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Options for effective mechanisms to support evidence-informed policymaking in RMNCH in Asia and the Pacific

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The Partnership for Maternal, Newborn & Child Health

Alliance for Health Policy and Systems Research

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Preface

This project focuses on the need for systematic collation and synthesis of country experiences to address evidence needs and support evidence-informed policymaking around implementation of interventions for reproductive, maternal, newborn and child health (RMNCH). The work was commissioned by the Partnership for Maternal, Newborn and Child Health (PMNCH) and the Implementation Research Platform, hosted by the World Health Organization (WHO), with the aim of informing future options for effective mechanisms to support evidence-informed policymaking.

In this document we review existing organisations and processes that provide evidence to policymakers, identify the evidence needs of policymakers in Asia and the Pacific and draw lessons and recommendations for different options for further development of evidence-response mechanisms. The work was conducted through a rapid evidence assessment, key informant interviews, and in-depth case studies in four countries (Bangladesh, India, Indonesia and Nepal).

This report is intended to inform the need for, and considerations to be taken into account in the development of, future evidence-response mechanisms. We believe the findings will be important for a range of stakeholders, including policymakers, researchers and funders at national, regional and global levels. It will have particular importance for those in the field of RMNCH but may have broader relevance in other fields similarly considering different mechanisms for supporting cross-country learning and promoting evidence-based policymaking.

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Summary

There is increasing global commitment to advancing women's and children's health. In an effort to accelerate progress in the Asia-Pacific region, the 2012 Manila Declaration has secured commitment from a wide range of stakeholders to work together, emphasising the particular need to strengthen accountability through measurement, monitoring and evaluation, alongside the potential for cross-country policy learning to inform the development of evidence-based strategies and policies to advance reproductive, maternal, newborn and child health (RMNCH).

Given the many challenges the diverse Asia-Pacific region and low- and middle-income countries more broadly are facing, there is an interest in understanding whether and how the development of similar evidence-response mechanisms in such settings might be suitable to enable more systematic collation and synthesis of country experiences to address knowledge gaps and support evidence-informed policymaking around implementation of essential RMNCH interventions.

This study sought to support these efforts through undertaking, first, a review of the nature and scope of mechanisms established elsewhere that have the explicit aim of promoting the use of research evidence by policymakers and actively engage policymakers in their efforts to do so. We refer to these mechanisms as 'evidence-response mechanisms'. We did so through a combination of review of the published literature and interviews with key informants involved in the delivery of such mechanisms to explore potential lessons for the Asia-Pacific region. Second, we sought to identify evidence needs of policymakers in Asia and the Pacific and existing resources in relation to RMNCH policies and interventions by undertaking detailed cases studies in four countries: Bangladesh, India, Indonesia and Nepal. In addition, we undertook key informant interviews with stakeholders at regional and global levels to better understand the perceived evidence resources and needs in the region from the regional and global funder, non-governmental and governmental perspective. In a third step, we synthesised the results to provide overarching lessons and practical steps for a possible RMNCH evidence-response mechanism in Asia and the Pacific. In doing so, we identified five core lessons emerging from our research, which we describe in detail below.

The development of an evidence-response mechanism needs to be driven by thorough assessment of evidence need

Our findings suggest that the development and implementation of any potential evidence-response mechanism ought to be based on a thorough assessment of need. By 'need', key informants foremost referred to evidence needs and relative priorities of stakeholders

within countries. However, it was also acknowledged that the process would require a systematic assessment of need in relation to evidence gaps around RMNCH in the region. Our study began to unpack some of the issues that help understanding how policymakers in the region view and would seek to use evidence. We found that views and expectations differ, even in the limited number of countries we were able to explore. Therefore, if an evidence-response mechanism was to be established in the region it would be of crucial importance first to better understand and secure agreement on the goals of such a mechanism and the evidence needs it would seek to address. Such an assessment would be especially timely since availability of and access to evidence in itself was not seen as a particular challenge. It is also important to note that use of evidence from other countries was not widespread and policymakers may have a preference to use national and sub-national evidence more effectively in the first instance. Experiences of those involved in the delivery of evidence-response mechanisms suggest that this first step should be given priority and significant investment in effort to ensure any mechanism was expected to add value.

The implementation of an evidence-response mechanism should build on existing resources rather than establishing 'something new'

An important finding throughout the study was recognition of the need to build on existing resources wherever possible rather than starting something new. This principle was applied to three main areas: (i) trust and relationships; (ii) institutional capacity; and (iii) existing networks and mechanisms. All three of these components were considered as crucial determinants in the likely success of an evidence-response mechanism and significant resources exist in relation to all three. These findings, matched with the institutional review findings, highlight further areas for capacity building (among evidence producers and users) within countries which could be developed within an evidence-response mechanism and for the level of new resources required. It was highlighted that a mechanism should ensure institutional independence and not create a dependency relationship for evidence with an external agency or country.

There is a need to secure ownership among those who produce and use the evidence

Our findings highlight the importance of identity in informing the configuration of a possible mechanism. An effective regional evidence-response mechanism has potential in theory to reduce boundaries at least at two levels: (i) country and regional interface by facilitating cross-country learning; and (ii) researcher and policymaker interface. These were both deemed potential benefits of a mechanism. However, our findings also suggest that it was important to maintain identity at each of these levels. Country ownership was considered key and countries must be involved on an equal footing. This may be challenging given governance concerns within countries and therefore capacity to contribute to and use evidence produced must be strengthened. Researchers and policymakers should also maintain specified roles to prevent doubt about objectivity and independence.

Incentives provide an important lever in the region and need to be aligned with the motivations of those engaged in the delivery of an evidence-response mechanism

In line with existing literature, we found that incentives were important and that it should not be assumed that these would be transferable from other regions. Particular features of the research environment in Asia and the Pacific were highlighted such as the role of

consultancy for academics; therefore the importance of financial incentives may differ compared with mechanisms in place in other regions. Understanding and aligning the incentives and motivations of both parties was felt to be crucial to developing a sustainable mechanism and one which would retain high quality individuals and thus in turn contribute to the long-term relationships which we have highlighted above. Understanding motivations and incentives can also be important in trying to promote behaviour change.

Different models of governance and leadership may be equally suitable but ownership and flexibility remained recurring themes

Although the specific governance model for an evidence-response mechanism would need to be determined by many factors including the aim and membership, we identified a set of themes that could be useful to consider in reference to governance and leadership in general: (i) country ownership; (ii) the role of the WHO; and (iii) flexibility. Key informants acting at global level highlighted that country ownership would be vital and this notion was confirmed by the country case studies. Informants debated the potential advantages and disadvantage of leadership by the WHO and similar observations were put forward by local stakeholders, who also raised the potential role of other UN agencies. However, informants remained uncertain about what such leadership and actual implementation could look like in practice. The potential role of the WHO was also raised with regards to the third issue of flexibility, as respondents promoted a model that was flexible and allowed for adaptation and innovation in governance and function.

In light of the scarcity of evidence about different evidence-response mechanisms, we find that there is an opportunity to consider evaluation from the outset of any new mechanism, although this will be challenging.

Abbreviations

AIIMS	All India Institute of Medical Sciences
APOHSP	Asia-Pacific Observatory on Health Systems and Policies
AusAID	Australian Agency for International Development
DfID	Department for International Development
HIV	Human Immunodeficiency Virus
HPNSDP	Health, Population, Nutrition Sector Development Program
ICDDR,B	International Centre for Diarrhoeal Disease Research, Bangladesh
INGO	International non-government organisation
IOMHS	International Observatory on Mental Health Systems
JPGSPH	James P Grant School of Public Health, BRAC University
KI	Key informant
MCH	Maternal and child health
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MNH	Maternal and neonatal health
MoH	Ministry of Health
NGO	Non-governmental organisation
NIPORT	National Institute of Population Research and Training
OECD	Organisation for Economic Co-operation and Development
PMNCH	Partnership for Maternal, Newborn and Child Health
RED, BRAC	Research and Evaluation Division, BRAC
RMNCH	Reproductive, maternal, newborn and child health
SAARC	South Asian Association for Regional Cooperation
SIVAC	Supporting National Independent Immunization and Vaccine Advisory Committees
SURE	Supporting the Use of Research Evidence

UN	United Nations
UNICEF	United Nations Children's Fund
WHO	World Health Organization

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The views expressed in this report are those of the authors alone and do not necessarily represent those of the PMNCH and the Implementation Research Platform. The authors are fully responsible for any errors.

CHAPTER 1 Introduction

1.1 Background

There is increasing global commitment to advancing women's and children's health. While significant progress has been made towards achieving the Millennium Development Goals (MDGs) 4 and 5, improving maternal and child health, many countries remain off track to meeting targets and improvements by 2015.[1] It is against this background that the high-level Commission on Information and Accountability for Women's and Children's Health was launched in 2011, which emphasised the need to improve global reporting, oversight and accountability to achieve sustained progress.[2, 3] More recently, the Manila Declaration, developed within the 2012 Asia-Pacific Leadership and Policy Dialogue, has secured commitment from governments, civil society, private sectors, multilateral organisations and development cooperation agencies to work together to accelerate progress on women's and children's health.[4] Achieving progress will crucially depend on the ability to monitor trends in maternal and child health on the basis of reliable information so as to inform the development of evidence-based strategies and policies. Accordingly, the Manila Declaration promotes accountability through measurement, monitoring and evaluation; it also encourages stakeholders to share experience in implementing and scaling-up interventions and innovations.

Providing opportunities to share experience is particularly timely, with global consensus having been achieved on promoting 56 essential interventions that were shown to be effective in improving outcomes in RMNCH.[5] Yet, despite this common understanding, the implementation and scale-up of these essential interventions has remained a challenge in many settings. There is thus a persuasive argument that those countries or regions that have successfully implemented and scaled up interventions for this experience could provide potentially useful lessons for advancing policy development elsewhere. At the same time, however, it is important to recognise that countries differ in relation to the starting point and potential for policy learning, which will be determined to a great extent by the specific health system and policy contexts, and the broader political and cultural environment within which countries sit. This holds for the Asia-Pacific region, where individual countries face ongoing and distinct challenges in their health services sectors and in mixed health economies contexts where NGOs, international organisations and government bodies all contribute to service implementation. Recognising the many competing demands for limited resources, countries will need to prioritise interventions for implementation and develop context-specific strategies for scaling up.

In relation to promoting cross-country learning, considerable progress has been made internationally to facilitate evidence-informed policymaking and cross-country learning through the establishment of structures or organisations with the explicit aim of promoting the use of research evidence by policymakers. Examples include the European Observatory on Health Systems and Policies, which seeks to support and promote "evidence-based health policymaking through comprehensive and rigorous analysis of the dynamics of healthcare systems in Europe",[6] or the 'On-call' Facility for International Healthcare Comparisons, which provides international evidence to the Department of Health in England.[7] In this report, we refer to these types of structures as evidence-response *mechanisms*. These 'evidence-response mechanisms' go beyond the 'mere' production of policy-relevant research by placing an emphasis on responding to specific policy questions from policymakers, and involving active engagement of policymakers in shaping these questions further.

Given the many challenges the diverse Asia-Pacific region is facing, or low- and middle-income countries more broadly, there is an interest in understanding whether and how the development of similar evidence-response mechanisms in such settings might be suitable to enable more systematic collation and synthesis of country experiences to address knowledge gaps and support evidence-informed policymaking around implementation of essential RMNCH interventions. There is particular interest in understanding the feasibility of implementing an evidence-response mechanism that operates 'on demand' to facilitate a more targeted response to specific information needs in the field of RMNCH in the first instance.

This study seeks to support this effort through:

- reviewing the nature and scope of existing mechanisms and processes that can be used to ensure policymakers have access to the evidence they need
- identifying evidence needs of policymakers in Asia and the Pacific in relation to RMNCH policies and interventions
- synthesising the findings to draw lessons and recommendations for different options of evidence-response mechanisms.

1.2 About this report

This report is structured as follows: Chapter 1 sets out the background to and motivation behind the study, then Chapter 2 details our methodological approach. Chapter 3 presents the results relating to existing evidence-support mechanisms and issues and challenges associated with these. Chapter 4 then moves focus on the needs of policymakers and resources currently available to them. The chapter summarises, compares and contrasts data from four country case studies (Bangladesh, India, Indonesia and Nepal). Chapter 5 provides a synthesis of the different study elements and provides key lessons and recommendations for establishing an evidence-response mechanism in the Asia-Pacific region for RMNCH.

The main body of the report is accompanied by a series of appendices which include data collection tools and each of the four country case studies in full.

CHAPTER 2 Methodology

2.1 Rapid evidence assessment

We carried out a review of the academic and grey literature on existing tools and mechanisms that aim to inform decisionmaking for health policy implementation, using the principles of a rapid evidence assessment. This is a comprehensive, rigorous and critical assessment of the scope and quality of available evidence, which follows the general principles of undertaking reviews in healthcare.[8]

The review sought to assess the nature and scope of approaches or mechanisms that are being used to ensure policymakers have access to the evidence they need. Our review builds on earlier work by Healy et al. (2007) which assessed the feasibility of a regional rapid-response mechanism to inform health system decisionmaking in Asia.[9] Healy et al. (2007) describe a range of health system information mechanisms in use internationally to inform the development of a potential response mechanism in Asian countries. Response mechanisms refer to those which can respond and produce information and evidence in response to a specific question from policymakers. In an extension to that work, the review presented here sought specifically to understand the functions and mode of operation of selected mechanisms, their issues and challenges and, where possible, evidence of effectiveness.

At the outset it is important to note that the process of making available necessary evidence to inform decisionmaking involves a number of steps. This research and dissemination continuum can include: (i) primary research involving data collection and analysis; (ii) secondary analysis and synthesis of existing studies to extract relevant and information; (iii) information sharing between researchers and policymakers; and (iv) the use of the available evidence in policy development and practice. Mechanisms to support evidence-informed policymaking may cover all of these activities, or focus on particular aspects, such as increasing capacity for primary research and analysis, or information sharing between researchers and policymakers.

Previous research has comprehensively mapped MNCH knowledge resources and access to these, making recommendations for knowledge management systems.[10] Against this background and for the purposes of this review we therefore focused on approaches or mechanisms that include an explicit element of information sharing or exchange between researchers and policymakers. By 'mechanism' we mean (organisational) systems or structures that have an explicit function of promoting the use of research evidence by policymakers, although this may be differently defined and achieved. We excluded mechanisms that focused primarily on the improvement of the quality of evidence or the

evidence base. An example for a mechanism of the latter kind is the Cochrane Effective Practice and Organisation of Care Group.[11] Likewise, we excluded mechanisms that focused on the development or strengthening of health information systems to inform decisionmaking, such as the Pacific Health Information Network.[12] We also excluded reviewing specific 'tools' or 'instruments', focusing on guiding and improving the process of translating research evidence into evidence-informed decisionmaking[13] such as through policy briefs or policy dialogues.[13, 14] Such instruments may play an important role in the effective translation of research for policy development within functioning evidence-response mechanisms but have been reviewed in detail elsewhere.[15–18] We make a distinction therefore between our review, which focuses on structures and requirements at an organisational level, and broader literature on knowledge transfer. In addition to concentrating on those mechanisms that involve an explicit element of information sharing or exchange between researchers and policymakers, we considered mechanisms that cover several countries in a given region or globally. These could be mechanisms where the client and provider are based in one country but seek evidence from a range of countries or mechanisms involving multiple clients and/or providers in a number of countries.

Despite setting clear inclusion and exclusion criteria, we recognise that boundaries are not clear cut and that our definition of 'mechanism' may miss relevant examples. The review as presented here was not designed as an exhaustive assessment of the entire evidence base but rather to capture enough of a range of type of mechanisms in order to gain an in-depth understanding and inform decisionmaking on potential future mechanisms for RMNCH. We did however use key informants to supplement the review.

Search strategy

The nature of the topic under review restricted the applicability of search strategies typically employed in a systematic literature review. Instead, we used an iterative approach, principally drawing on snowballing, to identify scholarly and grey literature of relevance to the topic under review as identified from bibliographic databases (PubMed, EBSCOhost) and the World Wide Web using common search engines (such as Google Scholar). In part informed by the work by Healy et al. (2007),[9] we used combinations of the following search terms: policy, health, dialog*, (on-call) facility, observatory, mechanism, platform, network, partnership, tool, evidence, hub. The search was further informed by the authors' (EN and EP) experience of evidence-response mechanisms, through the European Observatory on Health Systems and Policies and the On-Call Facility for International Healthcare Comparisons in the UK. We also followed up documents that cited papers and reports identified by our initial search. We further accessed websites of mechanisms identified as of potential relevance for this review for supplementary information.

However, when carrying out the searches it became apparent that detailed documentation on several evidence-response mechanisms identified or known to the authors was scarce or lacking. To enable assessment of functions and mode of operation, issues around challenges and effectiveness, we carried out interviews with a range of experts who are or have been involved in such mechanisms, either directly as contributors to or indirectly as commissioners of the production of evidence. Key informant interviews are described in detail below. Key informants were invited to: (i) provide additional documentation on evidence-response mechanism(s) they were familiar with; and (ii) review key features of

response mechanisms as identified from the rapid evidence assessment and presented below, and to provide additional information where appropriate and relevant. Key informant interviews also helped identifying further evidence-response mechanisms that our search strategy failed to identify. In one case, this identified a mechanism that is no longer in operation but was viewed to provide important insights for the purposes of this study.

Data extraction

Documents (scholarly articles, reports, website content) retrieved by our searches and considered relevant for the review were analysed by means of a common data extraction template as illustrated in Table 1. The characteristics identified were informed, in part, by those described by Healy et al. (2007)[9] and complemented by work by Lavis et al. (2006),[19] to enable the development of a set of criteria which would capture key features of each mechanism and allow systematic comparisons across them.

Table 1 Characteristics of response mechanisms

Characteristic	Description
Aim(s)	Stated aim(s) of mechanism
Functions	Stated ways in which mechanism seeks to achieve aim
Period of activity	Time period during which the mechanism is/was in active operation
Geographical focus	Primary geographical focus and coverage of mechanism
Principal structure	How mechanism is structured, eg secretariat, associated hub or centre
Coordinator/secretariat	Which institution(s) coordinate activity or lead secretariat
Sponsor/funder(s)	Institutions providing financial or other resources to support the mechanism
Topic focus	Stated topic focus, eg health systems
Principal mode of operation	How the work of the mechanism is determined, and by whom
Mechanism	Can the mode of communication be characterised by:[19] • push – efforts to link research to action are led by researchers, intermediary groups or other purveyors of research • user-pull – efforts to link research to action involve policymakers or civil servants and others 'reaching-in' to extract information required for a particular policy question • exchange – when evidence producers develop a partnership with those who use the research • large-scale knowledge translation platforms; includes elements of push, pull and exchange
Capacity-building function	Mechanism has explicit capacity-building function for either evidence producers or users
Information products[9]	Type of information products/outputs, eg policy briefs, case studies, country policy summaries, comparative analysis of systems, response to specific questions
Language(s) of publication	Language(s) in which products are published

2.2 Key informant interviews

As indicated above, we carried out key informant interviews with identified evidence users and producers operating at a regional or global level. The interviews focused on understanding the evidence needs of policymakers and needs of evidence producers. Recognising the limitations of published documentation around evidence-response mechanisms, we sought to include key individuals involved in existing evidence-response mechanisms, in order to gain a more thorough understanding of practical challenges and issues such as capacity and resource requirements.

Potential interviewees were identified according to their involvement with an evidence-response mechanism, membership of PMNCH, recognised expertise in RMNCH or evidence-based policymaking. We produced a long list of key informants as identified from the published and grey literature, the authors' own professional networks and the PMNCH network or experts. We discussed and agreed the final list of potential interviewees with PMNCH, and invited interviewees to participate in a telephone interview lasting up to one hour. The nature of questions asked varied according to the specialism of the interviewee. Common themes included challenges to evidence-informed policymaking in general and in the Asia and Pacific region in particular, the researcher–policymaker interface, and desired features of evidence-response mechanisms, including governance structure and functionality, among others. We have reproduced the interview topic guides in Appendix I.

Table 2 provides an overview of the key features of the 10 key informants participating in the interviews by area of expertise and/or affiliation. With permission interviews were audio-recorded and transcribed verbatim. Transcripts were analysed for recurring themes, informed partially through themes identified in the rapid evidence assessment but allowing for new themes to emerge. Negative incidences were also sought.

Table 2 Characteristics of key informants

Key Informant	Areas of expertise
1(a and b)*	Evidence-response mechanisms (Asia-Pacific, global)
2	Maternal, neonatal and child health; global initiatives
3	Health systems research, India
4	RMNCH, evidence for policy
5	RMNCH, child health, Asia-Pacific region
6	Health policy, evidence-response mechanisms (UK)
7	Knowledge transfer and exchange in public policymaking environments, evidence-response mechanisms (Africa, global)
8	Evidence-response mechanisms (Europe), health systems and policy research
9	Child health, knowledge hubs

NOTE: *joint interview

2.3 Country case studies

Understanding the needs of evidence users and existing resources and mechanisms within countries in the Asia-Pacific region is crucial to the development and implementation of any potential evidence-response mechanism. We therefore carried out in-depth case studies of four countries in the region: Bangladesh, India, Indonesia and Nepal. These were selected in discussion with PMNCH, taking account of the diversity of their development and progress towards the targets of MDG 4 (to reduce child mortality) and MDG 5 (to improve maternal health) (Table 3).

Table 3 Countries selected for case studies

	Setting	MDG4	MDG5
Bangladesh	Low income	On track	Off track
Nepal	Low income	On track	Off track
India	Lower middle income	On track	Off track
Indonesia	Lower middle income	Off track	Off track

Country case studies were undertaken in close collaboration with in-country partners. These were identified from the authors' professional networks in the region and were chosen on the basis of: (i) expertise in health systems and/or RMNCH; (ii) independence from government; (iii) availability and ability to undertake required components of work in a 4–6 week timeframe; and (iv) recommendation through professional network.

Each country case study comprised three main components and followed a common methodology involving:

(i) key informant interviews with policymakers to identify evidence needs and current and future means of meeting these needs

(ii) a country mapping of key institutions/mechanisms that currently respond, or have capacity to respond, to evidence needs in each country

(iii) a detailed analysis of the core capacities in three or four key institutions identified in (ii).

The purpose of key informant interviews was to understand how key actors in RMNCH policymaking use evidence in their day-to-day work, the role of evidence from other countries and the main sources of evidence drawn on. The interviews also explored views and priorities concerning the establishment of a potential future regional evidence-response mechanism. Institutional capacity, component (ii), was assessed according to five main areas: research capacity; experience in providing evidence for decisionmakers; ability to provide evidence in a responsive mode; supportive administration; and partnerships and networks. The categories were informed by previous assessments of capacity for health policy and systems research in low- and middle-income countries.[20, 21]

We designed a common protocol for country partners to support rapid data collection within a four- to six-week period. The detailed protocol is reproduced in Appendix II. In brief, in-country key informant interviews followed a structured questionnaire, co-designed by the research team at RAND Europe and country partners to ensure clarity and appropriateness. The core research team at RAND Europe supported country partners throughout data collection by providing further guidance and to identify and resolve any challenges to data collection. In addition to documenting and analysing the information gathered under each of the three components that formed part of the country case study as described above, country partners were also asked to note their overall impressions as it related to data collection and analysis. Country-specific findings were further analysed and synthesised by the core research team at RAND Europe to produce a country report. Country reports formed the basis of a comparative analysis of capacities, experiences and expectations presented in Chapter 4. Individual country reports are included in full in Appendices III–VI.

CHAPTER 3 Existing evidence-support mechanisms and associated issues and challenges

Key findings:

- Existing evidence-response mechanisms cover a wide range of health policy topics.
- Structures vary but typically involve a core secretariat or research 'hub' with a network of experts or institutions.
- Little is known about the effectiveness of existing mechanisms.
- The potential for a regional mechanism to support cross-country learning was recognised but key challenges were identified.
- Caution was raised that the need for and purpose of any mechanism should be established before initiating any mechanism.

3.1 Review of evidence-response mechanisms

We identified 12 evidence-response mechanisms and processes that have been or are being used to ensure policymakers have access to the evidence they need and which we considered of relevance in the context of this research. The key characteristics of these mechanisms are further illustrated in Table 4.

