Health Policy Analysis Institutes: Landscaping and Learning from Experience

Final Report

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Executive Summary

Introduction and rationale

Health policy analysis institutes (HPAIs) provide health policy research, analysis and public engagement so as to inform the development of health policy. In this study we understood a health policy analysis institute to:-

- Have the overall *purpose* of supporting health policy development and implementation through analysis and research
- Perform at least two of the following *functions*:-
    - Conducting policy-relevant research and analysis
    - Providing policy advice and technical assistance in policy formulation and evaluation
    - Conducting policy dialogues or fora at national and international levels, that is bringing together policy makers, civil society, and researchers to draw upon evidence and debate key policy questions
    - Training and capacity development for policy-makers
- Take any one of multiple *organizational forms*, but possess some degree of autonomy, and not be profit oriented
- Have health policymakers as its primary *clients* although also serve secondary clients such as civil society organizations and senior managers within the health system.

Aims and Objectives

This study aimed to:-

- ***Landscape -*** Map existing health policy analysis institutes in low and middle income countries so as to better understand the number and nature of existing institutions.
- ***Learn Lessons-*** Analyze (i) the different organizational structures (ii) the functions performed by health policy analysis institutes and (iii) the form and nature of donor support provided, so as to derive lessons about the factors that contribute to the effectiveness and sustainability of health policy analysis institutes in low and middle income countries.
- ***Advise*** – Make practical recommendations to the Rockefeller Foundation and the global health community about how best to support the development of health policy analysis institutes in low and middle income countries.

Methods

The study was comprised of three main components, namely:-

- A review of existing literature relating to think tanks and policy analysis institutes in general, as very limited literature was found that was specific to health policy analysis institutes;
- The development and analysis of a database containing basic data on health policy analysis institutes in low and middle income countries
- A series of six case studies of health policy analysis institutes in low and middle income countries.

Case study institutes were selected using the diverse case technique (Gerring 2007) that is we sought to identify cases that were diverse in terms of their organizational forms, specifically including NGO, university and government ownership; and to identify cases from different country situations, with a focus on Asia and Africa. Six case study institutes were selected, as shown in the table.

	Africa	Asia
NGO health-specific	Centre for Health and Social Services (CHeSS), Ghana (7)	The Institute of Health Systems (IHS), India (17)
Government organization	Health Policy Analysis Unit (HPAU), Ministry of Health, Uganda (13)	Health Strategy and Policy Institute (HSPI),Vietnam (17)
University based institution	Health Economics Unit (HEU), University of Cape Town, South Africa (15)	Health Economics Institute (HEI), Bangladesh (13)

Findings

Literature review
The literature on think tanks and policy analysis institutes suggests that a number of problems may arise with "in-house" policy analysis (Nathan Associates 2004): civil servants may lack independence, being heavily swayed by what the Minister wants to hear rather than what is truly the case; government officials may be short-termist in outlook, too focused on fighting fires to step back and see the broader picture; practical concerns centre on the poor quality of in-house analytical work due to a lack of capacity or lack of incentives for high quality analysis; and civil service structures may be stagnant leading to a search for "fresh thinking" outside of government.

While there is a sizeable body of literature on think tanks in low and middle income countries, none of this specifically addresses the role of sector-specific think tanks, such as health policy analysis institutes.

Database of Health Policy Analysis Institutes
A total of 78 health policy analysis institutes in low and middle income countries was identified, of which 38 were in Asia and 21 in Africa. Over 80% of these institutes have been established since 1990. In terms of institute ownership, the largest proportion (46%) were NGOs, 29% were attached to universities, and 20% were government bodies. A large majority of the institutes were involved in conducting policy relevant research and analysis, and providing policy advice to government. Fewer were involved in policy maker training, and conducting policy dialogues.

Case studies
With the exception of CHeSS, Ghana all of the institutes have been established for at least ten years. Since their establishment, their evolutionary paths have diverged. The Health Economics Unit (HEU), South Africa continues to operate on a relatively small scale, but has weathered substantial volatility in the health policy environment and has become a highly respected research institute providing evidence-based health policy advice to national and state governments. The HSPI, Vietnam is far less well known internationally but appears to be an effective and well-respected player domestically, informing national policy debates within Vietnam. Further it has managed to establish a broad funding portfolio and relatively large and stable staffing base. The fortunes of the Institute for Health Systems (IHS) in Hyderabad, India have varied. Both the institutes in Bangladesh and Uganda received substantial core budgetary support from donors at start-up and for a period of five years thereafter. However when these initial grants ended, the institutes found it difficult to find alternative funding sources to replace them. Both institutes have since contracted significantly in terms of staffing, volume of work and budget. CHeSS, Ghana is too young to yet determine what kind of evolutionary path it might follow.

Funding - there are substantial differences in terms of the funding profiles of the case study institutions, though most of them function on substantially less than US$1 million per annum. Funding levels at the HEI, Bangladesh and the HPAU, Uganda are such that concerned stakeholders recognize that these institutes are no longer viable in their current form. While the level of funding for all of the other

institutes studies looks healthier, nonetheless many were perceived by both internal and external stakeholders to be financially vulnerable. For example the HEU, South Africa is extremely reliant upon soft funding (80% of total funding). The IHS, India faces a similarly vulnerable situation. Of the institutes studied the HSPI, Vietnam has perhaps the most secure funding situation. It receives substantial funding from the MoH (about 60% of total revenues) which fully covers all basic salary costs. Some of the institutes appear largely dependent on shorter term projects funded by development partners for their main revenues. As such their research portfolio is largely driven by funders.

Staffing - with the exception of CHeSS in Ghana, all of the institutes studied relied primarily on in-house research staff, though sometimes these were supplemented by external consultants to fill particular gaps. Issues of how to identify, attract and retain well qualified staff were perceived to be challenges particularly for the HEU, South Africa and the IHS, India. Difficulties in recruiting and retaining staff are most acute for senior staff due to a short supply, low salaries compared to other opportunities and sometimes very heavy workloads.

Mission and functions - there was considerable consistency in the mission and functions of the institutes. Every institution was actively involved in the provision of policy advice, and almost all (with the exception of the Ugandan HPAU) also undertook policy relevant research. The two university institutes and IHS, India were most actively engaged in training and capacity development for policy and decision makers. Case study institutes have been less active with respect to their convening role, and indeed this was not a prominent feature of the mission statement of most institutes studied.

Policy influence - according to informants both HSPI, Vietnam and HEU, South Africa have made major contributions to policy development in their respective countries, and IHS also seems to have contributed at state and national levels. CHeSS was too newly developed for any such contributions to have been made, although informants felt that it has the potential to do so. At the HEI in Bangladesh and the HPAU in Uganda, any influence that the institutes once had, has now evaporated with diminished budgets. Respondents in Uganda pointed to several instances where opportunities to draw in domestic research evidence had been missed, due to the lack of an effective policy analysis institute. Personal links between institute members and policy makers were found to play a critical role in fostering trust and influence

Capacity development - The HEI in Bangladesh was perhaps the only institute to have benefitted from a planned and funded capacity development program. While internal capacity development was a key focus of the HEU, South Africa, neither it, nor any of the case study institutes have conducted serious organizational capacity assessments or developed comprehensive capacity development plans.

Conclusions

The study has demonstrated the considerable growth in specialized health policy analysis institutes in low and middle income countries over the past twenty years: while we identified 78 such institutions in LMICs, this probably considerably understates the number of such institutions, given the data sources we were dependent upon. From the case studies undertaken there is also evidence, that under the right conditions health policy analysis institutes can play a very positive role in promoting evidence-informed decision making in government. Certainly the case studies identified many instances where the HPAIs provided high quality, policy-relevant analysis that informed policy development and most probably led to stronger policies and better outcomes than would have otherwise been the case. The case studies however also demonstrate the fragility of many HPAIs (even the most successful), and the fact that even with relatively significant donor support during start up phases, some HPAIs ultimately fail.

The study identified a number of factors influencing the successful development of HPAIS including:-

- The development of a culture of evidence-informed policy making is perhaps the most important single factor influencing successful HPAI development, specifically demand from government for independent analysis is key;
- The establishment of a degree of autonomy – although a completely arms length relationship with key decision makers may be neither desirable nor feasible, establishing a degree of autonomy and buffers between an institute and the MOH is critical;
- Well networked and highly respected leaders are critical asset to HPAIs, however excessive reliance on a single charismatic or influential leader can lead to problems of its own;
- Funding is a critical challenge for many HPAIs, organizational strategies to develop a funding base which is (i) diverse (ii) provides some degree of flexibility and (iii) is not spread across too many small projects are important.

Recommendations

Recommendations are targeted at potential funders of HPAIs (including government), and also at stakeholders within HPAIs whether they are staff or board members.

Key recommendations for potential funders of HPAIs are as follows:-

1. Invest more in measures that support the development of a culture of evidence-informed policy;
2. Prioritize donor support to existing institutes as they hold a better chance of success; when investing in HPAIs respect country ownership and ensure appropriate engagement of stakeholders;
3. Avoid embedding HPAIs within Ministries of Health, while proximity is important for policy influence, there needs to be some degree of distance and mechanisms to protect the neutrality and autonomy of the HPAI;
4. Support HPAIs through the provision of longer term, flexible funding that can free the HPAI to develop an agenda which, while responsive to domestic policy needs, can also be innovative and forward thinking;
5. Support strategic thinking for organizational development of HPAIs, potentially through the adaptation and application of tools already developed by “The Think Tank Initiative”.

Key recommendations for leaders of HPAIs include:-

6. Develop plans and funding strategies for HPAI long term capacity development and organizational development, focusing in particular on support for HPAIs’ leadership and senior staff.
7. Seek to broaden and institutionalize relationships with the MOH and other policy making organizations so that relationships do not depend on the personal relationships of a few key institute leaders
8. Experiment with different strategies to develop HPAI’s convening role.

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In each of the six countries we would like to thank the staff of the health policy analysis institutes studied for their time and interest in this work, and willingness to subject their own organizations to outside scrutiny. In addition policy makers and other stakeholders in these countries very kindly gave of their time to be interviewed.

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List of Acronyms

CHeSS	Centre for Health and Social Services, Ghana
DFID	Department for International Development, UK
HEI	Health Economics Institute, Bangladesh
HEU	Health Economics Unit, South Africa
HPAI	Health policy analysis institute
HPAU	Health Policy Analysis Unit, Uganda
HSPI	Health Strategy and Policy Institute, Vietnam
IHS	Institute for Health Systems
LSHTM	London School of Hygiene and Tropical Medicine
MOHFW	Ministry of Health and Family Welfare, Bangladesh
Sida	Swedish International Development Cooperation Agency
TA	Technical Assistance

1. Background

The importance of strong health policies and systems to the achievement of global health goals has recently been widely recognized. However the health systems of many low and middle income countries are challenged through a lack of a sustainable financing base, shortages and maldistribution of health workforce, private sector actors that may detract from rather than contribute to health goals and a multitude of, frequently poorly coordinated, development partners. In recent months there has been a concerted effort to address these challenges, with multiple global initiatives[1] being launched. However investments under these various initiatives may be jeopardized if there is not strong in-country capacity to direct spending, guide implementation, and monitor and evaluate investments. The World Bank among other agencies is scaling up its own technical assistance (TA) capacity, but external TA is an expensive and not necessarily high quality solution; it cannot replace the need for sustained domestic capacity to analyse health policy issues, evaluate health systems strengthening strategies and advise policy makers.

In this context the Rockefeller Foundation has been considering how best to target its own investment to support the development of domestic capacity for health policy and systems analysis and national policy formulation. Capacity is often conceptualized at three different levels: the individual level, the organizational level, and the broader institutional or environmental level. While historically many capacity development initiatives have focused on developing individual skills, without supportive organizational (and broader institutional) contexts trained individuals may have neither the opportunity nor motivation to employ their skills.

This paper focuses on the organizational level, and on one particular type of organization involved in health policy development and implementation – namely health policy analysis institutes.

2. What is a Health Policy Analysis Institute?

Like think tanks, policy analysis institutes take multiple forms and are difficult to define. Different labels have been used to describe them - think tanks, policy analysis institutes, policy research groups, learning platforms and observatories.

A number of taxonomies of think tanks have been developed: by and large these focus on the structure of the think tank (particularly its degree of independence) and the mission or strategy of the think tank (particularly the extent to which it pursues a clear set of political values or ideology) (Ladi 2005). However most of the definitions and typologies are frustratingly vague. Perhaps the clearest definition is provided by McGann (2007) who states that:

> “Think tanks are public policy research, analysis and engagement institutes that generate policy oriented research, analysis and advice on domestic and international issues that enable policymakers and the public to make informed decision about public policy issues. Think tanks may be affiliates or independent institutions and are structured as permanent bodies, not ad hoc commissions.”

[1] Including, the International Health Partnership (UK and other partners), the Catalytic Initiative (Canada), the Norwegian government support to the Results-based Financing Initiative, and Providing for Health (France and Germany), as well as financing dedicated for health systems under the Global Fund to Fight AIDS, TB and Malaria and GAVI.

This study adopted a somewhat tighter definition based on the purpose, functions, organization and clients of a health policy analysis institute. Specifically, a health policy analysis institute was understood to:-

- Have the overall *purpose* of supporting health policy development and implementation through analysis and research
- Perform at least two of the following *functions*:-
  - Conducting policy-relevant research and analysis
  - Providing policy advice and technical assistance in policy formulation and evaluation
  - Conducting policy dialogues at national and international levels, that is bringing together policy makers, civil society, and researchers to draw upon evidence and discuss key policy questions
  - Training and capacity development for policy-makers
- Take any one of multiple *organizational forms*, but possess some degree of autonomy, and not be profit oriented.
- Have health policymakers as its primary *clients* although also serve secondary clients such as civil society organizations (including service providers and advocacy groups) and senior managers within the health system.

