, interviewed key informants were well informed about the Alliance's channels of communication, with the possible exception of the e-newsletter. However, many questioned whether these channels were known or used by anybody outside the HPSR community. Especially policymakers who were not already cooperating with the Alliance were unlikely to know about its products. In fact, little is known about the profile of the Alliance audience, and the evaluation was not able to shed light on this question, except to a limited way through the analysis of engagements on Twitter. Suggestions by key informants on how to reach a wider audience included (i) increased collaboration with WHO ROs and COs; (ii) the development of communications products that specifically target policymakers; and (iii) an increase in Secretariat staffing for managing the communications portfolio.

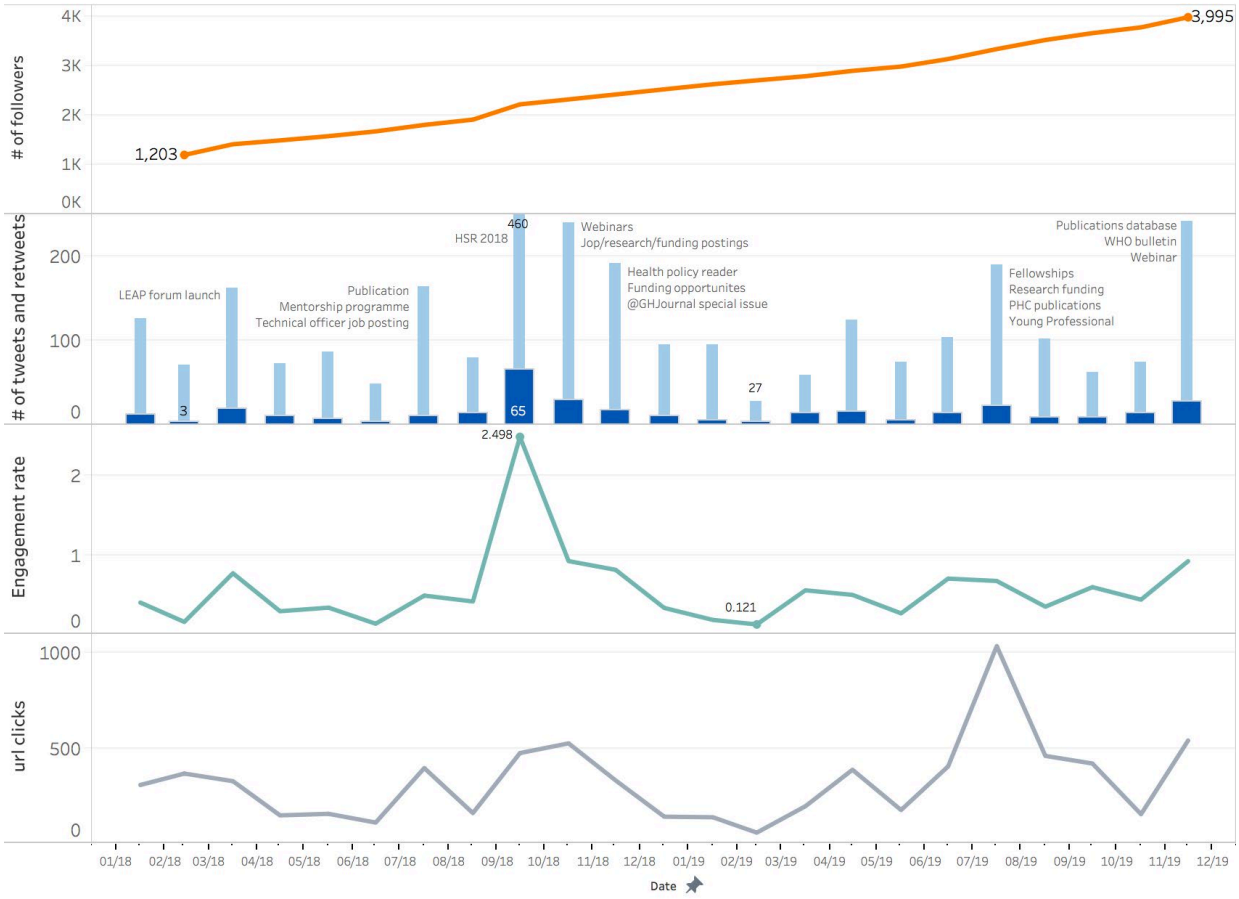
Social media review

Because of issues in the setup of the WHO website that limited the use of Google Analytics, a planned analysis of Alliance website traffic and downloads could not be implemented, and the social media review therefore focused primarily on the Alliance's use of Twitter as a communications channel during the period under evaluation.

