



Final Report

NICE International and the Bill and Melinda Gates
Foundation

**MID-TERM LEARNING REVIEW:
INTERNATIONAL DECISION SUPPORT
INITIATIVE (IDSI)**

September 2016

Submitted by Itad

Acknowledgements

The authors would like to acknowledge the support and participation of all involved in this Mid-term Learning Review. First and foremost, the team from the iDSI Secretariat, who at the time of this review were known as NICE International, and who have now moved to Imperial College's Institute of Global Health Innovation to continue managing the iDSI grant. The iDSI Secretariat team provided dedicated support throughout all stages of the review. We would also like to thank the main contacts for each of iDSI's core partners who were closely engaged throughout the review and provided substantial insights into iDSI and the global arena for priority-setting and universal health care: Dr. Kalipso Chalkidou, NICE International; Dr. Amanda Glassman, Center for Global Development; Professor Karen Hofman, PRICELESS SA; and Dr. Yot Teerawattananon, HITAP. The HITAP International Unit and WHO Indonesia provided great support to organise the country-visit to Indonesia, and NICE International provided great support from London and Delhi to organise the country visit to India, without which these visits would have been impossible. Gavin Yamey's review of an early draft of the final report helped to strengthen the final report with insights from the perspective of a global health expert. George Bowles, Research Assistant, supported the review team with desk research and analysis of the survey data. We would also like to thank all iDSI partners and others who gave generously of their time to participate in key informant interviews, complete the on-line surveys and meet with the review team in Indonesia and India.

The views expressed in this report are those of the evaluators. They do not represent those of iDSI or of any of the individuals and organisations referred to in the report.

Mid-Term Learning Review: International Decision Support Initiative (iDSI) Note from the Evaluation Team December 2016

This note from the Evaluation Team is intended to contextualise the Mid-Term Learning Review (MTR) of iDSI. It is meant to be read as a preface to the final report of the MTR.

The MTR covered the period from iDSI's inception in 2013 through to April 2016. Data collection primarily took place from March until June 2016. This included document review, key informant interviews and visits to India and Indonesia from mid-April to the beginning of May). During July and August, the review team focussed on synthesis, analysis and report writing. The main findings, conclusions and recommendations were presented at the iDSI Board meeting in September 2016.

In any evaluation of an on-going activity, events and developments will occur while the evaluation is being conducted which may have an impact on the findings. In conducting this MTR, the evaluation team endeavoured to take account of new information or developments taking place after April 2016, but inevitably there was less capacity to do this meaningfully as time went on and the focus moved from data collection to analysis and write up. The evaluation team acknowledges this limitation of the MTR.

Some of the developments not captured in the review, but which indicate iDSI's progress in advancing the evidence-informed priority setting agenda, include:

Advancing the evidence-informed priority setting agenda:

- A request for iDSI to provide strategic oversight and support to the medical technology advisory board (MTAB) in India to strengthen the systems and processes to embed health technology assessments (HTA).

- High-level engagement from Indian Council for Medical Research (ICMR) and Department of Health Research (DHR) at the *ICMR-DHR-iDSI Health Technology Assessment: Stakeholder Consultative Workshop* in July 2016 in Delhi, India.

Raising the profile of the iDSI Brand:

- The ICMR-DHR-iDSI Health Technology Assessment: Stakeholder Consultative Workshop in India (referenced above) was presented as a collaboration with iDSI rather than specifically with HITAP and NICE International.

Responding to demand from LMICs for resources on evidence-informed priority setting:

- The GEAR Database is being developed by HITAP to elicit health economics research questions from LMICs and to respond to recommendations from an iDSI Evidence-Informed Policymaking event in Seattle, October 2015.

The GEAR Database is intended to provide a rapid-response, one-stop-shop service for LMIC health economic analysts who support policymakers, and to function as a proactive way of translating iDSI Knowledge Products for an LMIC audience. It is due to be launched in December 2016.

The recommendations in the MTR are pitched as aspirational – to help iDSI achieve more than it may be currently set up to achieve. As such, the evaluation team acknowledges that some of the recommendations of the review have operational and financial implications which iDSI may not be able to take forward immediately given that resources of the current grant are largely committed to achieve the grant objectives. It is appropriate that iDSI focuses on achieving what it has committed to achieve with its current funding. The recommendations are intended for iDSI's Board and core partners to consider, further prioritise and decide which are feasible and relevant to focus on now, in the future or not at all. To help with this we have classified the recommendations in terms of the level of priority and complexity, and the potential resource implications.

MID-TERM LEARNING REVIEW: INTERNATIONAL DECISION SUPPORT INITIATIVE Report

Table of contents

Acknowledgements	2
Acronyms	6
Executive Summary	7
1. Introduction	12
2. Learning Review Purpose, Scope and Methodology	12
2.1. Purpose	12
2.2. Scope	13
2.3. Learning review methodology	14
2.3.1 Data sources and data collection	14
2.3.2 Data analysis	16
2.4. Process and management	17
2.5. Limitations	17
3. Context and Background	18
4. Findings	22
4.1. Strategy component	22
4.1.1 Summary of main findings	22
4.1.2 Findings	22
4.2. Management component	31
4.2.1 Summary of main findings	31
4.2.2 Findings	31
4.3. Technical component	42
4.3.1 Summary of main points	42
4.3.2 Main findings	42
4.4. Country Operations component	48
4.4.1 Summary of main points	48
4.4.2 Main findings: Country Operations	48
5. Conclusions	60
6. Recommendations	64
Annex A: List of Key Informants	72
Annex B: References and List of Documents Consulted	75
Annex C: Detailed Results and Additional Analysis	78
Annex C2: Network Survey	92
Annex C3: Governance and Management review (systems and processes)	101
Annex C4: Knowledge products review	104
Annex C5: Country Case Study Reports	109
Appendix A: List of documents	126
Appendix B: List of persons interviewed	128
Appendix C: Stakeholder Mapping	129

Appendix D: The Basics of Universal Health Coverage and the Context in India	132
Annex D: Evaluation Questions and Sub-Questions	161
Annex E: Terms of Reference	162

Acronyms

BMGF	Bill and Melinda Gates Foundation
CGD	Center for Global Development
DFID	Department for International Development (UK)
Gavi	Global Alliance for Vaccines and Immunisation (the Vaccine Alliance)
Global Fund	Global Fund for the fight against AIDS, TB and Malaria
HITAP	Health Intervention and Technology Assessment Program (Thailand)
HTA	Health Technology Assessment
iDSI	International Decision Support Initiative
KII	Key informant interview
KP	Knowledge product
LIC	Low-income country
LMIC	Low- and middle-income country
M&E	Monitoring and Evaluation
MDGs	Millennium Development Goals
MEEP	Methods for Economic Evaluation Project
MEL	Monitoring, evaluation and learning
MTE	Mid-Term Evaluation
NCD	Non-Communicable Diseases
NICE	National Institute for Clinical Excellence
NI	NICE International
ODI	Overseas Development Institute
PHFI	Public Health Foundation of India
PRICELESS	Priority Cost-effective Lessons for Systems Strengthening (South Africa)
ToC	Theory of Change
ToR	Terms of Reference
RAG	Red Amber Green
SDGs	Strategic Development Goals
UHC	Universal Health Coverage
WHO	World Health Organization
Wits	University of the Witwatersrand (Johannesburg)

Executive Summary

The International Decision Support Initiative (iDSI) is a relatively young, specialised partnership-based initiative established to provide policymakers with coordinated support in evidence-based decision making as a means to Universal Health Coverage (UHC). As a partnership, iDSI promotes priority setting knowledge, skills and processes through sharing experiences, lessons learned, and country-focused technical, practical support. The iDSI partnership brings together academic, analytical and practitioner expertise from a range of decision-making agencies, universities, government ministries and development think tanks with expertise in priority setting for health. iDSI is oriented around global and national public good elements including institution-building and strengthening processes along with information, knowledge generation and sharing objectives. Established in 2013, iDSI has now had more than two years of experience and has completed one funding cycle. It continues to occupy a unique policy space.

As it began a new funding cycle, iDSI partners and funders considered it a good time to review progress and identify useful lessons in order to help shape its future development. This report is the result of that review (referred to as the learning review). It was commissioned by iDSI under its grant from the Bill and Melinda Gates Foundation (BMGF). It is primarily intended to support internal reflection and learning by iDSI core partners and its Board, and to guide discussions and debate about how iDSI might shape its own future evolution. The learning review methodology was focused around the four components of iDSI (Strategy, Management, Technical and Country Operations). Data collection included more than 30 key informant interviews, 78 responses to two online surveys, document review, a review of iDSI knowledge products and two country case studies (India and Indonesia). Data analysis was guided by a set of questions linked to each of the four components. An Evaluation Oversight Committee was established by iDSI to oversee the evaluation and, specifically, to respond to both the inception and final reports. Additionally, Gavin Yamey, Professor at the Duke University Global Health Institute, quality assured an early draft of the final report and provided feedback from his perspective as a global health expert.

Although iDSI has secured multi-year funding through a single grant that is largely committed, the presumption of the review is that iDSI will seek additional funding to support additional activities and help fund operational expansion. The review takes as its starting point the idea that iDSI is an entity that can and will continue to grow and develop. Some of the recommendations of the review have operational and financial implications which may not be possible to take forward given that resources of the current grant are largely committed to achieve the grant objectives. The learning review covered the period from iDSI's inception to April 2016. The learning review process endeavoured to take account of new information or developments taking place between April and August 2016, but there was less capacity to do this as the review concluded. While the review aims to be high level such that individual events or developments will not affect its content (or, critically, its recommendations), there is a possibility that the most recent events and data not captured in the review may change the analysis or the recommendations. An important limitation of the learning review is in a fast moving environment, some key developments may have been missed and the it would never have been possible to capture the real time events that were occurring as the report was being written. However, while the review may not be fully up-to-date, it is thought that the challenges and recommendations raised are still valid for iDSI to consider.

Context

Priority setting in health is rising up the global health agenda as more countries adopt policies aimed at advancing universal health coverage. Ensuring that national resources fund the essential health services required to meet the needs of all people can strain resources and test political will. As countries transition to middle-income status and make more progress in health, the challenges of priority setting become harder, and competition over health resources creates difficult choices that need transparent, equitable and politically sustainable resolutions. This concern with maximising

health outcomes is only likely to increase over time, driven by the accelerating non-communicable disease burden and global health security challenges, an expanding choice (and cost) of health technologies and intervention options, and the uncertainties of the global economy that make annual growth in the health budget far from certain.

Findings

Strategy

The Strategy component focused on reviewing the current positioning of iDSI in the context of the changing global health agenda and the growth in attention to evidence-informed priority setting for UHC. The main strategy findings included that: iDSI fills an important niche through its focus on technical capacity, knowledge generation and country-centred process support and most key informants were positive about its role and achievements so far. iDSI's reputation is largely based on the reputation capital of its core partners who are credible, technically sound, and rigorous in approach. iDSI's vision is clear but open ended. Its strategy is generally identifiable but inconsistent and it is not clear how the operationalisation of the strategy is taken forward in practice. Progress is opportunistic (a positive and important element of iDSI's approach to hold onto) but it is difficult to identify, even in hindsight, how activities have shaped up against the strategy. iDSI's approach to global working is less clear than its country-focused work. In particular, its partnerships with WHO and with the global health funding organisations like Gavi, GFATM, UNITAID and others could be better structured.