Table 4 Key features of selected international evidence-response mechanisms

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
European Observatory on Health Systems and Policies[a]	To support and promote evidence-based health policymaking through comprehensive and rigorous analysis of the dynamics of health care systems in Europe	1998 to present	WHO European region and selected OECD countries outside Europe	The principal structure includes a steering committee, a core management team, a research policy group and staff. The Secretariat is based in Brussels, with 3 university-based research hubs (London, Berlin, Atlanta) working with networks of experts in countries in the WHO European region and beyond	WHO Regional Office for Europe	Consortium of WHO Regional Office for Europe, 9 governments in Europe, European Commission, European Investment Bank, World Bank, French National Union of Health Insurance Funds, London School of Economics and Political Science, London School of Hygiene and Tropical Medicine	Health policy and health systems	Annual programme of work agreed with steering committee	Push, pull	Multiple	Yes	**Published outputs**: Systematic health system reviews (Health Systems in Transition series) (approx. 4/year) Analytical studies (~4–5/year) Policy briefs(~5–9/year) Newsletters Academic papers Health policy bulletins *Euro Observer* (4/year) and *Euro Health* (4/year) **Direct communication**: Workshops and policy dialogues (7–13/year) **Web-based and electronic information**: Monthly electronic newsletter **Exchange**: Summer school to bring experts and policymakers together (1/year)

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
Asia-Pacific Observatory on Health Systems and Policies (APOHSP)[b]	To collect and analyse information and research evidence on healthcare systems, policies and reforms and make this knowledge available and easily accessible throughout the Asia-Pacific Region To draw cross-country lessons and disseminate them in formats that can be directly used for policymaking To contribute to capacity building in research, analysis and evidence-to-policy links. Modelled on the European Observatory on Health Systems and Policies	2011 to present	Western Pacific and South East Asian regions of WHO	The principal structure includes a steering committee, a research advisory group and a secretariat based in the WHO The Secretariat contracts and coordinates research institutions and networks; three research hubs were appointed in 2011, based in Thailand (International Health Policy Programme, Ministry of Public Health), Sri Lanka (Institute for Health Policy) and Australia (Universities of Queensland and Melbourne)	WHO Western Pacific	Partnership of governments, development agencies and research community; membership of Steering Committee: Hong Kong Special Administrative Region, Republic of the Philippines, Singapore, Thailand, Australian Agency for International Development (AusAID), Asian Development Bank, World Bank, WHO Western Pacific Regional Office, WHO South East Asian Regional Office.	Health systems and health policy and reform	Annual programme of work agreed with Steering Committee	Push, exchange	Multiple	Yes	**Published outputs**: Systematic Health Systems reviews (Health in Transition reports) (2 published in first year of operation) Policy briefs (1 published in first year of operation **Direct communication**: Policy dialogues (*yet to take place*)

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
International Observatory on Mental Health Systems (IOMHS)[c]	To build capacity to measure and track mental health system performance in participating countries at national and sub-national (provincial and district) levels. Modelled on the European Observatory on Health Systems and Policies	2009 to present	Asia-Pacific region with a focus on low- and middle-income countries	The principal structure includes the IOMHS Secretariat, an international steering committee and a management committee. Goal to progressively establish IOMHS country programmes, led by a country research director supported by research and administrative staff	Centre for International Mental Health, University of Melbourne	Not clear; the goal is to enter into agreements with governments, universities and other partner organisations, and to obtain funds for the establishment of country programmes	Created to support the WHO Mental Health Gap Action Program Mental health system reform and development	Work programme to be informed by partnerships with governments, universities, international and local NGOs and other partner organisations	Push, pull	Multiple	Yes	**Published outputs**: Journal papers (5–11/year) Books (0–2/year) Book chapters (0–6/year) Reports (<1/year) Policy briefs, succinct summaries of policy and practice lessons written by experts specifically for policymakers (volume not clear)
On-call Facility for International Healthcare Comparisons[d]	To provide timely, targeted, relevant and concise information on and analyses of health policy issues of relevance to policy thinking in England in a range of OECD countries	2005 to 2013	OECD countries	Core staff in research organisation (RAND Europe, Cambridge, UK), supported by university-based advisors and working with network of typically university-based	RAND Europe	Department of Health, England	Healthcare systems and policies	Responds to evidence requests on demand	Pull, exchange	Department of Health (England) as primary customer; decisionmakers in partner countries	No	**Published outputs**: Comparative studies (reports) (~4/year) Policy briefs (2 to date) Academic papers(~1/year) Other (professional journals) (3 to date) **Web-based and electronic information**: Regular update of project website

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
				experts in different countries								**Direct communication**: Limited to direct communication with funder (to agree on topic area, define research question, continuous exchange during study development) Presentations to wider Department of Health staff (~1/year) Presentations at national/international conferences or seminars (~1–2/year)
WHO Health Evidence Network (HEN) [e]	To give access to independent and reliable health information and evidence	2003 to present	WHO European Region	The principal structure involves core staff at WHO Regional Office for Europe, a steering committee and a network of ~35 (inter)national technical members	WHO Regional Office for Europe	WHO, European Commission, Ministry of Health France, Pfizer	Healthcare and public health	Combination of responses to specific evidence requests on demand and work programme agreed with steering committee	Pull, exchange	Multiple	No	**Published outputs**: Evidence reports (0–12/year) Joint policy brief and policy summaries with European Observatory HEN summaries of network members' reports (0–5/year) **Web-based and electronic information**: Newsletters (*HENews*), email updates on new publications and news **Direct communication**: email responses to

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
												specific questions
Evidence Informed Policy Network (EVIPNet)[f]	To promote the systematic use of health research evidence in policymaking with a focus on low- and middle-income countries	2005 to present	Global	The principal structure involves linked but distinct country-based and regional networks in Africa, Asia and the Americas, a global steering group, and global or regional resource groups	WHO regional offices in the four regions (Africa, Asia, Americas, Eastern Mediterranean Region)	WHO as per World Health Assembly Resolution June 2005	Health policy development and implementation	EVIPNet country teams and expert members of its Resource Group prioritise key issues	Push, exchange		Yes	Establishment of priority-setting mechanisms for policy-relevant research syntheses and primary research, policy briefs, policy dialogues, research syntheses

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
Supporting the Use of Research Evidence (SURE)[g]	To contribute to strengthening, supporting and evaluating EVIPNet in Africa and the the Region of East Africa Community Health (REACH) Policy Initiative	2009 to 2014	Africa (Burkina Faso, Cameroon, Central African Republic, Ethiopia, Mozambique, Zambia, Uganda, Tanzania, Rwanda, Kenya and Burundi)	Consortium of 9 universities and research institute partners in Africa, Canada and Europe plus the Ministry of Health Burkina Faso and WHO	Norwegian Knowledge Centre for Health Services (Scientific Coordination)	Funded under the European Commission Seventh Framework Programme	Healthcare policy and systems	Research project; produces evidence syntheses (unclear whether on demand); develops and evaluates different strategies for improving access to and use of research evidence in policy development	Push, pull, exchange	Multiple	Yes	**Published outcomes**: Evidence-based policy briefs (11 to date) Rapid responses (1 to date) SURE guides for preparing and using evidence-based policy briefs **Direct communication**: International Forum bringing together policymakers, researchers, representatives of civil society, journalists (one-off event)
Supporting National Independent Immunization and Vaccine Advisory Committees (NITAGs) (SIVAC)[h]	To support the development or strengthening of NITAGs and through the provision of tools and information to enable formulating contextually appropriate immunisation policies and programmes	2008 to present	Global with a focus on low- and middle-income countries			Bill and Melinda Gates Foundation	Immunisation		Push, exchange, pull?		Yes	Concept papers, technical support tools, courses, articles, workshops, knowledge sharing web platform

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
Global Network of WHO Collaborating Centres for Nursing and Midwifery Development[j]	To maximise the contribution of nursing and midwifery to advance states, member centres, NGOs and others interested in promoting the health of populations To carry out advocacy and evidence-based policy activities within the framework of the World Health Assembly and regional resolutions and the WHO programmes of work	1990 to present	Global	The Global Network has an elected governing body consisting of a secretariat elected from the member collaborating centres for four years; the secretariat functions as coordinating body of the network Network comprises 44 organisations (collaborating centres) in the six WHO regions	Rotating secretariat, currently (2008–2012): WHO Collaborating Centre for Nursing Research Development at the University of São Paulo at Ribeirão Preto College of Nursing, Brazil	WHO Partners include the International Council of Nursing, International Confederation of Midwives, Sigma Theta Tau International, Global Alliance of Nursing and Midwifery, PAHO, Brazil Ministry of Health	Nursing and midwifery	Development and coordination of education and training programmes and materials	Push	Multiple	Yes	Website, database, case studies
Compass: **women and children health knowledge hub**[k]	To contribute to the quality and effectiveness of Australia's engagement in the health sector in the Asia and Pacific regions through expanded expertise and an expanded knowledge	2008 to present	Asia and Pacific region	Core staff in three research institutes (University of Melbourne, Burnet Institute, Menzies School of Health Research)	Programme coordination and communications hub based at Burnet Institute	AusAID (Compass is one of four knowledge hubs funded by AusAID)	Women and child health	Produces evidence syntheses on four set priority areas (introduction, scaling-up, equity and integration of interventions)	Push		(Yes – development of learning materials)	Academic papers, briefing papers, courses

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
	base that is of practical value and used by stakeholders in development											
Social protection facility[l]	To improve the effectiveness of social protection programmes in Indonesia, Philippines, Thailand and Vietnam for low-income and vulnerable groups, by running responsive, customised training programmes mainly for government officials; the focus was on strengthening institutional and technical capacities of governments in areas such as policy development,	2001 to 2004	Indonesia, Philippines, Thailand, Vietnam	Australian National University managing contractor with partner, the Institute for Population and Social Research at Mahidol University in Bangkok	Australian National University	AusAID	Social protection, focusing on vulnerable children, health access to poor, community care for ageing populations and employment for people with disabilities	Responsive, customised training programmes, mainly for government officials		Government officials in southeast Asia	Yes	Capacity-building programmes as main output – 39, involving 305 participants, in three years Average 13 per year of operation. Project output reports online <1 per year

Name	Stated aim(s)	Period of activity	Geographical focus	Principal structure	Coordinator or secretariat	Sponsor or funder(s)	Topic focus	Principal mode of operation	Mechanism (push, pull, exchange or mix)	Audience or client	Capacity-building function	Information products – type and number (annually)
	social monitoring and statistics, programme design and administration											
Health Resource Facility[m]	To assist AusAID in making informed policy and operating decisions and ensuring access to broad range of quality assured expertise in health and HIV	2009 to 2014	All partner countries with AusAID health and HIV programme Major focus Asia-Pacific but also Africa and the Middle East	Managed by HLSP and IDSS	HLSP	AusAID	Health, with particular focus on HIV	Responds to specific evidence requests	Pull	AusAID staff and other clients approved by AusAID	No	Analysis/synthesis reports and policy advice

SOURCES:

[a] European Observatory on Health Systems and Policies. [Online] Available at http://www.euro.who.int/en/who-we-are/partners/observatory (accessed September 2012).

[b] Asia-Pacific Observatory on Health Systems and Policies. [Online] Available at http://www2.wpro.who.int/asia_pacific_observatory/APOHSP.html (accessed September 2012).

[c] Minas H., "International Observatory on Mental Health Systems: a mental health research and development network", *International Journal of Mental Health Systems*, Vol. 3, No. 2, 2009.

[d] RAND Europe. An 'On-call' Facility for International Healthcare Comparisons. Proposal for the extension of the project from RAND Europe, in collaboration with the Cambridge Centre for Health Services Research and the London School of Hygiene & Tropical Medicine. Cambridge: RAND Europe, 2011 (unpublished document)

[e] Health Evidence Network (HEN). [Online] Available at http://www.euro.who.int/en/what-we-do/data-and-evidence/health-evidence-network-hen (accessed September 2012)

[f] EVIPNet. [Online] Available at http://www.evipnet.org/ (accessed September 2012)

[g] SURE. [Online] Available at http://www.who.int/evidence/sure/en/ (accessed September 2012)

[h] Supporting National Independent Immunization and Vaccine Advisory Committees

[i] Global Network of WHO Collaborating Centres for Nursing and Midwifery Development. [Online] Available at http://www.parlatore.com.br/whocc/index.php (accessed September 2012)

[k] Compass: Women's and Children's Health Knowledge Hub. [Online] Available at http://www.wchknowledgehub.com.au/ (accessed September 2012)

[l] Social Protection Facility. [Online] Available at http://spf.anu.edu.au/english_activities.html (accessed December 2012); Dr Judith Healy
[m] Health Resource Facility. [Online] Available at http://www.ausaidhrf.com.au/ (accessed December 2012)

Evidence-response mechanisms as identified here cover a wide range of topic areas, stretching from broad fields such as health systems and health policy development to specific policy topics such as immunisation (SIVAC), women and child health (Compass) and HIV (Health Resource Facility). Most mechanisms were established during the past decade, typically as an ongoing mechanism, although four mechanisms were established on a time-limited (research) project basis and have already been completed (Social Protection Facility) or are due to be completed within the coming two to three years (On-call Facility for International Healthcare Comparisons, SURE, Health Resource Facility). In line with our search criteria, the geographical reach of evidence-response mechanisms reviewed here is multi-country, covering specific sets of countries (eg the Social Protection Facility covered Indonesia, the Philippines, Thailand and Vietnam), regions such as Asia and the Pacific (eg Compass, International Observatory of Mental Health Systems) or WHO regions (eg European Observatory on Health Systems and Policies), countries at different levels of development (eg SIVAC and EVIPNet: low- and middle-income countries) or have a global reach (eg Global Network of WHO Collaborating Centres for Nursing and Midwifery Development).

Although the precise configuration of the principal organisational structure varies across mechanisms, reflecting to a great extent the underlying funding and governance arrangements, the typical structure involves one core secretariat or research 'hub', which works with a network of experts or institutions. These collaborations can be formalised through direct contracting, as is the case for the European and Asia-Pacific Observatories on Health Systems and Policies, in which the secretariat contracts and coordinates research hubs alongside experts, or network membership agreements (eg HEN, Global Network of WHO Collaborating Centres for Nursing and Midwifery Development). Other mechanisms such as Compass and the International Observatory on Mental Health Systems appear to rely on more informal arrangements with regard to collaboration with experts in other countries. The On-call Facility for International Healthcare Comparisons initially maintained a network of experts in 13 countries who were formally contracted for a defined period of time against a set annual payment as a retainer; however, this model was subsequently replaced by a more flexible arrangement that allowed for ad-hoc contracting of experts to better meet the varying nature of evidence requests the Facility was tasked to respond to.

Where an evidence-response mechanism has been established as a time-limited research project, the core hub or coordinating group tends to be university-based (eg Social Protection Facility: Australian National University) or a research organisation (eg On-call Facility for International Healthcare Comparisons: RAND Europe; SURE: Norwegian Knowledge Centre for Health Services). Conversely, the European and Asia-Pacific Observatories, EVIPNet, the HEN and the Global Network of WHO Collaborating Centres for Nursing and Midwifery Development are coordinated by the relevant WHO regional office, or a subsidiary (eg WHO Collaborating Centre). In this context, it may be interesting to note that the International Observatory on Mental Health Systems (IOMHS), coordinated by the Centre for International Mental Health at the University of Melbourne, models itself after the European Observatory on Health Systems and Policies.[22] However, the latest published evidence on the IOMHS dates to 2009, at which point it was in the process of trying to achieve its goal, is to enter into agreements

with governments, universities and other partner organisations, and to obtain funds for the establishment of country programmes. It thus remains unclear to what extent the initiative has succeeded to establish itself as a sustainable evidence-response mechanism.

Turning to the functionality and activities of evidence-response mechanisms reviewed here, we find that the majority seek to produce evidence as well as build or strengthen capacity. The approaches pursued to build capacity vary, however, ranging from making available material and support tools (eg SIVAC; SURE), developing and offering training, courses or workshops (eg Global Network of WHO Collaborating Centres for Nursing and Midwifery Development; SIVAC; European Observatory on Health Systems and Policies), to mechanisms where capacity building constitutes the main purpose of the mechanism (eg Social Protection Facility). Active engagement of policymakers forms a key characteristic of most although not all mechanisms reviewed here, but the extent to which this engagement is being implemented in practice varies. For example, one of the core dissemination and engagement activities pursued by the European Observatory on Health Systems and Policies involves policy dialogues that seek to offer policymakers in a country or a group of countries a neutral platform to discuss a particular key policy issue on the basis of comparative evidence and sharing experience.[6] This active engagement is also seen in other response mechanisms, typically as part of the capacity-building component (eg Social Protection Facility; EVIPNet; SURE). The On-Call Facility for International Healthcare Comparisons presents an outlier in this regard; funded by the Department of Health in England, its main audience is the Department of Health, although reports are made available publicly and are therefore accessible to a wider audience. Engagement with policymakers is however restricted to those in the Department of Health.

The On-call Facility also presents an example of a mechanism that solely responds to evidence requests on demand (as issued by the Department of Health in England). A similar mechanism has been established by AusAID (Health Resource Facility), with a particular focus on HIV. Mechanisms such as the WHO Evidence Network and the SURE project also offer a (rapid) response mechanism, but these form part of a wider portfolio of evidence-analysis and synthesis activity. The European and Asia-Pacific Observatories on Health Systems and Policies and EVIPNet work on the basis of an (annual) workplan, agreed with a steering committee that brings together policymakers from different countries or system settings.

Little is known about the effectiveness of any of the mechanisms described here. Existing accounts of three evidence-response mechanisms, the On-call Facility for International Healthcare Comparisons,[23] the European Observatory on Health Systems and Policies and the HEN,[24] have identified a series of challenges, including:

- timeliness of evidence for policymaking process
- importance of context in using international evidence
- addressing poorly documented topics or areas of interest to policymakers
- aligning motivations of and incentives for researchers and policymakers
- format and presentation of evidence for policymakers
- developing partnerships between policymakers and researchers.

We explore these themes further by means of key informant interviews. In this context it will be important to review the findings of the SURE project, which seeks to develop and evaluate the effectiveness of five strategies for improving access to and use of research evidence in policy development, including: (i) the format for research syntheses; (ii) rapid-response mechanisms to meet policymakers' needs for research evidence; and (iii) deliberative forums involving policymakers and researchers with the involvement of civil society and the general public. These findings are expected to be available in 2014.

3.2 Issues and challenges of evidence mechanisms

We used the key informant interviews to further explore the themes listed above and views and perceived challenges to the establishment of a potential evidence-response mechanism for RMNCH in the Asia-Pacific region. Key themes emerging from the interviews included: (i) the value and challenges of the potential development or implementation of a regional evidence-response mechanism; (ii) the role of context in using international evidence to inform policymaking; (iii) issues around the governance of a (regional) evidence-response mechanism and the role of the WHO; (iv) clarity and alignment of purpose; (v) the researcher–policymaker interface and incentive structures; alongside (vi) measures of success and financial sustainability. We discuss these issues in turn below. The themes identified related to evidence-response mechanisms in general as well as specific issues around a potential mechanism for RMNCH in Asia and the Pacific region.

3.2.1 Regional mechanism: value and challenges

The perceived value of a regional mechanism was around (i) learning from other countries which have similar problems; and (ii) efficiencies.

Human resources for health was highlighted by one key informant (KI) as a specific example of where countries in South and South East Asia could learn from each other:

> *The point is that all of these countries have come up with their own sort of solutions to the problem; they are trying their own solutions so I think there is... There is a lot of learning the particulars, through having some network which allows for the solution.* (KI 3)

One interviewee commented that she perceived there was currently an increased openness to collaborating and sharing lessons within the region so that it was an appropriate time to consider the potential for a regional mechanism.

Efficiencies were referred to in the context of reducing duplication of effort and economies of scales:

> *The benefits would be efficiencies I think because there's only a finite amount of knowledge generation, uptake, resource, whether it's human resource or money, so it does make sense.* (KI 4)

Both of these potential benefits were provided with the caveat that they would only be realised if the mechanism met the evidence needs of policymakers within the member

countries. One informant also raised caution as to whether there would actually be economies of scale if individual countries were going to contribute:

> *Are there any economies of scale? I suppose very crudely by having a resource, in which case it needs to have some kind of central identity, otherwise there are no economies of scale, it's just a lot of small teams in different countries struggling, all to try and do the same thing. So I suppose behind all this is the notion of sustainability as well, isn't there, not just financial but if... there needs to be some ability for the whole thing to generate more value than it would otherwise if it was funded separately and 'cause' the more one decentralises, the more one's actually back to simply churning the money through the system so it goes into a central pot and then it's spat out again and goes to specific countries again when it's just being recycled.* (KI 6)

The diversity of the Asia-Pacific Region was raised as a major challenge. The diversity was felt to be particularly pertinent to women and children's health services, which tend to be culture specific. When given an example of other regional mechanisms such as the European Observatory on Health Systems and Policies, informants tended to argue that the Asia-Pacific region was yet more diverse and challenging, perhaps too challenging:

> *I would say yes of course the region has got more similarities probably within the region than with for example Africa, so I can see some benefits; even from a pure logistics point of view I can see some benefits of regionalisation. But I think below that this is just such a diverse region, I'd say more diverse than Latin America, certainly more diverse than Africa, and so this one in particular, I mean I think it would be nonsense to try and think that you could have something that would deal with, it would need the policymakers in Kerala or highly developed India versus remote Papua New Guinea and it just won't work.* (KI 4)

It was suggested that grouping countries on the basis of health system characteristics or similar evidence needs may be more useful than pursuing a regional approach:

> *[I] think it's hard to take it as an entity as a whole, it might be smarter to break it into pieces, who needs what and even how you serve such a vast region… island nation might work better together and feel like they could, it might be better, because they draw support from one of the bigger nations in Asia...' If they had an input into what they would like and how they would watch and receive this information and the support, it would probably be important.* (KI 2)

Key informants also drew on learning from establishment of the Asia-Pacific Observatory on Health Systems and Policies and suggested that the time and effort required to reach country agreement at the outset would be challenging for a regional mechanism.

3.2.2 Understanding context is crucial

Understanding the context within which evidence is produced and translated is crucial when using international evidence to inform policy development.[23] Context was first raised in specific relation to RMNCH policymaking: the need for context-specific evidence to inform implementation of interventions or packages of interventions:

> *So we know what works as a single intervention; we don't know what works at a packaged level very well because we have never, we rarely evaluate those complex packages, and then, thirdly, we don't know what works where. So the context, the idea of evaluating packages in context, is a big gap.* (KI 4)

It was more commonly raised in general relation to using international or global evidence to inform national or sub-national levels of decisionmaking. Key informants felt that without translation to the context to which it would be applied, there would be limited value of a regional or multi-country mechanism:

> *So I think this is what would have to be considered in any of these knowledge entities, that when you talk about policymakers it's usually policies in a particular country, what they want is something very particular to their country, they're not… 'We've had lots of discussions about this, what can you learn from other countries or from the region – are there common issues? But we keep getting back to the policymakers in particular countries saying, "Well my country's unique, I want some sort of study that's paramount very much to the context of my country and our concerns."* (KI 1)

The diversity of the Asia-Pacific region was thought to add to the challenge of a mechanism being able to provide context-specific learning:

> *I think the first thing in this that is particularly striking in this region is diversity of context, and I think that that is probably one of the biggest challenges because it leads on to my second point, which is insufficient local-level evidence.* (KI 4)

A mechanism seeking to draw learning from multiple countries must carefully address these challenges, but informants agreed that this was challenging:

> *Well you probably need case studies to focus on a programme and how it played out in that particular country or region compared to what happened in another region or country and what all the factors have been. So that's in-country comparative, you know comparing two or more countries might give those sort of answers, but that's quite an extensive proposition.* (KI 1)

> *[I] don't know how you get round the contextual specificity of implementing because presumably many of these 56 things [RMNCH interventions], there's synergies between them as well and therefore they're sort of packages, they're services and therefore it presumably critically depends where you start from as to how you would then implement them in different countries in the region; it's as diverse as Asia-Pacific. I mean the answers presumably are rather different in different places, in terms of also which ones you start with. I think it's a particularly hard requirement for any group to be able to provide that kind of response mechanism because it raises the question about what kind of evidence you're looking for, are you actually going to approach a group and say we want to know something about this and that includes maybe you have to come and visit, you have to go quickly round our regions, you have to go and visit a maternity hospital, you have to go and visit antenatal facilities, you have to go and talk to the Association of Midwives. If that's what they want, I mean that would be understandable, but that's quite a big commitment, that's quite expensive. It's not*

about sitting back at base somewhere reviewing the evidence and writing a report. It's completely different issues. (KI 6)

3.2.3 Governance and structure

In considering the possible structure and governance of a mechanism, the interviews highlighted four main issues: (i) the advantages and disadvantages of leadership from WHO or UN agencies; (ii) the need for country ownership; (iii) institutional independence; and (iv) the importance of flexibility and multiple approaches.