The Alliance joined Twitter in November 2016, just prior to the Fourth Global Symposium on Health Systems Research (HSR2016) in Vancouver. A search for the Alliance account (@AllianceHPSR) combined with the conference hashtag #HSR2016 returned 110 tweets, accounting for roughly three percent of all conference Twitter content. In April 2017 a tweet about the launch of the World Report on Health Policy and Systems Research generated the first major spike in social media activity with 165 engagements including 25 retweets, also generating a spike in social media traffic to the Alliance website.

Twitter analytic data since 2018 are presented in **Figure 6**. It shows the number of followers over time, the number of tweets (dark blue) and retweets (light blue) per month and the engagement rate, calculated by the number of likes, replies, clicks, follows and retweets, divided by the number of impressions. Twitter impressions are a measure of the number of times a tweet appears on a user's timelines. The number of URL clicks are included as an additional measure to document several points of deviation from the general trends captured in the engagement rate, as well as a measure of how much website traffic is directed by social media activity.

Figure 6. Twitter analytics March 2018-December 2019



Full data on Twitter followers were provided by the Secretariat for the 22-month period of March 2018 to December 2019. During this time, the Alliance made progress in developing and building its Twitter audience, adding 2,792 new followers (129 per month or an increase of 230%). The average rate of acquisition of new followers increased by 84 percent compared to the average rate of 70 monthly acquisitions prior to March 2018. However, a comparison of the about 4,000 followers in December 2019 with the more than 18,000 followers of the HSG Twitter account indicates that there is still much room for growth

On average the Alliance tweeted 14-15 tweets a month. This value is slightly skewed by an intensive period of activity during the Fifth Global Symposium (HSR2018) when 65 tweets were issued. The average for the Alliance Twitter account is therefore closer to 12 tweets per month, not counting the retweets.

The frequency of tweets is somewhat low and suggests limited time investment in social media with sporadic surges during key conferences, for the release of publications or of funding calls for fellowships or research. As the graphics in **Figure 6** illustrate, the number of tweets issued correlates with the engagement rate, but it does not seem to have a direct effect on the audience size which showed a steady linear growth with just a slight bump during HSR2018.

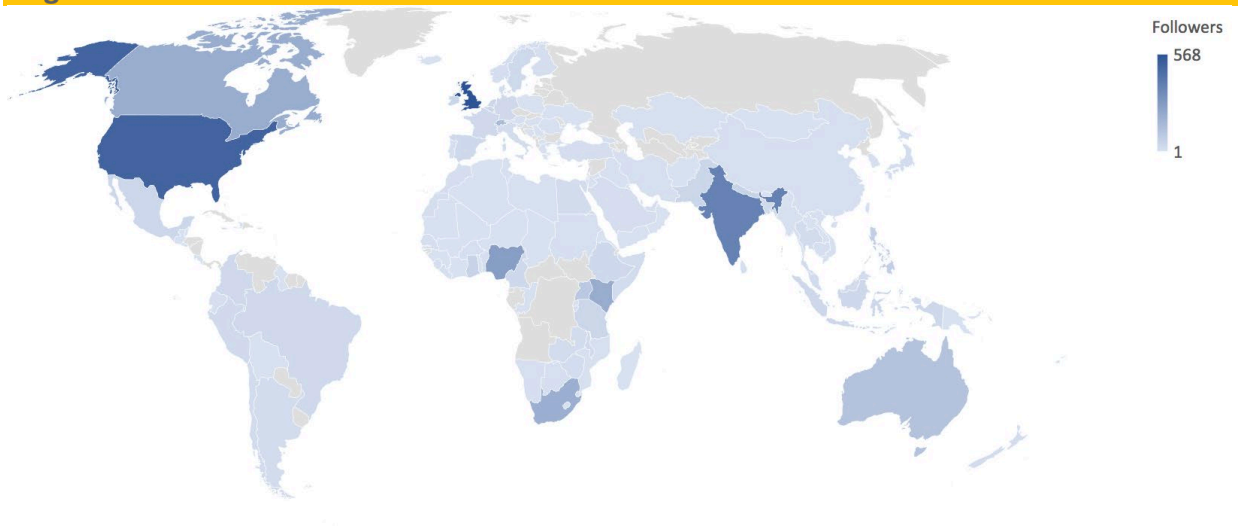
The average engagement rate during the review period was 5.5/1,000 Twitter followers. This is considered a very high engagement rate associated with influential Twitter accounts. During the period, the engagement rate had a slight upward trend indicating that the channel was maintaining influential status while also growing the number of followers.