Management

The Management component focused on analysing two separate but related strands of iDSI (governance and network structure) to assess the extent to which iDSI operates effectively. The summary of findings included that iDSI's governance and management structures and processes are progressively being professionalised and formalised. However, the Board is not yet operating at a strategic level and is more focused on sharing information than decision making. A small group of people from core partners and others who have been strategically involved in iDSI since its formation are the main actors in iDSI's governance and management. This has the potential to limit transparency, accountability and innovation. Core partners work together well and are actively involved in the network. Communication about the network's performance and impact is weak, and partners and stakeholders would like to be kept better informed in these areas. iDSI brings together partners with significant skills and experience. In some settings, iDSI partners have been instrumental in advancing priority setting institutions (for example, in Indonesia and India). However, there are some gaps in iDSI's reach into LICs/LMICs, and iDSI may not always have ready access to the range of skills needed to support countries to institutionalise priority setting (for example, specific health systems strengthening or political economy analysis skills in low income settings).

Technical

The Technical component focused on analysing how iDSI generates and manages knowledge in light of its strategy. iDSI supports the production of a wide variety of high-quality materials. The majority are peer-reviewed journal articles (63%) while others include reports from workshops/meetings, internal strategy documents, manuals and guidelines, and resources to support policy makers. What iDSI considers a knowledge product is not always clear; it can include a product like a newsletter but exclude an economic evaluation done at the country level in the context of iDSI technical assistance. iDSI's overarching research strategy is not explicit or visible to many partners in the network. There was a range of views about the objectives and products that iDSI should be supporting through its research programme. There was agreement that iDSI should be supporting capacity building and knowledge production in LMICs. iDSI does not currently have an explicit platform(s) that allows for knowledge to be strategically "pushed" out to relevant audiences or to link knowledge management to its high-level strategic and advocacy goals around evidence-based decision making.

Country Operations

The analysis of Country Operations focused on iDSI's approach to initiating and delivering country-level practical support. iDSI partners provide a range of technical and capacity-building support in the countries where they work, linked to the full cycle of designing, building, implementing and refining national capacity to institutionalise priority setting in a UHC context. iDSI partners' support at country level tends to be long term, multi-year commitments that embrace a range of interventions. Some of this support is unseen, hard to quantify and is highly dependent on individual capacity and country knowledge. iDSI's approach to technical assistance at country level is an important feature of its niche, and its ability to align its support to country-led demand is a distinguishing quality worth safeguarding. iDSI partners have an established track record and experience in several countries. Currently, this is more recognised by in-country partners around advocacy and capacity building than around institution building in the context of health systems reform. However, iDSI an important component of iDSI's practical support is establishing the foundations for institutionalisation of priority-setting. This effort is starting to show impact in several countries (examples from Indonesia and India are discussed in case studies). iDSI partners are viewed as credible, experienced, respectful and, most importantly, worthwhile engaging with in support of country goals. iDSI has uneven experience working with other priority-setting partners at the country level such as WHO.

Conclusions

iDSI is in the right place at the right time for what is set to become a steady growth in interest, commitment, investment and experience around priority setting at both global and country levels. iDSI needs to consider how it wants to evolve and how it is able to evolve given the funding and resources it has available. It has many of the components of what would be needed but is hindered by a lack of precision and clarity in its strategy, and a management approach that seems to be constraining growth (in size of the network, influence and knowledge). Its core partners have solid reputations and as a partnership it has built a reputation for integrity, commitment and capacity-building support. However, based on the findings of this review, if iDSI wants to grow in a way that makes it the go-to network for priority setting for UHC, there are some strategic, governance, networking, and knowledge management shifts it could usefully consider. iDSI will need to assess which of the recommendations are feasible within current funding and resources.

iDSI has either directly produced or supported the production of a wide variety of knowledge products at both global and country level. The research selection process is currently shifting from one that was fairly ad hoc or opportunistic (and thus lacked transparency) to one that is more rigorous and methodical. There is still a lack of clarity around the higher-level iDSI research strategy, as well as aspects of the selection process including who can apply and how decisions are taken. As yet, there are no concrete plans aimed at ensuring technical material is accessible to a wider policy audience.

iDSI partners deliver valued support to countries. While iDSI partners tend to provide support from a distance in most circumstances, there was a preference expressed by countries themselves for more long-term in-country technical assistance. Most of iDSI's support is focused on providing practical guidance and building specific skills (economic evaluation) and processes (such as Standard Treatment Guidelines, Care Pathways etc.). As countries advance their institutional arrangements, they need increasingly specialised health systems and institutional development expertise. At present, iDSI capacity in this regard is less evident in every setting where they work, although there are excellent positive examples including in India. A question for reflection is whether iDSI partners are overly constrained in relation to advancing the dialogue or shifting the conversation about evidence-based decision making in a country context.

Recommendations

Based on the findings and the conclusions, the key recommendations from this learning review are summarised below. The recommendations are high level for the most part and aim to help iDSI

consider options as it moves towards its next phase of development. The recommendations take as a starting point the idea that IDSI is more than its current grant and that it aims to diversify funding as well as increase its institutional presence in the future. The recommendations are designed to help IDSI to strengthen its strategic, operational and technical arrangements in light of fast-changing global and country contexts. Recommendations are organised in a suggested categorisation in terms of their (a) priority, (b) relative complexity and (c) resource implications.

Recommendation	Priority	Complexity	Resource implications
1. Clarify the partnership's strategy, vision and operational priorities.	1	3	3
2. Continue to make progress strengthening governance arrangements to provide greater transparency and legitimacy of decision making and to access additional expertise.	1	3	3
3. Develop and appropriately resource a global engagement strategy including the identification and engagement of priority partners.	2	3	3
4. Review IDSI's approach to country operations at both technical and operational levels to ensure it is adaptable and remains fit for purpose.	3	3	2
5. Identify the full range of skills and expertise needed and proactively seek these out specifically including political economy analysis, health systems strengthening and public institutional reform skills.	2	3	3
6. Reassess the current knowledge generation strategy to ensure that knowledge products relate clearly to other pillars of IDSI activity (including its country support and advocacy for priority setting for UHC); and build on recent developments to ensure the process of selection, quality assurance and uptake is transparent and robust.	1	3	2
7. Develop a knowledge management strategy that works in the service of the IDSI strategic objectives by promoting priority setting in health, supporting technical knowledge and building a broader understanding of the role of evidence-based decision making in health.	1	3	2
8. A vision for future discussion - Consider how the organisational structure within the partnership might be reshaped in order to better support its core business and make its products more accessible to a wider range of practitioners, policy makers, affiliates and beneficiaries.	2	2	2

Key to the table:

1 = Highest priority, high complexity such that additional support would be required, significant costs involved;

2 = medium priority, more complex (such as being a multi-stage process), and has cost implications (more than one meeting or could not fit into current job descriptions);

3 = lower priority, least complex, low or no cost.

1. Introduction

The International Decision Support Initiative (iDSI) is a partnership-based initiative established to provide policy makers (at sub-national, national, regional and international levels) with coordinated support in priority-setting as a means to Universal Health Coverage (UHC).¹ As a partnership, iDSI promotes priority setting knowledge, skills and processes through sharing experiences, lessons learned, and country-focused technical, practical support for “more systematic, fair and evidence-informed priority-setting processes.”¹ The aim of iDSI’s work is, thus, through encouraging evidence-based decisions about allocation of scarce resources for health, to contribute to better health for populations particularly in the context of achieving universal health coverage.

The iDSI partnership brings together academic, analytical and practitioner expertise from a range of decision-making agencies, universities and development think tanks with expertise in priority-setting for health. iDSI is oriented around global and national public good elements including institution-building and strengthening processes along with information, knowledge generation and sharing objectives. Established in 2013, iDSI has now had more than two years of experience and has completed one funding cycle. In 2016 it started its second phase with a slightly different group of partners and funders. As it begins a new funding cycle, iDSI partners and funders considered it a good time to review the progress iDSI has made as a partnership and to identify useful lessons that will support the partnership to evolve². This report is the result of that review process (referred to as the learning review). It was commissioned by iDSI under its grant from the Bill and Melinda Gates Foundation.

This report contains five sections following this one. Section 2 reviews the purpose, scope and methodology for the review. Section 3 provides an introduction to iDSI and a summary of the current context in which it is working. Section 4 presents the main findings of the mid-term review. Section 5 summarises the review’s conclusions, and Section 6 identifies priority recommendations. The annexes contain additional relevant data and results.

2. Learning Review Purpose, Scope and Methodology

2.1. Purpose

This learning review is an opportunity to assess progress, achievements and operational arrangements in order to support iDSI to make critical adjustments and build on its strengths moving forward, so as to remain fit for purpose to achieve its mission. This is a formative review focused on highlighting positive progress while identifying areas where specific actions might help the partnership move forward. The review’s primary audience consists of the core members of iDSI, the Board and iDSI’s funders, although a secondary audience,³ including wider delivery partners and potential funders, may also be interested in the findings. The objectives are elaborated in the Terms of Reference (ToR) (Annex E) and discussed more fully in the Inception Report.

Although iDSI has secured multi-year funding through a grant from the BMGF that is largely committed, the presumption of the review is that iDSI will seek additional funding to support additional activities and operational expansion. The review takes as its starting point the idea that iDSI is an entity that can and will

¹ iDSI website, <http://www.idsihealth.org/>

² The learning review is aimed at supporting the evolution of iDSI not as a review of the BMGF grant.

³ The secondary audience for priority setting in general was clearly identified in the 2015 Bellagio outcome statement and, indeed, illustrated by NICE – UK’s own history. As the document stated, “An explicit decision-making process, as used by HTA agencies, can be a valuable mechanism to identify and engage with key stakeholders and to outline rules for reaching a decision ... this explicit process can help to sustain coverage that is pro-poor, insulating decisions from politics. Building a strong relationship with the media, as seen in the UK with the National Institute for Health and Care Excellence, can support an HTA agency in explaining decision-making processes—which in turn can help to shield the agency from politics.” See: [Implementing pro-poor universal health coverage](#), December 11, 2015, *Lancet Global Health*, *Participants at the Bellagio Workshop on implementing Pro-Poor Universal Health Coverage*: Jesse Bump, Cheryl Cashin,

continue to grow and develop. The evaluation team recognises that some of the recommendations of the review have operational and financial implications which it may not be possible to take forward at this time. We have attempted to categorise the recommendations based on how much of a priority we consider them to be, the degree of complexity to implement the recommendation and the financial implications. We would suggest that the iDSI Board and core partners review the categorisation and revise it to reflect what is feasible given the operational and financial realities of iDSI.

2.2. Scope

This learning review covers iDSI from its inception in 2013 up to April 2016 taking into account the two phases of iDSI,⁴ its evolving strategy, core partners and funding situation. The focus of the learning review encompasses four separate but inter-connected lines of investigation (the evaluation components):

- a. **The Strategy component** focused on reviewing the current positioning of iDSI in the context of the changing global health agenda including increasing attention to evidence-informed priority setting for UHC.
- b. **The Management component** focused on analysing two separate but related strands of iDSI (governance and systems as well as communication and network structure) to assess the extent to which iDSI operates effectively.
- c. **The Technical component** focused on analysing how iDSI generates and manages knowledge in light of its strategy.
- d. **The analysis of Country Operations** focused on iDSI's approach to initiating and delivering country-level practical support.