Thus, health policy analysis institutes could range from being a standalone unit within a Ministry of Health, to being embedded in a university, or being an entirely separate private, non-profit organization. In cases where the health policy analysis institute was embedded within a Ministry of Health or University, we looked for the presence of mechanisms to protect its autonomy such as it having its own board, or institutional strategy or funding arrangements.

3. Purpose and Objectives

This study aimed to review evidence from and experience with health policy analysis institutes in low and middle income countries, with the aim of informing the Rockefeller Foundation's health systems capacity development strategy, and the strategy of other partners interested in capacity development for policy analysis.

Specifically the study aimed to:-

- ***Landscape -*** Map existing health policy analysis institutes in low and middle income countries so as to better understand the number and nature of existing institutions.
- ***Learn Lessons-*** Analyze (i) the different organizational structures (ii) the functions performed by health policy analysis institutes and (iii) the form and nature of donor support provided, so as to derive lessons about the factors that contribute to the effectiveness and sustainability of health policy analysis institutes in low and middle income countries.
- ***Advise*** – Make practical recommendations to the Rockefeller Foundation and the global health community about how best to support the development of health policy analysis institutes in low and middle income countries.

4. Methods

The study was comprised of three main components, namely:-

- A review of existing literature relating to think tanks and policy analysis institutes in general, as very limited literature was found that was specific to health policy analysis institutes;

- The development and analysis of a database containing basic data on health policy analysis institutes in low and middle income countries
- A series of six case studies of health policy analysis institutes in low and middle income countries.

4.1 Literature Review

A literature review on think tanks, observatories and theories concerning appropriate organizational mechanisms for promoting evidence-informed policy and social policy reform was conducted. Given the broad swathe of topics of interest, the review was inductive in nature. Articles from early searches were reviewed by both researchers and this was used to refine search terms and assist in future searches. In addition the review built upon two recent reviews: McGann 2006 that considered think tanks in low and middle income countries; and Healy et al 2007 that considered mechanisms for the provision of information and analysis to health policy makers with a particular focus on Asia.

The following electronic databases were searched: ABI/Inform Global (up to June 2009); EconLIT (1969 to March 2009); Public Affairs Information Service (PAIS International) (up to June 2009); PubMed (up to August 2009); Sociological Abstracts (up to June 2009); SSRN (Social Science Research Network) (to March 2009); and Wiley InterScience Search (up to June 2009). In addition, Google and Google Scholar were used to identify additional grey literature sources. See Annex 1 for a full list of search terms by database.

The searches included a combination of "health policy analysis institutes", "think tanks" and "health policy organizations." Reference lists of relevant studies were also searched. Technical reports and books were included in the review. While initially the searches focused on health policy analysis institutes, it was quickly found that there was a very limited literature on this topic. Accordingly search strategies were broadened so as not to restrict the search to publications in the health sphere but rather articles were sought which provided a broad understanding of policy analysis institutes, particularly those in low and middle income countries. The literature review focused in particular on the three themes addressed by the study, namely:-

- Appropriate organizational structures for policy analysis institutes, in particular issues around their independence and neutrality, and how appropriate organizational structures relate to contextual issues and also what are the institutional arrangements that might accord independence and sustainability to these institutes in the long run;
- Functions typically performed by policy analysis institutes;
- Donor support to policy analysis institutes including effective strategies for capacity development, and sustainability.

4.2 Database of Health Policy Analysis Institutes

The database of health policy analysis institutes was compiled through searching the following databases:-

- Alliance for Health Policy and Systems Research partners database (available on request from the Alliance)
- Global Development Network list of organizations (featured under "partners" tab on the GDN website)
- List of health "organizations" on the Eldis website.

In addition to these databases we searched (i) the websites of relevant regional networks (such as Equinet and the Asia Pacific Health Economics Network) and (ii) applicants to relevant calls of the Alliance for

Health Policy and Systems Research. In addition individuals who were well informed about the organizations working on health policy issues in low and middle income countries were also approached and asked to review emerging lists. Criteria for inclusion in the database were (i) the organization matched the definition of a health policy analysis institute presented above (ii) the organization was located in a low or middle income country.

Where available, basic data on the institution (mission, functions, year established, country of location, web address, organizational form) were extracted from web sources (primarily the institution's own website) and included in the database.

4.3 Case studies

The case study methodology was selected as it provides a structured approach to studying complex causal relationships through the in-depth study of a limited number of cases. It is an appropriate research method where multiple related factors are of interest and the relationship between them is not clear and may evolve over time.

Cases were selected using the diverse case technique (Gerring 2007, pp97), that is we sought to identify cases that were diverse in terms of their organizational forms, specifically including NGO, University and government ownership; and to identify cases from different country situations, with a focus on Asia and Africa. In addition to these criteria we required that all case study institutes be (i) established for a minimum of 5 years (in order to be able to document their history and experience) and (ii) have an explicit focus on the health sector (rather than being multi-sectoral think tanks that included health as one of the sectors addressed). Institutes within the database that met these criteria were classified by their form of ownership and selected so as to ensure a balanced regional representation.

Table 1 shows the institutes selected for case studies. The number in parentheses in each cell shows the number of interviews conducted as part of the case study. Unfortunately the institute finally selected in Ghana had been established for less than five years, however attempts to study other institutes in Ghana ultimately failed, and led the research team to select the Centre for Health and Social Services (CHeSS) instead. In addition to the six case studies conducted, the discussion and lessons in this report also draw upon two previous publications that describe the experiences of the International Health Policy Programme, Thailand (Pitayaransarit and Tangcharoensathien 2009; Pitayaransarit and Tangcharoensathien 2007).

Table 1 – Institutes selected for case studies

	Africa	Asia
NGO health-specific	Centre for Health and Social Services (CHeSS), Ghana (7)	The Institute of Health Systems (HIS), India (17)
Government organization	Health Policy Analysis Unit (HPAU), Ministry of Health, Uganda (13)	Health Strategy and Policy Institute (HSPI),Vietnam (17)
University based institution	Health Economics Unit (HEU), University of Cape Town, South Africa (15)	Health Economics Institute (HEI), Bangladesh (13)

Each of the case studies was conducted by a researcher from the country or region concerned, who was familiar with the institute but was not a member of it. The main data sources used in the case studies were the following:-

- Document review including published material from the institute itself (website, research publications, annual reports, published strategies and plans etc) and from other sources, as well as unpublished material (such as donor agreements).
- Financial information
- Key informant interviews – semi-structured interviews with a variety of purposively selected individuals who have different types of engagement with the institute, including founders of the institute, staff members, funders, members of the institute board and clients of the institute including policy makers and civil society. The overall interview guide is attached as Appendix 2.
- Discussion of draft report with staff members of the institute

For each case study a database of evidence was compiled that included data from the various sources identified above, such as electronic versions of reports, transcripts from interviews, and a record of the final meeting with institute staff. In some countries detailed notes were taken during the interview and then elaborated subsequently. In other countries, interviews were taped and verbatim transcripts of the interviews were made. Analysis was conducted first by the individual country research teams which developed reports specific to each country. The general study team then drew upon the country reports and the primary data sources to develop this report.

The overall protocol for the study was approved by the World Health Organization Ethics Review Committee subject to additional ethical review approvals being secured in each of the six case study countries. Given the tight time frame for this study (January –July 2009) and the fact that not all research institutions involved in the study had ethics review committees, it was not possible to secure ethical review approvals in all six countries, but country-specific ethics review took place in Ghana and India, and in the other settings the study design was discussed with and agreed by the head of the case study institution in advance of the research, and all interviewees also granted informed consent to their participation in the study.

This report is structured as follows. Section 5 presents the key findings from the literature review. Section 6 describes and analyses the findings of the landscaping of health policy analysis institutes. Section 7 synthesizes findings from the case studies. Section 8 presents conclusions and recommendations.

5. Literature Review

What are the current problems with health policy development and implementation in low and middle income countries, and why might health policy analysis institutes provide a solution to some of these problems? In most countries, government agencies such as MOH planning units or planning departments in Ministries of Finance, play a critical role in developing and implementing policies. A number of problems with an "in-house" policy analysis capacity may arise (Nathan Associates 2004):-

- civil servants may lack independence, being heavily swayed by what the Minister wants to hear rather than what is truly the case;
- government officials may be short-termist in outlook, too focused on fighting fires to step back and see the broader picture;
- practical concerns centre on the poor quality of in-house analytical work due to a lack of capacity or lack of incentives for high quality analysis;
- civil service structures may also be stagnant and politicians may turn to external actors for "fresh thinking".

An alternative model to the independent policy analysis institute is to draw upon analytical and policy support from university-based researchers. However there may also be problems with this approach, specifically such researchers may be driven more by imperatives to publish, than the desire to improve public policy. Further, in many contexts, university researchers are only weakly linked into policy networks and public policy debates. Such researchers may accordingly lack the skills to package evidence in ways that policy makers find relevant and accessible.

It has also been argued that think tanks may be more effective than government in fostering stakeholder engagement in public policy (James 2000). The proliferation of think tanks in low and middle income countries, particularly in Eastern Europe and the Former Soviet Union, has often been explained in terms of increasing levels of democratization (Stone, Denham et al 1998). Democratization has both facilitated the development of NGOs but also enabled policy development processes to become more open. This trend, together with new information technologies has increased the demand for the use of evidence in policy, and opened up prospects for policy analysis institutes.

All of these arguments concerning the role for policy analysis institutes are highly context specific: not all countries are facing (or have faced) rapid democratization; sometimes so-called independent policy analysis institutes are not very independent at all but rather heavily influenced by funding sources. Understanding the political and economic context in which policy analysis institutes operate is key. Sometimes the emergence of think tanks may primarily reflect the dissatisfaction of political leaders or parties with existing sources of policy advice (Stone and Denham 1998).

Both studies of policy analysis institutes (Nathan Associates 2004) and broader studies that explore the use of evidence in policy (Innvaer et al 2002) concur that there are a few key factors that influence the success of policy analysis institutes in terms of influencing policy and practice. These include:-

- The timeliness and relevance of findings;
- The production of credible and trustworthy reports;
- Close personal contacts with policy makers;
- Summaries of findings that present key actionable recommendations.

5.1 Organizational structures for PAIs

Struyk has written at length about the management and organization of think tanks, and his practical works provide sound advice for think tank or policy analysis institute managers and leaders (see for example Box 1). These works illustrate the importance of focusing on basic capacities – such as financial management systems, human resource management systems etc – as much as the more technical areas concerning communicating policy ideas. However, above and beyond this pragmatic advice, there remain ongoing debates about how best to organize and structure policy analysis institutes and what their comparative advantage is.

Autonomy and independence
While autonomy and independence are commonly held to be a core characteristic of think tanks, it is often difficult to pin down exactly what constitutes autonomy. Autonomy can take many different forms: while financial autonomy or independence may be the form most commonly considered, other aspects such as administrative autonomy (McGann 1995) and intellectual autonomy (James 1993) may be equally or more important. Osman et al (2002) highlight the complex web of factors that influence autonomy identifying ten different factors ranging from funding modalities, managerial control over issues such as recruitment, the agenda setting process, quality assurance mechanisms and the existence of "advisory firewalls" that can protect the coherence of research findings through providing a shield of specialist expertise.

A good example of the complexity of autonomy comes from China. According to Naughton (2002), during the 1980s, Chinese economic think tanks played a key role as centers of expertise, with distinctive philosophies and approaches to economic transition. Although they were all government-sponsored, they served as important alternatives to the policies and advice available within the formal government bureaucracy. In the 1990s, think tanks continued to play an important role but lost some of their distinctive personality.

Osman and El Nolla (2009), along with other authors note differences in the character of think tanks across different regions. For example think tanks in the US are typically highly independent non-profit organizations, whereas the European model is inclined to a more mixed model that depends both on public and private financing. In Asia, particularly East Asia, government-sponsored think tanks appear more common. There is no one "right" model for policy analysis institutes and ensuring a good fit between the model and the context in which it operates is perhaps most critical. In this light, some developing country authors (eg. Ojagbohunmi 1990, Osman and El Nolla 2009) have suggested that government sponsored think tanks, or even the development of policy analysis units within government departments, may be an appropriate strategy in developing countries. This argument focuses on the one hand on the need for reliable long term support for think tank activities, which may be difficult to secure without government support, and on the other, the fact that given the way government works in many developing countries, policy analysis units that are closely associated with government may stand a better chance of influencing policy, than entirely independent external institutions. If there is a close – financial or administrative -relationship between government and the policy analysis institute, then ensuring that the institute has appropriate mechanisms in place to prevent conflict of interest and to ensure independent analysis, is key.

Box 1
Best arrangements for a particular think tank: Organization of Research Staff

Struyk has identified the following models for analytical and policy work based on interviews and on-site observations at approximately 30 think tanks in six countries. Think tank research activities were most often organized either around a single research leader ('solo star' model) or around a team ('team' model). That is to say:

- The 'solo star' model: notable and influential researchers work independently with one or two

research assistants; the research often entails complex statistical analysis of large data sets, the results are published under the star's name.

- The team model: teamwork based approaches lend themselves to conducting large-scale research projects, program evaluations, and demonstration and pilot projects.

Struyk also identifies alternative staffing arrangements for think tanks:-

- very dominant resident staff; some supplemental researchers present but not necessarily integral to institute's operations;
- resident staff working with consultants;
- resident staff working with associates (which can also be organized under a solo star model);
- blend of resident staff, associates and consultants.

While identifying models in this way can be helpful, it often understates the variety of the models that exist in practice. So even if a think tank is operating under a 'solo star' model, it can still combine this with the 'very dominant resident staff' or 'resident staff with consultants' approaches.