Advantages and disadvantages of leadership from WHO

When asked about who could convene a regional mechanism, most respondents made some reference to the WHO. On the one hand, it was felt that the WHO may be the only agency to be able to facilitate a mechanism which would be felt to have legitimacy among countries in the region. It was also recognised that there may be a "trusting of the brand" with the WHO, that it would be a non-partisan organisation and that there may be opportunities to move leadership around countries because of the WHO's country-level representation. There were also perceived advantages in the gains that could be achieved from going with such an established entity as opposed to starting something new:

Not everyone still believes in WHO, but I believe that ministers of health and the member states still look to WHO for guidance and for direction and that they rely on WHO to provide that… While some want to create another independent entity as a magic bullet, but for sustainability, I would not do that. You could lose a lot of ground and traction by not going with something that's already established [like WHO]. (KI 2)

On the other hand, a number of key informants raised concerns that there would be disadvantages to the WHO having a lead role and even that it may not be an appropriate function for the Partnership or the WHO more widely:

Well I don't think organisations like WHO, I mean I think the thing to do is to think about, dare I say, conflict of interest? I mean I think WHO is supposed to be the technical UN agency but because of the politics they're not. I suppose the question is, [can] any organisation whose funding, whose livelihood, depends on this... be really independent? So I think government structures are very, very important but I wouldn't say are a UN agency. I definitely wouldn't say a UN agency. I would probably say a research organisation. (KI 4)

Need for country ownership

Interviewees agreed that country involvement and ownership was vital and that this must apply to all countries covered in the mechanism. Country-level membership and leadership was thought to be vital if the priority was on country learning:

I think [it] would be helpful to change the conversation a little bit and say really the action is at the country level, the policies on the book and the government action, the country level; that's how we're going to scale up and eventually make these changes. (KI 2)

It was felt important that countries would be able to take ownership of evidence produced from a mechanism in order to enact change:

> *I think we sometimes underestimate that issue of national ownership; so I've given lots of talks in different places where I've been talking about evidence in one part of the world and the decisionmakers said that's not our evidence.* (KI 4)

The potential political sensitivities between countries was also highlighted, emphasising the need for country membership on an equal footing. The physical location of the mechanism then becomes important and it was suggested that a lead role such as chairmanship could rotate between countries:

> *I would think something that doesn't have a fixed [unclear] between countries, that might work well because there is a lot of political sensitivity about these things, particularly in the South Asia region, so if it's say housing in India, and then the colleagues in Pakistan may not be so enthused about it... or in whatever, Bangladesh or Sri Lanka... I mean it turns out to be something that makes everyone feel like an equal partner in this, so I mean it's fine... you could start a network, maybe the first meeting held in India or wherever, but next year the chairmanship moves to another country and the secretaryship is in the other country, or you have a permanent secretary to one place but the leadership of the thing moves across different partners in the region. I think that would be better; if it's in one location only, it won't give the sense [that everyone is] an equal partner and that I think will eventually kill the idea off.* (KI 3)

It was recognised that real county ownership would require investment from countries and that this could be achieved through financial buy-in to the mechanism. Interviewees were split on the structure required to ensure equal country involvement. Suggestions included having nodes within each country or having a research institute that had a designated regional function. For the latter it was felt that this could be achieved based on an existing institutions in the Asia region, but that in the Pacific new institutions may need to be formed. Related to this point, it was argued that any mechanism should seek to build capacity within countries and that, even if an external agency is involved, the mechanism should not create a reliance or dependency for evidence.

Institutional independence

With regards to the institutional base for the evidence-producing function of any mechanism, interviewees did not appear to feel strongly about a specific type of institution but believed there should be clear criteria in the selection process. Most notably, institutions should be independent of policymaking and policymakers but have good understanding of this within their countries, preferably with skilled knowledge brokers. Further characteristics thought to be important were credibility and standing, and good existing networks. Informants believed that it was worth investment at the outset in setting objective criteria and carefully selecting institutions, as this would help to ensure the perceived trustworthiness of institutions and evidence produced.

Importance of flexibility and multiple approaches

Related to the ability to move the lead of the mechanism or steering committee around countries was the general concern that one size would not fit all and that flexibility should be maintained to allow a mechanism or mechanisms to evolve:

> *I think the most important thing is you want flexibility in the set up so that it can evolve and you don't set up something that can't be responsive because I think that's for me the biggest word, responsive. Who are we doing this for? If we're doing it for, well ultimately the primary stakeholders is the population but if we're doing it for policymakers they want you to be responsive. So I think the challenge is to have a sort of a loose but functional structure organisational set up that enables it to grow, to keep it organic, to let it try and fail.* (KI 4)

It was understood that flexibility in itself could be challenging and that funding practice and formats rarely allow such flexibility but that the gains would out benefit the difficulties in this case.

It was also felt that the function and methods of knowledge transfer or stakeholder engagement should not be overly determined at the outset and that multiple, simultaneous approaches would be required. The message of 'one size would not fit all' was brought out strongly. The literature also highlighted the need to use multiple dissemination and engagement methods.[24–26] It was noted too that the appropriateness of different methods would vary according to country and region, depending for example on the nature of policymaking. It was also noted that there was an opportunity for innovation in dissemination and engagement approaches and these needn't be driven by practice in longer established mechanisms in Europe and the West.

3.2.4 Need for a clear purpose

A consistent theme across interviews was that issues such as structure, governance and ownership could only really be assessed once the purpose and aim of a mechanism was clear. In fact a number of key informants, including those who were involved in regional mechanisms, argued that the real value you could have would be in spending time determining what evidence is needed, for whom and for what purpose, and then thinking about the design of the mechanism. For example:

> *You need to think about issues and particularly think about, you know, spend time really drilling down on what are the research questions that need to be answered and then set up a project or an initiative or something around those questions so that you avoid… You'll have wasted all of that time and effort of money on the governance side of things… so often people start with the structure and they think about function afterwards.* (KI 1)

It was suggested that a thorough situation analysis and diagnosis was required to identify what the bottlenecks are in the improvement of maternal and child health and then see what support may be necessary. For example, it may not be an issue relating to evidence but one of political will, or it may be that the greatest need is to support managers at district and sub-district levels and that this may not be best achieved through the establishment of an evidence-response mechanism.

3.2.5 **Researcher–policymaker interface**

The literature suggests that the interface and relationships between evidence producers and evidence users are crucial within a mechanism and that this should be facilitated at all stages of the projects. Even small, responsive groups, such as the UK On-call Facility found that considerable discussion with the client was crucial to agree on answerable health systems questions, and acknowledged that this is time consuming even when liaising with only one government department.[9] Others have highlighted the benefits of moving from researcher-driven processes, where research is summarised, to co-production processes, where managers and policymakers can work with researchers in understand the implications of research for the healthcare system.[27] Ssengooba et al. found that collaboration between scientists, policymakers and funding agencies made sharing of evidence and decisionmaking more efficient. It was felt that shared platforms for learning and decisionmaking among stakeholders were important in facilitating policy uptake and continued implementation.[28]

Key informant interviewees further stressed the importance of trust and relationships between evidence producers and evidence, pointing out that this often requires substantial investment of time by researchers and policymakers:

> *I think it goes back [to] the importance for the policy agency themselves to appreciate that they need to make an investment in this, it's not... I think there's a facile view that having a responsive facility means it's like a tap that you can turn on and off. I think in the long run that won't work or it won't work so well.* (KI 6)

Researchers felt the need to maintain trust with policymakers and felt that being responsive was one's means to do this, so responding in the short time frames required for the policymaking cycle and in areas that may be out with direct expertise:

> *You know if the health minister comes around and says "I want to know about tobacco" and you go "I'm sorry I can only tell you about family planning"; it doesn't really build a lot of trust.* (KI 2)

The relatively frequent turnover of senior policymakers was a challenge to evidence producers, but strategies were adopted to build relationships within different layers of policymaking to ensure some continuity and also to work through trusted intermediaries who may be there longer term:

> *We work closely with the ministry with various things, so because of that we're sort of unique, we're in this sort of unique position where we're able to know what the ministry is working on and what issues they're facing, and we're also able to get our work to them fairly easily. How much of that is actually picked up in terms of action, that I really can't say, but we definitely at least have some level of buy-in from the health ministry... And even then it's, there are like several layers to this, and it's like I'm going by ministry, so you have the top bureaucrats, which ultimately do what they like, but these guys [are not] in their jobs for too long, they get transferred every year or two years, and so forth, so there's always, even when we hold our meetings... there's always like a choice between shall we get the health secretary or shall we get people lower down who you think will stay, stay in longer, and I don't think there's any upset*

> *in that really, but it is good to involve who is where and trying to get people who will be involved.* (KI 3)

> *Understanding the chain of decisionmaking is important and working out who influences that decisionmaking process, and it may not be working directly with policymakers. I can think of lots of situations where that won't work, you've got to go with trusted intermediaries.* (KI 4)

The benefits of developing longer-term relationships for the evidence producers were that there was often less time spent negotiating, for example, around the formulation of specific questions and also expectations of what could be delivered:

> *If you're always negotiating with new people all the time it's extremely time consuming and rather wearying. If you have someone with you who is familiar with that process, either a research liaison officer or someone say in a policy or strategy team in a government department, if it's a Ministry of Health, who has a generic interest in these kinds of aspects and who might also be the sort of champion or the supporter of the external facility within the Department, because often policy team members might have very different understandings of what you can do for them.* (KI 6)

Overall it was felt that evidence producers or knowledge brokers needed to understand the political process within which they were trying to inform decisionmaking, but recognised that this was not necessarily an area where researchers would receive training. The following quote from one interviewee sets out clearly the types of skills that researchers in successful mechanisms may require, although others noted that these need not necessarily be within one person as long as the chain of skills and expertise were there overall:

> *You also need to have people who are credible on the research side and [who] very critically are not seen to have a vested interest in one outcome or another; [if] they're perceived to be clearly biased in one direction or another then their credibility will suffer with time. Then the second thing would be very strong technical skills because, as I mentioned before, you need to be able to review the literature and make sense of it and that's technical, not just in the narrow clinical sense of knowing how to assess the quality of a systematic review, but also that political science sense of really being able to unpack the policy process and unpack policy issues, the really good policy analysis work. Then the third is the communication; I before framed it as writing and that's certainly part of it, but there's a lot of it that is interacting with people [who] are dealing with the steering committee, dealing with key informants, doing the personalised briefing, facilitating the dialogue, which is an incredibly difficult role to play; [it] requires incredibly advanced communication skills. So I think of the ones we know [who] are doing incredibly well; [this] would be my off the cuff summary of what they have going for them right now.* (KI 7)

One less tangible advantage of longer established evidence-response mechanisms such as the European Observatory on Health Systems and Policies was thought to be that it could be culture changing for both researchers, who become more policy minded, and

policymakers, who are more research aware as over time these mechanisms permeate into training.

3.2.6 Alignment of incentives

The literature highlighted that while there may be a common goal of a mechanism, for example, to support evidence-informed policymaking, the incentives for evidence producers and policymakers are not always aligned and this should be considered in seeking to establish a sustainable mechanism. Policymakers often have ideological commitments to particular policy options and must work within resource constraints, political restrictions and time pressures.[24] Researchers have their own intellectual and professional commitments.[24] Certain issues, collaboration and approaches may be more interesting than others from a research point of view, but these may not reflect the areas that politicians perceive as being most important.[24] Ssengooba et al. (2011) found that the incentives for researchers to participate in research included the contribution to science, career development and being part of a large scientific network,[28] whereas policymakers were driven by the need to find simpler and cost-effective solutions to address the problems faced in their particular field.[28] Nolte et al. (2008) reported that country experts were motivated by interest in the work, but also felt under pressure to publish, and wanted to make sure that their work was visible in the form of published reports and articles for peer-reviewed journals.[23]

The key informant interviews raised similar issues and highlighted that incentives for researchers could vary by region and country and that some learning from mechanisms may not be directly transferable to other countries. For example, in the case of the European Observatory for Health Systems and Policies, it is generally recognised that authors of Health Systems in Transitions reports receive modest financial recompense for the work undertaken but that other factors such as publication and credibility are often strong incentives. This was not thought to translate directly to the Asia-Pacific region:

> *We've got to set up high expectations of payment, much higher than in the European region where, you know, there's an honorarium and there's about $3,000 to do a health transition report... But they are paying out way more money than that because that's what people expect in the region and I don't think they necessarily need the money any more than people in Bulgaria or Albania need it in Europe, but that's the market. So the money side is important.* (KI 1)

Informants also discussed the importance of incentives to ensure that top researchers or evidence producers are involved in the mechanism. The perceived success of the European Observatory for Health Systems and Policies was felt to be partly related to the ability to attract top researchers to undertake the work and to produce high quality outputs:

> *So certainly people don't give money for nothing, but on the other hand there's enough work out there, but to make it really… to attract the top people I think things like collaborations with world health institutions based in North America or Europe, those sorts of things, or publications in high impact journals. You know they are doing really meaningful research and they are the sorts of things that are actually going to attract the best people to do that kind of project.* (KI 1)

It was also raised that more explicit discussion was needed around the different incentives for policymakers and researchers and that meeting was not always straightforward:

> *It's quite interesting because when I think about the REF [Research Excellence Framework currently used in the UK], you know they wanted to have these impact case studies and things like that. I think we're going down a slippery slope and we don't realise it. I think we've probably already been partly down that slippery slope and some people have realised it and used it to effect, but I think what do we want? Do we want researchers to say they change the world when they didn't?... This is a really big opportunity for research and evidence to make a difference but I think we've got to be more conscious of what the challenges are as well as the opportunities.* (KI 4)

It is important to note that while these concerns were raised by several respondents, one informant, referring to EvIPNet and SURE in Africa, reported that this had not been an issue and that in interaction with policy had beneficial effects for academic research:

> *I mean not so far which might be a reflection of the fact that often the people who are doing this are doing it because they're passionate about making a difference and they're not trying to fulfil academic criteria, so it might be partly the... I think Nelson's view would be that probably that there's so much positive spin-off from learning about what the issues are that are driving the interests of policymakers and stakeholders that he ends up being that much better a researcher as a result. There [have] been at least two studies now showing that the researchers who are very actively involved in knowledge transfer are in fact more prolific than the researchers who aren't, and then of course you don't know which comes first, it could just be that they're prolific to start with but it could also just be that this stuff just keeps you so attentive to what the issues are and establishes the networks that you can rapidly go out there and do pretty high profile research that answers highly visible questions, so it can actually have positive returns on your research.* (KI 7)

3.2.7 Measuring success

There was a lack of evidence in the published literature on the effectiveness of mechanisms, although studies are currently under way to address this, for example, an evaluation of the rapid-response mechanisms within the SURE facility. The problem of how to measure 'success of mechanisms' was raised, particularly its impact on policy:

> *Well it's easier to evaluate whether they're contributing to knowledge, that is someone, you know if someone actually does a proper evaluation in relation to the literature... the quality of the research and the added value and whether it's new knowledge compared to what's available in the published literature and the grey literature. It's much harder, as you well know, to have an assessment on to what extent they're contributing to policy take-up and who's using this information, you know you'd have to do a fairly wide consultation to find out to what extent it's being used.* (KI 1)

For those involved directly with mechanisms, it was noted there often seemed a contradiction between the stated aim of a mechanism and how it was judged. In some cases the emphasis of the mechanism was on informing policymaking but review of the

mechanism was based more on academic outputs (KI 5), whereas in the case of the recently established Asia-Pacific Observatory for Health Systems and Policies, evidence producers are judged by the degree to which it is taken up in policy even though this is not in the stated role of evidence producers:

> *With the observatory the funders are very clear about saying, "Your job is to provide evidence." You know you are not a development partner per se – you don't ever sit at the policy table. But on the other hand they say, "We want to judge the quality of what you do by the degree to which it's taken up at the policy level." And of course there's a big gap between producing evidence and policy take-up and they've usually… you know actions and activities.* (KI 1)

3.2.8 The need for long-term investment

Several key informants highlighted that long-term investment would be crucial in the likely success of an evidence-response mechanism. This was because mechanisms take some time to become established but also because it is important to be able to retain high quality staff and continue to build on necessary skills:

> *As usual with [name of aid agency], you know they fund something for three or four years and then they look around for something else to do, which is a great pity and it's something that we're considering... because, you know, in all our experience it takes two to three years, or longer, to get something up and running and well known and people asking for information and knowing who the people are around the place who might be able to supply that knowledge. So it's a long length of time making these things and funders don't have a lot of patience.* (KI 1)

Related to this was the issue that existing initiatives could be built on, rather than looking to begin something new. Indeed groups such as the AusAID Knowledge Hubs already have the remit to provide policy-relevant knowledge on women's and children's health in the region. Informants cautioned strongly that it would be important to consider the added value of another freestanding initiative, particularly within maternal and child health, which was perceived to be an already crowded space. It was noted that it may be possible to build on an existing network unrelated to RMNCH through which necessary support or functions could be provided, and that significantly fewer resources would be required compared with the establishment of a new mechanism.

CHAPTER 4 Country case studies: evidence users and evidence providers

Key findings:

- Countries have different condition-specific priorities for RMNCH but a common problem with health systems and governance challenges.
- Expert opinion, primary and secondary data are the types of evidence most commonly used to support decisionmaking.
- The use of evidence from other countries varied between countries but did not seem widespread and in India was perceived to have little relevance.
- Expert opinion and face-to-face contact field and country visits were highly valued.
- There is a willingness to contribute to a regional mechanism, although some would prioritise having effective mechanisms to manage national and sub-national data.
- The effective use of existing evidence was thought to be a priority over generating new evidence.

This chapter summarises, compares and contrasts data collected in the four country case studies. In doing this we have tried to highlight the main findings; full and detailed country reports are provided in appendices III–VI. The chapter sets the context in which an evidence-response mechanism would operate before reviewing evidence-response mechanisms and associated challenges in Chapter 4.

4.1 Key informants

The key informant interviews sought to include a range of people involved in RMNCH policymaking in each of the four countries. This included employees of government and other stakeholder organisations such as non-governmental organisations, UN agencies and professional bodies. Government employees included those within ministries of health but also key personnel in policy and planning divisions, and technical and policymaking roles were among those represented. In total, 38 key informants were interviewed, 10 in Nepal and Indonesia and nine in Bangladesh and India. Full details of key informants are provided in the appendices.

4.2 Country priorities relating to RMNCH

When asked what the priorities for RMNCH were in their countries, respondents gave wide ranging answers, which could be classified largely in three categories: (i) specific health issues relating to maternal and child health; (ii) health systems factors; and (iii) governance. Examples of each are provided below in Table 5. A small number also mentioned broader societal factors, including hunger and poverty. Overall the findings suggest that there is commonality across countries in needing to develop an effective health system and broader system of governance in order to be able to implement relevant programmes. Broader literature suggests that governance and corruption are broader problems in all of the four countries, particularly Bangladesh and Nepal.[29] Differences arose in the specific health problems that were given priority, but all were related to major causes of maternal or newborn death. Interestingly, respondents in India and Indonesia framed their responses and priorities only in terms of health systems factors and governance and not by specific health or disease areas.

Table 5 Priorities for RMNCH policymaking in four countries

	Specific health issues	Health systems factors	Governance
Bangladesh	Post partum haemorrhage Sepsis Birth asphyxia	Human resources Emergency care Quality of care	Role of government unclear Coordination of multiple stakeholders
India		Human resources	Lack of rigorous policymaking
Indonesia		Funding channels Implementation and scale-up	Effective decentralisation
Nepal	Uterine prolapse Pre-eclampsia	Provision of emergency care in rural areas Referral system	Political stability Government commitment Political bureaucracy

4.3 Current evidence use

All informants reported that evidence was an important part of their day-to-day work. Few people had a dedicated resource to locate evidence, and one policymaker reported having a dedicated team for this.

4.3.1 Types of evidence

Table 6 summarises types of evidence informants used to support their decisionmaking; a further breakdown by government and non-government actors is provided in the full country reports.

Table 6 Types of evidence used to support work and decisionmaking

	Bangladesh (n=9)	India (n=9)	Indonesia (n=10)	Nepal (n=10)
Expert opinion	8	4	10	10
Knowledge of practice in other areas/countries	8	5	5	10
Primary data	8	3	10	10
Secondary data	9	3	10	10
Literature review	8	3	8	10
Case studies	7	4	7	8
Specialised databases	3	3	9	3
Other	Field reports Operations research Formative evidence Advocacy workshops Grey literature	Site visits Pilot projects Beneficiaries' opinion 'Programmatic evidence'	Expert forum/foreign speaker	

Table 6 highlights the broad range of evidence types used by the respondents. With the exception of India, there was relatively high use of most evidence types. The most highly used were expert opinion, primary data, secondary data and literature reviews, while case studies and specialised databases appeared to be used least. A similar range was used in India but among a lower proportion of key informants.

Looking across the four countries studied, informants in Indonesia appeared to make lower use of knowledge of practice in other areas/countries than the other three countries. Several respondents suggested additional sources of evidence which were used, and site or field visits were reported in two of the four countries.

When asked about challenges faced in accessing evidence, a common theme across countries was that availability of evidence in itself was not a problem but ensuring the evidence was up to date and that evidence was organised and could be easily retrieved were more challenging. In further discussion of the value of different types of evidence, it was clear that expert opinion, face-to-face contact and the ability to see interventions on the ground were important.

4.3.2 Use of international evidence

Key informants were asked specifically about their use of evidence from other countries in their day-to-day work. Reponses varied and some informants were more able than others to talk about this and give specific examples. Looking across the countries, there seems to be some pattern within each country, but important differences between them:

- **Bangladesh** – government informants reported limited scope to use international evidence. Non-government informants had greater scope but thought such

evidence was lacking from neighbouring countries where they would naturally refer.

- **India** – international evidence was thought to be difficult to transfer or replicate and therefore not relevant.
- **Indonesia** – six out of 10 informants could report specific examples of where they had specifically used evidence from other countries or regions to inform their work, including the Philippines, Bangladesh, Vietnam, Thailand, Malaysia, Japan, Australia and China. Countries tended to be selected on the basis of having similar population, economic or health system characteristics. Certain countries were also selected because of their perceived achievements in health and economic development.
- **Nepal** – Evidence from other, similar, countries was considered of value as it could save time and resources locally. Informants reported piloting programmes based on international evidence before full roll-out. Countries and regions referred to included the South East Asia region, South Asian Association for Regional Cooperation countries, India, Sri Lanka, Bangladesh and Indonesia. Evidence from Thailand and Pakistan was used, although less often.

4.3.3 Sources of evidence

The sources of evidence used included government sources, universities, professional organisations, NGOs and international organisations. The primary source of evidence varied between countries. In India, Nepal and Indonesia, internal government bodies were all a major source of evidence. India also relied heavily on academic institutions for sourcing evidence, while Bangladesh policymakers relied more on a single research organisation, ICDDR,B. There was evidence that policymakers would use the same experts or institutions repeatedly. In Nepal and Indonesia, international organisations were also highlighted as important. In all countries local NGOs contributed to the policymaking process.

4.4 Views on a new regional mechanism

All respondents in the four countries agreed that a new mechanism could be useful; however, there were differences in views of the aims and activities of such a mechanism. All respondents felt that a key part of the mechanism was that it would need to have local relevance and to adapt global evidence to local needs. Related to this, respondents from all countries felt that the mechanism should be situated within their own country.

Respondents were asked whether they would favour a *membership* model, in which they would be involved in the funding and management of a facility, or a *customer* model, where they would request and buy specific pieces of evidence. Respondents from Indonesia and Nepal primarily envisaged a mechanism in which countries would act as members. Some respondents from India advocated a customer model and several Bangladeshi respondents suggested a 'partnership' model, which was taken to build on a membership model with greater partnership between evidence producers and users. Respondents

advocating a membership model suggested that countries could pay a membership fee, and several people also suggested that external development partners (EDPs) would contribute a portion of the funding needed. Respondents in all countries argued that government and other stakeholder organisations could also contribute other forms of resources such as human resources, expertise and data. There were differences of opinion over whether a mechanism should be based within government or in another organisation. Those preferring a within government initiative suggested that such a close relationship with government would be crucial to ensure government buy-in and a model of having the mechanism based within government with support from outside organisations was suggested. However, more respondents, across the countries, felt strongly that a mechanism should be based outside government, to remain impartial and uninfluenced by politics. Although less popular than a membership model, it was argued that a customer model may be a means of helping the mechanism retain independence from policymakers. In India respondents made the case for a web-based mechanism that would be easily accessible to all.