Each of the evaluation components was investigated using a framework based on evaluation questions (Table 1).⁵

Table 1: The iDSI learning review evaluation questions

1. Strategy:
1.1. What is the context in which iDSI operates?
1.2. What is the strategic positioning of iDSI in this context?
1.3. To what extent do the activities that iDSI is implementing contribute to its strategy?
2. Management:
2.1. How effective and efficient are the iDSI governance arrangements?
2.2. Is iDSI's core global structure fit for purpose to deliver iDSI's strategy (in terms of member size, composition of disciplines, connectedness, centralisation and median trust)?
2.3. How effectively is iDSI managing/coordinating the partners (optimising value of each individual partner and the collective)?
2.4. How effective and efficient is resource management across the network?
3. Technical:
3.1. What knowledge products (KPs) have been produced by iDSI?
3.2. What is the process through which knowledge products are identified and produced?
3.3. What is the relevance of the KPs that iDSI produces?
3.4. Have the quality standards for producing and disseminating KPs been followed?
3.5. What is the uptake of KPs?
4. Country Operations:

⁴ iDSI's first phase or cycle was 2014–15; it has recently started its second phase (2016–19). These phases and iDSI's timeline are discussed in Section 3.

⁵ The full evaluation matrix is in the Inception Report, April 2016.

4.1. What is the scope of iDSI's practical support at country level?
4.2. How effectively is iDSI working with other actors at country level?
4.3. Is country support relevant?
4.4. How is the work that iDSI is doing at country level set up to deliver stronger country institutions?
4.5. How effective and efficient is resource management for sub-grants to in-country partners?

2.3. Learning review methodology

The learning review methodology was focused around the four review components and their related overarching evaluation questions. An evaluation matrix was developed to unpack these questions into a series of sub-questions and link them to specific data collection instruments and data analysis approaches. The data collection strategy and analysis approach are summarised briefly here.⁶

2.3.1 Data sources and data collection

The main data sources used for this review were:

Table 2: Principal data sources and data collection methods used to support the iDSI Learning Review

Data source	Data collection	Approach to data collection
Key Informant Interviews (KIIs)	28+ interviews with key informants	<p>Key informants included the range of partners engaged with iDSI since its inception in 2013 including academics, economists, policy makers, donors, multilateral organisations, and systems specialists from private and public sectors and at global, regional and national levels. Potential key informants were identified and grouped into three tiers depending on the depth and strength of their links to iDSI using criteria such as strategic funding relationship, co-authorship, joint working, etc., with tier 1 having the closest link to iDSI and tier 3 being less involved. All key informants in tiers 1 and 2 were contacted and as many as possible were interviewed. Tier 3 key informants were sent the network surveys (see below).</p> <p>Key informants were interviewed from all of iDSI's core partners; iDSI's non-executive Board members; iDSI's current and past funders; UK academics involved in the production of knowledge products and iDSI's governance structures; representatives from national governments (primarily MoH), academics, priority-setting initiatives and institutions; and global health funders and multilaterals. A full list of those interviewed is included in Annex A.</p> <p>Interviews were structured around the four learning review components with interview guides for each component. Based on guidance from the Evaluation Oversight Committee, each interview was focused on the learning review components most relevant to the key informant. However, the interviewer had flexibility to include questions from other components if it became apparent through the interview</p>

⁶ A more detailed account of the methodology is in the Inception Report (April 2016)

		that the key informant had information to share in that area. Most of the interviews for India and Indonesia were conducted face-to-face and most of the global-level interviews were conducted by phone or Skype. Written notes were taken during the interview and then refined into a written summary after the interview.
Document Review	100+ documents reviewed	Documents were provided by iDSI partners and shared through a drop box. ⁷ Additional documents were collected through country case studies (see below) and from key informants.
Network Analysis Survey	78 respondents	<p>An online survey instrument was sent to individuals identified by the NI Secretariat and the Evaluation Oversight Committee to elicit their collaboration, information provision, and information request relationships related to iDSI, as well as the existence of these relationships prior to iDSI. The objective of the network analysis was to describe the structure of relationships among iDSI collaborators in order to inform recommendations to improve the network structure with a view towards achieving iDSI's strategy.</p> <p>The Network Analysis Survey collected information on the size of the network and who the iDSI partners collaborate with (pre- and post-iDSI's inception); who provides information to the network and who partners request information from; the expertise and professional disciplines of iDSI's partners; and where iDSI partners are located. The Network Analysis Survey is in Annex C.</p>
Network Health Survey	78 respondents	<p>The Network Health Survey will help iDSI understand what the health of the core iDSI network is, as assessed by iDSI partners, and what issues could be prioritised for network development going forward. The survey was structured around four areas of inquiry – Network Purpose, Network Performance, Network Operations and Network Capacity. Respondents were asked to answer 20 questions to rank their perceptions of the iDSI network along a 5-point scale of strongly agree, agree, neither agree nor disagree, disagree, strongly disagree. There was also an option for "no answer". Three open-ended questions were also for all participants in the survey to elicit responses on iDSI's successes, challenges and partners' engagement with iDSI. An additional three open-ended questions were sent only to tier 3 survey participants (n=35) to elicit additional information from them on their understanding of iDSI's role in priority setting, what they would like to see iDSI do more of, and how their organisation and iDSI can best mutually support each other in achieving the objectives of iDSI.</p> <p>The Network Health Survey and the Network Analysis Surveys were sent out as one survey instrument. All responses are confidential. The Network Health Survey is included in Annex C.</p>
Country Case Studies	India Indonesia	Country case studies were undertaken in India and Indonesia to inform the analysis of iDSI's approach to country support and operations. The three priority countries for the current phase of iDSI's funding are India, Indonesia and Vietnam. In liaison with iDSI, India and Indonesia

⁷ The majority of the documents consulted were made available to the evaluation team by April 2016. Documents provided by iDSI after April 2016 and that also refer to activities undertaken between May and August 2016 have been incorporated as well as possible but there may be some missing. The formal cut-off date for the learning review is April 2016.

		<p>were selected as the two country case studies because of the learning opportunities they provide as models of the potential for large-scale impact of priority setting (Indonesia); and replicating and scaling up to the central level support provided at the state level (India).</p> <p>The country case studies consisted of a focused document review, followed by a country visit by two members of the core learning review team for 5–7 days to interview key informants at country level and collect further relevant documents. Key informants were proposed by the NI Secretariat; Health Intervention and Technology Assessment Program (HITAP) and WHO/Indonesia (for Indonesia), and NI (for India). Stakeholders interviewed included senior and mid-level government ministry representatives (primarily associated with the MoH); academics and researchers; multilaterals and funders of iDSI and/or relevant health systems strengthening initiatives in country; clinicians; and priority-setting institutions.</p> <p>The majority of the country-specific key informants were interviewed face-to-face. Those who were not available during the trips by the learning review team to India and Indonesia or are no longer based in-country were interviewed over the phone or Skype. Written notes were taken during the interview and then refined into a written summary after the interview.</p>
Knowledge Product Review	37 knowledge products reviewed	Knowledge products on the iDSI website listed as 'iDSI products' were used for the analysis. Based on interviews, documentary evidence and the country case studies, iDSI's approach to knowledge products were assessed against a framework comprised of the elements iDSI itself identified as its priorities (selection, relevance, uptake, capacity and communications).

2.3.2 Data analysis

The data analysis approach for each of the learning review components is summarised below.

Strategy: Interviews were coded thematically in order to ensure that findings from document reviews and interviews could be directly linked to the relevant evaluation questions. Evidence from the key informant interviews was synthesised and triangulated with the data collected in the network surveys and document review.

Management: Four primary data sources were used to identify the main management findings. These included the network analysis and the network health surveys, programme management data, thematically coded open-ended interviews with key informants, and other documentary data sources provided by NICE International (NI) with a focus on governance documentation. Country case studies provided some additional material. Evidence was synthesised and triangulated to extract the main themes.

Technical: Knowledge products were identified from the iDSI website and mapped according to type. Products were analysed and catalogued based on authors, organisation(s) involved, date published and thematic focus. They were also assessed against a normative framework of steps to be followed for an effective knowledge product development and dissemination process. Evidence from open-ended interviews with key informants was coded thematically and triangulated with findings from the network survey and the country case studies.

Country Operations: iDSI's country facing work was reviewed using a combination of the two country case studies (Indonesia and India), evidence from the key informant interviews, document reviews and evidence

collected in the network survey. Data from the key informant interviews conducted during and after the country case study visits were triangulated with findings from the document review and additional evidence where available. A more detailed description of the country case study visits and methodology is contained in each of the Case Study Reports in Annex C4.

Conclusions and recommendations: Once the data were analysed by learning review component, the main cross cutting themes were extracted to support the conclusions, which are presented in the form of answers to the main evaluation questions.⁸

2.4. Process and management

The learning review was undertaken during the period of March to September 2016 and was conducted in three phases including inception, data collection, and then synthesis and write-up. The learning review team comprised five members. An Inception Report was produced at the end of the inception phase (mid-April). Data collection was undertaken between mid-April and mid-July including the document review, key informant interviews, and the network survey. The two country case studies were undertaken in April (Indonesia) and May (India). Reports from the country case studies were submitted to iDSI partners for review and fact checking; comments from iDSI have been incorporated into final versions of the country case studies. This final report has been quality assured by internal and external reviewers.

An Evaluation Oversight Committee was established by iDSI to oversee the learning review and, specifically, to respond to both the inception and final reports. The Committee's role was to ensure that the evaluation was delivered appropriately and to a high standard. The Evaluation Oversight Committee was composed of Tony Culyer (iDSI Board Chairman), Robert Newman (iDSI Board Vice-Chairman), Kalipso Chalkidou (Director, NICE International), Yot Teerawattananon (Program Leader, HITAP), Damian Walker (Senior Program Officer, Bill and Melinda Gates Foundation), and Julia Watson (Senior Economic Adviser, DFID). The learning review team presented preliminary conclusions, and recommendations were presented to iDSI partners in early July for discussion and validation. The iDSI Secretariat shared this presentation with the Delivery Executive Group. Additional or outstanding data was also identified at that time.

2.5. Limitations

There were over one hundred potential key informants identified by iDSI and a sample was identified for interview. While the sample included the most important key informants, a few of these were unable to be interviewed. Where possible, additional key informants were identified in order to ensure the views were representative. However, as it was not possible to interview everyone, it is possible that critical ideas, information and views may not have been collected in the learning review process.

The evaluation time frame spanned the period from iDSI's inception to April 2016. The learning review process endeavoured to take account of new information or developments taking place after April 2016, but, inevitably, there was less capacity to do this meaningfully as time went on. While the learning review aims to be high level such that individual events or developments may not affect its content (or, critically, its recommendations), there is a possibility that the most recent events and data not captured in the review may change the analysis or the recommendations.

Country case studies were conducted in two countries although iDSI is engaged in six countries. The sample was agreed with iDSI partners and was based on those countries where there would be the best scope for learning. Views are largely a reflection of the findings from these two countries triangulated where possible with evidence from key informant interviews and other evidence to support more generalized findings.