Content analyses of Alliance tweets indicated the following key areas of focus and most used hashtags: #HPSR, #HSR2020, #healthsystems, #HSR2018, #PHC, #SDGs, #gender, #implementation research, #UHC, #technical support centre, #LMICs, and health policy. The top five tweets with the highest engagement rates all pertained to funding opportunities, mentorships and fellowships.

The dramatic increase in tweets during HSR2018 marks a highpoint for almost all Twitter analytics indicators (likes, retweets, clicks and follows) as shown in the engagement spike in November 2018. There was no corresponding spike in URL clicks, suggesting that tweets during the conference served primarily for social connectivity and discussion. In August 2019, URL clicks spiked, correlated with tweets announcing fellowship research funding for young professionals. Overall, there was a slight upward trend in the number of URL clicks during the time period.

The ten countries with the largest audiences for Alliance tweets are, in order of audience size, the UK, USA, India, Nigeria, Kenya, Canada, South Africa, Switzerland, Australia, and Uganda. The overall geographic spread of the Alliance Twitter audience is illustrated in **Figure 7.**

Figure 7. Twitter audience locations



The map illustrates that the social media communications of the Alliance are reaching into L/MICs that are primarily coloured in light blue, indicating opportunities for growth. Several of the followers of the Alliance accounts have themselves large audiences ranging from 50,000 to 200,000. When one of them tweeted about an Alliance funding call for female early-career researchers, it generated the most retweeted tweet about the Alliance. This documents the importance of engagement with high-profile members of the Twitter audience in order to expand the audience base.

3.3.6 Follow-up of tactical recommendations of the 2010-14 external review

This was integrated under Evaluation Question 1 (see Section 3.1.5)

4 CONCLUSIONS

The conclusions are drawn from the findings presented in Section 3. They are based on a synthesis of information collected from surveys, interviews and document reviews, reflecting consensus and majority views of stakeholders wherever they could be identified, and divergence of views including some outliers where they appear relevant. The conclusions are organised under the three evaluation questions of the Evaluation Matrix. **(Volume 2)**

- Is the mission and aim of the Alliance still relevant and to what extent are the objectives being achieved?
- Do the governance and the hosting arrangement of the Alliance contribute optimally to the achievement of the organisation's objectives?
- Is the work of the Alliance managed and monitored effectively and efficiently?

The first question is split into two areas of discussion, one focusing on relevance and the second on effectiveness.

4.1 ARE THE MISSION AND AIM OF THE ALLIANCE STILL RELEVANT?

The Alliance fills a major gap in health policies and systems research. The positioning within WHO legitimises its role as a convenor of policy- and decisionmakers and is its main unique characteristic. Its engagement with policymakers, thought leadership in health policy and systems research and the focus on low and middle-income countries are its main added values. Since its foundation, the Alliance has been a major contributor to the growth of the field of health policy and systems research, contributing to an expansion of the space that today challenges its own capacity as a thought leader.

Discussions of the goals and objectives of the Alliance with stakeholders indicate that there are distinct demands on the role the Alliance is expected to fill that are difficult to meet by a single organisation, especially by one with the constrained funding base of the Alliance.

- On the one hand, there is the demand to continue to exercise thought leadership in the theory and science of health policy and systems. The lead objective under the current strategy to meet this demand is the objective to **generate knowledge and innovation**, supported by the objective **to provide a forum for the research community** and the objective to **build institutional capacity**. With the expansion of the HPSR field since the creation of the Alliance both in terms of the research community and in thematic terms through developments in technology and the increased demand for understanding systems across sectors, the resource requirement for exercising effective leadership has grown since the start of the Alliance in 1999. The main current limitations of the Alliance to effectively fill this role are constraints in human and financial resources. This could potentially be overcome by renewing the original concept of an 'alliance', i.e. a grouping of financially well-resourced partners with a common vision who agree on pooling resources for knowledge generation or at least on coordinating their activities. With the growth of the global health initiatives, the landscape of global actors supporting health systems development has changed fundamentally since the start of the century. A renewed initiative to forge an alliance that includes these partners could potentially strengthen the Alliance's role in thought leadership.

- On the other hand, there is the demand for an increasing focus on applied science in health policy and systems, i.e. the translation of knowledge into policy- and decision-making practice. The lead objective under the current strategy to meet this demand is to **increase the demand for and use of knowledge** for strengthening health systems. Supporting the **development of capacity to conduct health policy and systems research** in countries with limited research funding and infrastructure is essential for assuring that evidence to inform policy and practice is grounded in the regional, national or local reality and is therefore an important supporting strategy. This role requires a presence or at least an influence in the places were policies are formulated and decisions are made and could only be achieved by close collaboration with WHO and its RO and CO infrastructure. The Alliance has evolved into this direction during the last two strategic periods, but it is still a long way from effectively filling this role.