The timeframe within which evidence users would request evidence varied greatly from a number of days to two years, in the case of one informant in India who argued that good research would take time. Most commonly, respondents referred to a timeframe of less than three months.

Asked whether policymakers currently had capacity to use such a mechanism, informants in Nepal in particular argued that some orientation and training would be required to make best use of a facility. Respondents in India also recognised that capacity among policymakers would be variable and that there was also a need for researchers to be able to understand the policymaking process and perspective of policymakers.

It is important to note that while the prospect of a regional mechanism that could draw on international evidence was valued by the key informants, it was clear that the more immediate priority for others was national and local-level data and evidence, and the need to have an effective mechanism for managing this.

4.4.1 Institutional capacity within countries

Mapping and assessments of the main research and evidence-producing organisations within each country demonstrate that there are institutions scoring highly against all of the criteria. These are detailed in the appendices and summarised below by country. We draw out some findings relating to relative strengths and weaknesses which can inform overarching lessons for evidence-response mechanisms. The detailed analysis in the appendices can further be used as a direct source from which to select potential nodes or hubs within a mechanism. The mapping and assessment of institutions within countries may of course have been influenced by a researcher's familiarity with particular institutions, but as country experts we believe they provide a comprehensive and useful account of institutions.

The **Bangladesh** case study cites only four research institutions of interest and the country lead noted that these were the only high quality research institutions she felt should be included in this analysis. The institutions with the strongest research capacity were the International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B), and the Research and Evaluation Division of BRAC (RED, BRAC). Other institutions cited are

the National Institute of Population Research and Training (NIPORT) and the James P Grant School of Public Health, BRAC University (JPGSPH). All of the four institutions influence policymaking in some way, although RED, BRAC is more distant from the policymaking process than the others, making this link only through its parent institution, BRAC. The ICDDR,B runs a joint programme with Johns Hopkins University (USA) in implementation research. All four institutions can carry out short turnaround research, and all but RED, BRAC respond to evidence requests from policymakers.

India has several well-funded research institutions with strong research capacity. These research institutions in general have a procurement system, which allows them easily to enter into contracts with different research organisations, and internet access for retrieving information and communicating research. The organisations produce quality outputs and five institutions employ a large proportion of staff with higher degrees there is limited evidence of the experience in these institutions of providing evidence to decision makers. While there is interaction between members of the institutions and decisionmakers, in many cases the research is not targeted towards informing policy. Exceptions are the National Health System Resource Centre and the Public Health Foundation of India, which provide policy-targeted research, and the White Ribbon Alliance of India, which targets policymakers, but whose main role is advocacy rather than research.

Institution mapping for **Indonesia** documents nine institutions, all with strong research capacity, with quality outputs, representation of relevant disciplines and highly educated staff. Many of the institutions listed have strong contacts with decisionmakers and provide policy-targeted research and input to policymaking. Examples of how this interaction operates are presented in the case study (Appendix V). Most of the institutions listed can conduct short- and long-term research projects and respond to requests from policymakers. In particular, collaboration of research institutions with government policymakers has included work on policy preparation and national strategic plan development. Organisations are strongly involved in many different national and international networks.

Nepal also has a strong research capacity, with the strongest research institutions, according to the mapping criteria used, Nepal Health Sector Support Programme, UNICEF Nepal and WHO Nepal. The Development Resource Centre also had strong output, but had low funding stability. In Nepal all eight research institutions cited scored well on interaction with decisionmakers, and seven of the eight scored strongly for their policy-targeted research and research informing policymaking. However, these institutions were felt to be weak at producing short turn-around research and research produced on the basis of a request from policymakers. Only one institution, the Development Resource Centre, scored strongly on these categories. The Nepal Society for Obstetricians and Gynecologists, although weaker than other institutions at research capacity, was strong in formation of partnerships and networks and was noted as organising national and international conferences.

We have summarised the relative strengths across institutions within each country
Table 7). Although we used a common protocol for data collection across countries, assessment of strength was subjective and therefore making comparisons across countries may be difficult. Rather the table may be better used to consider the relative strengths and weaknesses within a country.

Table 7 Summary of country research institution mapping

	Bangladesh	India	Indonesia	Nepal
Research capacity	+	+	++	+
Experience in providing evidence for decisionmakers	++	+	+	+
Ability to provide evidence in a responsive mode	++	-	+	-
Supportive administration	+	++	++	+
Networks and partnerships	-	+	++	-

It is notable, for example, that in Indonesia institutions tended to score highly against several criteria but the one area where lower scoring was seen related to their experience in providing evidence for decisionmakers and specifically evidence of interactions with decisionmakers. In India, it was found difficult to find evidence to support a scoring in this regard, and in Bangladesh there was only one institution, ICDDR,B, which was clearly stronger in this regard. The level of involvement of institutions in existing international partnerships and networks also varied. The detailed assessment provided in the appendices gives useful information on existing organisations, which could act as country hubs or nodes in a region-wide network. Despite pre-existing research capacity in all four countries, further development will be needed in most cases to enable research institutions to be able to provide a responsive service to policymakers, and to link these research institutions into a regional network.

CHAPTER 5 Synthesis and key findings

Key findings:

- The evidence needs for RMNCH policymaking in the region should be thoroughly assessed to inform, (i) whether an evidence-response mechanism would be appropriate, and (ii) what the purpose of any mechanism would be.
- Any mechanism should build as far as possible on existing institutional capacity, networks and links between evidence producers and policymakers.
- Capacity development among evidence users and evidence producers will be an important function of an evidence-response mechanism in the region.
- Country ownership and identity will be important to consider in a regional mechanism, particularly in an area as diverse as the Asia-Pacific region.
- The motivations of researchers and policymakers in the region should be understood and incentives aligned
- Governance and leadership should be planned carefully to ensure credibility and flexibility.

In this chapter we integrate our observations from the rapid evidence assessment, key informant interviews and country case studies to draw out key findings for a potential evidence-response mechanism related to RMNCH in Asia and the Pacific. In the final section of the chapter, we present a set of recommendations for the establishment of an evidence-response mechanism.

5.1 The development of an evidence-response mechanism needs to be driven by thorough assessment of evidence needs

One overarching finding from the interviews was that any potential evidence-response mechanism should be based on a thorough assessment of need, most notably the evidence needs and relative priorities of stakeholders within countries but also a systematic assessment of need in relation to evidence gaps around RMNCH in the region.

We only examined experiences and expectations of four countries, none of which were located in the Pacific region. Therefore our findings will have to be interpreted with a degree of caution. However, it is possible to identify types of need and how these may vary across and within countries. There was commonality across countries on specific aspects of RMNCH, for example human resources for health and the implementation and scale up of particular programmes. For decentralised countries in particular, issues of how to improve the processes associated with decentralisation was key. Yet there were notable differences in

the types of challenges faced, too. Thus, prioritisation of specific health issues relating to maternal and child health differed across countries and the wider governance environment was of greater or lesser concern. For example, in Nepal political stability was perceived as an important challenge for improving women's and children's health in the country.

Availability of evidence was generally not considered a challenge but developing effective means of organisation and support in applying evidence to the local context was highlighted as a potential issue as was support for sub-national level policymakers. There were differences in current practice and readiness among stakeholders over the use of evidence from other countries or areas. For example, in India, information on or from other countries seemed to be of lesser relevance for policymakers and evidence users more widely, while key informant interviews at the regional and global level suggested that there may be greater appetite for cross-country learning on behalf of evidence producers. There were different views on priorities for a future regional evidence-response mechanism, how policymakers would be involved and the relationship with evidence producers. However, there was a common view that a mechanism seeking to inform policymaking for a country should have a base within that country too. There was a view among interviewees currently involved in the delivery of evidence-response mechanisms that evidence-producing organisations or institutions should be independent from government. Conversely, some key informants in the selected country cases studies argued that government institutions would be more appropriate because of established and trusted relationships and the potential benefit from capacity building.

Our study has begun to unpack some of the issues that help us understand how policymakers in the region view and would seek to use evidence. We have shown that views and expectations differ, keeping in mind that we were only able to explore these in a limited number of countries. If an evidence-response mechanism was to be established in the region it would be of crucial importance to better understand and secure agreement on the goals of such a mechanism and the evidence needs it would seek to address. Such an assessment would be especially timely since availability of evidence per se was not seen as a particular challenge, which may not be surprising given that, in the words of one key informant, maternal and child health may be considered a "an already crowded space". Experiences of those involved in the delivery of evidence-response mechanisms suggest that this first step should be given priority and significant investment in an effort to ensure the mechanism will add value.

In the sections below we present key findings from the study that we believe would be important to consider, assuming the need for an evidence-response mechanism is established.

5.2 The implementation of an evidence-response mechanism should build on existing resources rather than establishing 'something new'

An important finding throughout the study was recognition of the need to build on existing resources wherever possible rather than starting something new. This principle was

applied to three main areas: (i) trust and relationships; (ii) institutional capacity; and (iii) existing networks and mechanisms.

Trust and relationships were emphasised, through the evidence review and key informant interviews, as key to the effective use of evidence (trust in the producers of evidence) and the mechanism (established relationships). This has important implications because trust and relationships take time to establish. Understanding the value of relationships between and across evidence producers and users will be key to informing the configuration of a mechanism. It also suggests that funding and support have to be sufficiently long term in order for relationships to form and for the full benefit to be realised. It is important to note that independence and scientific rigour were seen as particularly important characteristics for evidence producers, and to form core conditions for the development and fostering of trust and relationships. It was evident too in the country case studies that policymakers had trusted sources of evidence, although independence from government was not necessarily a determining factor.

The country case studies examined in some detail the profile of selected institutions within the fields of health systems or RMNCH research, illustrating the strengths of institutions that could be matched objectively to requirements of a potential evidence-response mechanism. The need for further strengthening of existing capacity was highlighted. The in-country institutional mapping pointed, in some countries, to relative weaknesses in the researcher–policymaker interface that could be addressed, or institutional strengths that could be brought together. At the same time it was highlighted that such a mechanism should ensure institutional independence rather than create a dependency relationship with an external agency or country. A further area of lack of capacity was in policymakers' ability to make use of the evidence produced by an evidence-response mechanism. This was highlighted by policymakers themselves and borne out in the data collected, for example, only one respondent had a dedicated resource to source evidence needed in decisionmaking. Our review of existing evidence-response mechanisms showed that capacity building forms a key function for the majority of mechanisms, whether in relation to evidence producers, evidence users (policymakers) or both. This will be important to consider in any potential mechanism in the Asia-Pacific region.

Finally, it was highlighted that an evidence-response mechanism may most usefully build on existing networks or mechanisms in the region and that these do not necessarily have to be focused on RMNCH. As noted earlier, there was a perception among some that international development and maternal and child health was already a 'crowded field' therefore putting in question the need for (yet) another network. It was also argued that there were relatively few individuals or institutions that had the desired strengths in research and policy focus, suggesting that these should not be spread more thinly over an increasing number of networks. It was further argued that the incremental costs of adding or incorporating a function or area of focus to an existing network would be marginal compared with the resources required to establish an entirely new entity. The in-country institutional mapping demonstrated that most institutions already contribute to international networks. It would therefore be useful to examine options for building on existing infrastructures. A further option may be to build evidence-response mechanisms into proposed regional hubs supported by the WHO.[4]

5.3 There is a need to secure ownership among those who produce and use the evidence

Similar to the need to understand the existing infrastructure and the core role of trust and relationships in the functioning of evidence-response mechanisms, and the related investment in time and resources required, our findings highlight the importance of identity in informing the configuration of a possible mechanism. An effective regional evidence-response mechanism has potential in theory to reduce boundaries at least at two levels: (i) the country and regional interface by facilitating cross-country learning; and (ii) the researcher and policymaker interface. These were both deemed potential benefits of a mechanism.

However, the findings also suggest that it was important to maintain identity at each of these levels. Country ownership and identity were seen as important to stakeholders nationally and internationally, and maintaining a country focus was considered essential. It was not immediately obvious that countries would automatically look to the Asia-Pacific region for cross-country learning. Instead, learning appeared to be seen most valued when based on neighbouring countries, aspirational countries or those countries with similar characteristics in their health systems and population. Therefore, while an evidence-response mechanism that is set in and reports on the Asia-Pacific region has logical appeal administratively, it will be important to understand better how countries perceive themselves within a group of countries and any issues that this may raise. One key informant for example noted that it would be important to be aware of political sensitivity and ensure all countries are included equally. Given that governance issues were a concern across the case studies it will also be important to consider country capabilities to contribute to a regional mechanism and to make use of the evidence produced.

The second area of identity to understand is that of researchers and policymakers. All would seek to work closely together but maintenance of professional identify, particularly on the part of researchers, was thought to be crucial in order to ensure credibility and independence. The linkage function between researchers and policymakers then becomes key within a mechanism and it is important to consider who would be responsible for this and what roles this person would have. We suggest the role of a 'policy-customer' for this below.

5.4 Incentives provide an important lever in the region and need to be aligned with the motivations of those engaged in the delivery of an evidence-response mechanism

Our review of the published and grey literature identified a gap in our understanding of evidence-response mechanisms, especially of their effectiveness. However, one area that has been studied in some detail related to the need to align motivations of researchers and policymakers.[23, 24, 28] Our study also found that incentives were important and that it should not be assumed that these would be transferable from other regions. Particular features of the research environment in Asia and the Pacific were highlighted such as the role of role of consultancy for academics, and that the importance of financial incentives may differ from mechanisms in place in other regions. Understanding and aligning the

incentives and motivations of both parties was felt to be crucial to developing a sustainable mechanism and one which would retain high quality individuals and thus in turn contribute to long-term relationships, which we have highlighted above. Understanding motivations and incentives can also be important in trying to promote behaviour change. In this context it may be interesting to note that the SURE collaboration has had a relatively high number of outputs despite only being established recently. This can be explained, largely, by the nature of funding of this mechanism. As a research project funded under the European Union Seventh Framework Programme outputs form a requirement and so provide an important incentive, but it is unclear whether this level can be sustained in the long run.

5.5 Different models of governance and leadership may be equally suitable but ownership and flexibility remained recurring themes

Although the specific governance model for a mechanism would need to be determined by many factors including the aim and membership, we identified a set of themes that could be useful to consider in reference to governance and leadership in general: (i) country ownership; (ii) the role of WHO; and (iii) flexibility.

The results from the global interviews showed that country ownership was considered vital and this notion was confirmed by the country case studies. Most policymakers favoured a membership model in which they had buy-in to the mechanism and involvement in agenda setting. There was further willingness for at least a proportion of funding to come to government. It was generally proposed that this could be supported by external funding but that governments could put in other resources such as human resource and physical spaces.

The potential advantages and disadvantages of leadership by the WHO were brought out clearly by the global key informant interviewees. A number of respondents in the country case studies also raised the potential role WHO or other UN agencies could assume, but it was not clear how this would be envisaged. The WHO was thought to have legitimacy and, as a non-partisan organisation, was deemed important for any organisation involved. However, the appropriateness of the WHO or PMNCH taking a leading role was questioned. The potential role of the WHO was also raised with regards to the third issue of flexibility, as respondents promoted a model that was flexible and allowed for adaptation and innovation in governance and function. Country key informants highlighted that governance was a problem in most of the countries. This may have important implications for the governance of an evidence-response mechanism and should be carefully considered.

5.6 Evaluating evidence-response mechanisms

As indicated earlier, our knowledge and understanding of the effectiveness and cost-effectiveness of evidence-response mechanisms remains limited, although key informant interviewees pointed to ongoing work in this area and suggested that those involved in mechanisms had means of monitoring the work they did. There is also a more substantial literature around knowledge transfer, which covers the tools and processes that mechanisms may use and even an advanced literature on how to evaluate knowledge

transfer tools and practices.[30] Although knowledge transfer is a function of a mechanism, we see it as distinct from the organisational structure and processes that have not been well documented.

There is an opportunity in establishing a mechanism for RMNCH to consider means of evaluation from the outset, although it was noted that this was very challenging beyond contribution to knowledge production. Given these challenges, formative evaluation may be particularly valuable. Such an evaluation would usefully draw on emergent findings from the SURE project, which seeks to develop and evaluate the effectiveness of five strategies for improving access to and use of research evidence in policy development, including: (i) the format for research syntheses; (ii) rapid-response mechanisms to meet policymakers' needs for research evidence; and (iii) deliberative forums involving policymakers and researchers with the involvement of civil society and the general public.

5.7 Recommendations for establishing an evidence-response mechanism

In order to inform more practical recommendations for an evidence-response mechanism, we have summarised the key features and actors of an evidence-response mechanism in Figure 1.

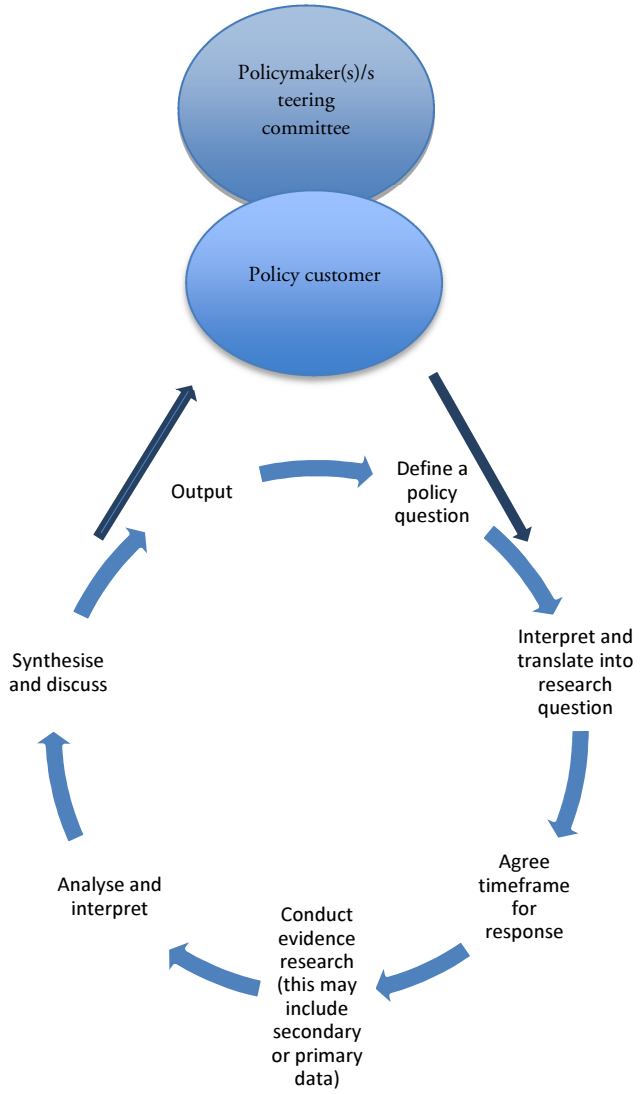

Figure 1: Key features of selected international evidence-response mechanisms

Source: Adapted from: Nolte et al. (2008)[23]

Our findings show that evidence-response mechanisms may differ in having direction from a steering committee or directly from a policymaker. This will vary depending on how responsive and rapid the mechanism attempts to be and on the number of clients or members. For regional mechanisms in the Asia-Pacific a steering committee is more likely, in which case it will be important to ensure there is appropriate representation from across the region and stakeholders.

It must be emphasised that the process of producing evidence in response to a policy question should be an iterative process to ensure common understanding of the question and policy-relevant findings. The role of 'knowledge broker' is often emphasised in

ensuring policy-relevant research but the emphasis in this role is often on the translation of findings at the final stage of dissemination.[31] A 'policy-customer', as we have presented it, is a key link between policymakers and researchers throughout the processes. The policy-customer has a pivotal role in the success of an evidence-response mechanism and may provide continuity in a context where policymakers often change. The need for an effective policy-customer highlights the investment that is required by policymakers. Emphasis is typically given to the need for researchers to change to become policy minded and focused, but the findings from this study and experience of evidence-response mechanisms suggest that this will not be enough without time and other resource commitments from policymakers. The recent WHO strategy on health policy and systems research highlights the need for more demand-driven research, emphasising the needs for improved alignment in the procurement of research.[32] It is important to recognise the need for ongoing involvement from the policy side throughout the research process.

Steps in establishing an evidence-response mechanism

We further outline a series of steps that would be required in taking forward a potential evidence-response mechanism in Asia and the Pacific for RMNCH below:

1. **Undertake a thorough assessment of need**
    - Consider the evidence needs and relative priorities of stakeholders within countries as well as a systematic assessment of need in relation to evidence gaps around RMNCH in the Asia-Pacific region.
    - This is important, as access to evidence in itself may not be the core challenge.
2. **Define the goal of the evidence-response mechanism**
    - From the needs assessment define the target audience(s).
    - Identify the goal for a mechanism that will best meet the evidence needs identified in step 1.
    - Secure agreement on goals and evidence needs the mechanism would seek to address.
    - From the goal define the most appropriate output(s).
    - Prioritise the functions, skills and actors required within the mechanism.
3. **Map existing resources and capacities nationally and regionally**
    - Map potential evidence-producing institutions against objective criteria. These may include: institutional independence, quality of research output, ability to respond to evidence requests in a timely manner, national and international networks and experience in delivering to policymakers.
    - Map existing sources of evidence used by policymakers. This should include a mapping of existing trusted relationships between policymakers and evidence producers.
4. **Identify key national and regional partners**

- Identify researchers and policymakers to be involved in the design of a response mechanism.
- Ensure adequate country representation within a regional mechanism.

5. Anchor the mechanism into an existing institutional structure

- From the mapping exercise identify existing institutions and networks where the mechanism could be based.
- Provide resources to develop further existing capacity where needed.
- Avoid creating a dependency relationship for evidence with an external agency.

6. Align incentives for evidence producers and policymakers

- Ensuring high quality researchers and policymakers keep involved in the mechanism will be vital.
- Provide appropriate incentives for researchers. This may vary in different countries. Incentives may be appropriate monetary recompense for work, opportunities for publication or ensuring the opportunity to undertake primary research alongside responsive work so researchers can continue to pursue an academic career.
- Incentivise good and routine use of evidence for policymakers.
- Consider the role of 'policy-customer' and whether this needs to exist as a specified role within the mechanism, to act as a bridge between research and policymaking.

7. Maintain flexibility

- Regularly review and evaluate the mechanism against the stated aims. Continue to build elements that work well but address those working less well.
- Establish funding and governance models that will allow flexibility. This will involve a long-term commitment as the value of an evidence-response mechanism is likely to grow overtime.

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Appendix I Interview guides for global interviews

Topic guide (broader expert group)

"Options for effective mechanisms to support evidence-informed policymaking for reproductive, maternal, newborn and child health (RMNCH) in Asia and the Pacific"

Introduction

We have been asked by the Partnership for Maternal, Newborn and Child Health and the Implementation Research Platform, WHO, to conduct research into potential evidence-response mechanisms to support policymaking in reproductive, maternal, newborn and child health (RMNCH) in Asia and the Pacific.

Questions

1. What do you think are the greatest challenges facing policymakers in relation to RMNCH in Asia and the Pacific?

2. From your perspective, what are the main evidence needs of policymakers with regard to RMNCH? How well do you think these are currently met?
   - Which areas are sufficiently covered, and how?
   - Which areas require more evidence are and why?

3. What are the main challenges to ensuring evidence-informed policymaking?

4. What are the main challenges for researchers in engaging with policymakers/ the policymaking process?

5. Are you familiar with any evidence-response mechanisms that aim to provide evidence to policymakers based on their identified needs? Please give details.

6. To what extent do you believe that there is the need for a region-wide evidence-response mechanism in relation to RMNCH in Asia and the Pacific region? If yes, what benefits could it bring?

7. What do you think would be the main challenges of setting up an evidence-response mechanism for RMNCH in Asia and the Pacific?

8. What would be important to consider in relation to establishing such a mechanism?
    - What researcher expertise would be needed?
    - How should researchers engage with policymakers?
    - What skills are needed for policymakers to be able to use evidence produced?
    - How can skills and expertise be developed where they are lacking?

9. What format should the evidence presentation take to most usefully inform policy-makers? Examples may include
    - published reports (eg policy briefs, short summaries)
    - web-based information
    - direct communication (policy dialogues)
    - other?

10. If such a mechanism was established, what organisational and governance structure would you think to be most appropriate and why? Examples may include
    - independent organisation
    - centre embedded in a large organisation
    - network of small centres
    - other?

11. What type of organisation should such a mechanism be based in (eg university, other research organisation, WHO) and why?