⁸ The evaluation team assembled in June 2016 for a two-day data synthesis and analysis workshop for this purpose.

3. Context and Background

The current context for evidence-informed priority setting in health

Priority setting in health – and its attendant challenges – is rising up the global health agenda as more countries adopt policies aimed at advancing universal health coverage.⁹ More countries are moving towards publicly financed health care systems that cover the whole population for essential health services, and specifically target the reduction of preventable illness and death, especially in children.¹⁰ By improving health and reducing the economic burden caused by sickness (both in terms of the direct cost of care and the indirect cost of lost income), UHC is an important driver of household well-being, boosting economic and social security and creating a very powerful safety net.¹¹ Household resources previously spent on preventable health conditions – including the growing burden of non-communicable diseases across almost all countries – can be redirected to investments in housing, education and the family economy. For every 10% gained in life expectancy, economies can expect a boost of 0.3% to 0.4% in annual growth.¹²

The global architecture is shifting to reflect the acceleration in country efforts to advance universal health coverage.¹³ Both WHO and the World Bank have identified UHC as a high priority and Margaret Chan called UHC, “the most single most powerful concept that public health has to offer.”¹⁴ ¹⁵ The G7 leaders explicitly commit to promoting UHC in the communiqué of the 2016 G7 meeting in Japan.¹⁶ The International Health Partnership has transformed itself this year into the UHC 2030 Alliance in order to promote UHC in their partnership countries and presumably beyond.¹⁷ UHC can only be achieved by greater domestic resource mobilization for health.¹⁸

Ensuring that national resources fund the essential health services required to meet the needs of all people can strain resources and test political will. This begins at the top of the priority-setting process with allocation of resources to health and health service delivery (Quadrant 1 in Figure 1), and continues through to allocation within health between priorities (Quadrant 2) and levels of care (Quadrant 3) right through to selecting drugs and technologies (Quadrant 4). As countries transition to middle-income status and make more progress in health, the challenges of priority setting become harder, and competition over health resources creates difficult choices that need transparent, equitable and politically sustainable resolutions. The ‘middle income dilemma’ affects many countries that have graduated from health development aid yet may not have the domestic resources to tackle the gap created by substantial populations that continue to face high levels of poverty and avertable mortality. At the same time, opportunities to more systematically

⁹ Universal health coverage (UHC) is defined by the WHO as a means of ensuring that “all people obtain the health services they need without suffering financial hardship when paying for them.” See: World Health Organization, What is Universal Health Coverage? [online], available at: www.who.int/features/qa/universal_health_coverage/en/ (accessed 26 March 2016).

¹⁰ Interview KI08

¹¹ UHC aims to create financial risk protection and to protect households from catastrophic health spending. The Lancet Commission on Investing in Health estimated that “150 million people each year because of medical spending, where catastrophe is defined as devoting more than 40% of non-food spending to health expenses. About a quarter of households in low-income and middle-income countries borrow money or sell items to pay for health care.” <http://www.globalhealth2035.org/sites/default/files/report/global-health-2035.pdf> For a brief summary of UHC, see the annex of the India Country Case Study (Annex C).

¹² WHO, Investing in health: A Summary of the Findings of the Commission on Macroeconomics and Health, WHO, Geneva, 2001.

¹³ UHC is one of the targets of the 2016-2030 sustainable development goals (SDGs), under goal 3: *Ensure healthy lives and promote well-being for all, at all ages*. Specifically, SDG 3.8 states that member states should, “Achieve universal health coverage, including financial risk protection, access to quality essential health care services, and access to safe, effective, quality, and affordable essential medicines and vaccines for all.”

¹⁴ Margaret Chan, Universal Coverage is the Ultimate Expression of Fairness. Acceptance speech at the 65th World Health Assembly; Geneva, Switzerland; May 23 2012. Chan quote re-election speech

¹⁵ UN Declaration on UHC (2012)

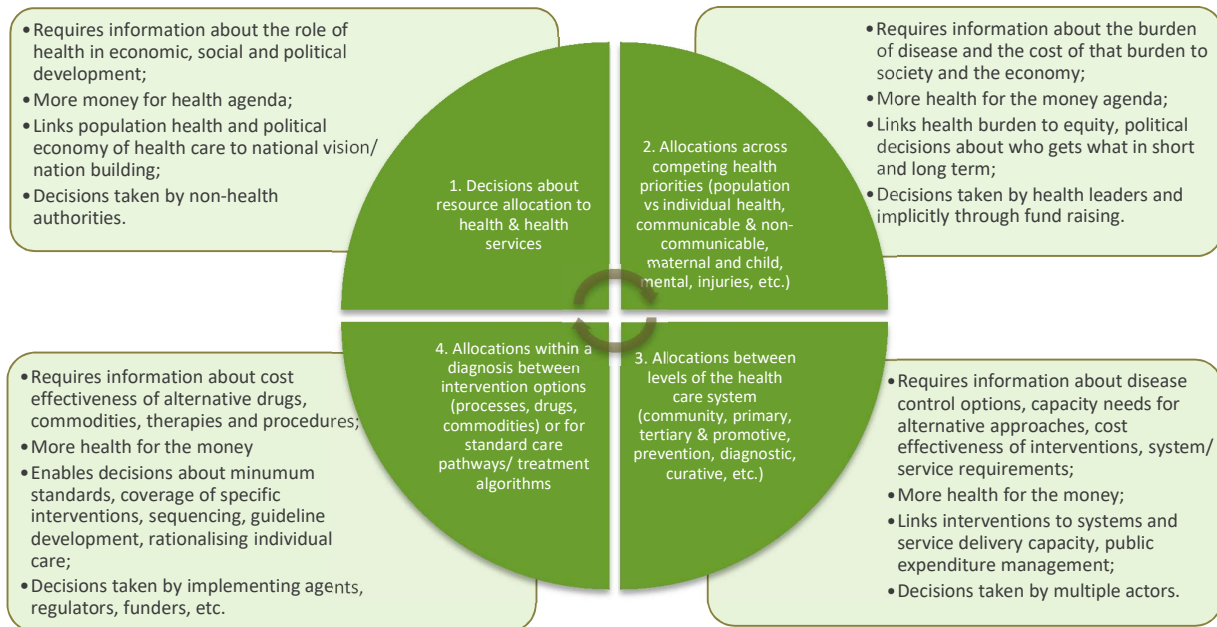
¹⁶ See: <http://www.mofa.go.jp/files/000160266.pdf>

¹⁷ See: <http://www.internationalhealthpartnership.net/en/> and also other examples of UHC partnerships forming such as that between China and several African countries: http://news.xinhuanet.com/english/2015-10/07/c_134687984.htm

¹⁸ See, for example, the Addis Ababa Action Agenda: http://www.un.org/esa/ffd/wp-content/uploads/2015/08/AAAA_Outcome.pdf

incorporate evidence-based decision making may increase as resources and capacity grow. Countries are increasingly looking for help with priority-setting challenges especially from other countries at similar stages of economic and political development.¹⁹ This concern with maximising health outcomes (more health for the money) is only likely to increase over time driven by the accelerating non-communicable disease burden and global health security challenges, an expanding choice (and cost) of health technologies and intervention options, and the uncertainties of the global economy that make annual growth in the health budget far from certain. Priority setting is a wide-ranging term and countries may have very different needs.²⁰ For example, countries such as Cambodia lack clarity still on how the health budget is allocated to begin with (Quadrant 1 in Figure 1).²¹

Figure 1: Different levels of priority setting in health



Introduction to iDSI

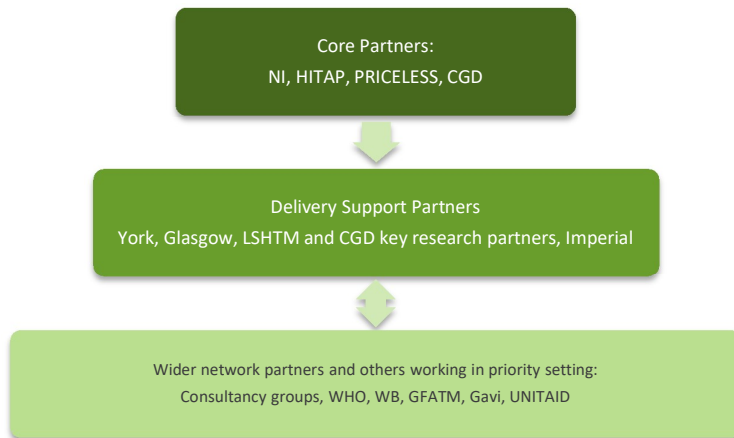
iDSI is a partnership of academics, policy makers and government agencies working together to support the establishment of sustainable processes to make evidence-informed, procedurally fair allocations for health. It does this through augmenting the role of priority setting in health systems in different settings. A core set of institutional partners are involved in the planning, management and strategic direction of iDSI. The core partners for the current funding cycle from BMGF (2016–2018) include NICE International, Health Intervention and Technology Assessment Program (HITAP), the Center for Global Development (CGD), and Priority Cost-effective Lessons for Systems Strengthening South Africa (PRICELESS SA). The list of core partners has evolved over time. During the previous funding cycle (2013–2015), the Centre for Health Economics (CHE) at the University of York was also a core partner.

¹⁹ Interviews KI05, KI07, KI14. Views about South–South partnerships were expressed by both Indian and Indonesian interlocutors interviewed for the country case studies also.

²⁰ iDSI has started thinking and writing about these very different but equally important levels of resource allocation decision making. A paper entitled “A new taxonomy of priority-setting in health” is in draft, authored by Ryan Li, Francis Ruiz, Kalipso Chalkidou and last updated 23 June 2016. However, while a useful thought piece, it is not clear how this thinking will influence iDSI’s approach or technical offer to countries.

²¹ Interview KI17

Core partners work with a wider set of delivery support partners that come together to work on the implementation and delivery of iDSI activities and programmes. These may be one-off partnerships or repeat partners. Delivery Support partners can include organisations such as national authorities or government ministries, research organisations, universities, professional bodies, NGOs and medical associations. iDSI considers a diffuse range of organisations working in priority setting as its partners (termed wider network partners) although rarely do these partners have formal agreements with iDSI, for example to deliver certain results such as a workshop or knowledge product.



iDSI's vision is "Countries making the right choices for better population health". **Its mission** is to "Guide decision makers to effective and efficient healthcare resource allocation strategies for improving people's health".

iDSI works in accordance with its six guiding principles: be demand-driven, provide sustainable support, complement other partners, be transparent and independent, deliver accessible outputs, that are scientifically rigorous, and evidence informed. How it is structured

Embracing these principles, iDSI operates on multiple levels including global, regional, national and sub-national and, through its core and delivery support partners, engages across disciplines to advance its mission. It states in its theory of change (Figure 2) that it combines demand-driven support and policy-informed knowledge products with institutional and procedural support to encourage better decisions about the use of resources for health. As resources are used more consistently to prevent, detect and treat the major burdens of disease across societies, the theory of change stipulates that population health improves.