Struyk suggests the following factors need to be considered when determining which model to choose:-

- type and size of projects;
- variability of the work load;
- flexibility of the staff;
- tax and social fund consequences;
- institutional reputation;
- special cases (reasons for making exceptions to the rule e.g. team organization with an opportunity to attract a distinguished scholar that fits into think tank's long term goals);
- legal environment.

Source: Struyk (2002)

Staffing and organization

The ability to attract and retain high quality staff, who have close links to policy makers and can produce credible, policy oriented findings is absolutely key to the success of policy analysis institutes, and perhaps one of the biggest challenges in low and middle income contexts.

Early writing suggested that policy analysis institutes should have an interdisciplinary staff composition and suggested a minimum "critical mass" of 20-25 full time professionals (Dror 1984), But commenting on East Europe, James (2000) suggested that many think tanks function effectively with a much smaller staff (5-10 people) combined with a network of advisors. Struyk suggests that 10 full time research staff constitutes a critical mass, and that reaching this level of staffing marks a shift from a low and often highly variable level of activity to a more established one with greater stability in funding, more projects and more policy opportunities (Struyk 2002). Several authors have indicated that the regular rotation of staff, from think tank positions into government and back effectively serves to strengthen links across organizations but also maintain the strong policy orientation of think tanks (Dror 1971, Osman and El Nolla 2009).

DeMuth (2007) also highlights the usefulness of involving not only researchers but also people with practical experience in government, politics, and the professions who have the knack for generalization and organized argument and the zest for reform.

Sustainability

The main revenue sources for policy analysis institutes are (i) grants from government, development partners (donors), or private foundations (ii) project based financing or consultancy (iii) revenue generation through the sale of services (such as regular market analyses) (iv) charitable donations and (v) endowments. While many US think tanks have an endowment that covers core operating costs, this is rarely the case in developing countries where policy analysis institutes tend to be much more reliant upon the first two sources of funding – core grants, and consulting fees. Some policy analysis institutes, particularly those that focus on the business sector or economy, may be able to raise considerable sums from selling products such as market analyses, but this seems unlikely to be viable within the health sector. Some health policy analysis institutes such as the Centre for Health Policy Research and Dialogue in Nepal have been established based primarily on the donations of a few individuals, however again this appears to be the exception rather than the rule. The biggest challenge, noted by many policy analysis institutes in low and middle income countries appears to be how to reduce reliance for financial survival on short term, donor-led, consulting projects. The problems associated with such short term contracts are many, but include the constant treadmill of proposal writing and contract negotiations, but also the loss of ability to respond to fleeting windows of political opportunity in terms of the policy agenda (Ali 2005).

5.2 Functions of PAIs

As the difficulties described above in defining a policy analysis institute suggest, policy analysis institutes not only take multiple different organizational forms, but also define the mission and scope of their work in differing ways and fulfill different functions.

There is a growing body of evidence regarding best practices in promoting the use of research evidence in policy (see for example Lavis et al 2006, Yaron and Shaxson 2008). This section does not attempt to summarize this literature, although Box 2 provides recommendations from a recent study of organizations that support the use of research evidence (Lavis et al 2008). Given the emerging consensus about best practice in this field, this section instead focuses on debates concerning the mission, scope and functions of policy analysis institutes.

Box 2 – Recommendations for those leading organizations that support the use of research evidence in developing health policy

- Collaborate with other organizations – operating within national networks and participating in international collaborations offers opportunities to learn from other organizations.
- Establish strong links with policymakers and involve stakeholders in the work – this was found to be a key organizational strength, although it did then raise the need to manage conflicts of interest.
- Be independent and manage conflicts of interest among those involved in the work – conflicts of interest were repeatedly cited as one of two key organizational weaknesses.
- Build capacity among those working in the organization
- Use good methods and be transparent in the work
- Start small, have a clear audience and scope, and address important questions – inadequate resources and insufficient skilled staff was so common a constraint that starting small and with a strong focus was thought to be key to success.
- Be attentive to implementation considerations even if implementation is not a remit.

Source: Lavis et al 2008

Values and mission

While the majority of policy analysis institutes and think tanks in low and middle income countries state their mission in a very value-neutral way (eg. to improve public policies through relevant and timely research), this is not universally the case. For example, several institutes encompass as part of their mission statement a commitment to protecting the rights of the poor, or representing perspectives of the poor, implying a set of values and perhaps an implicit critique of typical government policy making practices. Other institutes espouse more conservative values, for example encompassing "educating society on the benefits of a free economy[2]". Typically institutes that are closely allied with government or universities are more neutral in the wording of their mission whereas NGO institutes are more likely to have missions that are heavily influenced by values.

De Muth (2007) has argued that there are significant advantages to having a clearly articulated value orientation:-

> "We are schools in the old sense of the term: groups of scholars who share a set of philosophical premises….This has proven highly productive. It is a great advantage when working on practical problems, not to be constantly doubling back to first principles." (de Muth 2007)

However in practice, this may be one of the more complex issues for policy makers using policy analysis institute outputs, to grapple with: to what extent is the policy advice presented informed by an underlying set of values and how clearly are these values articulated? At one extreme policy analysis institutes may operate on a similar basis to advocacy groups, using research evidence to support already established positions, if this is clearly the case it may not be problematic, but in practice it may be difficult to ascertain the relative weights of ideology and evidence.

Scope

There are multiple ways in which the scope of a policy analysis institute could be defined, including the disciplines employed, the sectors of focus, and the stages in the policy cycle which the institute is trying to influence. Several analysts have argued that policy analysis institutes should be multi-disciplinary in nature, unlike many university departments, and hence bring a variety of perspectives to a particular policy problem. However many think tanks appear to have a particular focus on economics and economic policy (DeMuth 2007). In addition to multi-disciplinarity, more academic and more policy-oriented perspectives may also be brought in.

Stone (1998) and others acknowledge the existence of specialist think tanks, that is think tanks that focus on particular sectors or clusters of issues, but the literature appears to have very little to say about the relative advantages and disadvantages of such institutes.

It is widely acknowledged that policy analysis institutes may engage and try to influence at different points in the policy cycle. For example a presentation by the Global Development Network (GDN 2009) identifies the following points in the policy cycle:-

- Political agenda - influencing choice of policy priorities
- Issue analysis – influencing the range of policy options considered in relation to a already defined policy priority
- Policy decision making – influencing the acceptance or rejection of specific policy options
- Policy impact – concerned with evaluating the effects of policies.

[2] See http://www.imanighana.com/about.html

The same presentation suggests that these different steps in the cycle have different characteristics and accordingly in order to engage successfully at these different points, different types of organizational capacity may be required. For example, political agenda setting may be a process more open to advocacy and the intervention of intermediaries than policy decision making which sometimes occurs in a rather closed environment. Policy analysis institutes with a high media profile may be more effective at political agenda setting, than lower profile institutions (Abelson 2002).

The categorization above, of points in the policy cycle excludes that of advising on implementation challenges. James (2000) has argued that specialized think tanks are typically better able to work on the micro details of implementation, rather than broader policy issues, and this may be a particular niche for them. Further, Braun et al (2000) argue for the importance of this neglected area.

Finally, while think tanks have typically been thought of as national entities, focusing on analyzing national policies and establishing close relationships with national policy makers and other stakeholders, there are signs that this is changing. For example the Carnegie Endowment for International Peace recently announced a new strategy[3] to transform itself into a multinational institute with centers all over the world. This strategy reflected both the globalization of issues that it was concerned with, but also an attempt to reap economies of scale. Both of these arguments may be relevant to health policy analysis institutes.

Functions

The first three of the functions described in the section on definitions above, all appear to be functions commonly pursued by think tanks. However the training function appears to be a much less commonly pursued activity.

5.3 Donor support and capacity development programmes

Plumptre and Laskin (2001) note the willingness of foreign aid donors to fund the establishment of think tanks as a means of concentrating developmental expertise and providing a bridge between industry, universities and government. However with the exception of a programme run by the African Capacity Building Foundation during the 1990s (Ndulo 1995), until recently there does not appear to have been any concerted programme to support the development of general think tanks nor health policy analysis institutes. Instead donor support to such organizations appears often to be linked to specific development projects. This has changed recently with the “Think Tank Initiative”, supported by the Hewlett Foundation, the Bill and Melinda Gates Foundation and Canada’s International Development Research Centre, this initiative will provide core funding, in the first instance to 24 African think tanks for a period of ten years. US$30 million has been committed to support the first 5 years of this initiative. The careful background work and preparatory assessments conducted as part of this initiative appear to provide solid foundations upon which to support organizational development for policy research and analysis (McGann 2006, personal communication Marie-Claude Martin). In particular this program of work has developed useful practical tools for institutional assessment and assessment of the policy environment which can assist both with the selection of institutes for funding, and planning a strategy to support the institute. The tools developed also include evaluation tools to help assess the effectiveness of the grant and the outputs from the institutes.

Capacity Development

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[3] See http://www.carnegieendowment.org/events/?fa=eventDetail&id=954 for more details.

It is clear that a major challenge facing policy analysis institutes in developing countries is how best to develop and maintain sufficient capacity to provide credible analysis and advice across a range of issues, particularly in a climate of fragile and fragmented funding.

The literature in this field stresses the need for strong in-house government capacity as well as strong external policy analysis capacity (Yaron and Shaxson 2008). Effective, high capacity, think tanks cannot replace the need for capacity within government to process the policy advice received, consider the underlying values, the extent to which policy recommendations are aligned with the political agenda and stakeholder interests, and formulate policy accordingly. Indeed in most democracies, policy development involves an array of different actors – government agencies, universities, think tanks, advocacy groups etc, and it is perhaps the capacity of the overall network of policy actors and the linkages between these actors that is more important than any single organization (Mendizabal 2006).

There are some interesting capacity development models that look more holistically at the role of policy analysis institutes (or similar bodies) with respect to government capacity development. For example, public health observatories in the UK, were established not only to support public health departments to improve health, through providing relevant evidence, but also to ensure that staff of public health departments had the skills to access, understand, interpret and make effective use of evidence (Hill et al 2005). Under this model regional Public Health Observatories were developed partly to address concerns about the attrition of skills among public health experts operating at the local level in the National Health Service. Through developing an observatory with a critical mass of public health experts, and by rotating experts out of their local health authority and into more specialized "observatories" it was intended to prevent de-skilling, as well as promote exchange between networks of specialists. This model may have broader relevance to the development of capacity for policy analysis in the developing world.

Grant making for capacity development

Several of the programmes of international grant making to think tanks appear to have taken place in Eastern Europe and the former Soviet Union as part of the broader post-communist transition. In particular the Open Society Institute has provided support to such institutes, through its International Policy Fellowship program. This program sought to "develop and strengthen individual skills and abilities considered to be critical for making research relevant for policy making and through this aims to improve the quality of public policy analysis" (Pop 2005). The program included the following components:-

- training (in writing policy papers, advocacy and research design and methods);
- mentorship;
- enhanced networking between fellows;
- research technology (a laptop, email account, personalized web page);
- a stipend.

A case study assessment of the International Policy Fellowship program was very favorable in terms of impacts of the fellowship program upon the individual program beneficiaries but notes that the wider impact of the program on policy formulation depended considerably on the broader policy environment (Pop 2005). The assessment did not attempt to address the impact of the program on organizational capacity.

In Bosnia and Herzegovina the PRO-Project (Policy Research Organization-Project) sought to enhance local capacity to provide evidence to inform the policymaking process. (Struyk, Kohagen et al. 2007). In assessing the change in the policy development process in Bosnia and Herzegovina between 2003 and 2006, and specifically evaluating the effects of the PRO-Project, Struyk et al. (2007) conclude that there were substantive positive developments, in particular the dominance of the international community in policy debates was replaced by greater reliance on think tanks or policy research organizations. While the policy research organizations were successful in convincing the policy maker community of their

objective credibility, an important facilitating factor was that during this period policymakers became more receptive and demanding of evidence for decision-making.

Institutional linkages

Institutional twinning or mentoring relationships between stronger and weaker institutions is a common approach to capacity development and has been used with respect to think tanks. For example Stern (2000) documents the 30 year international collaboration between Indonesia and the Harvard Institute for International Development. Harvard's involvement included training government staff, having close and long-term relationships with government advisors, providing analysis on trade and commerce issues, and report-writing. Stern (2000) points out that the many years it took before technical assistance led to technical self-sufficiency reinforces the well known, but often neglected, fact that institutional development requires a long-term commitment by all parties: the donor, the implementing agency, and the recipient.

Networking across multiple organizations is often also viewed to be a mechanism to enhance capacity. In Africa the African Economic Research Consortium has worked for many years to enhance networks of researchers involved in policy-relevant economic analysis (see http://www.aercafrica.org/programmes/research.asp). Further, building on a recent meeting in Cairo there is a nascent Network of Think Tanks for Developing Countries (NTTDC) (Cairo Declaration 2009).

5.4 Significance of general literature to Health

It would seem that much of the general literature described above is relevant to the health sector. Some of the issues raised above in the context of general policy analysis institutes or think tanks may be particularly significant for HPAIs. Firstly, the fact that the work of HPAI's is narrowly defined in sectoral terms may mean that it is harder to maintain a sufficiently broad base of work to be sustainable. In order to compensate for this, it may be more important for HPAIs to become relatively more engaged in what has been referred to as "micro-policy implementation" (Braun et al 2000) rather than just straight research. Establishing a regional role whereby the HPAI can contribute to policy analysis and dialogue across several countries may also be important in this regard.

Some HPAIs appear to have grown out of NGO service delivery organizations (see section 6), and this adds a further type or model of policy analysis institute to the various classifications described above. AMREF in East Africa and ICDDRB in Bangladesh are perhaps the two best known organizations that have followed this development pathway. In such cases their interventions in the policy field may be driven not only by research and analysis but also by direct service delivery experience.