12. Where should such a mechanism should be based? (eg entirely within the Asia-Pacific region, in particular countries) and why?

13. Who should fund such a mechanism and how could the governance structure look like?
    - Who should be involved and to whom should it be accountable, examples might include:
        - Governments and/or funders are member/s of the mechanism (co-producers of evidence)
        - Governments and/or funders should have an advisory role/steering function only

- Governments and/or funders should set the research agenda
- Other?

14. What else do you feel would be important to consider?

15. Do you know of other similar plans or initiatives that would be important to engage with if this goes forward?

Topic guide (mechanism group)

"Options for effective mechanisms to support evidence-informed policymaking for Reproductive, Maternal, Newborn and Child Health (RMNCH) in Asia and the Pacific"

Introduction

We have been asked by the Partnership for Maternal, Newborn and Child Health and the Implementation Research Platform, WHO, to conduct research into potential evidence-response mechanisms to support policymaking in reproductive, maternal, newborn and child health (RMNCH) in Asia and the Pacific.

Specifically, we are interested in understanding the format and scope of what such a response mechanism could look like, and the requirements for setting up such a mechanism. Against this background, we would greatly welcome your views given your experience and expertise in work seeking to facilitate evidence-informed policymaking

Questions

1. Please can you start by telling us about the range of response mechanisms designed to inform policymaking with which you are familiar?

With respect to these mechanisms:

2. What are the main approaches the evidence-response mechanism/s use to provide evidence for policymakers?
3. To what extent do you believe the evidence-response mechanism/s are contributing to evidence–informed decision making? If so, which elements/functions/activities do you believe contribute most to this?
4. Would you say that, of the different evidence-response mechanism/s, some forms are better suited to some types of policy questions than others? (Eg health systems analysis, implementation) If so, please explain why.

5. We have been asked to consider potential models of evidence-response mechanisms to support RMNCH in Asia and the Pacific. We understand that the key issues for countries are not about effectiveness of different

interventions but how to implement these at larger scale. Of the evidence-response mechanism/s you are familiar with, which ones do you think would be most suitable to this purpose and why?

In general:

6. What form/s of engagement with policymakers do you believe an evidence-response mechanism should seek to pursue to be effective and why? *(policymakers as part of the mechanism (direct contributors of evidence); funders of the mechanism; advisors to the mechanism; external to mechanism but engaged through eg workshops to discuss evidence produced; other?)*
7. What do you think are the relative advantages of mechanisms that enable policymakers to directly request research or evidence to inform policy development (research/evidence 'pull')? What do you see as the main challenges of such a mechanism? (eg time commitment required; capacity issues)

Based on your experience or knowledge of evidence-response mechanism/s, we would like to ask you a set of more practical questions in terms of what would be important to consider in developing potential models for an RMNCH evidence-response mechanism in Asia and the Pacific.

8. Given the diversity of the Asia and Pacific region, how helpful, in your view, would it be for national and subnational policymakers to establish a region-wide evidence-response mechanism in relation to improving RMNCH (and elsewhere?)? What benefits could such a mechanism bring?

9. Format of mechanism:

- To what extent do you think that an evidence-response mechanism in this context should be based on push (taking evidence to policymakers) or pull (policymakers directly requesting specific evidence) model? Or mixture? Why?
- How important do you think cross-country comparative analysis would be in this context?
- What timeframes should an evidence-response mechanism work towards in order to usefully inform policymaking in the region (days/weeks/months?)?
- What form should the evidence produced take?
    1. Published reports (eg policy briefs, short summaries)
    2. Web-based information
    3. Direct communication (workshops, seminars, policy dialogues)
- In what language(s) should outputs be produced?

10. Expertise and capacity

- Where should the mechanism be located (eg university/research organisation; government; NGO; supra-national organisation; other?) and why?

- What forms of expertise and capacity would be required to meet the needs of an evidence-response mechanism? (eg knowledge brokers)
- What skills are needed for policymakers to be able to use evidence produced?
- How can skills and expertise be developed where they are lacking?

11. Governance and structure

- What principle model of operation would you recommend for a rapid response mechanism to take and why?
    (i) one centre responsible for managing the mechanism, producing the evidence (drawing on a network of experts) and engaging with client/s (policymakers)
    (ii) one centre responsible for managing the mechanism and engaging with client/s but with multiple partners producing the evidence
    (iii) one secretariat responsible for overseeing the mechanism with several centres/branches in different locations producing the evidence (and drawing on network/s of experts); client engagement is overseen by the secretariat but involves 'local' branches
    (iv) decentralised network of (small) centres principally working as (i) but with some form of coordinating mechanism
    (v) other?
- What type of organisation should such a mechanism be based in (eg university, other research organisation, WHO)? Why?
- Where should such a mechanism be based geographically? (eg entirely within the Asia-Pacific region, in particular countries) and why?
- What form of policymaker engagement would you see as appropriate for such a mechanism (eg policymakers as co-producers of evidence; as funders; as advisors; as participants in events; other)?
- Do you have suggestions for an appropriate governance model? (who should be involved and who should be accountable to whom)
- Who should fund such a mechanism? (eg national governments; international organisations private sector)

12. Overall, what do you think would be the main challenges of setting up an evidence-response mechanism for RMNCH in Asia and the Pacific?

13. What else do you feel would be important to consider?

14. Do you know of other similar plans or proposed initiatives that would be important for us to know about?

15. What do you think would be some specific lessons from your experience or knowledge of evidence-response mechanism/s that would be useful in informing the development of potential models of RMNCH evidence-response mechanisms in Asia and the Pacific?

ADDITIONAL QUESTIONS FOR THOSE CURRENTLY DIRECTLY INVOLVED IN A MECHANISM

Please explain the organisation and structure of the [name of mechanism]

- number and type of staff/FTE
- number and location of offices;
- funding mechanism;
- governance structure [is there an external reference group])
- Stakeholders/membership

Appendix II Country case studies: protocol for the in-country partners

I. Summary of proposed work

The attached summary proposal outlines the overall programme of work. Within the country case studies there will be four components of work:

i) key informant interviews with policymakers to identify evidence needs and current and future means of meeting these needs
ii) a country mapping of key institutions/mechanisms which currently respond, or have capacity to respond, to evidence needs in each country
iii) more detailed analysis of 3-4 of these key institutions with respect to key capacities
iv) collating the evidence in a country report

We outline each of these in more detail below with an expectation of work involved for each, both by RAND and country partners. Key interview questions and criteria are given/attached where relevant.

II. Key informant interviews

Country partners will be asked to conduct key informant interviews with decisionmakers at national and sub-national levels in order to ascertain evidence needs in relation to the implementation and scale up of essential RMNCH interventions in country. Interviews will build on past experience of key informants as well as current and future needs. They will explore type of policy questions, evidence types, timescales (eg days, weeks, months) within which evidence is required, existing and possible sources of evidence and relative advantages and disadvantages of them. As well as exploring evidence needs for RMNCH more generically interviews will use two or three exemplar RMNCH interventions to enable targeted discussions of specific evidence needs while also allowing for comparison between countries.

We anticipate a number of steps in completing this section of work:

Step 1: Identification of key informants

Please identify key informants for interviews and share with RAND. Informants should be decisionmakers involved in RMNCH policymaking representing different actors:

- *policymakers (national and sub-national) – eg from Ministry of Health, Ministries of Finance, Planning and Development, where possible to get understanding at national and sub-national, eg state district levels*
- *non-government organisations – national and local NGOs and international NGOs with presence in your country (see PMNCH members http://www.who.int/pmnch/members/list/en/index.html)*
- *key funders related to RMNCH programmes including bi-lateral and multi-lateral organisations*
- *professional bodies (eg provider associations, public health associations) where relevant*
- *any other you may feel relevant in this context.*

We anticipate for in-country partners to conduct between 8 – 10 interviews. Please provide us with a list of potential interviewees as soon as possible to enable discussion with the Partnership for Maternal, Newborn and Child Health (PMNHC) to ensure key actors are captured.

Step 2: Conducting key informant interviews

We have provided a letter of support from PMNCH to help in the recruitment of key informants. We have also attached a consent form that should be completed before the start of each interview.

We are providing in Appendix 1 an interview guide that should be used when conducting the interviews and organising data for reporting. We hope that these will be used in the format of a semi-structured interview and that you will be able to explore relevant issues as they arise during the course of the interviews.

Where possible we would like interviews to be recorded and transcribed. When this is not possible, full notes should be written up. From the interviews we will ask you to provide a summary of evidence needs identified and the nature and scope of any evidence-response mechanisms used.

III. Country mapping and more detailed analysis of key institutions

Again we see two main steps within this component of work.

Step 1: Country partners are asked to provide an overview of institutions or mechanisms such as networks within their country that currently have, or have the potential to fulfil, a role in meeting the needs of policymakers. These are institutions/mechanisms that have an explicit purpose of informing decisionmakers and promoting evidence-informed policy. This may be in a reactive model where they are approached directly by decisionmakers for

evidence or proactive where they take an active role in taking evidence to decisionmakers. Ideally we are looking for institutions or mechanisms with this role, or potential to take this role, in relation to RMNCH, but would also be interested in getting a better understanding of relevant mechanisms in the broader field of health systems and policy evidence.

We do not anticipate for you having to list all research institutions in your country. Instead, we ask you to identify key institutions/mechanisms. Table 10 below lists a set of criteria that may provide useful guidance to identify such institutions. For each of the criteria we would ask you to assess the strength of the supporting evidence to allow for a relative capacity ranking of the institution in question.

Table 8 Criteria for institutional assessment

Criteria*	Possible supporting evidence	Assessment of strength
Strong research capacity	Evidence of: • substantial research funding • quality outputs (eg. international publications and conferences) • relevant disciplines represented among researchers (eg policy analysis, health services research, public health) • significant proportion of staff with higher degrees/PhD • stability of funding • other indicators of research quality	Please indicate your assessment of strength in relation to each criteria each using ++ (very strong in this area – a leading institution within the country/internationally) + (strong in this area) - (relatively weak) - - (weak in this area)
Experience in providing evidence for decisionmakers	Evidence of: • nature of funding • interaction with decisionmakers • ability to produce a range of external dissemination outputs and engage in related activities • policy-targeted research • research informing policymaking	
Ability to provide evidence in a responsive mode	Evidence of: • short turnaround research as well as longer-term research programmes • producing research on basis of request from decision/policymakers	
Supportive administration	Evidence of: • procurement system that allows institution to enter into contracts with different funding organisations relatively easily • access to IT, and internet support enabling access to databases and other sources of data conducive to producing high quality research and to facilitating effective and rapid communication	
Partnerships and	Evidence of: • participation in national, regional	

networks	and/or global partnerships or networks • active work and research produced within these

*These should refer in the first instance to RMNCH, but where lacking may also refer more broadly to health systems and policy research capacity.

We do not require detailed information on each of the institutions or mechanisms identified at this stage but an indication of relative strength as indicated above. The criteria are provided as a guideline and may be added to. We anticipate that this work will be driven by your expertise but may also be supplemented by web-based research and key informant interviews as required. Please document the sources of information you use. Please note that you may wish to include institutions or mechanisms that do not necessarily have a strong track record as indicated by the criteria above, but provide potential to meet these in future. Where this is the case we ask you to explain why you would include these.

For each institution identified in the mapping please provide:

Name of institution or mechanism:

Address:

Type of institution/mechanism:

[eg network (specify members), academic institution, NGO]

Main aim/function of institution:

Summary assessment of capacity:

[as indicated above]

Source of information:

[eg key informant interview, database searches, own experience]

Comments

[This may capture any additional thoughts on the institution in question, for example, where institutions may not meet (all) criteria as yet but might do so in future [please explain how], and any other observations not captured in the above criteria]

Step 2. Having produced a mapping of key institutions in the country, this step will involve a more detailed analysis of between two and four of these. These focus institutions will be agreed upon following discussion with RAND Europe and will be informed through the summary assessment above. The analysis of these institutions will cover largely the same criteria as above but will go into further depth and record actual examples. We will provide you with a finalised list of criteria to use and headings for reporting. We anticipate that an interview may be

required with a representative from the selected institutions in order to collect and verify information required.

IV. Guidance on reporting format

- Data from the key informant interviews should be reported using headings as set out in the interview schedule in Appendix 1. If available, please share the English transcripts of the interviews with RAND Europe.
- The mapping will be delivered through: (i) a table with summary assessment for identified institutions; (ii) three to five pages on each key institution selected for further analysis.

Interview Guide –RAND Europe/PMNCH	
I About you	
We are interested in your role with respect to RMNCH policymaking.	
1. Can you tell me about your job/role, in particular with respect to RMNCH?	
1.1 job title:	
1.2 time in current post:	
1.3 primary role and responsibilities:	
1.4 role in policymaking:	
1.5 to whom are you accountable:	
1.6 who is accountable to you:	
II About RMNCH policymaking in your country	
We are interested in understanding the evidence needs of decision-makers in relation to RMNCH policymaking and implementation in your country.	
2.1. Who in *[name of country]* is involved in RMNCH policymaking and implementation of essential interventions? (explore different stakeholders and roles)	

2.2. What do you see as the greatest challenges in improving RMNCH in your country? and why?
2.3. To what extent do you think these challenges are related to a lack of evidence? Do you lack evidence about what should be done (nature of the intervention)? About how it should be done (implementation)? Other?
III Using evidence in policymaking
We are interested in knowing how you use evidence available in your country; and in identifying which types of evidence are most useful to you. We would also like to ask you specifically about the ways in which you use evidence from and comparisons with other countries to inform your decision-making.
3.1. How important is evidence to inform your work/decision-making?
3.2. How do you generally go about finding the evidence that you need to support your decision-making?

3.3. What type of evidence do you use to support your work/decision-making?	
Please consider the following types: expert opinion, knowledge of practice in other areas/countries, primary/secondary data, literature reviews, case studies, databases	
3.3.1 Expert opinion	☐ Yes ☐ No ☐ Yes ☐ No
3.3.2 Knowledge of practice in other areas/countries	
3.3.3 Primary data 3.3.4 Secondary data	☐ Yes ☐ No ☐ Yes ☐ No
3.3.5 Literature review	☐ Yes ☐ No
3.3.6 Case studies	☐ Yes ☐ No
3.3.7 Specialised databases	☐ Yes ☐ No
3.3.8 Other, please describe	
3.4. What type of evidence do you feel is most helpful for developing policies or decisionmaking (why)?	
3.5. How important is the format of the research output in determining what type of evidence you use (and why)? *Prompts: journal papers, policy briefs, verbal presentations, face-to-face discussion*	

3.6. How easy do you find it to make systematic use of evidence in your day-to-day work?
3.7. To what extent do you feel the following are important barriers to the use of evidence in your day-to-day work ? *Prompts: time constraints, limited access to evidence needed, limited expertise in interpreting evidence, evidence not that important in decision-making, other...*
About international evidence and comparison: nature and needs
We would like to ask you specifically about how you use evidence from other areas/countries
3.8. How important is evidence from other countries for your work/decisionmaking and why?

3.9 What countries would you look to (regionally and globally) and why?	
3.10 Can you give an example of having used evidence from another country to inform decision-making in your work? (If no, go to 3.12)	
3.10.1 What question did you seek to answer?	
3.10.2 How did you go about identifying the evidence?	
3.10.3 What was the nature of the evidence (eg expert view/meeting, comparative study, systematic review, case note, other)?	
3.10.4 How was the evidence made available?	
3.10.4.1 Verbal: meeting/discussion ?	☐ Yes ☐ No

3.10.4.2 Written: academic/research paper?	☐ Yes ☐ No
3.10.4.3 Written: policy brief?	☐ Yes ☐ No
3.10.4.4 Written: report?	☐ Yes ☐ No
3.10.4.5 Other, please specify	
3.10.5 How useful did you find the material and why?	
3.10.6 What would have enhanced the usefulness of the evidence you had available?	
About international evidence and comparison: transferability	
3.11. In general, how easy do you find it to use evidence from other countries to inform policy development in your country?	
3.12. What are the difficulties?	

About international evidence and comparison: relevance
3.13. Do you think that the knowledge and experience gained in your country offers lessons for health policymakers in other areas/countries?
IV Understanding sources and provision of evidence
We are interested in understanding the sources and provision of evidence available to policymakers nationally and internationally. There are a range of sources that can provide evidence to inform policymaking. These include government-internal sources, university-based research groups, non-governmental organisations, consultancy groups, as well as expert networks, (inter) national conferences, international organisations. We are interested in learning what types of sources you use on a regular basis and how useful you find these.
4.1. What organisations/institutions do you feel are able to best provide the evidence that you need?
4.2. Which types of sources do you use to obtain evidence?

4.2.1 National organisations/groups/mechanisms. *For each organisation, please describe the frequency of collaboration (eg systematically, monthly, only a few times a year)*	
Organisation	Frequency

4.2.2 Organisations/groups/mechanisms based in other region/country or international organisations/groups/mechanisms. *For each organisation, please describe the frequency of collaboration (eg systematically, monthly, only a few times a year)*	
Organisation	Frequency

4.3 Among the providers identified above, please select the three sources that you use the most and provide details about:
4.3.1 Their responsiveness: do they react to requests for evidence or do they proactively provide it? If you request it, how long does it typically take for them to provide evidence?
Organisation 1:
Organisation 2:
Organisation 3:
4.3.2 Their expertise: how much do they know about RMNCH? What is the quality of research provided?
Organisation 1:
Organisation 2:
Organisation 3:
4.3.3 Their relationship with policymakers: are they solicited by the policymakers? Do you work closely with them?
Organisation 1:
Organisation 2:
Organisation 3:
4.4 What evidence resources do you think can be leveraged in Asia and the Pacific and globally to address evidence needs in your country?
V Developing new mechanisms to meet the needs of policymakers

We have been asked to develop possible models for a mechanism that could be responsive to policymakers' RMNCH evidence needs in Asia and the Pacific. The details of the mechanism have not been worked out but it would be a resource that could respond to specific evidence requests from policymakers. We would like to ask a hypothetical set of questions to help us understand your needs.
5.1. Firstly, how useful do you feel such a mechanism would be? Why?
5.2. Do you already have access to such a mechanism? (eg other topic areas, world regions)? Please give details of mechanism and how useful this is to your day-to-day work.
5.3. If you had a dedicated team available to source evidence for you, what would be your ideal scenario?
5.3.1 What type of RMNCH policy questions would you like to seek evidence for? (explore in relation to reproductive, maternal, newborn and child health)
Using the example of increasing the proportion of under 5 year olds receiving antibiotics for pneumonia:

5.3.2 What evidence would you need to inform policies around the provision of antibiotics from pneumonia?
5.3.3 What would be your ideal timescale for requesting evidence (days, weeks, months)?
5.3.4 What would you like to learn from other countries in the region?
5.3.5 What form would you like the evidence to be presented in (eg research report, expert opinion, policy brief, verbal briefing)?

5.4. Where do you think such a mechanism should be based (eg Ministry of Health, independent research organisation, university, other)?
5.5 Would it matter if it was based in this country? Why?
5.6 If an evidence-response mechanism was developed to support RMNCH policy development and implementation in this region would you/your organisation be likely to prefer a **membership relationship** and be involved in the funding and management of such a body? or would you be likely to prefer only a **customer relationship** and request and buy specific pieces of evidence?
5.7 How closely would you/your team like to work with those providing the evidence?
5.8 If an evidence-response mechanism was developed to support RMNCH policy development and implementation in this region would you/your organisation be willing to contribute to resources (research capacity, financial or human resources)?

5.9 How should funding of such a mechanism be arranged? *Eg a charge for each policy brief/study? A country membership fee? Each country contributing work from their national research institutes? Funding from external donors? Other?*
5.10. Do you feel you and other policymakers currently have the capacity to make good use of such a mechanism? If no, what would be needed?
5.11. What else do you feel would be important for us to consider when making recommendations about possible mechanisms?

VI. Other
6.1. Are there other issues related to evidence support for implementing essential RMNCH interventions that you feel is important to discuss?
6.2. Is there anyone else you feel would be particularly important to speak to in relation to this work?

Appendix III Country case study: Bangladesh

Country Lead:

Anita Sharif Chowdhury, senior research associate, Research and Evaluation Division (RED), BRAC

1. Profile of key informants

The study participants were a mix of decisionmakers representing the Health and Family Welfare Ministry of Bangladesh Government, NGOs, key RMNCH funders (bi/multilateral organisations, UN bodies) and professional bodies. Purposive sampling technique was used to select participants, keeping in mind to capture the key players of RMNCH in Bangladesh. Nine key informants participated in the study. All of them have extensive experience in RMNCH policymaking and/or research in Bangladesh.

Table 9: Key informants in Bangladesh: post, time in current post and reported roles and responsibilities

Post	Time in current post	Primary role and responsibilities	Role in policymaking
Director, Health (Care International)	4 years	To identify gap in health system; to design need-based programmes, also provide strategic support to the organisation to develop new programme and provide support to different projects	To produce and generate evidence through our programmes and facilitate informed or evidence-based decisions through dissemination; advocacy for policy change
Assistant director (MCH) and deputy programme manager (Maternal Health Services)	4 years	To evaluate and produce reports Involved in Monitoring & Evaluation; oversees the maternal and neonatal death data	Contributes to the operational plan from MNCH unit; prepares the draft for the directors to give their inputs before the minister's approval
Deputy director Maternal and Child Health Services	2 years	Deputy director; supports program/service delivery at the field level that requires inputs starting from manpower development, logistic support , fund management, new procurement	MCRAH programme planning; implementation in the country; we recommend policies to the ministry from our previous experience and also make recommendations for the operational plan
Chief advisor, JICA	6 years	Oversees the project implementation issues; also interacts with govt counterparts	Trying to influence policy; advocacy

President Bangladesh Neonatal Forum (BNF), Secretary Bangladesh Pediatric Association Society (BPA), founding secretary general and vice president Bangladesh Perinatal Society (BPS), Pro Vice Chancellor BSMMU	4 years	Represents Bangladesh at the Neonatal Forum and as a secretary general of the BPA; tries to improve the health services for neonatal and child health; works closely with those who are involved in policymaking regarding child health	Contributing to evidence dissemination to policymakers
Chief of party (MCHIP),Save the Children, Bangladesh	5 years	Director, integrated safe motherhood, newborn care and family planning projects; therefore responsible for the 'total package'	Maternal health and new born health; particularly playing influential role in newborn health and also working in how to strengthen the health system and prioritise service delivery at district level and below
Health and population advisor	3 years	Overseeing the health and population issues concerning the Department for International Development (DfID)	
Deputy director MCH	3 years	Contributing to the implementation part of the Maternal Newborn Child Adolescent Health (MNCAH) programme according to the national policy and guidelines of maternal newborn and child health	In RMNCH we give input in the formulation of the sector plan and the operational plan, and while developing and revising strategies related to RMNCH
Health specialist, UNICEF	9 years	Concentrates on newborn and infant health; works with govt; work on the UNICEF-supported MNCH programme; work with the ministry in policy formulation leveraging UNICEF's advantageous resources in influencing policymaking	Involved in the development of the operational plan; drafted the newborn and child health part; will be rapporteur of the maternal strategy revision

2. RMNCH policymaking in Bangladesh

The Ministry of Health and Family Welfare, mainly its two directorates – Directorates General of Health Services (DGHS) and Directorate General of Family Planning (DGFP) – are responsible for RMNCH policymaking and implementation in Bangladesh. The government works in close collaboration with a range of stakeholders across the country, maintaining a symbiotic relationship to formulate policies and strategies as well as developing health system service delivery in RMNCH. The stakeholders, which include development partners, bi/multilateral donors, NGOs and UN bodies, contribute to the Ministry's operational plan, which determines different strategies to implement the Health, Population, Nutrition Sector Development Program (HPNSDP) and sets yearly targets of different indicators. The stakeholders also influence the government through advocacy; they suggest and recommend new projects, and improve implementation strategy and service delivery in line with MDGs 4 and 5. They also provide the required evidence to government and professional bodies. These stakeholders each have capacity and strength to influence policy in different aspects. The UN agencies are in an advantageous position when making available new RMNCH initiatives, as are some of the NGOs, which also have practical implementation experience in the community. The donors are technically sound in prioritising and investing in initiatives, and the professional bodies have the

technical skills to decide 'what works' and acknowledge the priority needs in achieving MDGs 4 and 5.

Recognising their influence and complementarity, the stakeholders have formed an alliance to influence the government by creating a strategic partnership. For instance partners working in child and newborn health have formed an alliance involving donors, UN bodies, international non-governmental organisations (INGOs) and professional bodies like the BNF, the BPA, the BPS and government representatives. For any new initiative to improve newborn and child health, the alliance involves these partners to influence government through meetings, dissemination workshops, study tours and policy dialogues.