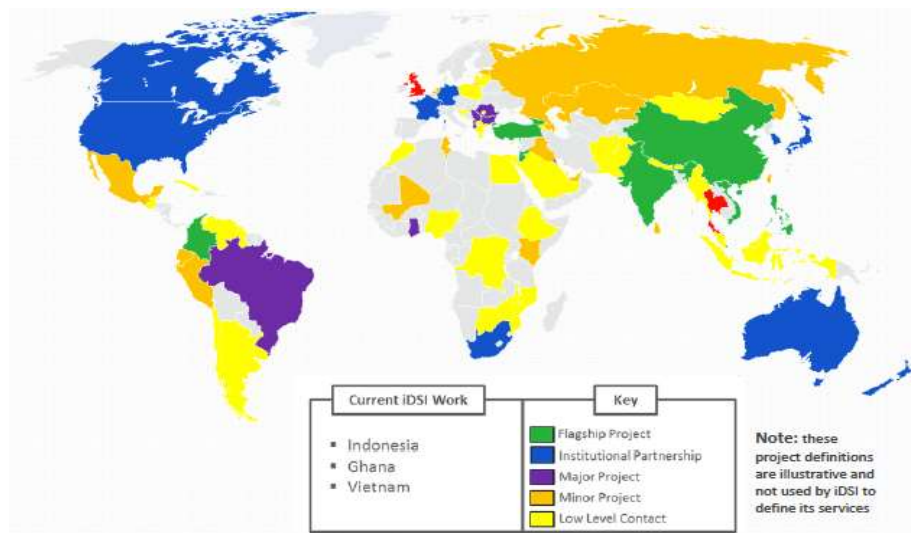
Figure 2: iDSI's Theory of Change, 2016



Through its individual core partners, iDSI has links with many countries across the world although it tends to focus on a half a dozen or so at a time for long-term operational support. About 60% of these are middle and high income, and the balance are low-income countries. The map shown in Figure 3 illustrates the range of

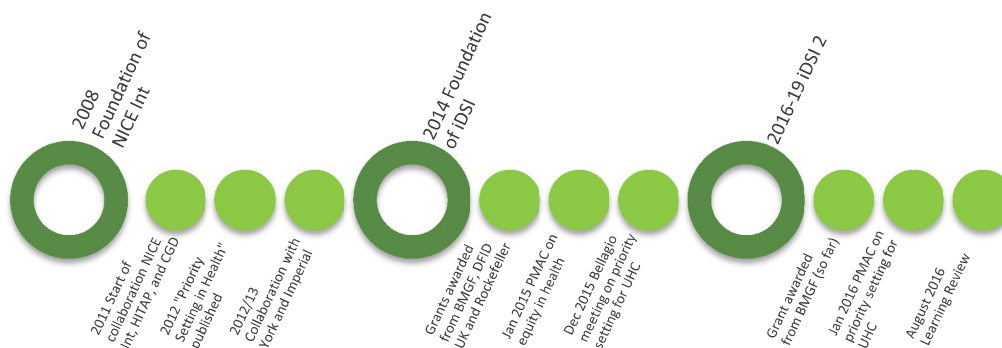
countries linked into iDSI either through institutional partnerships (for example as a delivery support partner) or through country partnerships, including projects in India, Indonesia and Viet Nam.²²

Figure 3: Map showing iDSI's links across the world, 2014²³



iDSI is still a young organisation. NICE International was only created in 2008 and iDSI as an organisation is only in its third full year of operations. The timeline in Figure 4 shows the principal dates and events in iDSI's lifespan. However, such has been the capacity of its members and need for its principal areas of focus, iDSI has grown very quickly indeed and demand for its unique combination of services and support continues to grow.

Figure 4: iDSI timeline 2008 to 2016



²² This map is slightly out of date particularly in relating to iDSI's flagship projects in more recent stages of the partnership's work but it is replicated here as it illustrates the wide geographical range of iDSI's links and partnerships. iDSI's major country partnerships are currently with India, Indonesia, Viet Nam, China, Ghana, South Africa, The Philippines, Myanmar.

²³ The map is from slide 14 of the International Decision Support Initiative (iDSI) Business Model by Accenture Development Partnership in 2014

4. Findings

The findings are organised according to the four components of the learning review (Strategy, Management, Technical and Country Operations). The specific organisation of each of the component sub-sections is laid out individually but they are structured similarly. Each sub-section starts with a summary of the main findings for that learning review component and then works through the findings in detail.

4.1. Strategy component

4.1.1 Summary of main findings



- iDSI fills an important niche through its focus on technical capacity, knowledge generation and country-centred process support, and most key informants were positive about its role and achievements so far;
- iDSI's reputation is largely based on the reputation capital of its core partners: credible, technically sound, rigorous in approach;
- iDSI's vision is clear but open ended. Its strategy is generally identifiable but inconsistent and it is not clear how the operationalisation of the strategy is taken forward in practice. Progress is opportunistic (an important element of iDSI's approach to hold onto) but it is difficult to identify even in hindsight how activities have shaped up against the strategy;
- iDSI's approach to global working is less clear than its country-focused work. In particular, its partnerships with WHO and with the global health funding organisations such as Gavi, GFATM, UNITAID and others could be better structured.

4.1.2 Findings

Outline of the section structure, overview of the evidence base, response to the EQs

The findings of the strategy component cover evidence related to iDSI's strategy and its ability to pursue its strategy at both global and country levels, given the current context in which it is working. The conclusions drawn from the evidence regarding iDSI's position, strategy and role in priority setting are presented in Section 5 as answers to the evaluation questions.²⁴ After assessing the way that iDSI operates in the rapidly evolving global context, iDSI's strategy is analysed in light of its vision and mission. The findings then review how iDSI is advancing the critical elements of the strategy: its niche, including its skills and expertise, its partnerships, and its approach to working at global and country levels.

iDSI in context

Demand for assistance with priority setting for health – an essential component of UHC – is growing but it is a complex process with multiple layers and processes including sustained political will, technical skills, transparency and systems administration capacities. Efforts to advance priority setting are accelerating in a wide range of political, economic and health settings.

For a partnership like iDSI, the global health agenda and the growing emphasis placed on UHC creates an opportunity to advance its strategy and promote priority setting to new, receptive, audiences. Although still a young partnership, iDSI comprises organisations that have been working for years both separately and together on supporting priority-setting approaches, cost-effectiveness tools and strengthening the integration

²⁴ The Strategy component high-level evaluation questions were: What is the context in which iDSI operates? What is the strategic positioning of iDSI in this context? And, to what extent do the activities that iDSI is implementing contribute to its strategy?

and acceptance of priority setting in practical terms in a range of countries. In the context of UHC, decision-making processes also have to be seen as legitimate, or undertaken by mandated institutions or processes and these institutions need nurturing as well. Legitimacy or mandate is crucial to building transparency in the use of public resources and accountability to rights holders within health systems, notably citizens. It also strengthens the organisation's role in arbitrating the use of resources which means saying no as well as yes. iDSI, as a partnership supporting priority setting in all its facets, thus aims to support countries to engage policy makers, providers and consumers of health with rigorous evidence-based decisions, clear criteria and the tough, resilient skin needed to help ensure that citizens get the best health outcomes for their health money.

As a partnership of institutions, iDSI is growing its capacity and reach at a time when demand from countries for priority-setting skills is likely to accelerate as a result of growing interest in UHC. iDSI has entered a new funding cycle; its network is growing and it is extending its work, for example through the regional hubs, and at country level, such as in India and in Myanmar. iDSI will face difficult decisions about the allocation of its own resources and capacity. Although it is a network that “responds to demand” (iDSI website), there are clear risks associated with over-extending and duplication and there are certainly trade-offs between supporting countries at different stages of their UHC journeys. This review will thus also support iDSI's own decision-making processes as it starts to deepen its role in the new global agenda.

iDSI's strategy and approach

iDSI's strategy is recognised as aiming to fill an important, under-served niche in priority setting. We found strong evidence to suggest that iDSI is meeting an important need in supporting priority setting. A number of informants raised this issue in interviews and the evidence of the country operations in India and Indonesia confirms this. Many informants, for example, considered iDSI an “exciting development”, the right direction of travel, an important step forward, and a chance to fill what was called an “anomalous gap”²⁵ in the spectrum of technical support available, “given the WHO resolution”.^{26 27} One key informant suggested, “the success of UHC depends [in part] on how you use your limited resources and that this is the role of iDSI.”²⁸ As a partnership that aims to increase awareness about the role of priority setting in UHC, generate knowledge, and support implementation over the long term, iDSI brings together a range of skills and competencies to the challenges of strengthening priority setting and brings “a more rigorous approach to health system decision-making.”²⁹ Furthermore, there is increasing interest in UHC especially from low- and middle-income countries and demand is outstripping supply.³⁰ In practice, iDSI aims to accompany and support reforms in partner countries; work on advancing the state of knowledge and practice; and influence the global environment. It is seen as a “timely” and “appropriate” initiative.³¹ It is widely understood that iDSI helps policy makers make better decisions and that this is a suitable space to be working in.³²

iDSI as a partnership is making clear advances towards building more understanding of and commitment to priority setting in a range of contexts. Key informants identified iDSI as “able to bring new knowledge and insights to policy makers in country”, “plugging HTA into the policy making process”, creating a “practical

²⁵ KI09

²⁶ Interview KI08, KI21, KI22. Resolution WHA67.23 was passed at the 67th World Health Assembly in 2014: http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R23-en.pdf?ua=1

²⁷ The network survey responses generally reinforce this range of comments and its proportionate weightings. While the majority considered that partners linked to iDSI had a common purpose, about a third were ambivalent or did not fully agree that all partners do in fact share a common purpose. Linked to that, more than seven out of ten respondents considered iDSI had shared strategies and objectives but a little over a quarter of respondents either did not agree, actively disagreed or chose not to express a view. The network survey is in Annex C.

²⁸ KI19

²⁹ KI07

³⁰ Interviews KI19, KI14, KI08

³¹ Interview KI08

³² Interviews KI05, KI03, KI01

platform for agencies to work effectively” and repeatedly, creating opportunities for “collaboration”. For some respondents to the network survey, iDSI enables partners to do “more together than they could do individually”, and through its support to low- and middle-income countries, iDSI is building capacity and extending partnerships. Many respondents considered the opportunity iDSI offered them to be part of a wider network of like-minded people, one of iDSI’s strengths.³³

iDSI’s own presentation of its strategy is not consistent. iDSI presents itself slightly differently in different iterations of its strategy (Table 3). Three recent versions of the strategy were identified and analysed for consistency. All iterations of the iDSI strategy have some similarities. The overlapping points of the three iDSI presentations of its own strategy shown in Table 3 include that iDSI (a) is a partnership, (b) it supports priority setting, and (c) it offers technical and institutional capacity. For example, they all speak of partnership although always in the context of partners within iDSI rather than partnerships with governments or countries. All the iterations refer to providing support to policy makers and decision makers. There are some important differences as well. The BMGF grant proposal (presented by iDSI as its most up-to-date strategy) focuses on priority-setting support as a means to improving health while the other iterations still on the website refer to priority setting for UHC. Additionally, the BMGF grant narrative refers to a “practitioner-led, government to government partnership”. The Strategic Overview on the iDSI website does not talk about being government-to-government but rather says it includes “leading government institutes” in its partnership. The ‘pop up’ version makes no immediate mention of governments either in the network or as beneficiaries.