6. Landscaping of Health Policy Analysis Institutes

A total of 78 health policy analysis institutes were identified, or which 38 were in Asia, 21 in Africa, 8 in Latin America, 8 in Easter Europe and the former Soviet Union and 3 in the Middle East. We believe that this most probably understates the total number of such institutions, especially in regions such as Latin America and the Middle East where the first language of communication is unlikely to be English and therefore there may be little incentive to participate in predominantly Anglophone networks. In addition 41 multisectoral institutes were identified which explicitly mentioned health as one of several areas of focus. For comparison purposes, the Global Development Network database on "think tank"-type organizations currently has more than 2500 such organizations in low and middle income countries, focusing mainly on political and economic issues.

Table 2 below shows the start date of the 63 institutions for which data were available. 81% of the HPAIs (51 out of 63) were established since 1990, and 35% of them (22 out of 63) since 2000. Thus most HPAIs are relatively recent with steady growth occurring during the past 20 years. This is broadly comparable to data collected by McGann on think tank growth. Writing in 1999 McGann (2005) observed that two thirds of all think tanks had been established during the past 19 years and half since 1980. Interestingly both McGann (2007) and the data below appear to suggest a slackening off in growth during recent years.

For the older institutions it was clear that they had generally gone through several major restructurings. For example, the Ifakara Health Institute in Tanzania started out as a field site of the Swiss Tropical Institute but has made major changes to its mission and staffing so as to transform itself into an independent Tanzanian institute with a focus on development new knowledge and relevant evidence for health policy and practice. Similarly, AMREF in East Africa started out as a flying doctor service, but increasingly is positioning itself as a health policy analysis institute, basing its analysis, at least in part, on its programme of service delivery.

Table 2 – Start date of HPAIs in database

	Before 1990	1990-1994	1995-1999	2000-2004	2005-2009	Total*
Africa	3	6	6	3	3	21
Asia	6	6	5	9	2	28
LAC	2	1	3	1	0	7
FSU			2		2	4
Middle East	1			2		3
Total	12	13	16	15	7	63

* Data on start date missing for 15 institutes

Table 3 reflects the institutional ownership of the institute, or at least the auspices under which it was initiated. NGOs dominated, however it was also interesting to note the number of university and government based institutes, particularly in Asia. While NGOs were dominant in South Asian countries (Bangladesh, India, Sri Lanka), many South East Asian and East Asian countries had invested in institutes closely linked to government (for example Cambodia, China, Thailand, Vietnam) and in institutes closely affiliated with university departments (eg. China, Indonesia, Thailand). A handful of institutes were identified that described themselves as international organizations, this included ICDDRB in Bangladesh, AMREF and the African Population and Health Research Centre.

Table 3 - Institute ownership

	NGO	University	Government	International Organization	Total
Africa	12	5	2	2	22
Asia	11	15	11	1	38
Latin America & Caribbean	7		1		8
Eastern Europe & Former Soviet Union	4	2	2		8
Middle East	2	1			3
Total	36	23	16	3	78

For Africa and Asia, web searches were used to clarify the type of functions that the institutes conducted. Information on functions performed was available for 32 of the 38 Asian institutes identified and 18 of the 22 African institutes identified. As Table 4 shows, most institutes were engaged in conducting policy relevant research and analysis and providing policy advice. Fewer, although over half, conducted policy dialogues. Very few (particularly in Africa) were involved in policy maker training, instead training efforts were focused more on local researchers and health professionals. Only six institutes articulated that they had a role in data archiving and analysis, but many mentioned a role in promoting the development of networks.

Table 4 – Functions fulfilled by institutes in Asia and Africa

Function	Number of Institutes conducting function in Asia (total 32)[4]	Number of Institutes conducting function in Africa (total 18)
Conduct policy relevant research and analysis	31 (97%)	16 (89%)
Provide policy advice and technical assistance to policy process	27 (84%)	15 (83%)
Conduct policy dialogues	21 (66%)	10 (55%)
Conduct training and capacity development for policy makers	9 (28%)	0 (0%)
Conduct training for local researchers & health professionals	22 (69%)	15 (83%)
Data archiving and analysis	4 (12%)	2 (11%)
Build up partnerships and networks	15 (47%)	9 (50%)

7. Synthesis of Case studies

7.1 Brief Overview history and evolution of case study institutes

Table 5 shows basic data regarding the history and evolution of the six case study institutions. With the exception of CHeSS in Ghana, all the institutes have been established for at least 10 years, and some, such as those in India, South Africa and Vietnam have been active in some form for twenty years or more.

Table 5 – Overview of Case study institutes

Institute	Year of foundation	Founders	Legal Status	Location
Health Strategy and Policy Institute (HSPI),	1987; 1998 in its current	MOH through the Hanoi Medical University	Public entity under jurisdiction of MOH	Building inside the MOH Hanoi

[4] Although 38 Asian institutes and 21 African ones were included in the database, information regarding the functions conducted was available for only 32 and 18 respectively.

Vietnam	form			
Health Economics Unit (HEU), South Africa	1990	Professor Di McIntyre (health economist)	Part of the University	School of Public Health and Family Medicine, University of Cape Town
Institute for Health Systems (IHS), India	1990	Dr Prasanta Mahapatra (serving civil servant in state government)	NGO, registered as a society	Stand alone campus including space for teaching & research
Health Economics Institute (HEI), Bangladesh	1998	MOH through Dhaka University with donor support	Formally established institute within Department of Economics, University of Dhaka	Within University of Dhaka
Health Policy Analysis Unit (HPAU), Uganda	1999	Govt of Uganda as part of Uganda's 1998 Public Service Reform Programme	Integral to MOH	Within MOH
Centre for Health and Social Services (CHeSS), Ghana	2008	Dr Sam Adjei (Retired senior civil servant) and Dr Tony Seddoh (Ghanaian currently based at The Global Fund, Geneva)	Registered NGO	Small stand-alone office in centre of Accra near MOH, larger purpose built research site on outskirts of town

The factors leading to the establishment of the HPAIs differ. In at least three cases – Ghana, India and South Africa – the institute was established by respected individuals in the field. Dr Sam Adjei and Dr Prasanta Mahapatra were both well regarded civil servants, and Professor Di McIntyre a well-regarded researcher. For the South African HEU, the decision to establish a separate institute, rather than working as core teaching staff of the School of Public Health and Familiy Medicine was apparently taken in order to give the group a discrete identity and raise the profile of the body of work produced. This was noted by a staff member to be: *'incredibly helpful in terms of seeking external funding'*. In India, Dr Mahapatra first tried, unsuccessfully, to develop capacity for health policy analysis in existing government institutes, and in the university, before deciding to establish an autonomous body.

For the other three cases, the HPAIs have largely been established through organizational agreements. For example, Vietnam's Health Strategy and Policy Institute (HSPI) has evolved from a series of past institutions. Initially created in 1987 as the Centre for Human Resources for Health it was initiated through collaboration between faculty at Hanoi Medical University, and the network of advisors around the Minister and Vice-Minister of Health at that time. As in the South African case study, interviewees in Vietnam commented on the opportune moment at which the institute was established: Vietnam was in the throes of moving from a centrally planned economy to a market based one, lots of new policy issues were emerging, and the period marked a new degree of openness to external ideas and the use of evidence in policy making. The Centre was later renamed the Centre for Social Science and Health in 1996, and HSPI was finally established on November 11th, 1998 by the Prime Minister in its current form.

The institutes in Bangladesh and Uganda were both established by government, with strong support from external funding agencies. The Health Economics Institute (HEI) in Bangladesh was established in July

1998 through a formal memorandum of understanding between Dhaka University and the Bangladeshi Ministry of Health and Family Welfare (MoHFW), and a subsequent statute by Dhaka University. The establishment of the institute was facilitated by funding from a large DFID project that was channeled through a newly established Health Economics Unit (HEU) at the MoHFW. In Uganda, the Health Policy Analysis Unit (HPAU) in the Ministry of Health was founded in October of 1999, following Uganda's 1998 Public Service Reform Programme, which placed Policy Analysis Units in all central government ministries to better link policy advice and analysis with planning. The HPAU in the Ministry of Health became effective in October 1999. Government paid salaries of core staff, but substantial support was received for the Unit, during its early years, from external funding agencies.

Since their establishment, the evolutionary paths of these institutions have diverged. The Health Economics Unit (HEU) at the University of Cape Town continues to operate on a relatively small scale, but has weathered substantial volatility in the health policy environment and has become a highly respected research institute – both at the national and international levels - which also provides non-ideological, evidence-based health policy advice to national and state governments. The Vietnamese HSPI is far less well known internationally but appears to be an effective and well-respected player domestically, informing national policy debates within Vietnam. Further it has managed to establish a broad funding portfolio and relatively large and stable staffing base. The fortunes of the Institute for Health Systems in Hyderabad, have varied, it would seem largely in relation to the Director of the Institute. During its early years (1990-97) it operated informally and largely at a low level, depending substantial on voluntary inputs. From 1998-2003 the founder, Dr Mahapatra, was posted to the Institute as Director, on deputation from the Indian Administrative Service. During this period there was substantial scaling-up of the Institute's program of work. Unfortunately however, one of the new initiatives (involving post-graduate training in health administration) failed to materialize despite heavy investment by the Institute, and as a consequence during the mid-2000s the Institute had to shift gears, focusing more on remunerative activities to pay off outstanding debts. By the late 2000s the Institute had once again reached a stable footing, but the recent departure of the Director (for an overseas post) and the appointment of a new Director in 2009 mean that the Institute continues to face some uncertainty.

Both the institutes in Bangladesh and Uganda received substantial core budgetary support from donors at start-up and for a period of five years thereafter. However when these initial grants ended, the Institutes found it difficult to find alternative funding sources to replace them. Both of these institutes have since contracted significantly in terms of the volume of work conducted and budget. While the HEI, Bangladesh has managed to maintain many of its staff positions given its links to the university, the HPAU, Uganda has lost most of its staff. Subsequent sections describe this process in more detail.

7.2 Organizational structure and governance

7.2.1 Governance and Leadership

The literature review described the tensions between establishing policy advisory institutes that were sufficiently independent to provide neutral advice, but also had sufficiently close connections to policy makers to be influential. Governance structures, and in particular Boards, can be critical in this respect. Frequently they have a role in identifying strategic direction for the Institute, facilitating a diverse funding portfolio and ensuring quality standards are met. All of these elements have the potential to protect the institute from inappropriate political interference. This section first describes the governance and leadership arrangements in place in the study institutions and then analyzes how these arrangements have affected issues of independence and neutrality.

Of the six case study institutes, three – CheSS, Ghana, IHS, India and HEI, Bangladesh, had their own Board. As NGOs, both CHeSS and IHS are required to have Boards. The HIS, India Board is currently composed of 13 members including the Director of the Institute but can be increased to 21 members. While currently no Board member is formally appointed by government, government officials nonetheless hold a substantial number of places on the Board and the IHS constitution allows for formal government representatives on the board. CHeSS, Ghana has a board of 8 members, which met for the first time this year. The HEI, Bangladesh is self governing and reports to the syndicate of the university through the Board of Members. The Board includes 15 members, 5 positions of which are statutorily held by University officials and 2 by MOHFW officials. In addition to the Board the HEI also has an Academic Board focused on more technical issues. The Board should meet on a quarterly basis but typically meets two or three times a year.

Of the remaining three institutes, the HEU, South Africa has no independent advisory or governance structure but reports through the usual university channels. Falling under university management did not appear to be problematic in the view of any respondents, although good personal relations and stable leadership have clearly played a part in making this arrangement effective.

For the two institutes based in Ministries of Health the issue of governance and autonomy was a substantial issue that emerged in many of the interviews. In both cases the institutes – HSPI in Vietnam and the HPAU in Uganda did not have any separate governing or advisory body and reported directly through MOH channels.

Originally, the HPAU in Uganda was created as an independent unit reporting directly to the Permanent Secretary, well above the heads of departments. This reporting structure aimed to give the unit autonomy and power to influence policies coming from technical departments, and also avoid conflicts of interest with department heads. According to a former staff member of the unit, the reporting line and the structure was not practical given the bureaucratic and hierarchical structure of government and since there were many persons senior to the head of HPAU who were effectively bypassed by this arrangement. While staff managed to make the arrangement workable through employing informal channels of communication, during further organizational re-structuring in 2000, the HPAU was shifted to report to the Director General Health Services. At a later date the unit was moved even further down the reporting structure and it is now under the Health Planning Department where it reports to a head of a division (three levels below the Permanent Secretary). This downgrading perhaps also reflected dwindling resources and capacity within the unit (see below). Current plans for restructuring within the Ministry of Health include providing a higher grade position for the Head of the HPAU and seeking to raise its profile. However in its current (and proposed) form, the Unit has no clear separation from the broader MOH and therefore can no longer be classified as an independent HPAI.

While HSPI, Vietnam does not have any formal Board structure it does have a Scientific Committee (responsible for maintaining quality standards) and an Advisory Committee with responsibility for overall strategic direction. Critics however suggest that both of these committees are dominated by government officers, and that while HSPI, Vietnam has some independence it still finds it difficult to criticize government's policy line. While HSPI, Vietnam is currently perceived as effective because the evidence it generates is well-used by the Ministry, this success is at least in part contingent upon the good personal relationships between the ministry leadership and institute leadership. The relationship has not always been so harmonious, for example in the past the Director of the HSPI was not invited to Ministerial weekly meetings which severely undermined the influence of the Institute on Ministerial policy.