3. Use of evidence in policymaking

All the participants have mentioned that they need evidence in decisionmaking as well as influencing policy. Participants representing the government mentioned using evidence to support their operational plans or the five- or three-yearly plans in two ways: (i) they seek evidence from their own Management Information System, national surveys, and experience from the evaluation and assessment reports of the previous five- or three-yearly plans and field reports to prepare different strategies and an operational plan; (ii) they incorporate evidence-based suggestions and recommendations from the stakeholders in the operational plan or HPNSDP. The government seeks expert opinion on these recommendations and is keen to accept those that are endorsed by the professional bodies like BNF, BPS, BPA, OGSB and the Bangladesh Medical Association (BMA). One interviewee said that it is the 'stakeholders' responsibility to nourish government with the required evidence'.

The non-state participants reported that it is very important for them to generate in-country evidence to influence policymakers for any intervention aiming at influencing policymaking. They need to ensure that a certain intervention will work in the prevailing health system and the existing socio-cultural and ethnic context. Therefore in order to generate or advocate particular evidence, the stakeholders often create strategic partnerships with relevant agencies, government representatives and professional bodies.

In order to gather evidence the stakeholders undertake operations research and impact evaluation. Non-state participants (INGOs) that are involved in project implementation mentioned that they value grey literature about programme implementation. They also valued in-country and out-country programme visits to gain hands-on experiences and finding out the right component which would be useful to the national context.

Table 10 summarises the types of evidence that are used to support decisionmaking.

Table 10 Types of evidence used to support work/decisionmaking in Bangladesh

Evidence type	Participants representing	
	Government (n=3)	Non-government (n=6)
Expert opinion	2	6
Knowledge of practice in other areas/countries	2	6
Primary data	2	6
Secondary data	3	6
Literature review	2	6

Case studies	2	5
Specialised databases	1	GOVT(1) , WHO(1)
Other, please describe	Field reports, MCWC reports	Operations research, formative evidence, impact evaluation, grey literature, advocacy workshop

The majority of the interviewees felt that policy briefs and policy dialogues are much more effective than other methods in reaching policymakers. Almost all the participants mentioned that an important part of their job depends on the systematic use of evidence. However, most interviewees said they face barriers in using evidence systematically: in culture of evidence use (n=5), time constraints (n=5), lack of skill in interpreting evidence (n=5), generating meaningful and authentic data (n=4), or lack of evidence (n=5).

One of the government participants mentioned that the lack of coordination between the two ministry directorates is a constraint in using data effectively in day-to-day work.

Participants from the donor agencies mentioned that they have a very good internal network from where they can easily access and use evidence they require, but that time constraints was a problem, as was the lack of in-country data.

The government participants said they have very limited scope to use international evidence. They mostly prefer regional and South Asian Association for Regional Cooperation (SAARC) countries' data. Mostly they look for Demographic and Health Survey data. These data help them to compare their own progress by indicator and set yearly targets for different indicators in the operational plan to achieve the ultimate goals set in the HPNSDP. They also reported that it was rare for them to look at global data for comparison.

The non-government participants mentioned similar countries and said that for innovation and state-of-the-art implementation they probably look at global and regional data, but prefer regional data. SAARC countries are looked to because there share with Bangladesh socio-economic and cultural characteristics, and their health systems are similar. They need to consider whether particular evidence can be adapted in the existing health system along with the health system's current resources, financial and human. Sometimes ethnicity and cultural context are also considered. As one of the participant said, "the major issue is context".

Table 11 synthesises the countries that are looked to for evidence and the reasons that motivate comparison.

Table 11 Countries that Bangladesh looked to for international evidence

Countries looked to	Reason for comparison
India, Nepal, Sri Lanka, Pakistan, Indonesia, Thailand, China	Neighbouring country, similar characteristics
Peru, Cambodia, African countries (incl. Rwanda)	Good source of evidence for RMNCH
SAARC countries, South East Asia, Malaysia, Philippines	Similar characteristics
Europe (cited by one respondent)	"To see where we are at"
African countries	Because the organisation of the interviewee is present in Africa as well, running the same kind of activities
Africa	For examples of interventions in resource-poor set-ups

Despite their preference for national and regional evidence, the majority of interviewees believe that policymakers are open to international evidence if it is proven relevant and effective. All participants thought that other countries should look to Bangladesh for many reasons, the achievements in some of the indicators of MDGs 4 and 5, despite various challenges (over-population, scarcity in financial and human resources, lack of political commitment), being one of them.

4. Sources and provision of evidence

It appears that there are very limited choices regarding good institutions producing RMNCH evidence. The governmental research agency under the Ministry of Health lacks capacity as a research organisation. There was a consensus that the organisation in Bangladesh that provides the best evidence is ICDDR,B, a research-based organisation which has earned an international reputation through its research and innovation in public health.

The country health system significantly depends on government-NGOs partnership. The evidence generation and evidence use for policy formulation has become the sole responsibility of the donors, the development partners and the NGOs. These stakeholders use their organisational network and capacity to produce evidence and utilise it to inform policy. They often work with different groups affiliated with different international universities or hire national or international consultants for this purpose.

Table 12 presents capacity rating for the main institutions identified.

Table 12 Mapping of the main evidence providers in Bangladesh

Criteria*	Possible supporting evidence	International Centre for Diarrheal Disease Research, Bangladesh (ICDDR,B)		National institute of Population Research and Training (NIPORT)		James P Grant School of Public Health (JPGSPH), BRAC University		RED, BRAC	
Strong research capacity	Evidence of:								
	substantial research funding	ICDDR,B's activities are supported by about 55 donor countries and organisations, including govt of Bangladesh, UN specialised agencies, foundations, universities, research institutes and private sector organisations and companies that share the Centre's concern for the health problems of developing countries and value its proven experience in helping solve those problems. The Centre is governed by a distinguished multinational Board of Trustees comprising 17 members from around the globe	+		+	From different donors	+	RED's core funding comes from BRAC. RED mainly carries out research to generate evidence for BRAC programme, to help create an analytical basis for programmatic decisionmaking and fine tuning of the programmatic effort. It also undertakes collaborative and commissioned research on important development issues with a particular focus on developing countries. MNCH donors include DfID, Aus AID, Gates Foundation, EKN (kingdom of Netherlands)	+
	quality outputs (eg international publications and conferences)	ICDDR,B publishes frequently in world class journals and organises and hosts conferences like ASCON (ICDDR,B Annual Scientific Conference) (every year) and CAPGAN (Commonwealth Association of Paediatric Gastroenterology and Nutrition) conference	++		-	A rather new institute (founded 2005) and still very much dependent on external faculties from ICDDR,B or international and national universities. It organises conferences on different public health issues	-	RED research findings are regularly disseminated through seminars, symposiums and conferences. In 2011 alone RED published 16 primary articles in peer-reviewed journals, three books, 17 working papers and 14 popular articles in newspapers and newsletters. It organises different national and international seminars, workshops and talks to enhance its research capacity and dissemination. Organised few international conferences, eg on fortified rice, entrepreneurship. MNCH unit had published 4 articles in renowned journals this year	+
	relevant disciplines represented among researchers (eg policy analysis, health services research, public health)		++		- -		+	RED has 9 units, of which 5 represent relevant disciplines of health services research and public health – environment, food security & nutrition, health system, MNCH. Impact assessment is special unit which consist of researchers from different background who conduct impact evaluation studies of BRAC programme	+
	significant	The centre has 10 units. It has child	++	In the research wing one	- -	About 100 researchers	+	It has 75 researchers; 15 have	+

proportion of staff with higher degrees/PhD	health unit as well as reproductive health unit. For instance child health unit has 20 scientific officers; among them 3 have PhD and 3 are currently enrolled in PhD programme. All other have Master of Public Health (MPH) coming from different backgrounds like anthropology, medicine, sociology		has PhD, among the 6 researchers. They are mostly managing the research projects carried out by different research firms		working in different projects from different backgrounds. A significant number have MPH and 4 have a PhD. There are 10 mid-level and 10 senior level staff with significant research experience in public health		doctoral degrees, most of others have master degrees from reputed national and international universities. Units related to public health have researchers with master degree in public health (doctors as well as non-doctors), nutrition, anthropology, population science and statistics	
stability of funding		+		+	Funds based on projects. But decisionmakers are keen to fund JPGSPH as it not only generates high quality evidence but also has a mandate to use this knowledge to advocate to relevant stakeholders and policymakers that it is a lead partner for the Global Fund for HIV/AIDS Tuberculosis and Malaria (GFATM). The various research activities fall under the three centres, are under GFATM package 913, or are independent projects of the Centre of Excellence on Universal Health Coverage, funded by the Rockefeller Foundation. One of the objectives of JPGSPH is to generate essential evidence necessary to guide the design of Universal Health Coverage policies and programmes and to monitor and evaluate their implementation. The Centre for Health Systems Studies conducts pioneering studies of the public health system in a developing country in order to highlight the diverse channels and avenues through which healthcare is provided to the population. The Centre for Gender Sexuality and HIV/AIDS is a UN AIDS collaborating centre. Has a formal agreement	+	Core fund plus funds from different collaborative and commissioned research	+

						between UNAIDS and the BRAC University School of Public Health (BSPH), and is designed for research, policy, advocacy and training activities using state-of-the-art methods and technologies of teaching and learning		
	other indicators of research quality				- -			RED's unique advantage is having access to the nationwide grassroots infrastructure of BRAC and its different programme Partners of current collaboration and commissioned research include IFPRI, LSE (UK), Global Development Network, Sydney University, University of Aberdeen RED also welcomes interns from international universities to facilitate their research work and assigns senior researchers for mentoring and guidance RED has data management and field management unit to support and ensure quality of data collection, data entry, cleaning and data coding. Also to recruit and train enumerators. RED has 1,700 enlisted short-term enumerators who conduct survey and collect data in the field
Experience in providing evidence for decision makers	Evidence of:					.		.
	nature of funding	Donor funded	++	Govt		Donor funded		
	interaction with decisionmakers		++		+		+	
	ability to produce a range of external dissemination outputs and engage in related activities		++		+		+	BRAC has capacity to influence decisionmakers and organise different activities to disseminate and advocate, targeting govt policymakers and other decisionmakers. But RED does not usually have direct interaction with decisionmakers. It supports BRAC health programme through evidence generation. BRAC health programme uses it to influence policy changes
	policy-targeted	Translating Research into Action	++		+	JPGSPH's uptake policy-	+	RED has not been involved in policy

	research	(TRAction) is a joint project of ICDDR,B and Johns Hopkins University for carrying out implementation research to test effective strategies to expand and improve MNCH, nutrition, reproductive health and family planning and tuberculosis services in Bangladesh. The project started in February 2011 and will complete in September 2014. It is funded by USAID through URC. Under this, the child health unit has approached govt to introduce a 'targeted approach' to address equity issues in child health like remote and poverty stricken areas				targeted research. For instance 'MOVE-IT Bangladesh' is a pilot project which aims to assess the efficacy and feasibility of and interoperable electronic information system for universal registration of pregnant mothers and their children. This initiative focuses on three priority areas: comprehensive health information systems; innovative use of digital technologies; and universal access to maternal, neo-natal and child health services		research directly	-
	research informing policymaking	For instance: management of severe pneumonia at the first level facility-administering oral antibiotics. Performed efficacy trial first, then approached govt to test it at govt set up for scaling up; govt agreed and it is now being piloted to be scaled up Similar piloting going on for neonatal sepsis management in community	++		+	P4P performance – an innovative service delivery model to provide financial incentives to the institution as a way to enhance their performance on MNCH services in Bangladesh as part of GOB, UNICEF's ongoing MNCH and MNH projects	+	RED has not been involved in policy research directly but as part of BRAC undertakes research to inform policymaking and can have influence on govt policymakers. Other decisionmakers from different stakeholders (NGOs, donors, UN body, professional bodies) see BRAC as an influential body in the development sector of Bangladesh including public health	-
Ability to provide evidence in a responsive mode	Evidence of:								
	short turnaround research as well as longer-term research programmes	For instance a study in Tangail is observing facility-based quality improvement – it is a longitudinal study observing changes at different indicators of QOC	++		+		+		+
	producing research on basis of request from decision/policymakers	Very often decision/policymakers from state and non-state approach for evidence For instance HIB vaccine trial was performed by ICDDR,B, and it is currently trialling Rota-virus vaccine	++		+		+	Decisionmakers and policymakers do not approach directly to RED. RED's primary interest is to support its programme through knowledge and evidence generation. Donor funded health intervention is performed by BRAC health programme and all the built in OR, baseline, endline and impact assessment studies by RED	-
Supportive administration	Evidence of:								
	procurement system that allows institution to enter into contracts with different funding		+		+		+		+

	organisations relatively easily							
	access to IT, and internet support enabling access to databases and other sources of data conducive to producing high quality research and facilitating effective and rapid communication	Has a library with over 50,000 journal titles and 15,000 books, which is one of the largest and most modern in South Asia	++		- -		+	+
Partnerships and networks	Evidence of participation in national, regional or global partnerships or networks			Measure, ICF Macro	+	Bangladesh Health Watch-JPGSPH serves as the Secretariat for a civil initiative called Bangladesh Health Watch (BHW), which is a multi-stakeholder civil society advocacy and monitoring network. The main objective of BHW is to improve the health of the population and health systems through monitoring progress, critically reviewing policies and programmes, and playing a catalytic role in making lasting changes in the health sector. Funded by the Swedish International Development Cooperation Agency (SIDA)	BHW	
	Evidence of active work and research produced within these			BDHS, MMS		Challenges of achieving health equity (2006) report highlighted inequities in health and addressed ways to propagate ethics to action. An assessment on the situation of health workforce in Bangladesh (2007) with special focus on production, availability, and quality of services. Status of health sector governance in Bangladesh (2009) assessed critical elements of health service delivery and identified actionable points for the policymakers		

Key: ++ (very strong) ; + (strong in this area) ; - (relatively weak); - - (weak in this area)

5. Developing a new mechanism for policymakers

All the respondents were very enthusiastic about the idea of a possible mechanism responding to the evidence needs of the policymakers. The most frequent and most felt expectation was that the mechanism would provide country-specific evidence.

They acknowledged that gathering and organising evidence to inform policy was time consuming, and felt that the mechanism could give them access to policy briefs and pooled data. They wished that such documents could be downloaded in no time from a dedicated website. Expectations were that the mechanism should be 'ready to use', 'easily accessible', 'like a one stop mall'.

Table 13shows the preferences of the respondents on the characteristics of the potential mechanism.

Table 13 Preferences for potential new mechanism in Bangladesh

Respondent organisation	Would such a mechanism be helpful?	Client/membership relationship	Preferred location	Contribution to resources	Timeframe	Funding arrangement	Whether policymakers have the capacity to use such a mechanism	Comments
1 Donor	Yes	Both		No financial contribution but can provide consultation	Within days	Govt funded		
2 NGO	Yes	Both		Yes	Within days	All options except country membership fee		
3 Research	Yes	Partnership		Want to share experience without funding	Depends on the urgency	Funding from external donor		
4 NGO	Yes	Membership		Like to exchange experience and knowledge	Within days	Funding from external donor plus charge for policy brief; initially it should be free		
5 Donor	Yes	Membership		Share human resources and skill without funding	Three months	Contributing work being a research institute		
6 Prof. body	Yes	Partnership		Currently can't commit	Very quickly	Mix of all options except charge for each brief		
7 Govt	Yes	Partnership		Exchange data	Within days	Funding from external donor and contributing work from research institute		
8 Govt	Yes	Membership		Collaborate in resource sharing	Within months	Country membership fee		
9 Govt	Yes	Membership		No participation	Within days	Donor funded, country membership fee		

Almost all the participants felt that the evidence mechanism should be based in an independent research institute or university. Several emphasised the need for appropriate collaboration between the government and the mechanism staff to ensure ownership. The majority thought that the Ministry of Health should not be the base of the mechanism.

The option of creating a partnership with the hypothetical mechanism was unanimously chosen over customer relationship. Many suggested that government and the relevant stakeholders' collaboration would be beneficial for the mechanism, so each could explore and use their expertise and capacity to attain the common interest.

Some concerns were expressed about the capacity of the policymakers to make good use of the mechanism. The main reason was the issue of 'transfer' (staff not staying at the same post long enough) and the second was the lack of public health exposure or relevant research training.

When asked about the way they could use such a mechanism for a specific question, 'how [is it possible] to increase the proportion of under 5 year old receive antibiotics for pneumonia?', interviewees made the comments reported in Table 14.

Table 14 Evidence needed to increase the proportion of under 5 year olds receiving treatment for pneumonia in Bangladesh

Evidence needed to inform policy	What you want to learn from other countries	Preferred type of output
How effectively it could be managed in the community	Same issue from neighbouring countries	Operations research, process documentation
The role of antibiotics in reducing pneumonia	Prevalence case detection rate in the community and management	Summarised information
At the community level, how to identify and manage pneumonia	Successful evidence where community intervention was possible	Scientifically documented and should be valid
Antibiotic use can be effective in pneumonia in community	Antibiotic use can be effective in pneumonia in community	Operations research, process documentation
Whether it is ok to use community workers to administer antibiotics; we also need to know the side effects of antibiotics	How they are providing the antibiotics to the needed children; what the mechanism is; whether there is any regulation to administer antibiotics	Research report using primary data, also expert opinion
Community workers can administer antibiotics and effectively manage cases	The prevalence, case management in the community	All kinds of evidence
Role of antibiotics in pneumonia	Number of under 5 children, type of antibiotic case fatality rate, prevalent organism, etc	All kinds of evidence
Consultation from the expert forums of Bangladesh	How they are administering antibiotics in the community	Policy brief
Percentage of children with pneumonia who seek care at facility	The prevalence, community management	All kinds of evidence

Comments

Those findings highlighted that the culture of evidence use in the public sector is below what one could expect and there are multiple factors responsible for this lack of opportunity for innovation: relevant training in public health, frequent transfers, and staff without relevant experience and inappropriate qualifications. There is also a severe dearth of good research institutions in the public and private sector in the country.

Method

The findings are based on a very small sample so might not be transferable, but serve to understand the culture of evidence use, and the gaps and needs to some extent within the process of influencing RMNCH policy formulation in Bangladesh.

Appendix IV Country case study: India

Country lead:
Dr Kranti Suresh Vora, Consultant

1. Profile of key informants

Key informants were mix of evidence providers (n=6) and users (n=3) (Table 15). The organisations represented varied and included national and state governments, NGOs, international development agencies, professional organisations and academic institutions. Most key informants were senior people who had been working on RMNCH issues in India for 10–20 years. All interviewees have been involved to a certain extent in policymaking in a technical or advisory capacity.

Unfortunately, owing to time constraints, it was not possible to set up an interview with one of the final decisionmakers in the policymaking process – an Indian Administration Services (IAS) officer or an elected official.

Table 15 Key informants in India: post, time in current post and reported roles and responsibilities

Post	Time in current post	Primary role and responsibilities	Role in policymaking
Officer on special duty for Hon. Health Minister, Gujarat and exec. director (FW)	4 years	Technical backstopping for programme and policy, preparing technical notes for the minister, scrutinising proposed programmes and policies	Advisor for policy and programmes for the health minister
Deputy director (Ministry of Health and Family Welfare)	4 years	Planning, implementation, monitoring MNCH programmes, especially immunisation and Janani Shishu Suraksha Yojana	Technical inputs and providing data to frame policies and provide evidence for policymaking
Honorary professor in Gujarat Institute of Development Research	Many years [sic]	Advisor to institution for research projects related to health, women, demography and migration	Not directly; indirectly through research and advisor for planning commission and other committees. Some of his research has been influencing policymaking or modified programs for 30 years

Director, Indian Institute of Public Health, Gandhinagar	2 years	Administration and leadership for the new institute	Not a direct role but collaboration with national and state govt
Program officer (Reproductive Health) UNFPA	16 years	Advising in programme design and implementation at national and state level; monitoring and evaluation of programmes	Part of advisory committees, when asked provide evidence
Advisor (Public Health Administration), National Health Systems Resource Centre, Former Deputy Director (RCH), Tamil Nadu	4.5 years	Technical support to health ministry; influences policymaking and health system development in high focus states	Yes [sic]
Coordinator of Reproductive Health at Action Research and Training for Health (ARTH)	15 years	Works in reproductive health, child health and health system, but more particularly on reproductive health	Advocacy role and provides evidence; provides programme support to the state govt, if is invited for consultation; then offers expert opinion
Programme Director of The Federation of Obstetric and Gynaecological Societies/ Indian College of Obstetricians & Gynaecologists/govt of India, ex-president of FOGSI	6.5 years	On behalf of FOGS, conducts training programme for doctors in Emergency Obstetric Care and deals with all related issues	Not sure if FOGSI has a role in policymaking. Provides services as private practitioners. Advises govt when asked but it is up to them if they listen or not
CEO, Amaltas India	4.5 years	Technical lead for research and consulting	Evaluation and strategy development

2. RMNCH policymaking in India

According to most interviewees, IAS officers (health secretaries and health commissioners at the national and the state levels) and elected officials such as ministers and chief or prime ministers are the final decisionmakers. They work with a range of stakeholders, including technical staff, academics and experts. NGOs have a role in advocacy and programme implementation. Professional organisations participate in policymaking in an advisory capacity on request. A growing trend promoting the creation of public–private partnerships also contributes to improving the capacity to provide quality healthcare and access to healthcare services. Most stakeholders participate in the formulation of policy questions and the design of policies; however, the final approval remains in the hands of IAS officers and ministers. As there is no clear pathway of policymaking it depends on the individual policymaker what kind of evidence is used and how it is interpreted.

The involvement of other stakeholders depends on their personal relationships with these policymakers. Because of a lack of rigorous policymaking process, there are some major challenges that are still to be addressed in the key areas of RMNCH, such as human resources shortages (in quantity and quality). Even if some decisions are made and some policies implemented, there may still be a lack of clarity, which confuses field level workers and has a negative impact on the implementation of programmes.

3. Use of evidence in policymaking

Almost all the key informants agreed that the issue is not the absolute lack of evidence but the scarcity of evidence-based policies, for various reasons. The most common to emerge from the interviews was time constraints: IAS officers and ministers do not have time to read, analyse and use evidence for policymaking. Further, they sometimes have limited skills and capacity to understand evidence, often because they lack awareness of and exposure to evidence. Political pressures and the need to satisfy a set of predefined priorities also prevent policymakers from using evidence as much as they are supposed to. The frequent turnover of IAS officers and their tendency to come up with a new policy to mark their tenure were also cited as reasons for non-use of evidence.

There was no consensus on which evidence format is most commonly used, but most interviewees agreed that "seeing is believing", as site visits and face-to-face discussions are considered to be the most powerful ways to present evidence. Table 16 provides a more detailed account of evidence that was thought to be relevant.

Table 16 Types of evidence used by policymakers in India to support their work

	Government representatives (n=3)	Non-government representatives (n=6)
Expert opinion	1	3
Knowledge of practice in other areas/countries	3	2
Primary data	1	2
Secondary data	1	2
Literature review	2	1
Case studies	3	1
Specialised databases	3	
Other, please describe	Beneficiaries' opinion, local studies, lessons learnt from other states, 'programmatic evidence'	Site visits, pilot projects, evidence from interventions

Note: Two interviewees didn't answer that question, because they were not aware of which type of evidence policymakers are using.

International evidence and case studies or pilots carried out by NGOs were thought to be difficult to transfer or replicate and therefore not relevant. The size of India and its cultural and geographical diversity make it difficult to compare with any other country in Asia or globally. Interviewees were more prone to mention comparisons within the country, but even evidence from southern states was thought to be irrelevant for northern states because of the geographical and cultural inherent differences.

The lack of operations research was also thought to be a reason why evidence is not being used for policymaking. Most key informants agreed that programme implementation issues constitute a very important challenge in improving RMNCH in India. NGOs which are involved in programme implementation may know the ground realities but their work is too focused geographically and hence at times evidence users may think it is not replicable or cannot be scaled up. Interviewees thought there is a clear need to involve more field level staff in research and to increase their capacity to document evidence and communicate it in a clear and efficient manner.