There are, of course, areas of overlap and interdependence between the two roles of theoretical leadership and support for application in practice, but there is nevertheless a tension between the two that creates a strain for the Alliance. The Alliance has been trying to negotiate these and has thereby been confronted even more acutely by its own resource limitations as well as by the expectations of different stakeholders who are trying to pull the Alliance in either direction.

This also affects the current discussion on organisational structure. As a purely applied science unit for HPSR, full integration into the WHO structure would be functional or even advantageous. As a global leader for systems thinking in health policy, on the other hand, the Alliance needs independence from political influence with which it is already struggling because of its narrow donor base, but which would increase if it were subject to governance by the World Health Assembly.

There is a demand for the Alliance to continue its mission in global HPSR as outlined in its current four strategic objectives that continue to be relevant. But there is also a need for action to assure that these objectives can be met adequately. A broader partnership base and increased resource mobilisation would be a first critical step.

4.2 Did the Alliance achieve its objectives during the current strategy period?

The Alliance achieved (and often over-achieved) the output targets of the reporting framework used for the period from 2016 to 2019. However, the cumulative targets were set low and never adjusted during the four-year implementation period. The weak link of performance indicators to workplans, the lack of formal indicator definitions and the absence of a consolidated performance monitoring database were additional weaknesses limiting the strength of performance data for inferences on the achievement of strategic objectives. A new performance monitoring framework to be implemented from 2020 onwards is under development but had not yet been completed at the time of the evaluation.

The grant-making process of the Alliance was transparent and fair. Criteria of equity and gender equality were applied. Eligibility criteria were adapted to the purpose of each proposal call. The increasing tendency towards commissioning small-budget research grants was driven by the aim to meet or surpass the indicator target of number of publications in scientific journals. The question on whether this affected the quality of supported research was not examined by the evaluation.

This question is also linked to the role definition. Small grant-funding has a role in capacity-building and in contextualised implementation research and knowledge translation, but it is not a strategy for building or maintaining theoretical leadership in HPSR.

4.3 Are the governance and the hosting arrangement of the Alliance fit for purpose?

The question about the effectiveness of the current governance arrangement is closely linked to the question about the institutional arrangement, and specifically to the Alliance's relationship with WHO. The close association with WHO is essential for the Alliance to realise its objectives, especially if it continues to strengthen its focus on applied science. It was beyond the scope of the evaluation to determine whether this is best realised by continuing the status quo as a hosted partnership, by full integration into the structure of WHO, by aiming to become a co-sponsored programme hosted by WHO, or by any hybrid model currently under discussion. However, a strong message emerged from the evaluation that can be summarised in the statement that '*form should follow function*'. Organisational and governance changes may be necessary, but they should be preceded by a clear definition of strategic direction and, equally important, the proof of the financial and organisational capacity to implement this direction. This links to the conclusions drawn in **Section 4.1**.

Current governance arrangements received mixed reviews. The STAC was considered an essential body to assure the scientific and technical legitimacy and credibility of the Alliance, whatever organisational model for the Alliance is pursued. The Board was considered efficient because of its small size but its influence on governance was rather light and primarily delegated to the Board Chair. Power on the Board is distributed and exercised asymmetrically. The voices of donor representatives dominate which is not unusual among similar organisations but more evident in the Alliance Board because of its small size. Whether the Alliance needs a separate Board, how the role of this Board should be defined, and what structure it should have will depend on the organisational path chosen which in turn will depend on the chosen strategic direction.

4.4 Is the work of the Alliance managed and monitored effectively and efficiently?

In the past two biennia, the Alliance executed between two-thirds and three-quarters of its programmable funds for activities and operations. Human resource budgets were executed at about 80 percent. Although planned prudently in relation to anticipated income, human resource expenditures made up less than 20 percent of programmable funds because of carry-overs from previous planning periods. The view that the Alliance Secretariat was under-staffed was widespread among interviewed and surveyed stakeholders and the perception of a high level of work pressure was common among interviewed staff. A correlation of low programme execution with understaffing of the Secretariat is therefore highly plausible. The issue was exacerbated by a high level of staff mobility, especially in the second biennium. A high level of work stress and a non-supportive work environment were cited by several current and former staff members as an underlying reason for the high mobility.