Box 3 – HSPI Autonomy

The degree of autonomy a health policy analysis institute such as HSPI experiences is highly dependent

on the nature of the relationships between institutions, and in particular its relationship with the main policy implementing body, the MOH. A delicate balance needs to be struck between fulfilling its mandate for independent advice on the one hand, whilst not jeopardizing its policy relevance.

In Vietnam, the impact and effectiveness of the HSPI in influencing health policies is closely linked to the strong and positive relationship between the institute director and the Minister of Health. Because of the political context in which the HSPI operates, the institute is challenged to maintain a perceived independence from the MOH in its scientific undertakings and policy contributions, yet not be so politically distant that its relationship with the MOH is estranged.

To protect against political instability and ensure institutional sustainability, there is a need for HSPI to review how to move away from channels of policy influence that depend on one individual policy champion to a collective institutional capacity to influence policy. One of the ways in which to maintain its scientific credibility is to demonstrate the strong technical quality of its research, through for example publishing results in international peer-reviewed journals. However, to-date, HSPI capacity has been mostly dedicated to producing internal project reports or responding to MOH requests. Furthermore, processes for staff recruitment have also been identified as a potential detractor from HSPI autonomy. Like other government offices, HSPI has limited power to recruit staff according to its needs. According to respondents, in many cases, the recruitment process is for "formality" only, or occurs through executive fiat as the government simply assigns staff to the HSPI.

Given the policy context in Vietnam the very close relationship between HSPI and the MOH appears to have been appropriate and productive to-date, but this question of neutrality and political relationships is one that HSPI, and many HPAIs, will need to keep under continuous review.

7.2.2 Funding

Table 6. Funding Profiles of Case Study Institutes

Source of Funding	**HEI Bangladesh (2008) (%)**	**CHeSS Ghana (2009) (%)**	**IHS India (Avg 2003 – 2009) (%)**	**HEU South Africa (avg. 2004-2009) (%)**	**HPAU Uganda 2008/09 (%)**	**HSPI Vietnam (Avg 2004-2009) (%)**
Multilateral agencies (EU, WHO)		16	22	12	0	18
Bilateral agencies (SIDA, DFID)		15	18	67	0	11
Private foundations		58	20	0	0	13
Government (national/provincial)			36	5	100	58
NGO (local and international)				7	0	0
Academic/research organisations	100	11	5*	8	0	0
Other				0	0	0
Approximate Annual Budget (in US$) (where two figures are given this indicates a range of annual funding)	66,500	680,000	92,871 - 178,500 during past three years	790,000	26,000	1,300,000 (2007)

* Indian Council for Medical Research

As table 6 illustrates there are substantial differences in terms of the funding profiles of the case study institutions, although it is notable that all but one of them are operating on substantially less than US$1 million per annum. Funding levels at the HEI, Bangladesh and the HPAU, Uganda are such that concerned stakeholders recognize that these institutes are no longer viable in their current form. The funds which are currently provided for these two institutes are entirely from their parent organizations (the University of Dhaka, and the MOH Uganda, respectively) and cover largely salary costs. The HEI, Bangladesh is now actively considering how best to re-invent itself. Staff at the Institute said that they are considering broadening the scope of the Institute – for example focusing on public economics broadly (including, health, education, environment etc). As mentioned previously the MOH Uganda is also still considering how best to house a policy advisory function.

While these two institutes are currently barely functional, both during their initial years received substantial donor funding. The HPAU,Uganda received an average of US$245,000 per annum for the first five years of its life, largely from the World Bank and as part of a broader health sector reform project. The HEI, Bangladesh received on average US$194,000 per annum from DFID, through a technical assistance programme linked to the Bangladesh SWAp. Thus both of these institutes received a total of about US$1 million. While in Uganda most of this funding was project-based funding, ie. linked to specific projects or activities, the budget for the Bangladeshi HEI included funding for capacity development such as overseas training for staff, purchase of equipment, establishment of a resource center, renovation of the physical infrastructure and library resources. However despite this secure funding, neither institute was successful in attracting significant additional funding. Thus in Uganda for example, although the government doubled its funding to the HPAU between 2002/3 and 2005/6 as donor funds dwindled, this was nowhere near sufficient to replace the original donor funding. The reasons behind the cessation of donor funding to the Bangladeshi HEI are complex, encompassing issues of donor aid management, political transitions, conflicting priorities and personality clashes. They are described in more detail in Box 4.

While the level of funding for all of the other institutes studied looks healthier, nonetheless many were perceived by both internal and external stakeholders to be financially vulnerable. For example the HEU, South Africa is extremely reliant upon soft funding (80% of total funding). The largest source of funding (45%) comes from Sida to run the Masters in Health Economics. About one third of this grant is designated for bursaries for students, which is of no direct benefit to HEU. This grant will end in 2011, and although the HEU does receive some funding from the University for its teaching, this does not nearly cover teaching costs. As a consequence the HEU may be faced with the prospect of cross-subsidizing its considerable teaching commitments through research and other grants.

> *'They survive but they spend a lot of time chasing money......it's just silly that a Unit as successful as this has to spend so much time looking for a bit of money here and a bit of money there'* External Observer, South Africa

While the HEU does a substantial amount of advisory work for government, very little of this is remunerated: the bureaucratic hurdles in establishing and operating contracts with government are viewed as too cumbersome to typically be worthwhile. The International Health Policy Programme (IHPP) in Thailand, also faced challenges in funding its work for government. It found that it received many "unfunded mandates" from government, but also found that its ability to respond to these were critical in terms of establishing relationships and the institute's reputation. Fortunately core institutional funding ultimately allowed IHPP to be responsive to such requests, but few of our case study institutions have the luxury of core institutional funding.

The IHS, India seems to face a similarly vulnerable situation, in particular an attempt a few years ago to launch a new Masters program involved substantial upfront investment by the Institute. The attempt failed and appears to have shaken the financial viability of the Institute for several years. The Institute is now trying again to launch the Masters program, it believes that such a program may offer a more stable source of revenue, particularly if the government decides to support students to participate in the program.

Of all the institutes studied the HSPI, Vietnam has perhaps the most secure funding situation. It receives substantial funding from the MoH (about 60% of total revenues) which fully covers all basic salary costs, however salaries are topped up by funding from external projects.

As can be seen, with the exception of the initial input of donor funds in Bangladesh and Uganda, funding received by HPAIs is typically project-specific and linked to particular deliverables. As noted in the literature review, one of the key challenges for many policy analysis institutes is to maintain an appropriate proportion of flexible, core, funding. The more limited the amount of flexible funding, the harder it is for a policy analysis institute to be strategic, to challenge prevailing orthodoxies or to respond to unfunded requests for policy advice from the MOH.

With the exception of HSPI, Vietnam, funding was an issue for all of the institutes studied. Although HEU, South Africa had clearly been savvy in terms of its interpretation and navigation of the funding context, none of the institutes had a clear financial or fund-raising strategy, and none had professionalized the fund raising role. Research and policy analysts were meant to do this as an "add on" to their core roles. Proliferation of multiple small scale projects was sometimes perceived as a problem. For example, a challenge noted by HSPI, Vietnam staff was that managing so many small unlinked projects resulted in large amounts of administrative effort and time; their research portfolio between 2005 to August 2009 comprised a total 64 projects, where 70% were short-term projects of less than one year, 25% were medium-term project of 1-2 years, and 5% were longer-term, taking more than 2 years to complete. Staff at the HEU, South Africa noted that initially they had been almost entirely reliant on small, short term project funding, but had successfully managed to ensure that over time they had a number of larger,

longer term programs that provided them with greater financial security. However for many institutes it seems that funding strategies remain relatively passive and responsive, rather than pro-active.

Box 4 – Financial support to the Health Economics Institute, Bangladesh

The HEI was established in 1998 as part of broader swathe of health reforms in Bangladesh which were supported through a Sector Wide Approach (SWAp). As part of these broader reforms, a new Policy Research Unit was created within the Ministry of Health and Family Welfare (MOHFW) and a Health Economics Unit was established within this. DFID provided the principal support for both the Health Economics Unit and the HEI. This support was channeled through a UK private consulting firm, separate from, but related to DFID's support for the SWAp. In terms of the division of responsibilities between the HEI and the Health Economics Unit, the HEI was supposed to conduct research and teaching on health economics and thereby support the Ministry in making evidence-informed decisions. The government Health Economics Unit was meant to commission short studies and research, and also help channel research findings into policy. While this division of responsibilities made sense in the abstract, it appears that there was a continuous tension between the two units.

DFID's intention was to fund both the HEI and the HEU for 5 years (the duration of the SWAp and the DFID SHAPLA project that supported it) and then review. If the SWAp had run its course smoothly the natural transition for the second 5-year SWAp would have been to a pooled fund for technical assistance supported by several donors, with an increased proportion of Government of Bangladesh finance.

However by early 2002, many of the activities under the SWAP had stalled following the change in government from Awami league to BNP. For example there was a big push to reverse one of the major reforms that the Health and Population Sector Programme had introduced, namely the unification of health and family planning infrastructures. The new government, as is common in such settings, rejected many of the reforms made under its predecessor, and often individuals associated with these reforms were not viewed to be supporters of the new government. As a consequence the HEU, and much of the DFID-supported program of work appeared to be out of favour with the BNP administration. As Government no longer supported the donor provided technical assistance projects, they were wound down.

With the BNP administration sidelining the HEU, the HEI, being based separately in Dhaka University, was somewhat more immune to the political polarization. However, the HEI had not yet reached a point of maturity in terms of developing solid management systems and a diversified portfolio of projects and grants. Further, it no longer had any direct link into the MOHFW, so the feasibility of it being able to influence government health policy was substantially reduced. These conditions led to the dwindling of support to the HEI described in the text.

7.2.3 Staffing

With the exception of CHeSS, Ghana, all of the institutes studied relied primarily on in-house research staff, though sometimes using external consultants if necessary to fill particular gaps. The practice at CHeSS, Ghana of depending heavily upon external researchers (primarily those based at the University of Ghana, Legon) presumably reflects the somewhat unpredictable funding patterns during these relatively early days in the institute's establishment. CHeSS, Ghana currently hires researchers part time, for a particular project, and so far appears to have been successful in contracting well qualified researchers (largely with post-graduate degrees from overseas) in a variety of different disciplines.

Table 7 – Current staffing at case study institutes

HIGHEST DEGREE	POSITION	HEI Bangladesh	CHeSS Ghana	IHS India	HEU South Africa	HPAU Uganda	HSPI Vietnam
PhD	Prof./senior researcher	5	1	0	4	0	7
Masters	Researcher	5	1	4	3	1	14
	Junior researcher	0	0	4	1	0	
	Technical support staff	1	0	4	1	0	
Bachelors	Junior researcher	0	3	4	1	0	9
	Administrative & other staff	4	2	10	4	0	12
TOTAL		15	7	26	14	1	42

When first established, the staff in the HPAU, Uganda comprised a Senior Health Planner, a Principal Policy Analyst and a Senior Policy Analyst (all government funded positions) and two technical assistants (donor funded). This team remained in place until 2003 when donor funding ceased and the head of the unit and the two technical assistants left. From 2003 until 2008 the unit continued functioning with only two staff. Presently the HPAU has only one staff member, the Principal Policy Analyst (PPA), and the unit is perceived as greatly diminished in functionality.

The number of staff within each HPAI ranges from a single individual working in the unit (HPAU, Uganda) to 42 (HSPI, Vietnam). The breadth and depth of educational background also vary greatly, while half of the research staff at HEI Bangladesh have a PhD level education, none of those at IHS, India currently do.

Issues of how to identify, attract and retain well qualified staff were perceived to be challenges particularly by the HEU, Cape Town and the IHS, India. The IHS has struggled to hire senior and experienced health researchers, particularly in the director's position. The new director recently appointed has research experience, but none in the field of health research. The reservoir of research skills at IHS is quite small - only four of the current staff (including the new director) have substantive (at least 3-4 years) research experience, and even among this group few are nationally recognized. During the last two decades beginning and mid-career staff have joined IHS who have later gone on to become well-recognized senior researchers in the field serving in other national or international institutes. Interviews with the current and past staff members found two major reasons why staff tended to leave IHS as their career developed. First, as the researchers gained in experience and recognition, the financial position of the Institute could not provide them with financial stability and so they left for better paying jobs. Second, and equally importantly, the small pool of senior staff in the organization meant that such researchers carried a heavy burden including fund-raising, mentoring new researchers and report-writing for an increasing number of small grants. At the same time, senior staff felt that there were insufficient opportunities to specialize in aspects of the field that particularly interested them. So burn out of good researchers was a major problem faced by the Institute. As one former staff member said:

"*When I was there, I worked long hours and enjoyed it; but then I found it difficult to carry on due to financial and family needs*". (former staff member, IHS, India)

The issue of recruiting senior staff was also identified as an issue at the HEU, South Africa. The unit has not been able to recruit a single person with a PhD in the last seven years. Respondents attributed this to two main factors; first the global shortage of health economists (particularly senior people with experience in low and middle income countries) and secondly the University salary structure. The University has a relatively compressed salary structure meaning that junior researchers are relatively well paid compared to government, but senior people could earn a lot more in government. The HEU estimates that the salaries it can offer senior researchers are 40% lower than market value. As a consequence, the HEU has found itself mentoring and training up a large number of more junior people, who having gained appropriate experience, then leave to better paid positions in government. Like the IHS, the difficulties in hiring more senior level staff mean that existing senior staff bears a very heavy workload, and there is a real danger of burnout. However several external respondents commented on how lucky the Unit is in terms of the personalities of senior staff and how these have in turn influenced the culture of the HEU and indeed made it an appealing and supportive place for many to work.