4. Sources and provision of evidence

Academic institutions such as the Indian Institute of Management, the All India Institute of Medical Sciences (AIIMS) and the Indian Institute of Public Health were thought to be major sources of evidence along with government organisations such as the Indian Council of Medical Research (ICMR) and the National Institute of Health and Family Welfare (NIHFW). Policymakers at national and state levels were said to seek evidence through all those institutions regularly. NGOs such as ARTH are also involved in providing evidence for policymaking at state level. Sources used, type of evidence looked at and frequency of collaboration with sources depended on individuals and their attitude towards the process of policymaking and importance of using evidence. Most interviewees remained vague about the collaboration.

On other hand, researchers need to improve their ability to draft policy briefs or such short documents that can be understood by policymakers to improve use of evidence. A more collaborative and proactive approach would also be helpful. NGOs need to develop capacity to conduct operations research and document implementation process. Skilled human resource is also an issue with government organisations. Premier organisations such as the ICMR and the NIHFW do not have many scientists trained for public health research.

The mapping of national resources revealed that different organisations have the capacity to conduct different types of research. For example, the ICMR[1] and the AIIMS have the capacity to carry out clinical research while the NIHFW can carry out programme-related research. NGOs such as ARTH can carry out operations research on a focused geographic area, while the Public Health Foundation of India (PHFI) can carry out mainly public-health-related research. As pointed out earlier, most of the resources limitations are related to the availability of a skilled research workforce to carry out different types of research needed for policymaking. Other constraints related to governmental organisations were the complex administrative processes and the need to carry out independent research and publish results. Many key informants felt that because NGOs work in a concentric area the evidence they provide is not always relevant.

[1] Several interviewees questioned the relevance of the ICMR in the specific context of RMNCH policymaking: they consider the ICMR as "too technical" to be really helpful to the policymaker.

Table 17 summarises the research capacity of the main institutions identified in India through the interviews and mapping exercise. A more collaborative approach might be a solution to ensure that policymakers have access to evidence or are willing to develop a mechanism that includes the whole range of stakeholders.

Table 17 Mapping of research institutions in India

Criteria	Possible supporting evidence	All India Institute of Medical Sciences	National Institute of Health and Welfare	Action Research and Training for Health	Indian Council of Medical Research	International Institute of Population Sciences	National Health System Resource Centre	Public Health Foundation of India	White Ribbon Alliance of India
Strong research capacity	Evidence of:								
	substantial research funding	++	++	+ Usually for state govt and international organisations	++	++	Funding is by govt		Not much research funding as main role is advocacy
	quality outputs (eg international publications and conferences)	-	+	Publishes many papers and reports	-	++		Yes, ++	Has some international publications
	relevant disciplines represented among researchers (eg policy analysis, health services research, public health)	Mostly clinical research as it is a medical sciences institute providing clinical care to patients	-		- -	+ Limited capacity	All disciplines are represented	Yes, ++	No
	significant proportion of staff with higher degrees or PhD	No	-	No, majority do not have higher degrees	++	Almost all the staff has higher degree	Some of the staff have a PhD; many have masters degree in public health	++	Majority of staff
	stability of funding	Stable funding as funded by govt mostly and international development agencies such as WHO	+		+	++			Yes

	other indicators of research quality			Has been conducting quality research for past 15 years					Limited
Experience in providing evidence for decisionmakers	Evidence of:								
	nature of funding	Govt and international development agency	++	State govt, national govt and international organisations such as MacArthur Foundation	From govt	Mostly govt and international agencies such as Population Council, USAID, ICF Macro	Govt funding	Funding from govt and other sources	++
	interaction with decisionmakers	Yes, +	++	Interaction with state level decisionmakers mainly, occasionally with national level	++	Limited interaction with decisionmakers	Close interaction with decisionmakers	Faculty members involved in policymaking in advisory capacity	Govt and international donors
	ability to produce a range of external dissemination outputs and engage in related activities	Not sure	++		++	Yes			Yes
	policy-targeted research	Not much	+	Not much policy-targeted research, mostly programme implementation research	Not much research is policy targeted	Most research is related to demography and quantitative data related	Most research is policy-targeted	Some research is policy-targeted and informs policymaking	Yes
	research informing policymaking	Some, yes -	+	Some of the research informs policymaking		Yes			Yes
Ability to provide evidence in a responsive	Evidence of:								
	short turnaround research as	Not sure of	Not sure of turn-	Mostly longer-	Am not sure of	Not sure of	Not sure of	Don't know	Not sure of

mode	well as longer-term research programmes	short-term, long-term research yes	around of research	term research programmes	short turnaround research	short turnaround research	short turnaround research but carries out long-term research	about short-term research but carries out long-term research	short turnaround research
	producing research on basis of request from decision/policymakers	Am not sure	+	At times		Yes+	Yes	At state level at some places	Yes
Supportive administration	Evidence of:								
	procurement system that allows institution to enter into contracts with different funding organisations relatively easily	Yes++	Not known	++, has collaborated with international organisations and govt	++	++	Not sure; has not been attempted so far	Yes, has collaborated with international organisations	Yes++
	access to IT, and internet support enabling access to databases and other sources of data conducive to producing high quality research and facilitating effective and rapid communication	Yes, ++	+	Yes +	++	Yes ++	Yes	Yes, ++	Yes, ++
Partnerships and networks	Evidence of participation in national, regional or global partnerships or networks	Yes, +	+	Yes, +	+	++	Yes	Yes, ++	Yes, ++
	Evidence of active work and research produced within these	Yes, -	-	+	-	++		Yes++	Yes, +

5. Developing new mechanism for policymakers

Key informants unanimously agreed that the new mechanism should be independent in order to be acceptable by all stakeholders. The mechanism should not be built from an existing governmental organisation or university.

There was also consensus that funding should be a mix from governmental funding and multi-national donors. There were mixed opinions about how the arrangement should work – membership or customer relationship. Some argued that membership would give a sense of ownership and improve the use of the mechanism. Others felt that developing a customer relationship would help the mechanism retain its independence and encourage requests by policymakers.

Many felt that the credibility and relevance of the mechanism would be increased if it were to be based in India, which would also make the collaboration between evidence users and providers easier.

There was agreement that the most useful format of evidence should be a document that is short and simple in order to be read and understood by busy policymakers, or a verbal presentation, face-to-face discussion or field visit that would make the evidence more vivid. It was thought that the timeframe of evidence gathering should be variable, depending on the type of project or evidence required. Some mentioned the need to maintain regular (weekly) contacts with the providing organisation, while some acknowledged that good research is a mid- to long-term process. Some believed that ongoing work with experts or using reliable routine evaluation data would shorten the timeframe.

Two key informants felt that the new mechanism should ensure that a context is provided and that the diversity of nations in Asia and the Pacific is represented. There was a strong push for a web-based mechanism that is easily accessible to all. Leveraging available resources in the Asia-Pacific region such as Matlab in Bangladesh, the Population Council, universities in various countries such as the University of Singapore, diverse Australian research organisations, and organisations and institutions available in India such as PHFI would be useful.

Table 18 presents the vision of the different interviewees for a regional mechanism.

Table 18 Preferences for potential new mechanism in India

Respondent organisation	Would such a mechanism be helpful?	Client/member relationship	Preferred location	Contribution to resources	Timeframe	Funding arrangement	Type of evidence	Output types	Whether policymakers have the capacity to use such a mechanism	Comment
1 Govt	Very	Customer relationship	It should be independent. Better if based in India	Financially, if feels it is useful	Consultation once a week	Funding by donors, govt, beneficiaries and corporate sector	More on implementation – reasons for failures, common perceptions and behaviour change	Web-based information, including datasets	No, not accessible	
2 Govt	Yes	Customer relationship. Can get data regularly and if necessary request evidence	Easier if in India	Financially	Depends on the project	Funding through multinational agencies. Institutions such as Bill and Melinda Gates Foundation	Improve processes, new inputs (eg nutritional status in National Family Health Survey 3-2006) Anaemia in mothers	Easy to analyse reports	No	Interviewee mentioned MOU from the IIPH as a mechanism they fund and use.
3 Gujarat Institute of Development Research	Yes	Membership for ownership	It needs to be independent (not a ministry nor a university) but it doesn't matter if it's in India or not	Research capacity	Good research takes time		Nutrition of mothers			

4 The Indian Institute of Public Health	Yes	Membership	More convincing if in India	Human resources and research capacity	Days	Should be independent to generate evidence; example is NHSRC, which is funded by govt but set up separately.	Operational issues: if there is evidence of a large programme, an evaluation which demonstrates effectiveness. In short, operations research type of evidence. Accountability of staff		It depends on the individuals	NHSRC was created for this purpose only. To conduct national level research to help policymaking and programme implementation. But one institution is not enough
5 UNFPA (United Nations Population Fund)	Yes. It is needed	Customer relationship. Need to think about accountability	More relevant in India	Technical assistance and funding	At least 24 months to get robust evidence that is well documented	External funding and govt funding	Explaining processes and implementation	Verbal briefs and face-to-face explanations	Yes, but need good linkages	
6 National Health Systems Resource Centre (NHSRC)	Very useful	Customer relationship	It should be decentralised, to reach the local level. It should be in India		Weeks or months, it takes time to document evidence. Operations research can give evidence in a short	Contribution from govts and external donors	Operational evidence on maternal morbidity, child health issues	Policy brief and reports as they facilitate implementation of policies and operational research outputs	Yes. But implementation is an issue	

					period of time from routinely collected data					
7 Action Research and Training for Health (ARTH)	Very useful	The mechanism should be both proactive and reactive. Independent organisation is an university may be an option.	More credible if in India	Human resources and research capacity	Systematic research needs weeks and months	Combination of govt and external donor funding would work	Monitoring of programmes and impact evaluation are important. For example, impact assessment of JSY (safe motherhood scheme) on stillbirth rates and maternal mortality ratio are not made	Written reports and policy briefs		NRHM is such a mechanism; it has committees and technical support group but these are ad-hoc measures; there needs to be something more permanent
8 The Federation of Obstetric and Gynaecological Societies of India (FOGSI)	Yes	There should be an advisory committee for the ministry comprising experts including from professional organisations. Govt is realising that it needs to involve professional organisations in decisionmaking and we are being invited to many meetings.		Technical advice and pilot projects		Govt		Presentations	Higher officials need to be more accessible. Also after convincing central level people, we have to work with state level officials, as health is a state subject	

		There is still need for more public private partnership to reduce maternal mortality								
9 Amaltas	Yes		It should be a web-based platform. More relatable if in India.	It would depend on the mechanism	Large-scale research always takes longer time; timely monitoring and evaluation data can provide evidence at short notice	Funding can come from the govt or programmes	Regular evaluation data on implementation issues	A mix. Reports are useful but shouldn't be too long	It depends on how it is presented. Policymakers think in terms of delivery, policy and legal frameworks; researchers need to think in a similar manner	Something like Solution Exchange, a web-based platform that gathers requirements for evidence and to which everyone can contribute. It is an effective mechanism. It is important to consider degree to which the information will drill down. There needs to be heterogeneity; too many of international policy recommendations are bland. Trying to come up with something that fits all makes it unusable. Recommendations need to be genuine and retain granularity. Providing a context would help make them more heterogeneous and useful. It should be possible to make cross-country

	comparisons and provide a context of setting

Other:

- Skilled human resource was thought to be one of the important challenges to improving RMNCH in India in addition to lack of monitoring and evaluation and learning from other states. One of the reasons for dearth of skilled human resources is lack of human resources policies in the public health system, which leads to absence of a clear career path and more turnover of workers.
- Briefing and increasing awareness among policymakers, both IAS officers and elected officials, about use of evidence in policymaking and looking at national and international evidence for domestic policymaking.

Methods issues:

- Most key informants felt the questionnaire was too long and repetitive.
- Many found it difficult to answer questions in section 3.
- The pneumonia example was too specific.

Appendix V Country case study: Indonesia

Country lead:

Dr Tiara Marthias, Centre for Health Service Management, Faculty of Medicine, Universitas Gadjah Mada

1. Profile of key informants:

We conducted 10 interviews. Interviewees were selected on the basis of their involvement in policymaking at national, provincial and district level. Time in current post varied from three months to seven years. Table 21 shows that key informants reported a range of roles and responsibilities, from decisionmaking to implementation and adoption of policies at provincial and sub-district level. One interview had a technical role and was responsible for providing information and data to support decisionmaking rather than direct decisionmaking.

Table 19 Key informants in Indonesia: post, time in current post and reported roles and responsibilities

Post	Time in current post	Primary role and responsibilities	Role in policymaking
Head of Planning and Development Bureau (municipality)	3 months	Programme planner and policymaker	Reducing maternal mortality by improving human resource competency, infrastructure, standard operational procedures
Health of Municipality Health Office	1 year 2 months	Regulator, facilitator and motivator in improving quality of health service	Improving human resources, facilities, infrastructure; writing standard operational procedures
Head of National Bureau of Family Planning	5 years	Population	Final decisionmaker in family planning bureau
Head of Family Planning Bureau (Province)	7 months	Implementing govt tasks in family planning and family welfare; coordinating functional activity of the family planning bureau; facilitating general planning	Implementing policy from national level and translating them to programme, activity and provincial level
Health of Province Health Office	1 year 6 months	Coordinating all the funding, human and other resources relating to health and provincial level	Leading the health policymaking process (decisionmaker)
Head of Provincial Bappeda (Planning and Development Bureau)	1 year 6 months	In charge of putting together programme based on governor's vision	Role at technical level, eg organising meeting plans
Staff in APBN 3 sub-unit (National Expenditure Budget), within Bureau of Planning and Budgeting	2 years	Provision of information and data to support planning for APBN 3 budgeting	Gives input directly to head of Bureau of Planning, Ministry of Health
Director of Children's Health	2 years	Initiator and holder of programmes for policies relating to newborns to	Assessment of policy need and adoption of process of technical polities at provincial level

		adolescents	
Head of Sub-Directorate of Health and Community Nutrition	7 years	Coordination of national planning, health promotion and community	Formulating policies related to health promotion and nutrition community
Director of Primary Health Service (BUKD), Ministry of Health	6 months	Leading the primary health care department in Ministry of Health, including coordination of 5 sub-departments	Developing mechanisms to improve healthcare at primary level

2. RMNCH policymaking in Indonesia

Most key informants listed government bodies and agencies as having a leading role in RMNCH policymaker in Indonesia, for example, the Department of Health, Central Bureau of Statistics, Social Service Bureau, Provincial Planning and Development Bureau, Women and Community Empowerment Office and Family Planning Bureau. To a lesser extent, professional organisations (eg Indonesian Paediatrician Association, Indonesian Midwife Association, Indonesian Medical Association, Indonesian National Nurses Association) and NGOs (Fostering Family Welfare/PKK) were given as examples of organisations involved in RMNCH policymaking and implementation. When asked about priorities for RMNCH in Indonesia, respondents rarely referred to specific conditions or interventions with RMNCH but rather to system factors such as effective decentralisation, implementation and scale-up, funding channels, coordination and inequalities across geographic regions. Seven out of the 10 respondents reported that they felt these challenges arise from lack of evidence, specifically referring to lack of: information or data sub-national levels, up-to-date evidence, evaluation of locally implemented programmes and technical support to enable policymakers to make best use of the evidence available. Three respondents thought that sufficient evidence was available and that this was not an explanation for persisting challenges in RMNCH.

3. Use of evidence in policymaking

All respondents reported that evidence was either important or very important to informing their work and decisionmaking. Most said they generally go about finding the evidence they require by using internal government research and health information systems. Internal surveys, the web and academics were also given as means to source evidence required. All respondents reported using expert opinion, primary data and secondary data (Table 19). Knowledge of practice in other areas or countries and case studies were the least used of all examples given. Four respondents gave further examples of types of evidence they use, including specific reports, organisations and forums involving expert discussion. Respondents had different views on what sources and formats of data they considered most useful. Expert opinion and verbal and face-to-face meetings were considered the most useful format for evidence, and internal evidence was thought the most useful source of evidence, including from the Centre of Data and Information within the Ministry of Health.

Table 19 Types of evidence used to support work and decisionmaking in Indonesia

Evidence type	Informants reporting use (n)
Expert opinion	10
Knowledge of practice in other areas/countries	5
Primary data	10
Secondary data	10
Literature review	8
Case studies	7
Specialised databases	9
Other, please describe	Reports such as *Basic Health Research* (2) NGO and university partner (1); forum involving expert discussion and foreign speakers (1)

Respondents reported that they found it relatively easy to access evidence, referring to internal data resources, but commented on the difficulties in keeping this updated and in a common format to facilitate comparisons across divisions and geographical regions. Only one respondent reported having staff who could be used to search for relevant evidence. Others noted a lack of human resources and expertise in interpreting evidence.

When asked specifically about international evidence and comparisons, six out of 10 respondents could talk about examples of when they had specifically sought or used evidence from other countries or regions to inform their work (Table 20). Where respondents couldn't give specific examples they reported that evidence from other countries was potentially important but only as a base reference because Indonesia has a different health system from other countries.

Table 20 Countries Indonesia looked to for international evidence

Countries/regions looked to	Reasons for comparison (if stated)
Philippines	Similar characteristics to Indonesia (govt system, decentralisation)
Bangladesh	Very big population; similar economic conditions but faster progress to MDG targets
Vietnam	Perception that 10 years ago Indonesia was better than Vietnam for health status of children but now Vietnam better
Thailand (n=2)	Specific health insurance system
South Korea	To compare govt system
Malaysia (n=2)	Neighbouring country
Japan	
Australia	
China	Success in economic development

Table 20 shows that policymakers primarily looked at other countries in the region, based on similarity of government or health system, or because of the potential to learn from successes of other countries. There were two main methods for seeking international evidence: reviewing of published literature or case studies through country visits. Respondents valued written and verbal feedback. The main difficulties respondents reported in using evidence from other countries was how to adapt it to the local context.

4. Sources of evidence for policymakers

Respondents reported a range of sources of evidence that they used, which could be grouped into five main categories:

- internal government data centres, eg Data Centre within Ministry of Health
- universities, eg Universitas Indonesia, Universitas Gadjah Mada
- professional organisations, eg Indonesian Paediatrician Association, Indonesian Obstetrics and Gynaecology Association
- NGOs
- international organisations, eg WHO, UNICEF, Asia Development Bank.

Internal centres and sources were most likely to be used systematically. Universities were mentioned more in relation to obtaining expert opinion rather than seeking published research or commissioning to undertaking research. It was not clear to what extent external organisations were responsive to specific requests from policymakers. Respondents most commonly reported soliciting research from internal organisations.

5. Developing new mechanisms for policymakers

All 10 respondents thought it was a good idea for there to be a mechanism that could be responsive to policymakers' needs in Asia and the Pacific. Reasons included: ability to have regularly updated data and evidence; to allow international comparisons; and to enhance responsiveness and ability to provide specific evidence according to requirements. Several respondents added the caveat that it would have to have local relevance and applicability and adapt global evidence. Respondents reported that they did not have access to such a mechanism at an international level although felt there were parallels with the online system they used to source evidence internally, which could be used to source evidence from areas other than health.

When given the hypothetical example of sourcing evidence to inform decisionmaking around increasing the proportion of under 5 year olds receiving antibiotics for pneumonia, most respondents said they would want a response to evidence requests within three months (the maximum stated time was six months). It was commented that evidence provision should coincide with budget and planning cycles. All felt that the mechanism should be based or have representation in Indonesia. Several respondents reported that existing government data and information centres or planning bureaus would be suitable bases for a mechanism, although it was noted that an independent organisation may be more appropriate to prevent conflicts of interest among different potential users of the evidence; universities, including Gadjah Mada University (UGM) and University of Indonesia (UI) were given as examples. All respondents suggested that their organisations would be willing to contribute to a mechanism that provided financial, human or physical resources. A country membership fee was favoured as a funding mechanism as it was felt all countries should contribute, but respondents suggested that donor resources would be required in addition. All but one respondent favoured a 'membership model', where they were actively involved in the funding and management of a mechanism, over a 'customer model', which would involve requesting and buying specific pieces of evidence for their needs. Table 21 provides an overview of the characteristics respondents would like to see in a future mechanism.

Table 21 Preferences for a potential new mechanism in Indonesia

Respondent organisation	Would such a mechanism be helpful?	Client/member relationship	Preferred location	Contribution to resources	Timeframe	Funding arrangement	Type of evidence	Output types	Whether policymakers the capacity to use such a mechanism	Comment
1 Govt (national)	Yes	Membership relationship	Ministry of Health, Indonesia	Financial	Weeks	Country membership fee	Use of traditional non-healthcare workers to give medicine	Report, seminars, workshops	Not sure, have never been part of network or mechanism	Felt workshops would be a means to promote inter country collaboration
2 Govt (national)	Yes	Customer relationship	Ministry of Health, Indonesia	Financial	3 months	Funding from all departments within Ministry of Health	Data and evidence relevant to primary care, particularly at provincial and district levels	Research report, policy brief	Yes	Needs to be easily accessible for all units
3 Gov (national)	Yes, very useful	Membership relationship	National Institute for Health Research and Development, MoH, Indonesia	Not sure	<3 months	Country membership fee and contribution from Ministry of Health	Find out how other countries lower the maternal mortality ratio; funding allocation mechanisms	Presentations, policy briefs	Need more human resources	Felt that membership model would make govt have proactive role. Would need to be reasonably affordable and easy to access
4 Govt (national)	Yes	Membership relationship	National Institute for Health Research and Development, MoH, Indonesia	Yes, type not specified	To fit schedule of budget development	Country membership fee	How other countries have operated within budgetary constraint	Country experts, reports	Yes	Needs to be supported by law
5 Govt (national)	Yes	Membership relationship	National Bureau of Planning and Development, Indonesia	Yes, type not specified	1–2 months	Not clear	Evidence on relationship between urbanisation and RMNCH	Field visit reports	Not clear	Mechanism needs to be relevant and applicable for Indonesia
6 Govt (municipal)	Yes	Membership relationship	Ministry of Health, Indonesia	Financial, human resources	<6 months	Funding from MoH within budget, further funding from	Synchronisation of management information systems with	Research report, expert opinion	Yes	Outputs need to be in a form that is clear and understandable

						external institutions or donors	other agencies			
7 Govt (provincial)	Yes	Membership relationship	Regional planning development board, Indonesia	Human resources	-	External donor (subject to conflict of interest)	-	-	Yes but needs improvement	Believed funding from external agencies would be appropriate but would have to be aware of their agenda
8 Govt (municipal)	Yes, if applicable to local govt	Membership relationship	Ministry of Health	Financial, human resources, research capacity	3 months	Govt funding and donor funding	Evidence to support sound allocation of resources, synchronisation of planning at all levels of govt	Research reports, expert opinion	Not clear	Evidence should be in format that is understandable and user friendly
9 Govt (provincial)	Yes	Membership relationship	University (eg Gadjah Mada University or University of Indonesia)	Physical location, human resources, funding	1 month	Donor funding	Methods to improve coordination between many stakeholders in policymaking process	Annual report, expert opinion	Needs some improvement	Mechanism should be collaborative, composed together among all stakeholders
10 Govt (provincial)	Yes	Membership relationship	Independent organisation	Management	1 month	Govt funding and external donor funding	Innovation in data collection and surveillance	Research reports	Yes	Mechanism needs to bridge the interests of central and local govt

6. Institutional mapping

Table 22 provides a listing of institutions and relative strengths and weaknesses that were identified as institutions with RMNCH/health systems strength and potential for acting as a possible hub or part of possible future mechanism. Several of the institutes listed are already being routinely used as sources of evidence by policymakers in Indonesia, for example, the National Institute of Health Research, Centre of Health Service Management, Gadjah Mada University (UGM), Centre for Health Research, University of Indonesia (UI) and country offices of international organisations such as WHO, UNFPA and UNICEF. The table also demonstrates that several of the institutions are already members of regional networks. The assessment of strengths of the institutions by country partners shows common strengths across institutions in research quality and outputs but some variance in experience of interacting with policymakers and acting in a responsive capacity to policymakers. These areas of variation may be an important consideration when considering the best fit of institutes within a future mechanism.