Table 3: Various presentations of iDSI's strategy

BMGF Grant narrative	Strategic Overview of iDSI	Website ‘pop up’ strategic overview and narrative
iDSI is “a practitioner-led, government-to-government partnership that facilitates and supports priority-setting” to “guide national and global decision-makers to effective and efficient health care resource allocation strategies for improving people’s health.” ³⁴	“The International Decision Support Initiative (iDSI) is an innovative global partnership of leading government institutes, universities, and think tanks, to support policymakers in priority-setting for universal health coverage (UHC).” ³⁵	“iDSI is a sustainable, adaptable, international mechanism to provide policymakers (at sub-national, national, regional and international levels) with co-ordinated support in priority-setting as a means to UHC.” ³⁶

Despite having a clearly articulated vision and a recognised niche, there were questions about the clarity of the strategy and how well iDSI is operationalising its strategy. Among key informants, there were comments about iDSI’s strategy along the lines that it was “still very technical”, “confusing”, “lacks clarity”, and “not clear how it will be operationalised”.³⁷ These views were echoed in the country case studies to some extent and some partners were not sure of iDSI’s strategic plan (or that of its representative partner in country).³⁸ The network survey results further reinforce this sense. In the network survey, for example, although a majority of respondents considered that iDSI partners shared a common purpose (68% of respondents agreed), more than 26% were ambivalent or disagreed. A significant number of qualitative responses captured a sense of

³³ These views were drawn from the network survey (qualitative questions) and interviews KI18, KI05, KI11, KI13.

³⁴ iDSI Grant Proposal Narrative to the Bill and Melinda Gates Foundation, 1 December 2014, updated March 2015.

³⁵ <http://www.idsihealth.org/about-us/>

³⁶ Strategic overview of iDSI: <http://issuu.com/idsi1/docs/idsistrategicoverview/11?e=15279625/11091935>

³⁷ Interviews KI03, KI10, KI05

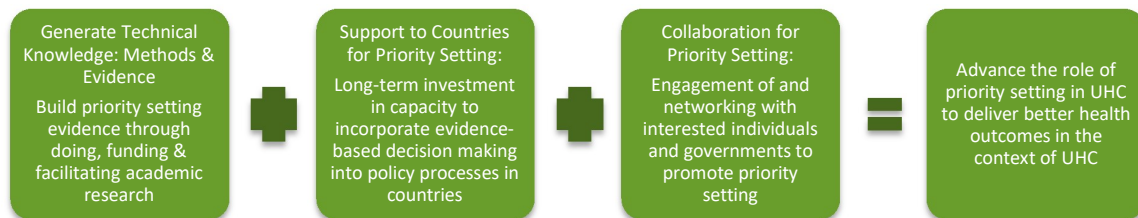
³⁸ For example, see the Indonesia case study.

confusion about priorities within iDSI, the role of specific core partners versus the partnership, and a desire for greater clarity about leadership and operational processes.

iDSI's area of expertise

iDSI offers a unique combination of skills and expertise including “end-to-end” support for priority setting policy and practice. Figure 5 shows the different iDSI priorities or areas of focus that both key informants and respondents to the network survey referred to most often when talking about iDSI's niche or areas of expertise. Among the comments made by key informants and those responding to qualitative questions in the network survey, views about iDSI's core business were roughly evenly split between the three priorities shown in the figure: knowledge generation, country support, platform for collaboration.³⁹ Key informants recognised that iDSI works mainly in and around the technically complex processes linked to health assessment. A “practitioner to practitioner” network that links countries “to academics and think tanks”, iDSI was seen by key informants as potentially able to do more than any of its core partners could do alone while still undertaking technically rigorous research. The combination was appreciated and iDSI was universally viewed as “technically sound”, focused, and knowledgeable about its areas of expertise (health assessment methods, priority setting processes and how they work in practice).

Figure 5: iDSI areas of expertise mentioned most often by key informants



These three areas of engagement (knowledge, country support and collaboration) as well as its other areas of work, move forward each at their own pace and cannot all be orchestrated harmoniously all the time. On the one hand, iDSI has both the credibility and the patience to “walk beside the country partner”⁴⁰ as country partners build their national institutions, and key informants recognised that the combination of technical knowledge and institution-building experience for priority setting were both important to iDSI's unique role. This was reinforced by views expressed in the network survey where one of the priorities for iDSI was seen as “practical support for countries”. This “hand-holding role”⁴¹ is a central part of iDSI's niche. However, an important challenge to success is that iDSI partners are not in the driving seat and do not therefore control the *pace* of progress. These partnerships can thus be long (several years) especially in low-income, low-capacity settings. Progress may advance at incremental rates for months or may suddenly take off, absorbing a lot of time and limiting capacity or space for other activities. On the other hand, generating evidence and knowledge about HTA methods, or being able to engage flexibly in sometimes fast-moving global (or country) agendas and fully respond to opportunities may command a different pace of work. Some practitioners found iDSI's pace was incompatible with the production of knowledge products (too fast or too slow, and geared to meeting the needs of donors and fund reporting rhythms and deadlines).⁴² The various roles that iDSI engages in are thus operationally very different from one another and this will have implications for its own allocation

³⁹ Contrast this with the three work streams identified in the iDSI business model: research (technical and methodological work), governance & process, and demonstration projects. However, in its recent proposal to the BMGF, iDSI identified its three priorities as practical support, knowledge products, capacity building and awareness raising.

⁴⁰ Interview KI04

⁴¹ Interview KI09, KI04

⁴² For example, evidence from Interview KI22

of resources – especially human resources – in balancing inputs into the three areas of its work that are most valued by informants.

iDSI's core and delivery support partners

Partners are defined by iDSI in terms of their proximity to the core work of iDSI, sub-grantee arrangements and the type of deliverables they are responsible for. However, partners themselves do not always know what their role is or what it means to be an iDSI partner. iDSI comprises several layers of partners centred around its **core partners** (see Section 3). Being a core partner involves being responsible for deliverables under the grant⁴³ and being closely involved or engaged in the week-to-week decision making. The core partner group is “an organic arrangement” linked to funding but also to being “catalytic”.⁴⁴ In discussions with key informants, individual core partners are often substituted for iDSI as an entity; several key informants freely interchanged references to NI, CGD, HITAP or PRICELESS with references to iDSI. Some partners were not sure if they were aligned to NICE International or to iDSI. Among key informants, one pointed out that while their organisation was listed as the partner to iDSI, it was actually individuals who were engaged in the work of the partnership. Another said that iDSI engaged them in practice as several “individuals” whereas it would be more effective to coordinate with them internally as a group.⁴⁵ Further removed from the core partners, some key informants said they were not sure of their standing in the network and they considered their role “unclear”.⁴⁶

Delivery support partners (organisations that iDSI works with and through) were identified by key informants as including York University, Glasgow University, London School of Hygiene and Tropical Medicine (LSHTM), CGD [sic], Imperial College London, the Economist Intelligence Unit, and the Office of Health Economics. iDSI also identifies a range of **wider network partners and other actors** working in priority setting and those most commonly named included a wide range of organisations including larger and smaller private sector management consultants such as Deloitte, PWC, Access and Oxford Policy Management; UN agencies such as WHO and the World Bank; global funding organisations such as GFATM, Gavi, UNITAID; and universities such as LSHTM, York and others. None of these is exactly like iDSI, however. Among key informants, many of whom were drawn from both delivery support and wider network partners, there was sometimes confusion about what kind of partner they were. For example, one informant said that they partnered with iDSI on some specific research as an individual but their institution was listed as a partner and this was “perhaps a little misleading”.⁴⁷ Another said, on the other hand, that several individuals at their institution who engaged with iDSI each had individual relationships with the network and it might be more productive and efficient to engage them as a group.⁴⁸ Several informants and respondents to the network survey said they were not sure of their status or whether they were really in the network; many of these partners had links primarily to only one of the core partners.

There are a range of other organisations working in the priority setting space, generating and using a range of tools to support priority setting (vertical and horizontal) or cost-effectiveness analysis and related health technology assessment techniques that were not mentioned by key informants but which countries are actively using to support decision making. iDSI partners seem to focus on a specific range of priority setting instruments and mechanisms. There are others actively used as well and it would be important for iDSI to be aware of these and familiar with them. For example, the Poverty Action Lab aims to build knowledge about what interventions work, under what conditions and at what cost.⁴⁹ The Institute of Health Metrics and

⁴³ Interview KI01

⁴⁴ Interview KI09

⁴⁵ Interviews KI21, KI23

⁴⁶ Comments from the qualitative questions in the network survey.

⁴⁷ Interview KI20

⁴⁸ Interview KI23

⁴⁹ <https://www.povertyactionlab.org>

Evaluation (IHME)⁵⁰ and the Disease Control Priorities (DCP3)⁵¹ programme support resource allocation choices between different disease burdens as well as interventions within disease choices. The LiST tool, One Health tool, and a range of modelling tools help identify the health returns on different investments to reduce the burden of disease. There are also a growing number of tools designed and implemented by different organisations to identify the best combination of interventions or minimum thresholds or standards for different diseases. These include priority setting questions that tackle indirect as well as direct costs and sometimes opportunity costs.

iDSI's ability to deliver its strategy

The features that have enabled iDSI to make rapid progress in a short space of time also create potential barriers to fully advancing its strategy. iDSI is centred around a relatively small and highly cohesive partnership with shared values, a common intellectual and technical approach and a common vision about its role. The core members of iDSI have experience, a track record and, crucially, the reputations needed to advance its strategy. As discussed in Section 4.4, this has been instrumental in opening up opportunities at country level. For partners outside the core, however, iDSI was not always transparent or accessible. Some said they would not know how to make contact without being invited: *“Right now, to be in the priority setting business, you need to be in the know about what networks and hubs and organisations are where and what they are doing. So how can an affiliate take advantage of the network or hub to create a wider network? You need to know people just to be in touch to begin with ... which can be hard for new thinkers.”*⁵² Many identified that they had little connection to the whole network and really only communicated with one or a few other individuals.⁵³ Several pointed to the website as being full of interesting material but not particularly helpful or accessible. Several informants also mentioned that all the iDSI core partners also have “lives outside the network” which for some informants was a strength as it enabled partners to constantly introduce new thinking. Others, however, suggested that this also meant that iDSI and its needs could be squeezed by other priorities.⁵⁴

iDSI partner countries

iDSI focuses on working in a relatively small number of countries in order to pursue its strategy of building long-term partnerships to support institution and capacity building. This creates a challenge for iDSI as although this strategy promotes high-quality technical assistance and builds iDSI's reputation, it can be operationally and resource intensive. While one of the main strategic pillars of iDSI is to offer practical country support, there is a clear recognition in iDSI that the less advanced countries are on their UHC journeys, the more support they need but also that they need that support for a longer time.⁵⁵ Although not universally the case, these countries tend to be lower income, have weaker health systems and have higher burdens of preventable morbidity and mortality.