Issues of identifying and retaining staff at the HSPI, Vietnam appear to be less significant than at some other institutions. HSPI, Vietnam benefitted throughout the 1990s, from investments in capacity development by Sida/SAREC through training of young professionals at Master and Doctoral level at overseas universities, and in particular a collaboration with the Karolinska Institute. This has helped build a cadre of senior researchers at the Institute and there has been zero international brain drain of qualified Masters and Doctoral researchers, all returned back and served in Vietnam and only 2 PhD level staff have left the Institute during the past six years.

HSPI, Vietnam staff are not highly paid but non-financial incentives are important. Like HEU, South Africa the low turnover is attributed to high morale and commitment: staff say they are well recognized by high level officers, proud of their work and their contribution to society, have a good working environment, and are provided an adequate income. While it was felt that the level and mix of researchers was appropriate at the moment, respondents felt that the skill mix was perhaps inadequate to deal with a number of emerging, complex problems in the Vietnamese health system, and also that it would be important to supplement existing staff with staff who have greater expertise in managing policy and advising on policy issues.

7.2.4 Management systems

The two university based entities (HEU, South Africa and HEI, Bangladesh) both relied entirely on University based management systems for all functions such as human resource management, financial management, procurement etc. Similarly the two entities based within Ministries of Health (HSPI and HPAU) used government systems. Accordingly it is only the two independent institutes (CHeSS and IHS) which needed to develop management systems of their own.

By and large management systems were not perceived to be a critical constraint upon the functioning of the institutes, indeed the independent and well established management structures at the HEI, Bangladesh were viewed to be part of the reason for its longevity under difficult circumstances. It was only in the case of the recently established CHeSS that management systems were viewed to be an institutional challenge. The one issue however that was consistently raised in cases where the institute was dependent upon the management systems of a parent organization was reimbursement levels. In Vietnam, Bangladesh, Uganda and South Africa concerns were expressed that prevailing salary levels were too low to attract and retain qualified staff. HSPI, Vietnam had found a solution to this by using grants with external agencies to "top up" salaries. The HEU, South Africa was actively exploring a special university provision allowing certain professions to be paid "above-rate-for-job" to see how they could take

advantage of this. In Uganda, many respondents suggested that a health policy analysis institute would be better placed outside of government for this reason, among others.

A further management related issue, observed in both CHeSS, Ghana and HSPI, Vietnam was the fact that technical/research staff often ended up filling administrative and management gaps that could be better and more efficiently addressed by administrative staff.

7.3 Mission, Functions and Influence

7.3.1 Mission, Functions and Scope of Work

Table 8 compiles the mission statements from each of the study institutions. The only institution lacking such a mission statement was the Health Policy Analysis Unit in Uganda. While the phrasing differs across institutes, there is a considerable consistency in terms of the elements addressed by the mission statement, including a focus on the ultimate goal of improving the performance of health systems and/or enhancing health gains, through capacity development and policy relevant research. This consistency is also reflected in the assessment of functions undertaken by the different institutions (see Table 9). Institute mission statements typically did not articulate the values of the institute, although several refer to addressing the needs of the poor and vulnerable, and promoting equity. In interviews with staff at the HEU, South Africa, values related to equity and social justice were frequently mentioned and were perceived to be shared across staff. At the IHS, India multiple respondents stressed the importance of the fact that the HIS was not pursuing any partisan or political agenda and that it was committed to the use of scientific evidence to strengthen health systems.

Table 8 – Mission statements of case study institutes

Health Policy Analysis Institute	Mission Statement
HEI, Bangladesh	To establish an academic institute within the University of Dhaka for teaching and training in order to develop, strengthen and build up capacity of the health sector professionals, academicians, and health service managers, and for organizing and conducting practical policy-oriented research for the Sector.
CHeSS, Ghana	To support the different partners in achieving health gains in the population, focussing on results on the ground, health services that are responsive to the needs of the population and on the population strata where public health challenges are most important: targeting the poor and vulnerable – all in coherence with national policies and processes
IHS, India	To groom skills, gather evidence and generate knowledge, for people's health. The Institute strives to build local capacity and the global knowledge base for public health and socioeconomic development. IHS activities fall into research, education, training and various other services. The Institute conducts health systems research on applied and operational issues to improve equity and efficiency of the health care sector. IHS offers training programmes to improve managerial skills and health system research capability in India.
HEU, South Africa	To improve the performance of health systems through informing health policy and enhancing technical and managerial capacity in Sub-Saharan Africa. Its foundation is academic excellence in health economics and management.

HPAU, Uganda	Not available
HSPI, Vietnam	To conduct research in the area of health policies and strategies to provide evidence for policy making; to provide consultations on the issues of health policies and strategies to Ministry of Health; to conduct continuous training on development of health policies and strategies; to collaborate with international partners in the research areas concerning with health policies and strategies.

Table 9 – Functions carried out by case study institutes

FUNCTIONS	HEI, Bangladesh	CHeSS, Ghana	IHS, India	HEU, South Africa	HPAU, Uganda	HSPI, Vietnam
Conducting policy-relevant research and analysis	Actively engaged	Actively engaged	Actively engaged	Actively engaged	Seldom	Actively engaged
Providing policy advice and technical assistance in policy formulation and evaluation	Actively engaged	Actively engaged	Actively engaged	Actively engaged	Actively engaged	Actively engaged
Conducting policy dialogues at national levels	Seldom	Actively engaged	Not done	Seldom	Not done	Not done
Conducting policy dialogues at international levels	Not done	Not done	Seldom	Seldom	Not done	Not done
Training and capacity development for policy-makers	Actively engaged	Intended, but not currently done	Intended but not currently done	Actively engaged	Not done	Intended, but not currently done
Conduct systematic reviews	Not done	Not done	Not done	Seldom	Not done	Not done
Commission research or reviews	Not done	Not done	Not done	Not done	Not done	Not done

Every institution was actively involved in the provision of policy advice, and almost all (with the exception of the HPAU, Uganda) also undertook policy relevant research. The two university groups and IHS, India were most actively engaged in training and capacity development for policy and decision makers (although given funding constraints the HEI, Bangladesh has not been very active in this area recently). While the HEU, South Africa was originally conceived to focus on research, over time it has evolved a stronger focus on capacity development activities and training programmes targeted at an audience from across Africa and this now makes up a core part of its activities. This conscious change in

strategy was in recognition of the dearth of health economics capacity in South Africa and Africa as a whole. Several HEU staff commented that teaching has become an important avenue through which to feed back research findings to people working within the health services. Further, it serves to keep HEU staff well informed about the concerns of policy makers and managers, thus contributing to the relevance of their work.

The HEI, Bangladesh was established with a strong focus on training and research. While its offerings of short term training have almost dried up since the DFID grant ended, there has continued to be a strong demand for the Masters in Health Economics that it offers.

Currently, the IHS, India does not provide academic courses. It previously started an academic course in health administration but failed to get recognition for this course from the university with which it was working, so the course was closed down. IHS is now it is in the process of establishing an academic degree course (a Masters in Public Health) in collaboration with the LV Prasad Eye Institute. The government is interested in IHS developing such a course and has recently provided land to IHS to establish the requisite training facilities. A senior government official remarked that the health ministry intends to require all its managers to study public health, and thus the new course will have an automatic intake from the government health service. While this course has not yet started, plans are well advanced.

The HSPI, Vietnam provides some training for MOH health managers on planning, implementation, monitoring and evaluating local programs, though this seems quite limited. Further, the HSPI has plans to develop post-graduate health policy training beginning in 2011. CHeSS, Ghana intends to provide training for policy and decision makers but has not yet in initiated such programs.

With respect to hosting policy dialogues, CHeSS, Ghana has already run some policy dialogues on the topic of health insurance, but the HEU, South Africa was the only other institute that seemed to host such policy dialogues on a regular basis. Similarly the HEU, South Africa was the only group to host international policy fora and dialogues. Several respondents to the Ghana study suggested that CHeSS could play a critical convening role, helping to bring together different types of actors who might have something to contribute to health systems strengthening, but this convening role was not often associated with the HPAIs studied.

The case study tool had also enquired about commissioning of research and conducting systematic reviews. None of the case study institutions were actively engaged in commissioning research and the HEU, South Africa was the only institute that conducted systematic reviews, albeit on an occasional basis.

There was a surprising degree of commonality in the themes and issues that the different HPAIs had addressed. Many of the institutes had conducted analyses around issues relating to health financing (health insurance and user fees); the role of the private sector; development assistance (SWAps and the effectiveness of donor assistance) and hospital autonomy. Perhaps the one clear difference in terms of the scope of the work between the different institutes is that the HEU, South Africa included within its portfolio of work, not only highly applied policy work but also studies that were more academic in nature (encompassing for example issues in research methodology, the policy process, the use of evidence in policy, and conceptual studies). Clearly this broader portfolio of work at HEU reflects the nature of research staff, funding to the HEU, and the greater maturity of the institute compared to some others studied. What remains unclear is the extent to which such methodological and conceptual work is critical to promoting the quality of other more applied policy work conducted within the institute.

7.3.2 Policy relevance, communication and dissemination

Considerable differences emerged between the policy institutes in how their agenda of work was developed, and the extent to which their financing, governance and organizational structures made them directly responsive to government. Two of the institutes, CHeSS, Ghana and IHS, India appear largely dependent on shorter term projects funded by development partners for their main revenues. As such, they are in a very responsive mode, but often may not be responding directly to government's needs but rather those of research funders'. The institutes in Bangladesh, Vietnam and Uganda, all have (or used to have) longer term agreements regarding their financial arrangements, and hence might be thought to have sufficient decision space to develop a more autonomous program of work. However the physical location of the institutes in Uganda and Vietnam, combined with their reliance on the government for funding, means that in practice their agendas have been very strongly driven by government needs. The HEI in Bangladesh had the fortunate combination of long term funding and a degree of distance from government, in the sense that it was located outside of government, and its funding flowed via a third party. However it did not have the scope to take advantage of this position. Only the HEU, South Africa appears to have combined sufficient long term financing with a position outside of government, to develop a truly autonomous agenda.

Consequently, much of the work undertaken by the case study institutes appears to be heavily driven by requests from government or donors. For example, in 2001-2002, HEI, Bangladesh responded to ad-hoc policy advice requests from the MoHFW by producing briefing papers on topics such as procurement and effectiveness of donor assistance, studies on user fees, costing of essential (health) services packages (ESP), and health insurance. HSPI, Vietnam responds to MoH requests for health strategy and policy advice and appraises prospective policies for approval as required by the government or the National Assembly. For example, HSPI, Vietnam will review the social impact of health policies prior to their approval and it participates in projects assigned by the MOH. The primary outputs of such commissioned research are often research reports, frequently combined with verbal briefings. Products from institutes also encompass manuals, actions plans etc. indicating the very practical, implementation-oriented work that such institutes often undertake.

Only the HEU, South Africa, and to a lesser degree the IHS, India, appear to publish articles in peer-reviewed journals, or books or book chapters. Both the HEU, South Africa and HSPI, Vietnam case studies highlighted that there were time and workload constraints to their publishing more research, especially in international peer reviewed journals. In the context where the availability of skilled human resources is a key constraint, there are clear trade-offs to be made between focusing on informing and influencing government health policy, and getting research findings published.

Engagement with mass media appeared somewhat limited. Only the IHS, India and the HEU, South Africa have a communications officer, and in the case of the HEU this post was only recently filled. Indeed it is only recently that the HEU, South Africa has begun to engage with journalists in a more proactive manner. Respondents noted that this was largely sparked by an incident where a report of the African National Congress's task team on National Health Insurance was leaked to the media, which resulted in much misinterpretation which HEU staff attempted to correct through newspaper articles and interviews. Similarly, the experience of IHS, India in engaging with mass media, has been somewhat mixed, and occasionally the institute has found itself having to defend work it has done. Further the institute found that media engagement also tended to take up substantial amount of time of senior staff. The HEU is just beginning to undertake background briefings for journalists on health issues in South Africa as a means to try to raise the general level of health literacy in the media. It is noticeable that the HSPI Vietnam, while having a large staff does not have any communications officer. Presumably the close and trusted relationship between the Institute and the Ministry might actually inhibit broader engagement with other communication channels.

7.3.3 Policy Influence

According to informants, both HSPI, Vietnam and HEU, South Africa had made major contributions to policy development in their respective countries, and IHS also seems to have contributed at state and national levels. CHeSS was too newly developed for any such contributions to have been made, although informants felt that it has the potential to do so. At the HEI, Bangladesh and the HPAU, Uganda, clearly any influence that the institutes had evaporated with diminished budgets. Respondents in Uganda pointed to several instances where opportunities to draw in domestic research evidence had been missed, due to the lack of an effective policy analysis institute.

In Vietnam informants were of the opinion that HSPI had made important contributions to several policy development processes, including the national policy on injury prevention (2002), the national strategy on preventive medicine (ongoing) and the draft law on Health Insurance (2007), as well as the development of a health sector master plan for several provinces and cities. Similarly government respondents in South Africa also cited multiple ways in which the HEU had contributed to policy, areas frequently identified included health equity, health financing, drug policy, primary health care and district health systems. When asked to give examples of HEU's impact on policy, one government official said,

> *'Oh, there are several ... I don't know where to start. The work that they've done around the user fees in the public facilities, the work around medicine pricing, the work around costing of tertiary services, perceptions of the public around the public health system. I mean there's a whole host of research work that they've done that's actually influenced policy'.* Government Official, South Africa

The IHS, India helped draw national policy makers attention to cause of death statistics and was one of the first stakeholders within India to contribute to the conceptualisation of family health insurance policy. In addition IHS has contributed at the state level to government's efforts to improve the health system. The case study concluded that IHS has the potential to make an important contribution to policy but has not been able to do this consistently given the ups and downs in organisational capacity described above.