Table 22 Mapping of institutions and relative strengths in Indonesia

Criteria	National Institute of Health Research and Development (NIHRD)	The SMERU Research Institute	Centre for Health Service Management, Gadjah Mada University	Centre for Health Research (CHRUI)	Indonesian Institute of Sciences (ISI/LIPI)	Save the Children, Indonesia	UNFPA, Indonesia	UNICEF, Indonesia	WHO, Indonesia
Research capacity									
Substantial research funding	++	++	+	++	++ ISI/LIPI has conducted a wide range of research, from health to zoology and environmental assessment; conducts various research at national and local scales	++	++	++	++
Quality outputs (eg international publications and conferences)	++ Has produced various national health research findings (Basic Health Research of 2010, Health Facility Research of 2011) Products are always used as source of raw data and reference for researchers nationally and internationally	++ Internal research publication is released annually; most research was presented in national or international seminars. SMERU was established in 1998, and has produced many research reports	++ Some products presented in national and international seminars and published in several peer-reviewed international and national journals. Not all research published	++ Has conducted various research at national and local scales. Most findings are necessity for informing policymakers to develop new policies or revise the current policies. Findings are disseminated in various accredited national and international journals, and presented in many conferences nationally and internationally	++ The findings are disseminated in various accredited national and international journals, and presented in many conferences at national and international level. ISI/LIPI also has an internal annual publication and national seminars on its research findings	+	+	++	++
Relevant disciplines represented among researchers (eg policy analysis, health services research,	++ NIHRD consists of multi-disciplinary researchers, in	+ SMERU has multi-disciplinary researchers, mostly from an	++ Multi-disciplinary researchers, including in public health, tropical	+ Researchers graduated from various fields of study including	++ Has more than 1,300 researchers, including in	++	++	++	++

public health)	medical sciences, pharmacy, public health, environmental health, complementary and alternative medicine, food and nutrition	economics background, some in health or nutrition, few in public health	medicine, anthropology, health economics and health financing, health management, nutrition and public policy, political sciences, clinical medicine	anthropology, sociology, public health, nutrition, medicine, law, economics, psychology and geography	biomedical research, social sciences, engineering, environmental research				
Significant proportion of staff with higher degrees or PhD	++ More than 60% of staff (researchers) have PhD	++	++ More than 60% of staff (researchers) have masters and PhD, part-time consultants and also medical specialists	+ 7 (25%) have PhD	- Approximately one-third of researchers have masters and PhD; from website, more recruitment for senior researcher is warranted	+	+	++	++
Stability of funding	++	++ Funding comes from donor agencies, never from govt agencies, mostly for medium-term (1–2 years) contract for research. Main donors include the World Bank (pro-poor research commencing in 1998), Social Protection in Asia (SPA), AusAID (ADRAs). Lead researcher said in interview there has never been a shortage in funding from donors. SMERU has also worked with the govt of Jakarta	++ Main source of funding is international donors with many mid and log-term funding from AusAID, IDRC, WHO, USAID	+ Funding from various sources, especially through bidding and non-bidding	++	+	+	+	+

		City, to assess the effectiveness of conditional cash-transfer programme in poor-urban setting. This was jointly funded by Jakarta govt and SMERU funds							
Other indicators of research quality	++	(none provided)	++ Long-term collaborations with donors, indicating satisfaction from clients	+ Set of data from studies is also used by other researchers from other institutions and universities	(None provided)	+	+	++	++
Experience in providing evidence for decisionmakers									
Nature of funding	++	++	++	++	++	++	++	++	++
Interaction with decisionmakers	++ Presenting the findings of research to the Minister of Health and other echelons within the Ministry of Health to inform them about findings of the certain research. Review on specific policies, such as the national health security system	- Solicitation mostly carried out through indirect communication: donor agencies would approach the related govt agency, and then contact SMERU to conduct the necessary research or evaluation study. In one instance, SMERU collaborated with the Ministry of Women Empowerment, and SMERU managed to raise its own funding	++ Presenting the findings of research to the Minister of Health, Bureau of Planning and Budgeting Close contact and collaboration with national and regional decisionmakers on health topics	+ Some research conducted based on request of decisionmakers	+ The Indonesian Institute of Science is part of the govt research institute ISI/LIPI has the authority to approve researchers at each R&D unit from every ministry and trains researchers from ministry R&D units	++	++	++	++
Ability to produce a range of external dissemination outputs and engage in related activities	++ National seminars, regional and international	++ Dissemination extensively through advocacy meetings with	++ National seminars, regional symposiums, international	++ Dissemination through national and international seminars and conferences	++ Seminars and conferences at national and international level	++	++	++	++

	symposiums, international seminars, conference, national and international accredited journals	related govt agencies, and was also invited by the Bappenas (National Bureau of Planning and Budgeting) to discuss the policy plan on pro-poor subsidy (2012, not yet published)	seminars, conferences, national and international journals						
Policy-targeted research	++ Giving input regularly to the Ministry of Health from the research findings	++	++ Review on specific policies, such as national insurance for delivery and neonatal services	+ Research includes review of policies	+ Some research involves review of policies	++	++	++	++
Research informing policymaking	++	++ Giving input to the Bureau of Planning and Budgeting through dissemination meeting and formal discussion (cash-transfer programme)	++ Giving input regularly to the Ministry of Health, provincial and district offices from research findings Assisting with development of legislation on hospitals	+ Some findings are important to the policymakers	- Not focused on influencing policy, more on scientific research	++	++	++	++
Short turnaround research as well as longer-term research programmes	++ Many small research activities are conducted by using longitudinal data from the result of national scale research. Longer-term research investigates basic health (2007, 2010 and 2013)	++	++ Several short-term research projects (of 3–6 months) requested by donors. Mostly longer-term projects	+	+ Large number of long- and short-term research projects	++	++	++	++
Producing research on basis of request from decision/policymakers	++ The research conducted is not	+ SMERU usually rarely responded	++ Examples include	++ Almost half the research activities are	- Not focused on this	+	+	++	++

	merely on what the govt needs but also on request, such as the human health development index	to research projects requested or funded by the govt, instead always through the solicitation of international donor agencies. But recently, some of its research projects were the product of joint collaboration with the govt of Indonesia (this includes the preparation of pro-poor policy with the Bureau of Planning and Budgeting, still in preparation phase)	Jampersal (health insurance for delivery and neonatal care), evaluation and development of national strategic plan for malaria and TB, both solicited by policymakers	based on request, especially from the WHO					
Supportive administration									
Procurement system that allows institution to enter into contracts with different funding organisations relatively easily	++ Collaboration with other international agencies, particularly in relation to funding, should follow the funding mechanism of the govt of Indonesia	++ Most research activities from various funding institutions are taken by bidding	++ Has a formal/legal acknowledgement that allows the institution to sign contracts with funding organisation, and has done so in the last 14 years	++ More than half of research activities are from competitive bidding	++ More than half research from competitive bidding	++	++	++	+
Access to IT, and internet support enabling access to databases and other sources of data conducive to producing high quality research and to	++ The institution is supported by high quality of IT with high speed broadband internet connection	++ 4 dedicated IT staff, 5 support staff to manage the external contracts and financing. Internet connection at	+ Supported by dedicated IT team and has internet support; no broad access to international journals yet	++ Office is facilitated with high speed broadband and IT experts	++ High speed broad band, IT experts, online publications	++	++	++	+

facilitating effective and rapid communication		SMERU office							
Networks and partnerships									
Evidence of participation in national, regional or global partnerships or networks	++ National research vaccine network, local health research network, Indonesian clinical epidemiology and evidence-based medicine, Indonesian public health association, universities WHO Collaborating Centre for Health Systems Research and Management, WHO Collaborating Centre for Prevention and Control of Micronutrient Malnutrion	++ Health Equity and Financial Protection in Asia (HEFPA), 2009–2013, involving 6 Asian countries, coordinated by Erasmus University	++ Part of Asia Network for Health System Strengthening; Human Resources for Health Knowledge Hub; Equitap; Indonesian Health Policy Network; Indonesian Health Care Quality Network (IHQN)	++ Partnerships: the National Family Planning Coordinating Board/BKKBN; the Ministries of Health, Population, Coordination of People's Welfare, Women's Affairs, Internal Affairs; the National Planning Board/Bappenas; the Central Bureau of Statistics (CBS) and other demographic institutes; BNN; BNP. International agencies that collaborated with the CHR-UI include: the Asian Development Bank (ADB), AusAID, AIDSCAP, Family Health International, HIV/AIDS prevention project/HAPP (ASA), Ford Foundation, JICA, Pathfinder International, Population Council, RAND Corp., UNDP, UNFPA, UNICEF, UNESCO, WHO, the World Bank, USAID, the Yamaha Foundation, JPHIEGO, PATH, JSI, Mercy Corps and HCPI	+ Not in specific networks, but has several international collaborations, including with University of Queensland; bilateral collaboration with Taiwan and national university collaborations	++	++	++	++
Evidence of active work and research	++ Further analysis		++ Started the national	++ All the research	+ In form of	++	++	++	++

produced within them	of the national health research has been conducted by researchers from universities and local health research institutions	journal on Indonesian health policy (recently); conducts online training on health policy research on national scale; published research papers on international peer-reviewed publication (*The Lancet*) within Equitap collaboration	activities in the CHRUI come from these networks	research papers, national seminar

Key: ++ Very strong: this is a leading institution within the country/internationally; + Strong in given area; - relatively weak in given area; -- weak in given area

Appendix VI Country case study: Nepal

Country lead:

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1. Profile of key informants

We conducted 10 interviews with key informants from government organisations, national NGOs, international development agencies and professional organisations. Interviewees were selected on the basis of their involvement in research and policymaking and their expertise in reproductive, MNCH. The time respondents had been in their current post varied from one month to 10 years. Table 23 shows the range of roles and responsibilities of key informants.

Table 23 Key informants in Nepal: post, time in current post and reported roles and responsibilities

Post	Time in current post	Primary role & responsibilities	Role in policymaking
Policy and Planning Division, Ministry of Health	17 months	Policymaking, international coordination, funding arrangements	Policymaking and planning
Family Health Division, Ministry of Health and Population	3 years	Programme planning, budgeting, monitoring and supervision	Providing technical support to the maternal and neonatal health programme
Joint Secretary, Social Development Section, National Planning Commission	Over 3 years	Facilitate social development sector-related policy formulation; implementation of the policies, and their monitoring and evaluation	Assist in drafting policy papers
Maternal and Child Health Advisor, Nepal Health Sector Support Programme	2 years	Programme planning, supervision and monitoring, capacity building of govt staff, providing programme support, working with donor agencies	Technical role
UNICEF Maternal and Neonatal Health Specialist	Over 3 years	Providing technical support to the govt	Reviewing country policies and plans on MNCH and providing expert advice to the govt in using new plans and policies
National programme officer, WHO	1 month	Skills development, technical support to Family Health Division, Nepal	Technical advice
Safe Motherhood Network Nepal	1 year	Awareness raising, policy advocacy	Advocate for and create awareness about safe motherhood and neo-natal health from policymakers to family level
Secretary, Nepal Society of Obstetricians and Gynecologists	1 year	Organisational profile raising, participation in research and policy advocacy	Guideline development, advocacy of policy changes
Executive chairman, Nepal Health Research Council	Over 3 years	Regulating health research, conducting research	Providing evidence to policymakers generated by self and others

Director, Development Resource Centre	10 years	Coordination of administration, development of research proposals, management of field research activities and communication with Executive Board members	Conduct research and provide recommendations for revision of govt health policy

2. RMNCH policymaking in Nepal

RMNCH policymaking in Nepal is under the remit of the Ministry of Health and Population. Within this ministry, the Department of Health Services is responsible for implementation of policies and the Family Health Division of this Department also contributes, providing evidence and using it to develop new strategies and policies for RMNCH. Local NGOs and professional organisations contribute to policy development and advocate changes in practice, while INGOs and other EDPs such as WHO and UNICEF bring international research and best practice models from other countries and provide expert guidance, technical advice and support in implementing new policies and collecting evidence. One respondent mentioned that research institutions may also be involved in providing evidence for policymaking.

Specific challenges relating to conditions or interventions within RNMCH were noted as uterine prolapse, pre-eclampsia, providing comprehensive emergency obstetric care to pregnant women in remote districts and providing mass awareness campaigns. Poverty and hunger were also cited as being two of the main problems leading to poor maternal and child health. Two respondents also commented that one system problem was a poor referral system at a local level, in part due to difficult terrain. Further challenges came from political instability, political bureaucracy and a lack of commitment and funding from government for new initiatives, programme implementation or research.

A few respondents independently mentioned that lack of some types of evidence was a challenge for policymaking. Studies on the cost and efficiency of certain interventions were mentioned as an area of particular need; health systems research was another. It was highlighted that although research is conducted in Nepal, evidence is not collected systematically, which can lead to duplication of efforts. In addition there is no mechanism for monitoring the quality of research or for presenting evidence to decisionmakers. Respondents had mixed opinions on the need for further evidence. Two felt there was enough evidence, others commented that there was a need for further or more up-to-date evidence in particular areas; others thought that more organisation and systematic use of evidence was needed.

3. Use of evidence in policymaking

All respondents stated that evidence is very important to inform policy development and decisionmaking. One commented "Evidence is like a food for life to the policymakers like us." Particular examples included the use of evidence to map the needs of the population and different population groups, to understand local issues and to convince the government and the population of the need for new policies.

Respondents reported that they identified evidence through international organisations such as the WHO, UNICEF and Jhpiego. Others reported finding evidence online, and through international journals. Other methods of information sharing were meetings and conferences, and through experts. Some respondents reported that they conduct primary data collection or derive information from government health organisations or national surveys.

Table 24 Types of evidence used to support work and decisionmaking in Nepal

Evidence type	Informants reporting use (n)
Expert opinion	10
Knowledge of practice in other areas/countries	10
Primary data	10
Secondary data	10
Literature review	10
Case studies	8
Specialised databases	3
Other, please describe	-

As shown in Table 24, all of the 10 respondents reported using a wide range of types of evidence in their work developing policies or making decisions. They emphasised that the best form of evidence for them came from within Nepal, demonstrating local needs and from a local context. There was concern that evidence should have been recently updated. Respondents also reported making use of international guidelines that had already been used in other developing countries, and best practice examples from other South Asian countries. In some cases these had to be interpreted to understand the feasibility of programme application to the local context. Some individuals stated that they would use government studies, or studies from independent, trustworthy organisations.

Participants most commonly felt that face-to-face discussions were the most helpful format for research output to be used by policymakers, allowing them to seek clarification of any concerns. It was highlighted that policymakers, particularly those who are older, may not always be comfortable searching for information online. Three respondents felt that policy briefs were a useful format. It was commented that written documents such as papers were useful to achieve wider dissemination. More than one respondent commented that all formats were useful, but for different purposes, depending on the target audience.

The most common barrier cited to the use of evidence was that of time constraints. Other barriers included the availability of good-quality, up-to-date evidence. This was thought to be due to low research capacity and funding availability, lack of access to online documents and journal papers, and poor organisation of the evidence which was available. Lack of motivation among policymakers to use evidence and not understanding how to use it was also mentioned.

Interviewees said that evidence from neighbouring countries where the context was similar was very useful for their work and could save time and resources locally. Evidence from other countries was used as a basis for developing similar programmes in Nepal, although it was recognised that it was important to understand the country context from which the evidence was derived; unless countries were very similar, such programmes would need to be adapted to the local context. This was sometimes done by piloting interventions based on international evidence in Nepal, before full roll-out. International evidence could also be used as a baseline to develop similar within-country evidence. Policymakers in Nepal also use guidelines developed by international organisations such as the WHO.

Evidence was most often used from other countries in the South East Asia region or by members of the SAARC. Respondents also mentioned using evidence from neighbouring countries and other developing countries; those commenting on individual countries cited Bangladesh India, Indonesia and Sri Lanka as the countries from which evidence was most frequently used, with some use of evidence from Pakistan and Thailand.

The most frequent formats for international evidence used were systematic reviews, academic papers and verbal communication from individual experts or through meetings. Respondents also made use of written reports, policy briefs and WHO guidelines.

Suggestions to improve the usefulness of international evidence included better access to the full text of reports and articles, better publication and hence sharing of research evidence, further discussion with policymakers in the country from which the evidence was derived to collect the views of experts working in the country, and further discussion with policymakers and managers within Nepal to make use of evidence.

4. Sources of evidence for policymakers

Respondents reported using a range of sources of evidence, which could be grouped into five main categories:

- government organisations, eg Department of Health Services, CBS
- international organisations, eg WHO, UNICEF, Save the Children
- NGOs, eg NewERA, Development Resource Centre
- the Nepal Health Research Council (NHRC)
- international literature, eg the *Lancet*, Cochrane reviews, Pubmed.

In general sources used were believed to be of high quality and those working in them had a good relationship with policymakers. Some sources were difficult to access as content was not free, for example access to journal articles through Pubmed.

Table 25 summarises the research capacity of some research institutions in Nepal.

Table 25 Mapping of research institutions in Nepal

Criteria	Possible supporting evidence	Family Health Division, DoHS, MOHP, Nepal	Nepal Health Sector Support Programme	Development Resource Centre	Nepal Society for Obstetricians and Gynecologists	Ministry of Health and Population (Policy and Planning Division)	UNICEF Nepal	WHO Nepal	National Planning Commission
Strong research capacity	Evidence of:								
	substantial research funding	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)
	quality outputs (eg international publications and conferences)	Strong (+)	Strong (+)	Strong (+)	Weak (-)	Weak (-)	Strong (+)	Strong (+)	Weak (-)
	relevant disciplines represented among researchers (eg policy analysis, health services research, public health)	Weak (-)	Strong (+)	Strong (+)	Weak (-)	Strong (+)	Strong (+)	Strong (+)	Weak (-)
	significant proportion of staff with higher degrees or PhD	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Weak (-)
	stability of funding	Strong (+)	Strong (+)	Weak (-)	Weak (-)	Strong (+)	Strong (+)	Strong (+)	Strong (+)
	organisational base up to the local level	Very strong (++)	Strong (+)	Very strong (++)	Strong (+)	Strong (+)	Strong (+)	Weak (-)	Weak (-)
Experience in providing evidence for decisionmakers	Evidence of :								
	nature of funding	Weak (-)	Weak (-)	Weak (-)	Weak (-)	Strong (+)	Strong (+)	Strong (+)	Strong (+)

	interaction with decisionmakers	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)
	ability to produce a range of external dissemination outputs and engage in related activities	Weak (-)	Weak (-)	Strong (+)	Weak (-)	Strong (+)	Strong (+)	Strong (+)	Weak (-)
	policy-targeted research	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Weak (-)
	research informing policymaking	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Strong (+)	Weak (-)
Ability to provide evidence in a responsive mode	Evidence of:								
	short turnaround research as well as longer-term research programmes	Weak (-)	Weak (-)	Strong (+)	Weak (-)	Weak (-)	Weak (-)	Weak (-)	Weak (-)
	producing research on basis of request from decision/policymakers	Weak (-)	Weak (-)	Strong (+)	Weak (-)	Weak (-)	Weak (-)	Weak (-)	Weak (-)
Supportive administration	Evidence of								
	procurement system that allows institution to enter into contracts with different funding organisations relatively easily	Very strong (++)	Strong (+)	Strong (+)	Weak (-)	Strong (+)	Strong (+)	Strong (+)	Weak (-)

	access to IT, and internet support enabling access to databases and other sources of data conducive to producing high quality research and to facilitating effective and rapid communication	Strong (+)	Strong (+)	Strong (+)	Weak (-)	Weak (-)	Strong (+)	Strong (+)	Weak (-)
Partnerships and networks	Evidence of participation in national, regional or global partnerships or networks	Weak (-)	Weak (-)	Weak (-)	Strong (+) organises national and international conference	Strong (+)	Strong (+)	Strong (+)	Weak (-)

5. Developing new mechanisms for policymakers

All respondents felt that a mechanism for policymakers could be useful, suggesting that such a mechanism could act as a forum for discussion of policy issues and sharing of evidence and experience. They thought broad types of evidence were needed; several respondents reported that there was a need for cost evidence and best practice examples from other countries. Others commented that it would be useful to find out about the feasibility of implementation of programmes in other countries, challenges faced during implementation and outcomes data (Table 26).

All respondents who felt able to comment suggested that a membership relationship would be preferable to a client relationship, as this would increase the legitimacy and ownership of the programme. To increase ownership, some thought that a mechanism should be located within a government body, with support from outside institutions. Others disagreed, suggesting that a new mechanism should be based outside government, so it remained impartial, transparent and uninfluenced by politics.

Most respondents said that a mechanism should be based in Nepal, as a country which is doing well in its progression towards achieving the MDGs and reducing the maternal mortality rate. It was also stated that Nepal has a high level of acceptance of new policies and plans, and is ahead in the use of evidence compared with other countries in the South Asia region. Others mentioned the benefits that Nepal would accrue from having the mechanism located in their country, including having easy access to it, and better evidence access for university students.

Respondents suggested that some contribution to the funding should come from government, along with support from NGOs and EDPs. Many organisations within and outside the government were willing to contribute human resources and research expertise, and it was suggested that WHO and UN institutions should provide financial and technical support.

Table 26 Preferences for a potential new mechanism in Nepal

Respondent organisation	Would such a mechanism be helpful?	Client/member relationship	Preferred location	Contribution to resources	Ideal timeframe for requesting evidence	Funding arrangement	Type of evidence	Output types	Whether policymakers the capacity to use such a mechanism	Comment
1 Govt	Yes, a forum would be useful to discuss policy-related issues	Membership	Within a govt institution, in a country which can take a lead and provide evidence	Family Health Division can provide evidence; human resources, research capacity	1 week	Part of the funding should come from govt	Cost-effectiveness evidence, eg cost of vaccines and treatments, and outcomes	Expert opinion, regional workshop, annual meeting	"I believe so"	A long-term project should be planned
2 UNICEF	Useful for all policymakers.	Membership	Within a govt body	UNICEF can provide evidence, expert advice, research capacity, human resources, financial resources	Depends on nature of the evidence	Contributions from external donors, govt, research institutions, international organisations	Evidence on how to improve referral arrangements	Expert opinion, regional workshop, policy briefing, online report, journal	Yes, although some level of orientation may be needed	
3 Govt	Yes, if well implemented based on country's needs	Membership	Outside govt to be more transparent and less political. Nepal would be a good base	MOHP can provide evidence and information related to policy work	1 week, but depends on timeline of the study	20–25% contributed from the govt, remainder from EDPs and partner organisations	Feasibility studies in different countries; cost-effectiveness studies	Research report, policy brief, expert opinion	Yes, although some level of orientation may be needed	

4 WHO	Yes, to get answers for policy needs	Membership	-	WHO team can provide evidence and technical guidance, research capacity, human resources	-	Some from the govt; remainder from partner organisations and EDPs	-	-	Yes, particularly if some training is provided	Most policymakers are not very internet friendly, so other approaches will be needed
5 Development Resource Centre	Yes, to collect together evidence	-	Managed by NGOs, under leadership of Family Health Division, Nepal govt	Development Resource Centre can contribute human resources and research capacity	1 week	Nepal govt should contribute, remainder from UN and WHO	Best practice, challenges they faced while implementing projects	Expert opinion, policy brief, verbal briefing	Yes	
6 Nepal Health Research Council	Yes, help exchange of evidence, innovations and interventions.	Membership	Govt ministry, but managed jointly by health research council and policy of planning division		6–9 months	Contribution from national institutions; also support from external donors	Best practices in management of common problems. How to use the evidence	Research reports, policy briefs	-	Need to consider local realities such as resource constraints, political situation
7 Nepal Health Sector Support Programme	Yes	-	Govt, with assistance from other institutions. Could be based in Nepal	NHSSP can provide research capacity, but no funding. Can provide research-related support	1 week	-	Cost , efficiency, feasibility studies, behaviour change studies, studies of service quality	Policy briefing paper, expert opinion, regional workshops, international conferences	NHSSP could provide some research-related support	It would be useful to be able to access online journals free of cost. International commitment and cooperation

										are important to implement long-term interventions
8 Nepal Society for Obstetrician and Gynecologists	Depends on size of mechanism	Should be funded by external partners	Independent organisation in Nepal with research expertise	NPSOG can provide human resources and research expertise	Less than 2 weeks	Should be funded by external partners, such as PSI, IPAS, UNFPA	Best practices and different aspects of policy and project implementation	Expert opinion, policy brief, workshop, training, conferences	-	
9 Govt – National Planning Commission	Useful for resource and evidence sharing	Membership	CBS and Ministry of Health in Nepal	National Planning Commission has no capacity to contribute resources	2 months	Govt membership fee, with additional contribution from EDPs	How to fight poverty, under-nutrition and associated RMNCH problems	Policy brief, research report, expert technical assistance	Very few people who could make the best use of such a mechanism	A mechanism should be based regionally and focus on strengthening human resources for future research and policy review
10 Safe Motherhood Network Federation, Nepal	Yes, for up-to-date information	-	Ministry of Health, Nepal	SMNF could provide research expertise and human resources	15 days	Should be funded by a partner organisation	Best practices, assessment study, cost study	Policy brief	Yes, if given training	A dedicated team is required for sustainable use of the mechanism