All the countries that iDSI is formally engaged with currently are middle-income countries and are primarily in Asia reinforcing iDSI's own observation that its value added is clearest in countries with higher capacity and more complex health sector decisions to take. These iDSI partner countries are at different stages of integrating or institutionalising the different levels of priority setting into their systems. For example, India has created a new government body (the Medical Technology Assessment Board) to unite and formalise priority

⁵⁰ <http://www.healthdata.org>

⁵¹ <http://dcp-3.org>

⁵² Interview KI03

⁵³ Aspects of iDSI's communications, networking, governance and knowledge management will be discussed more fully in the next three sections of the findings chapter of this report. They are raised here to help point to some of the ways they link to the ability of the partnership to advance its strategy.

⁵⁴ Interview KI10, KI19, KI06, KI16

⁵⁵ For example, see the iDSI Business Model, 2015. This point was raised in several interviews by key informants KI10.

setting in the context of its ongoing process towards UHC (with direct support from iDSI). However, although iDSI states it is “demand-driven”, it also aims to expand into sub-Saharan Africa and into low-income countries. How it will do this operationally, given the dilemma identified and the political and institutional challenges associated with weaker health systems, is not entirely clear but will rely to some extent on the creation of regional hubs, as well as increasing engagement with GAVI and the Global Fund as major influencers of health resource-allocation decisions and their reach into LICs. The regional hub strategy is part of the iDSI plan to make country support “more responsive, scalable” and “sustainable through strengthening South-South partnerships.”⁵⁶ Partnerships with South Africa and China are geared towards supporting the implementation of the hubs, which are currently more advanced in Asia than in Africa. For direct iDSI country partnerships, country selection will be based on three criteria: political window of opportunity; potential impact; and strategic priorities.⁵⁷ iDSI’s country selection was viewed as “good” as it gets the right “combination of criteria + research.”⁵⁸ Several key informants identified iDSI as generally stronger and more sure-footed when it was working at country level.⁵⁹

iDSI’s focus at the global level

Although iDSI engages at the global level, neither its aims nor its strategic approach to global working were clear or visible. However, there is evidence that iDSI partners engage across a range of ways at global level and are deeply embedded in some of the key processes currently under way. The Prince Mahidol Awards Conference (PMAC) in 2015 and especially in 2016 were identified by many key informants as important elements of the iDSI strategy and excellent opportunities for iDSI core partners to extend their network, showcase their research work and promote their approach to priority setting. iDSI partners were part of a small group at the Bellagio meeting in 2015, which gathered some of the leading thinkers about priority setting in the context of UHC, producing a comment piece for the *Lancet*.⁶⁰ However, much of iDSI’s global efforts appear from the outside to be opportunistic rather than planned, although many were highly constructive (for example, the recent joint iDSI–WHO workshop in July 2016).⁶¹ iDSI is not, though, *primarily* seen by key informants as a global player or oriented around a structured global agenda. One informant, for example, suggested that the role of global engagement should be to get a better balance between “being demand-driven but also moving things in a specific direction.”⁶² By this, they were suggesting that iDSI take specific actions (through communications, knowledge management and other methods) to engage in and drive the global debate. This idea – of proactively shaping the agenda – would require iDSI to be more systematic about its messages and its approach and, especially, about being present at a wider range of meetings. As it would also require iDSI to prioritise what and how it engages, it would be more helpfully guided by an explicit set of objectives for global engagement. Currently, those objectives are not entirely clear.

Getting the level of input to engage methodically and productively to achieve global objectives (but not overly expend time and resources) could be tricky since global engagement could so easily consume a huge proportion of iDSI resources (time, capacity, funding) with limited results. The risks associated with investing time and resources in global processes that did not deliver concrete results were identified by key informants. Indeed, iDSI invests its resources where it expects to have the most discernible impact. For

⁵⁶ Interviews KI16, KI06, KI09

⁵⁷ Interviews KI16, KI09, KI04

⁵⁸ Interview KI15

⁵⁹ iDSI’s approach to country operations is discussed more comprehensively in section 4.4.

⁶⁰ [Implementing pro-poor universal health coverage](#), December 11, 2015, *Lancet Global Health, Participants at the Bellagio Workshop on implementing Pro-Poor Universal Health Coverage*: Jesse Bump, Cheryl Cashin, Kalipso Chalkidou, David Evans, Eduardo González-Pier, Yan Guo, Jeanna Holtz, Daw Thein Thein Htay, Carol Levin, Robert Marten, Sylvester Mensah, Ariel Pablos-Méndez, Ravindra Rannan-Eliya, Martín Sabignoso, Helen Saxenian, Neelam Sekhri Feachem, Agnes Soucat, Viroj Tangcharoensathien, Hong Wang, Addis Tamire Woldemariam, Gavin Yamey

⁶¹ “Strengthening health technology assessment systems for reimbursement purposes in countries” workshop, scheduled to take place in July 2016, Geneva.

⁶² Interview KI06

example, one observation about the Joint Learning Network (JLN) processes was that some years ago the JLN took a “shallow approach to country facing work, and required too much time to be spent in meetings held at considerable expense in tropical locations which was not judged to be the best use of iDSI’s limited resources”.⁶³ However, another informant suggested, on this particular point, that linking iDSI to the JLN, now that it is actively managed by the World Bank and on a different footing, would be a means to connecting iDSI’s tools “to a more global network, and would enable it to use its knowledge to shape global metrics”.⁶⁴ This example illustrates though that the global environment evolves constantly and iDSI would benefit from reassessing its role regularly and frequently.

Key informants pointed out that iDSI needs to learn to work with the main global health organisations.

Many suggested that iDSI does not fully understand how these organisations work or the political economy of decision making within them. To build better knowledge and to establish trust between iDSI and these global funding agencies, some key informants thought that it was essential for iDSI to do the ‘heavy lifting’ around creating opportunities to work together and to ensure that the experience of working together is successful and productive. Ideas for coordinated working included that iDSI spend more time in Geneva and invest more in carving out its niche at the global level. Another idea touched on was that iDSI could focus on building its own immunisation or disease specific knowledge (AIDS, TB or malaria) to then enable it to demonstrate how iDSI approaches can impact on a global fund area of focus. In fact, malaria was identified as “a perfect storm” for iDSI to tackle: it is shaped by complex problems that require trade-offs, there are modellers and thought leaders in and around London (where iDSI is headquartered), it is a high priority for iDSI funders (both Gates and DFID), it is a high priority for the Global Fund, it is a serious problem for low-income countries, and there is scope to carve out important health benefits.⁶⁵

Working with the large global health funding organisations but at a country level is another option. This would be best addressed country by country but iDSI could play an important role in supporting priority-setting capacity building in countries transitioning out of GFATM funding. Again, Indonesia was raised as an example since iDSI is already engaged there.

Working with WHO

A more structured partnership with WHO would create many opportunities to advance the global agenda and support countries but it would also require compromise and that can sometimes mean giving up some intellectual and operational control. For most countries, especially lower- and middle-income countries, WHO is usually positioned very close to the Ministry of Health. They are the go-to technical agency and, for better or worse, they can act as a gate-keeper. With the HTA resolution agreed at the World Health Assembly in 2014⁶⁶ and calling on all countries to integrate HTA into their health systems and decision making processes, WHO is a leading agent of change in low- and middle-income countries. There are several good examples of collaboration between iDSI and WHO including meetings in March and July 2016 and close interaction in some countries such as Indonesia, Sri Lanka, Nepal and Bhutan.

iDSI has an uneven relationship with the World Health Organization at global, regional and country levels despite having overlapping agendas and scope for a mutually beneficial partnership. Some of this may be down to differences in approach to priority setting although several key informants highlighted the extent to which there are diverse views within WHO itself about priority-setting approaches. The fragmentation among different WHO departments also reflects different priority-setting interests and broader priority-setting debates especially in lower-income settings which are linked to public expenditure reform, accountability and health systems strengthening, more than they are to HTA techniques. Several key informants pointed out that WHO is not a homogenous entity and priority setting takes place in several of its departments and geographic divisions (for example, the CHOICE group, the pharmaceutical department, the financing and UHC

⁶³ Interview KI09

⁶⁴ Interview KI05 and additional comments

⁶⁵ Interview KI14, KI19

⁶⁶ The drafting of this resolution was supported by HITAP. http://apps.who.int/gb/ebwha/pdf_files/WHA67/A67_R23-en.pdf?ua=1

department, regional offices, and some country offices). There are some methodologically different approaches at play (the CHOICE group takes a zero-based approach while iDSI prefers an incremental approach to priority setting⁶⁷). The differences in approach to priority setting could helpfully be based more on country size and scope to make meaningful changes to priorities than on socio-economic status alone. For example, what can be done to affect and shape health spending in Nigeria, with its massive health budget (which on a per capita basis seems very low) is quite different from what can be done in a small country.⁶⁸

While partners closest to iDSI suggested that WHO felt competitive with iDSI, others with a more disinterested perspective suggested that it was iDSI that needed to “figure out how to work with WHO”. Some informants thought that iDSI has to be “more realistic” about what it takes to work with WHO in practice. For example, one key informant related an episode from the recent past in which iDSI tried to engage WHO in endorsing a more or less finished product. It became evident during the subsequent discussions that WHO cannot endorse an intellectual product, put its crest on it and profile it on the WHO website if it has not participated in its development.⁶⁹ According to several key informants, WHO is not always easy to work with being sometimes “slow, complex and bureaucratic.”⁷⁰ Nonetheless, all key informants, including those who recognised the challenges of working with the WHO, concurred that difficulties and methodologies notwithstanding, iDSI “needs to work through this, and figure out how to make the relationship with WHO work”.⁷¹ It does work well in some settings. For example, the relationship between iDSI and WHO in Indonesia is more “symbiotic”.

Working with other global organisations

Influencing health outcomes at country level, especially in low-income countries, could be more effective through the large global health funding organisations such as GFATM, Gavi and UNITAID. Many informants raised the potential of better, more cohesive working with global health funders as “an opportunity” to support capacity building to do economic evaluation. iDSI also recognises these benefits of engagement with global health funders. This is particularly the case for new medicines, vaccines and commodities and there was wide agreement that there was scope for iDSI to make a positive impact on economic evaluations especially in these areas. The advantages for many were clear: they have large amounts of funding to procure drugs and commodities; they are focused on some of the highest burdens of disease and mortality in low-income countries; and the countries they “serve” have limited capacity to spend their funds better or demand more value for money.⁷² The Clinton Health Access Initiative may be a fruitful partnership through their work on market shaping and support to getting new medicines into countries using advanced guaranteed purchasing mechanisms and other interventions. The World Bank is an important partner to iDSI as well because it is deeply engaged in economic evaluation (and has a lot of economists). The World Bank also invests substantially in capacity building for economic analysis.

⁶⁷ For example, the incremental approach starts with the existing service delivery package and makes decisions about what to add while the zero-based approach requires the justification for existing as well as additional interventions.

⁶⁸ Interview KI08, KI14

⁶⁹ Interview KI19 and an example given about the development of a web-based resource that WHO would not ‘co-author’ or even lead the process unless it helped to create it and had a share in shaping the result.

⁷⁰ Interviews KI08 and others

⁷¹ Interview KI02, KI07, KI01, KI19, KI14

⁷² Interview KI07, KI14, KI02, KI19

4.2. Management component

4.2.1 Summary of main findings



- iDSI's governance and management structures and processes are progressively being professionalised and formalised with many of the elements that are necessary for a well-functioning organisation. However, the Board is not yet operating at a strategic level as it serves more to exchange information rather than to take strategic decisions.
- iDSI has been founded and developed by a small, dedicated group. While this ensures a consolidated and cohesive way of working, over time, it has the potential to limit transparency, accountability and innovation. It is thus relevant to consider how the management and governance arrangements could be adapted

to ensure iDSI continues to grow and strengthen.