Personal links between institute members and policy makers can play a critical role in fostering trust and influence and when asked to comment on the influence of a particular institute on health policy, government informants often referred to the contribution of specific trusted individuals (even if the analytical work had come from a broader team).

> *... The policy inroads that X can make are very considerable, really because of her long history and association with the ANC and her ability, and also because of the links that she has. I think this means that she is very readily listened to.'* (external stakeholder, South Africa)

> *"This director has clear vision to influence policies. He is also very close to the Health Minister. He regularly participates in a meeting of all MOH departments every Friday. Frequently, the Minister officially and directly requests him to do some works for MOH. He also has many strategies to meet and talk to the Minister."* (government official, Vietnam)

In Ghana while CHeSS was too young to have already influenced policy, government officials were clearly pre-disposed to work with it because of the fact that key CHeSS staff (particularly the director) were well known to them.

> *"I got to know of CHeSS from X…..Recently, we said that with all the experience he has and the people he worked with, they can help us develop our new programme and given the background*

of the people I know in CHeSS, it is an institution that I personally can work with in the sense that they understand our needs better than I do because they have been part of the process of health reforms over the years till date. …….The only problem is that, we see CHeSS as part of us." (government official, Ghana)

The central importance of key individuals to the policy influence capabilities of the institutes can be a double edged sword. In particular the personalization of influence can introduce instability: if one or two key people leave the institute then influence may wane. One of the strong conclusions emerging from the Vietnamese case study was the need for HSPI to review how to shift from a model of one individual policy champion to a collective institutional capacity to influence policy. Further in Ghana, one government official acknowledged there were issues that he would not want to ask CHeSS to work on as key individuals within CHeSS had too close an involvement in the Ghanaian health system and hence might not be able to analyze it objectively.

A further issue explored in interviews was how the position of the institute (in terms of its legal status) affected its ability to influence policy. As reflected in the literature review an initial hypothesis was that being located in an academic setting might mean that the institute conducted less policy relevant work. This did not appear to be the case in South Africa:

'No, I don't think HEU suffers from that problem. I think they're very much out there.. … [T]heir overall objectives and goals are to influence policy and the best way to influence policy is to actually understand what policy-makers are looking at and what are their challenges. And they interact with us on a fairly regular basis. They sit on committees that we're involved with. They aren't at a distance so they're in the mix of decision-making as such. … [In different government programmes,] somebody from HEU's usually involved in some or other way … So they haven't behaved like what I would call a stakeholder, you know, which has an external plan and is coming to discuss it with us, they're very much in the mix … We don't feel lobbied by them because we kind of see them as part of us' (government official, South Africa)

One respondent did seem to suggest that part of the reason why HSPI, Vietnam was so much trusted by the MOH, was the very close organizational relationship between the two:

"We trust HSPI as HSPI is a part of MOH. They are very keen in research, especially health system and health policy research. In addition, HSPI will be responsible on whatever the impacts of their recommendations are....As for the [name of external agency], I don't trust them: they come and go." (government official, Vietnam)

Clearly there is no fixed yard stick in terms of the appropriate institutional distance between a health policy analysis institute and its target audience. Context, the nature of funding, individual characteristics, formal and informal relationships are some of the many factors that affect the trust and influence.

Box 5 – The advantages and disadvantages of a University location: the HEU, South Africa

All senior HEU research staff indicated that in the South African context, being placed in a university environment was preferable to being positioned in government or being an independent NGO. One respondent reflecting on recent Ministerial politics suggested that if the Unit had been positioned in government *"we would not have survived. The Unit would have fallen apart, just like the Department of Health fell apart"*. Foremost amongst the advantages of working at a university is therefore the protection afforded by academic freedom, especially when being critical of government. At the university, *'there isn't really any pressure to apply any particular ideology or politics, as long as we*

follow scientific principles'. This was particularly important under apartheid but remains true today .

HEU staff noted that proximity to government is not always important for certain types of policy work, such as *'work that's more at a conceptual level and seeking to encourage different ways of thinking'* . Such work does not necessarily need direct feed-in to government processes: what matters is *'to support those working in government to see their own world differently so they can act differently in it. And you do that partly because you're not in government'*. Overall, then, the sense was that the academic environment is important, especially when the political environment is not enabling.

Very practical advantages of a University location were identified: large donors and international agencies appear to prefer funding university institutions rather than NGOs because of perceived financial risk. The university environment allows the teaching of accredited courses. While teaching is not lucrative it allows the HEU to fulfil its capacity-building mission. The academic environment also provides valuable opportunities to engage with colleagues who are working in similar areas: this helps to generate new research ideas and also helps to build internal capacity. Being part of the university provides access to some resources: the Director's post at HEU is funded by the university; the HEU also benefits from the university's administrative systems even though these are somewhat bureaucratic . The HEU however is largely soft-funded - this is one of the disadvantages of working in this particular university environment. A bigger disadvantage of working in the university environment is the low salaries, especially for senior staff (see discussion in text).

The HEU has also brought benefits to the University: it has successfully promoted its profile in Africa, especially through the delivery of a Masters programme. As HEU has been active in the policy arena, this has boosted the '*social responsiveness'* of the university. The HEU has found the School within which it is located very supportive of its work, although this might not be the case at all universities: *'I know that a lot of ... research groups find academic politics really problematic and turf battles and all sorts of battles over resources and those sorts of things. We haven't really, we've been extremely fortunate. I think that we're located in a very supportive department, a very supportive Faculty, and I think it does make a ... big difference'* .

7.4 Capacity Development

The HEI in Bangladesh was perhaps the only institute to have benefitted from a planned and funded capacity development program. The initial grant from DFID included funding for overseas training of HEI staff (a total of one PhD and seven Masters degrees were supported through the grant), and for supplies and equipment including the establishment of a resource centre, and physical renovation of the institute. Unfortunately the limited life of DFID support to the institute and the hostile policy environment prevented these investments from coming to full fruition.

> *"Where HEI failed - or perhaps where the [consulting company] support did not have sufficient time to support capacity building, was in building capacity within the university to mobilise research and other funds from a variety of different sources. Had the university developed a consulting capacity, there would have been scope for the sort of income generation that is needed to keep this type of unit functioning at a high level, but the level of dependency on the DFID funding was too high, so when the funds were withdrawn .....then there was insufficient capacity to mobilise funds from other sources."* (external stakeholder, Bangladesh)

In Uganda, it was acknowledged that minimal, if any, capacity building activities had been undertaken with HPAU staff during the period for which the World Bank grant was active.

The HSPI, Vietnam did not have a targeted institutional capacity development plan, but had benefitted from a long standing Vietnam-Sweden Research Cooperation Programme that has been active since the 1990s. Under this programme a number of staff received Masters and PhD level training in Sweden, and institutional links with the Karolinska Institute were established. The HEU, South Africa is strongly committed to staff development and the case study report notes the investments made by the Unit in mentoring, on-the-job training, payment of fees for staff registered for postgraduate degrees at the University of Cape Town, and dedicated time to work on degree requirements. The HEU has also benefitted immensely from a number of senior staff and associates (such as Di McIntyre, Lucy Gilson and Gavin Mooney) who have prioritized the capacity development aspects of their work. While internal capacity development was a key focus of the HEU, and capacity issues are reviewed on a regular basis, neither it, nor any of the case study institutes have conducted serious organizational capacity assessments or developed comprehensive capacity development plans. Most likely such plans have not been developed due to the lack of funders interested in supporting them, nonetheless a more strategic and comprehensive approach to capacity development may be of benefit to the institutes, and perhaps encourage investment in this field.

Partnerships and Consortia

Staff at the HEU, South Africa also noted the importance of linkages to universities outside of the country. Strong and long term links with the London School of Hygiene and Tropical Medicine (LSHTM) and the Karolinska Institute were thought to be particularly productive, and as the relationship with LSHTM has evolved into a broader consortium, HEU's role has also evolved into one which both benefits from and contributes to capacity development efforts. IHS, India has also benefitted from multiple links and partnerships although the majority of these are with in-country institutions . In the HEI, Bangladesh, university politics proved difficult to navigate, resulting in few networks and few links to other universities being established.

While HSPI Vietnam has strong links to the Karolinska Institute and strong professional networks with researchers at provincial and district levels, it seemed that its international research networks are more limited than those of HEU for example, and that they tend to be ad hoc in nature.

> *"…. There should be an official way of collaboration, maintaining and sustaining such collaborations, wider partners and more official arrangement. Now HSPI invites them on a project based, no continuity and not sustainable. HSPI need more hands, and spend time for thinking and policy interface."* (government official, Vietnam)

Relationship to Government Capacity Development

Capacity within government to process and apply policy advice developed by health policy analysis institutes is key to the ultimate success of the institute. One of the concerns expressed in the literature centers on the possibility of external HPAIs "gouging" government capacity – attracting government staff away to better paying jobs in more attractive environments. Clearly, from the evidence already presented, this is not a concern in many of the institutes studied: the HEU South Africa contributes substantially to government capacity development both through formal training and mentoring of staff who then leave for government; in Vietnam a close and symbiotic relationship between HSPI and the MOH exists.

The one context in which this seemed a real concern, was with respect to CHeSS Ghana, where the current business model relies extensively on contracting staff already employed by universities and by government. While this model enables government staff to top up salaries and facilitates collaborative work across organizational boundaries, it also raises serious questions about the net effects of CHeSS – in its current organizational form - upon government capacity.

8. Conclusions, discussion and recommendations to funders

This study set out to investigate what factors contribute to the effectiveness and sustainability of HPAIs. Our initial study design led us to focus on three main categories of factors namely: the organizational structure of the HPAI (and relatedly its degree of independence); the functions that it performs; and the nature of support that it receives (including support for capacity development). In addition to these three factors, the context within which the institute functions was also found to be critical. The conclusions and discussion are structured around these four dimensions: environment, organizational structure, functions and support. This section also provides a review of the study strengths and weaknesses, and finally, recommendations both for external actors interested in supporting HPAIs, and for HPAIs themselves.

8.1 Factors contributing to the effectiveness and sustainability of HPAIs

The Policy Environment

Perhaps the most important single factor influencing successful HPAI development is a supportive environment, specifically in terms of demand from government for independent analysis. In Vietnam this had clearly been a positive factor supporting the development of HSPI, and in India policy makers at the state level very clearly articulated a demand for evidence to inform the decision making process.

> *"Nowadays this is an era of evidence-based decision making. Policy makers need more information or evidence to support their decisions, not just from their thought. It is a new environment which happens not only in health sector but also other sectors or in other words it is for all, throughout Vietnam."* (government official, Vietnam)

> *Now very precious time, precious resources, precious opportunities are lost or forgotten because I have not been given the benefit of advice. …. And if they are able to tell me this is what happened in Maharashtra or Gujarat or some other country, these are the ways they have improved the health services, here is the evidence for that. I think it becomes much easier for state government particularly to focus on those areas and whenever there are any contrary kind of ideas coming up from the political system, we can juxtapose this and tell them....look this is the evidence we have and that's why we are doing this..."* (government official, India)

In contrast, in both Uganda and Bangladesh, while the cessation of funding was the most visible factor leading to the decline of the HPAIs, in fact the underlying factors identified by respondents in both cases was a lack of government support for the unit. This was clearly the case in Bangladesh, where the incoming government rejected the organizational reforms implemented by its predecessor, but more broadly respondents in Bangladesh questioned the commitment of the government to using evidence in policy. Respondents in Uganda raised similar questions with respect to the decline of the HPAU.

> *"……..Do they not see what is happening? Are they not interested? So at the end of the day you cannot blame the person in the unit you have to blame the people at the top they have not provided the resources , the leadership to correct this situation they have shown*

some level of disinterest maybe they also do not appreciate the importance of policy analysis……" (nature of informant to be clarified, Uganda)

In South Africa, the HEU was established four years before South Africa's first democratic elections in 1994 and thus was established at a period when there were the beginnings of a new climate of openness, and in particular openness to critiques of the apartheid health system. However over the years there have been periods when government has been more or less receptive to HEU advice, and there have been particular policy issues where HEU has had to play much more of an advocacy role than a direct policy influence role. Its ability to shift between these roles bears testimony to the relevance and quality of its work, its independence, and a diversified financial base that few of the other case study HPAIs have.

Governments come and go: it is clearly not feasible or desirable to predicate the existence of or support to an HPAI upon a particular government being in place, but the importance of a policy culture that emphasizes evidence and its use in policy cannot be underestimated.

Organizational Structures
The literature review identified a number of advantages to housing health policy analysis functions in an independent entity compared to either government run organizations (such as Ministries of Health) or universities. The principal arguments are captured in Table 10.

Table 10 – Arguments for and against housing policy analysis functions in different types of organizations

Characteristic	**Government-run organizations**	**HPAIs**	**Universities**
Independence	Limited independence from government	Independence in agenda setting and research	Independence in agenda setting and research
Time horizons	May be focused on immediate decision making needs	Longer term orientation	Longer term orientation
Quality of analysis	Limited incentives for high quality analysis	High quality analysis	High quality analysis
Scope for fresh "out of the box" thinking	Limited due to traditional bureaucratic culture	Scope for fresh thinking	Scope for fresh thinking
Organizational flexibility	Situated in relatively inflexible bureaucratic structures	Flexibility in organization & management structures	May be constrained by university bureaucratic structures
Public Engagement	Less likely to foster public engagement	Ability to foster broad public engagement.	Less likely to foster public engagement
Policy focus	Centrally concerned with policy	Centrally concerned with policy relevance	More focused on academic excellence than policy relevance

The policy think tank literature stresses the importance of a location outside of government in order to maintain a neutral and potentially critical stance. The case study institutions in this study were purposively selected to reflect differing "distance" from government. Two of the case study institutions, HPAU Uganda and HSPI Vietnam were very closely associated with government. For the HPAU the fact

that it was embedded within government appeared to have brought largely negative consequences. Even during the period it was well funded it was clear that its position within the organizational structure created difficulties: while it was meant to provide advice directly to the permanent secretary the hierarchical culture of decision making at the Ministry made this a difficult arrangement to manage. Further, after the decline of World Bank funding the HPAU became entirely dependent upon government funding, and was not in a position to act in entrepreneurially to raise resources for itself.