The biennial workplan, the quarterly reports and the operational workplan were the main planning and monitoring instruments used by the Alliance. The three instruments were poorly aligned and

lacked specific information essential for management control, such as implementation targets and timelines. Repeated modifications of activities without explanation and justification, as well as changes in the reporting format, made it difficult to establish a clear picture of the effectiveness and efficiency of programme delivery.

In terms of generating planned outputs and outcomes at lowest costs, the operations of the Alliance during the last two biennia were highly economical. There is, however, a plausible correlation with the high work pressure reported by many staff members of the Secretariat.

During the last two biennia, the Alliance enhanced its visibility by developing and implementing a coherent communications strategy. However, little is known about the profile of the Alliance audience, and the evaluation was not able to shed light on this question, except to a limited way through the analysis of engagements on Twitter. The social media footprint of the Alliance increased steadily and by the end of 2019, the Alliance was on a good trajectory of building an audience of Twitter followers, including in low- and middle-income countries.

5 RECOMMENDATIONS

The evaluation team formulated six recommendations that flow directly from the conclusions drawn on the basis of evidence generated by the findings of the evaluation. They do not reflect the opinions or views of the evaluators, but rather a synthesis of the views and the evidence presented by stakeholders or drawn from the analysis of documents provided to the evaluation team. Where stakeholders expressed divergent views, majority views are respected while also accounting for the roles, positions and knowledge levels of different stakeholders. In some cases, stakeholders expressed wide ranges of views with considerable divergence. In these cases, further processes of exploring and building consensus on strengthening the Alliance are recommended.

THE ALLIANCE STRATEGY IN 2021-2025

Recommendation 1. The four strategic objectives of the 2016-20 Strategic Plan are ranked differently by different groups of stakeholders, but all of them are supported by some. A change in strategy is not supported, however, there is a wide consensus that the Alliance does not have sufficient resources to adequately fill the space that is defined by the vision that underlies these objectives. The evaluation team recommends that in the process of defining the objectives for the 2021-25 Strategic Plan, the Board should consider the human and financial resources that are required to meet them and link the definition of each objective to an estimate of resource requirements and a strategy for raising them.

Recommendation 2. In order to achieve the vision that underlies the four strategic objectives, the Alliance should attempt to renew its global partnership base by approaching the global institutions that are actively involved in generating and using evidence for health systems and policies with a proposal for a renewed cooperative platform to advance evidence-based health policies at global, regional and country-level. These should include, in the first line, the large global health initiatives that have emerged over the past twenty years since the Alliance was founded. This effort should be led by the Board with support of the Secretariat.

Recommendation 3. The strategic objectives for 2021-25 will require a performance monitoring framework with clearly defined measurable indicators, sources of information and targets. The framework should be managed by dedicated Secretariat staff qualified for monitoring and evaluation and supported with improved monitoring tools that allow the Board and other relevant stakeholders to access information about the evolution of the performance at any time. Indicators and targets should be reviewed by the Board annually and corrected or adapted as necessary while each time documenting what changes were made and why.

THE ALLIANCE GOVERNANCE AND HOSTING ARRANGEMENTS

Recommendation 4. Decisions about the governance and the institutional structure of the Alliance are interlinked. There is, at this time, no strong support for changing the status quo of the Alliance as a hosted partnership of WHO. Deliberations about changes should be preceded by a clear definition of the vision and the strategy on how to achieve it. While the functions of the STAC are not questioned, there are views that the oversight exercised by the Board is weak and that power within the Board is asymmetrically distributed in favour of a small number of core donor delegates. This should be addressed by the Board, but not in isolation of the process of defining the vision, strategy and institutional structure of the Alliance.

MANAGEMENT OF THE ALLIANCE

Recommendation 5. Management of the Alliance by the Secretariat requires considerable strengthening. The evaluation has documented a number of interrelated management weaknesses that, throughout the 2016-20 strategy period, have contributed to the inability of the Alliance to fully implement its workplan and budget. There is little indication that this was addressed effectively by the Board. Human resource management issues and a stressful and unsupportive work environment have also contributed. The evaluation recommends that the Board commission a thorough management review of the Alliance Secretariat by specialists in this field with a particular focus on organisational structure and culture and on planning, monitoring and reporting processes. The outcome of this review should be clear recommendations for improving the management structure and processes of the Secretariat.

Recommendation 6. The evaluation registered widespread acknowledgement that the communications of the Alliance improved considerably during the 2016-20 strategy period. These are, however, relatively new developments and there is still room for further improvements. With the improved communications and products developed by the Alliance, there is now an increasing need to better define, segment and expand the audience for these products. This should be addressed by the Secretariat within its workplan for 2020/21.

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