By contrast the arrangement of the HSPI Vietnam appears to have worked relatively well. While the close relationship between the HSPI and the Ministry of Health has raised some outsider criticism of the independence of HSPI research, the institute appears to have had a considerable degree of influence upon policy, and in the relatively closed policy making environment of Vietnam it is difficult to imagine an entirely external institute achieving the same degree of influence. HSPI's role was further supported by a clear demand among policy makers for evidence. The Vietnam case study highlights the need for the HSPI to strengthen those mechanisms (such as its Board, and Advisory Committee structures) which protect its neutrality and independence, but it seems that it's "half in, half out" position has served it well in the past in Vietnam's specific policy context.

While it has been suggested that universities may be more focused on academic excellence than policy relevance, a university location for an HPAI, as demonstrated by the HEU, South Africa does not necessarily undermine its policy relevance. Indeed several advantages to a university location were identified: the presence of teaching programs, particularly teaching programs that target policy makers, can help develop closer links with policy; being situated within the broader structures of a university means that the HPAI may receive additional financial and operational/managerial support, and benefit from the exchange of ideas with academics working in other fields. Overall these linkages can help support sustainability, for example, in Bangladesh autonomy from government and the strength of university structures helped ensure the survival of the institute, even after donor funds ceased.

Besides the nature of the organizational entity, one other organizational aspect stood out as being critical to an HPAI's effectiveness. It is clear that effective, well networked and highly respected leaders are a critical asset to HPAIs. Such leaders are key in terms of gaining public confidence and social credibility, mobilizing resources to support the HPAI, attracting motivated staff, and interacting with target audiences and influencing policy. Such leaders may be particularly critical during the start up phase of a new institute (such as CHeSS) where the reputation of the institute depends largely on the reputation of the individuals involved. However reliance on a single charismatic or influential leader can be problematic, as discussed in the context of the HSPI Vietnam, the ability of the institute to institutionalize and diversify its relationships with both funders and policy makers is key to broader organizational development, and this move beyond one leader, needs to be consciously planned for.

HPAI Functions

The core functions performed by almost all HPAIs (based both upon the database of HPAIs and the case studies) include the conduct of policy-relevant research and the provision of policy advice. The case studies provide evidence, that under the right conditions, the policy relevant research and analysis undertaken by HPAIs can positively influence policy-making in government. Certainly the case studies identified many instances where the HPAIs provided high quality, policy-relevant analysis that informed policy development and most probably led to stronger policies and better outcomes than would have otherwise been the case.

Beyond these two core functions (policy-relevant research and the provision of policy advice), there was a very mixed picture in terms of what functions HPAIs performed, and it was difficult to assess how these additional functions contributed to HPAI effectiveness and sustainability. For example, while the

literature suggests that think tanks can play an important role in fostering stakeholder engagement and bringing fresh new perspectives to policy. The case study institutions had undertaken stakeholder engagement to only a very limited degree, and this kind of function was not clearly evident in the mission statements of the case study HPAIs. Only in the case of CHeSS was this kind of convening role articulated by stakeholders to be something which the organization wished to undertake, and given the newness of CHeSS this reflected ambitions rather than current reality.

While relatively few of the institutes included in the database undertook policy maker training, some of the case study institutes did, and (as noted above) felt that this function was extremely valuable both in terms of its primary goal (better trained policy makers) but also in terms of strengthening links between HPAIs and the clients they sought to serve.

There were notable differences between institutes in the extent to which they sought to publish their research and analysis. While it seems possible that a strong focus on publications may help both to drive quality, and to disseminate findings to a broader audience, it is clearly not essential to policy influence, and institutes such as the HSPI, Vietnam appear to have been very effective in influencing policy while placing very limited emphasis on publications. The role of publication in HPAI's policy influence needs to be better understood.

Support to HPAIs

A major challenge for many HPAIs is ensuring a diversified and flexible funding base. Initially new HPAIs need to diversify their funding base so that they are not dependent upon one single source of support. Both the HPAIs in Uganda and Bangladesh faltered at this initial step. After this, HPAIs need to focus more on securing a funding base that allows sufficient flexibility in their program of work, to be able to take new initiatives and have some degree of freedom in terms of setting their own agenda. Otherwise, heavily dependent upon short term project funding as many HPAIs are, there is a danger that they become little more than glorified consulting firms, responding to the priorities set by external donor funding. Relatedly there is a need for HPAIs to consolidate their funding base and move away from multiple small grants, which are typically associated with high transaction costs, to larger, longer term more flexible funding – which is often difficult to come by.

In this funding evolution government, as well as external donors, can potentially play a critical role as a source of stable and secure funding, although out of our case studies it was only in Vietnam that this had transpired.

In principle, external support to an HPAI might also be used to drive organizational strengthening. While DFID support to HEI Bangladesh did seek to do this, the grant was suspended before a sustainable level of capacity could be established. More broadly, few of the institutes appeared to have long term strategies or capacity development plans.

8.2 Strengths and weaknesses of the study

The greatest weakness of our study is that we have very superficial information on a large number of HPAIS in low and middle income countries (through the database) and more in-depth information on only six HPAIs (through the case studies). Given the great diversity of HPAIs it is difficult to draw generalizable conclusions from this mix of data.

While the study has mapped the HPAIs in detail, the study design did not include a careful or objective analysis of the impact that the HPAIs have had on policy, nor was it feasible to make comparisons with

similar situations where HPAIs do not exist. Accordingly our study casts light on what factors might contribute to the effectiveness and sustainability of HPAIs, but it does not draw firm conclusions about how effective they are.

The HPAI database was developed based primarily upon other databases and internet based sources. It is probable that the 78 institutes found through these means understates the true number of such institutions.

While the study suffered from the problems outlined above. It also had a number of strengths, specifically:-

- the three different methods of data collection (literature review, database, and in-depth case studies) allowed us to triangulate between different sources
- this cross-country study was one of the first to draw explicit comparisons between different types of policy analysis institutes in different low and middle income settings, and was, we believe, the first to do so in the health sector.

8.3 Recommendations

Strengthening health systems requires investments in basic care infrastructure and health technologies, health human resources training and supply, and appropriate, equitable health financing approaches. However, investing in the availability of technically sound, scientifically credible institutions with some measure of autonomy is also an important part of strengthening health systems. The development of successful health policy analysis institutes requires long term horizons, continuity of leadership in order to gain social credibility, confidence and trust among political stakeholders, and ideally a relatively supportive political environment. What contributions can governments, funders and HPAIs themselves make to promote stronger health policy through the contribution of HPAIs?

Key recommendations for potential funders of HPAIs (including governments) are as follows:-

1. *Invest more in measures that support the development of a culture of evidence-informed policy* - All partners with a stake in the success of HPAIs, and more broadly evidence-informed policy should consider investing more in measures that support the development of a culture of evidence-informed policy particularly among government actors in low and middle income countries. A multiplicity of different factors can help: build evidence-based reviews into SWAps; support research priority setting exercises led by policy makers; consider requirements that new policies are accompanied by reviews of available evidence; support capacity development among policy makers and civil society to access and apply evidence in their work. Having a strong demand for policy-relevant evidence is key to the success of HPAIs.
2. *Prioritize donor support to existing institutes* – the case studies of HPAU Uganda and HEI Bangladesh highlight the pitfalls of donor investment in totally new institutes. Investment in the development of a new institute, from scratch should only be undertaken as a last resort when there are no alternative institutes to work with, and even then should be approached cautiously: the fact that no HPAIs have developed may point to a hostile environment for such entities. In making investments in HPAIs, donors should respect country ownership, ensure appropriate engagement of stakeholders and commit to long terms support for organizational and financial sustainability.
3. *Avoid embedding HPAIs within Ministries of Health* – Ministries of Health require capacity for analytical and policy functions, yet do not make good homes for HPAIs as defined here. HPAIs need to be close but not too close to government. The appropriate degree of proximity depends upon the political context and decision-making culture, but even in relatively closed

policy environments where proximity is important, there needs to be some degree of distance and mechanisms to protect the neutrality and autonomy of the HPAI.

4. *Support HPAIs through the provision of longer term, flexible funding* – even successful HPAIs in LMICs struggle to secure longer term flexible funding that is necessary for them to be able to drive their own agenda and invest adequately in functions such as capacity development and communication. From the funders perspective it may make sense to focus such support around a mutually agreed, but fairly flexible, agenda of work. The scope for endowment funds should also be explored. Such flexible support may be quite small, and should only constitute a proportion of total funding – based on the budgets of the case study institutions an extra US$70,000-100,000 of flexible funding per annum could make a big difference to many institutes.
5. *Support strategic thinking for organizational development* – many HPAIs appear to act in quite a passive manner, responding to opportunities and threats as they arise rather than developing strategic plans that help to diversify their funding base, develop institutional capacity, extend their networks of influence, or strengthen their communications functions. Tools and approaches that facilitate more strategic thinking about organizational development and shift institutes from a more passive to a more active mode would be useful. In light of this, the assessment instruments developed by IDRC as part of the "Think Tank Initiative" should be reviewed and adapted to ensure their relevance to sector-specific HPAIs and their application within HPAIs supported.

Key recommendations for leaders of HPAIs include

6. *Develop plans and funding strategies for capacity development* – capacity development is key to the success of HPAIs, while HPAIs typically think of capacity in terms of individual skills and training for staff (which are indeed important) more attention needs to be paid to the development of networks both domestically (for example links to government, and to other research institutes) and internationally (for example, long term relationships with collaborators). With respect to staff capacity development, senior staff are critical in many respects yet it is particularly among this cadre that issues of burn out and poor retention due to relatively low salaries appeared to be greatest. Capacity development initiatives should recognize the critical role of senior HPAI staff, and explore ways to attract and retain them, and provide them with space to think and continue to grow.
7. *Seek to broaden and institutionalize relationships with MOH and other policy making organizations* – many HPAIs depend on the personal relationships of one or two senior staff members to facilitate access to government, and to ensure that key policy messages are appropriately conveyed to government. While the credibility of individual HPAI leaders may be critically important at the early stages of HPAI development, it is important for HPAIs to have in place clear plans to broaden the network of relationships and to institutionalize connections with government so that they are not dependent on one or two individuals.
8. *Develop HPAIs convening role* – HPAIs have the potential to act as convenors, that is actors who can provide neutral territory on which to bring together different actors to discuss policy relevant issues. This role amongst HPAIs in developing countries appears however to have been under-developed. Both HPAIs and their funding partners should experiment with this role more.

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Annex 1 – Search strategies by search engine

Social Science Research Network (SSRN)

http://papers.ssrn.com/sol3/DisplayAbstractSearch.cfm

- Health policy institutes (all 56 references screened – 0 retrievals)
- Policy organi* (top 100 screened / 1000 – 0 retrievals)
- "policy organization" (all 2 references screened – 0 retrievals)
- "policy organisation" (all 1 reference screened – 0 retrievals)
- "policy institute" (all 18 references screened – 0 retrievals)
- "policy institution" (all 3 references screened – 0 retrievals)
- "observatory" (all 6 references screened – 0 retrievals)
- Policy organization (top 200 screened / 889 titles – 2 retrievals)

Under EBSCOhost meta-database, the following databases were searched:

Academic Search Premier, Africa-Wide: NiPAD, American Bibliography of Slavic and East European Studies, Business Source Premier, CINAHL, EconLit, ERIC, Human Resources Abstracts, International Political Science Abstracts, PsycINFO:

Search terms

- health policy organizations OR health policy institute OR think tank NOT US NOT Europe (n=26 474 records; screening of first 200 titles yielded 0 retrievals)

- health policy organizations (n=52 records, 0 retrievals)

- health policy institute NOT US NOT United States (n=187, 1 retrieval)

Public Affairs Information Service (PAIS International)

- 1526 results found for: (think tank) or (health policy institut*)

- 54 results found for: [(think tank) or (policy analysis institute*)] AND (health) AND (international)
    - Results yielded mainly center-websites (e.g. Center for Demography and Aging, or GAVI, or Public Health Agency of Canada)

- 229 results found for: [(think tank) or (policy analysis institute*)] AND (health); yielded 2 peer-reviewed articles (same as the previous search):

Sociological Abstracts [none included]

- 363 results for ((think tank) or (policy institut*)) and health
    - First 25 abstracts screened were not related to think tanks, unless it was research published by think tanks, or had 'policy' in the title or were about a particular policy

- 23 results found for: (think tank) and health – 0 included

- 316 results found for: (policy institute) and health
    - First 50abstracts screened were neither related to think tanks nor pertinent to this project.

ABI/Inform Global [none included]

- 6614 documents found for: (think tank*) OR (policy institut*)
- 478 documents found for: (think tank*) OR (policy institut*) AND (health)
    - Subset of above search, in scholarly journals: 23 documents found for: (think tank*) OR (policy institut*) AND (health)
    - Subset of above search, in references/reports: 3 documents found for: (think tank*) OR (policy institut*) AND (health

Wiley InterScience Search

- **think tanks in developing countries (n=13) – kept 4 articles**

Google search

"think tank" NOT US, NOT United states
"think tank" "case study" NOT US, NOT United states
"think tank" "capacity development" NOT US, NOT united states
"think tank" "organizational capacity"
All of above completed, searched first 10 pages of results.

"policy analysis institute" instead of "think tank" in above searches