- Core partners work together well and are actively involved in the network. NI and HITAP play the larger roles especially in communicating about the work of the network. CGD plays a more limited but strategic role, strengthening collaboration across the network. PRICELESS is the least integrated partner in the broader network and with the core partners (and is also the newest partner).
- There are high levels of trust, collaboration, engagement and understanding of the network, and the core partners are appreciated for the support, expertise and technical resources they inject into the wider network.
- Communication of the network's performance, activities, and impact is weak. Partners and stakeholders would like to be kept better informed, for example, to hear about lessons learned or to be engaged in thematic discussions (electronically).
- iDSI brings together partners with significant skills, experience and a strong reputation in many of the areas necessary to deliver on its strategy. However, there are gaps in iDSI's reach into LICs/LMICs and concerns about whether iDSI has ready access to all the necessary skills and experience to support countries to link priority setting to broader health systems strengthening and reform processes and this might have implications for country selection and scope of work.

4.2.2 Findings

Outline of the section structure, overview of the evidence base, response to the EQs

The findings of the management component cover evidence related to iDSI's governance, management and network structure. This component focused on analysing these separate but related strands of iDSI to assess the extent to which iDSI operates effectively. The conclusions drawn from the evidence regarding the structure, roles, efficiency and effectiveness of iDSI's governance and management structures, and the extent to which the network is set up in a way which helps iDSI to effectively achieve its strategy are presented in Section 5 as answers to the learning review questions.⁷³ After assessing the governance/management bodies, the network structure is assessed with respect to collaboration, trust, communication, and the positions occupied by the different core partners. The section finishes with high-level findings on resource management.

⁷³ The Management component high-level evaluation questions were: How effective and efficient are the iDSI governance arrangements? Is iDSI's global structure fit for purpose to deliver iDSI's strategy (in terms of member size, composition of disciplines, connectedness, centralisation and median trust)? How effectively is iDSI managing/coordinating the core partners (optimising the value of each individual partners and the collective)? How effective and efficient is resource management across the network?

Background to iDSI governance structures

iDSI is governed through three structures: the Board, the Delivery Executive Group (DEG) and the External Reference Group (ERG). The Board is composed of executive and non-executive members, with the executive members made up of representative of each of the core partners. All governance groups have been formalised with associated ToRs presented to the Steering Committee⁷⁴ at the October 2015 meeting and finalised in early 2016. The Board and the DEG members are in place; the ERG has not yet been constituted. The iDSI partnership is supported by a Secretariat embedded in and hosted by NICE International. The Board is responsible for overall stewardship and strategic direction of iDSI. The DEG provides quality assurance, signs off on key outputs, and is responsible for oversight of the day-to-day work of iDSI. The ERG will provide a sounding board and a critical external voice for the partnership. NI, as the host of the Secretariat, provides overall support to the network on grant management, contractual issues and as the primary point of communication with funders, as well as having a key role in governance and technical delivery as a core partner (see Annex C for a table which summarises the purpose, composition and ways of working of the Board, DEG, ERG and Secretariat).

iDSI governance structures

iDSI's governance structures are evolving and professionalising as iDSI grows. Governance structures have evolved from iDSI 1 to iDSI 2. There was strong agreement among key informants that the governance functions and management arrangements have been professionalised under iDSI 2 and that they continue to move in the right direction of travel.⁷⁵ Prior to January 2016, oversight and governance were provided by: a Steering Group made up of representatives of core partners and external stakeholders; a Product QA Group, comprising the core network partners; and NICE International, which took direct responsibility for the majority of oversight, management and coordination duties, as well as for hosting the network.⁷⁶ However, the composition and the remits of the Steering Group and Product QA Group were not clear to some partners closely involved in iDSI, including some who were part of these structures.⁷⁷ As mentioned above, the ToRs for the Board, DEG and ERG have been finalised, and these structures are being operationalised. The first Board meeting was in January 2016. The DEG has been constituted and is operational. While the DEG is not yet meeting monthly as planned, it held its first meetings in April and June 2016, and a third meeting is scheduled for shortly before the September Board meeting.

While governance is professionalising, the Board does not as yet appear to be playing a strategic role. It is notable from reviewing the agendas and minutes of the Steering Committee meetings in 2014 and 2015 and the first Board meeting in January 2016, that there has been **a steady and positive trajectory** in professionalisation, with many components of a professional Board either in place or being put in place. These include action tracking, a managed risk register, terms of reference for the governance groups, and flow-charts to guide strategic decision making.⁷⁸ The January 2016 Board meeting covered a variety of highly relevant topics including the familiarisation with current governance structures and processes, technical discussions about research products and practical support, and the network component of the MEL framework. However, based on a review of the minutes and comments from key informants who attended the Board meeting, despite the relevance of the topics discussed, the focus was more on information sharing than strategic decision making.

⁷⁴ The Steering Committee pre-dated the Board and is now defunct.

⁷⁵ KI02, KI15, KI16, KI17,

⁷⁶ iDSI Business Model

⁷⁷ NI15, KI02, KI13, KI17

⁷⁸ iDSI Board and Steering committee agenda and minutes from meeting held on 05/2014, 10/2014, 10/2015, 01/2016

Key informants expressed a need for Board meetings to be more structured and decision-focused going forward, with clear documentation of decisions and action points.⁷⁹ As part of its shift towards a more institutionalised and sustained partnership, it was suggested that the iDSI Board take the major strategic decisions that guide the partnership's evolution. The January 2016 Board meeting minutes notes this intention although does not note any decisions that were taken by the Board. This point was discussed at the January Board meeting and it was minuted that the vice-Chair was "keen for the Board to focus on strategic discussions, and for the agenda to be clear on what items are for information, for discussion/input, and for decision". It was further proposed that future meetings be structured over two days with the first day focused on updates and the second day set aside for the Board to conduct strategic discussions. It was also proposed that the DEG discuss and finalise the Board agenda before the meeting.⁸⁰ However, it is not explicit in the minutes if the Board approved these proposals. Similarly, it is not easy to track the status of action points between meetings, as the action tables from one Steering Committee meeting were not fully carried through to subsequent meetings, or to the first Board meeting. When the question was asked to the iDSI Secretariat about how the status of action points is tracked, the response was that a lot of the follow-up occurs via email, but is not documented in the tables. So far, the approach to addressing and documenting governance action points has not been formalised. It is recognised that it is early days in iDSI's transition to a Board governed structure since there had only been one Board meeting at the time of this review. In the current stage of institutionalising the Board and formalising the processes associated with Board governance, attention could be focused on identifying explicit decision points and action tracking.

A small group of committed people are heavily involved in the governance and management of iDSI. While this has enabled iDSI to develop quickly and effectively to 'punch above its weight', it may limit transparent governance and growth going forward. The four main representatives of the core partners are all represented on both the Board as executive members and the DEG, and are also the leads for their respective organisations on the delivery of the work of iDSI. Additionally, the Board Chair is also the Chair of the DEG. As the arrangements stand, the DEG is reporting partially to itself, the Board and DEG are chaired by the same person, and the DEG and the Board are making decisions that impact on the work conducted by the core partners. Given that the DEG reports to the Board, and its role is to oversee the day-to-day work of iDSI and make decisions on practical support and knowledge priorities, it may be appropriate for there to be more independence between these two bodies.

As iDSI grows or aims to broaden and achieve a larger reach with more partners, having the same group of people lead on governance, management, resource allocation, technical delivery and knowledge management could have the effect of alienating newcomers or creating conflicts of interest. Among key informants as well as respondents to the network survey, there were concerns expressed that there seems to be an "inner circle" or a "group of friends" that is running iDSI, and that the Board does not have enough independence.⁸¹

The shape of the iDSI network

iDSI core partners are at the centre of iDSI as a network and have an essential role in the delivery of iDSI's activities that is based on their ability to work together to define and pursue priority activities. The roles and responsibilities of core partners in terms of the activities that they are leading/implementing were defined during the preparation of the proposal for the BMGF and are based on their strengths. All partners are closely engaged in most aspects of iDSI's core deliverables while, in addition, each core partner is responsible for concrete deliverables.^{82 83} Core partners generally reported working together well, being well aligned

⁷⁹ KI02, KI17, KI07

⁸⁰ iDSI Board meeting January 2016 – Minutes 22-2-16

⁸¹ KI102, KI105, KI107, KI17

⁸² iDSI Grant Proposal Narrative, Proposal submitted to the Bill and Melinda Gates Foundation, September 2015.

⁸³ KI16, KI01

around the strategy and having a good level of trust and collaboration. They also reflected that a reason why they work well together is because they have done so before and it was a natural fit to come together in iDSI. On the one hand, this has been raised as a concern of the “inner circle”, but there are also positive elements to having a cohesive, strongly connected centre during network initiation. A core partner reflected that “iDSI was formed and has grown over the past few years based on like-minded individuals coming together. Not a bad thing but perhaps need to be more strategic as we go forward”.⁸⁴

The current network has a dense, relatively closed core. Networks configured this way are effective in the early stages of network formation but tend to stifle innovation and problem solving if they do not open up as networks grow. Table 4 describes the pre-iDSI and current iDSI network structures. It shows that a dense core of actors existed before iDSI was formed⁸⁵ and that this density has been maintained as iDSI formalised and grew by almost 50% from 78 to 116 nodes, or individuals were named as part of the network.⁸⁶ What is particularly striking in this network is the number of ‘triangles’ – sets of three actors who have relationships with each other. Based on chance alone for networks of these sizes, we would expect to see approximately 30 triangles in the pre-iDSI network and 70 triangles in the current network. However, there are 173 triangles in the pre-iDSI network and 697 in the current network; hence, nearly five times more triangles than expected in the pre-iDSI network and ten times more triangles than expected in the current network.

Triangles indicate how cohesive and closed a network is. A network with a greater proportion of its actors bound by triangles is typically more effective at sharing and using complex, tacit knowledge, and executing tasks efficiently. During a network’s formation stage, having many triangles tends to be a positive indicator that the network has been effective in connecting actors to work together in practice. However, over time, a network with many triangles can indicate that partners are in ‘group think’ and spend too much of their time only communicating and collaborating with each other. This can close down the positive disruption that comes from newcomers, and it can stifle innovation and problem solving. A high number of triangles once the formation stage is completed could indicate that the network has not taken action to open up its processes to new ideas and new thinking.

Table 4: Pre-iDSI and current iDSI network characteristics⁸⁷

Metric	Pre-iDSI collaboration network	Current iDSI collaboration network
Nodes	78	116
Density	0.07	0.07
Triangles (n)	173	697
Trust (mean)	4.43	4.45

⁸⁴ K109

⁸⁵ The iDSI network has an overall density of 0.07, where 7% of all possible ties exist, although the core (or centre) of the network appears much denser as can be seen in Figure 6 where there is a close clustering of nodes in the centre of the figure.

⁸⁶ This means the network added 38 new individuals globally from pre-iDSI to 2016.

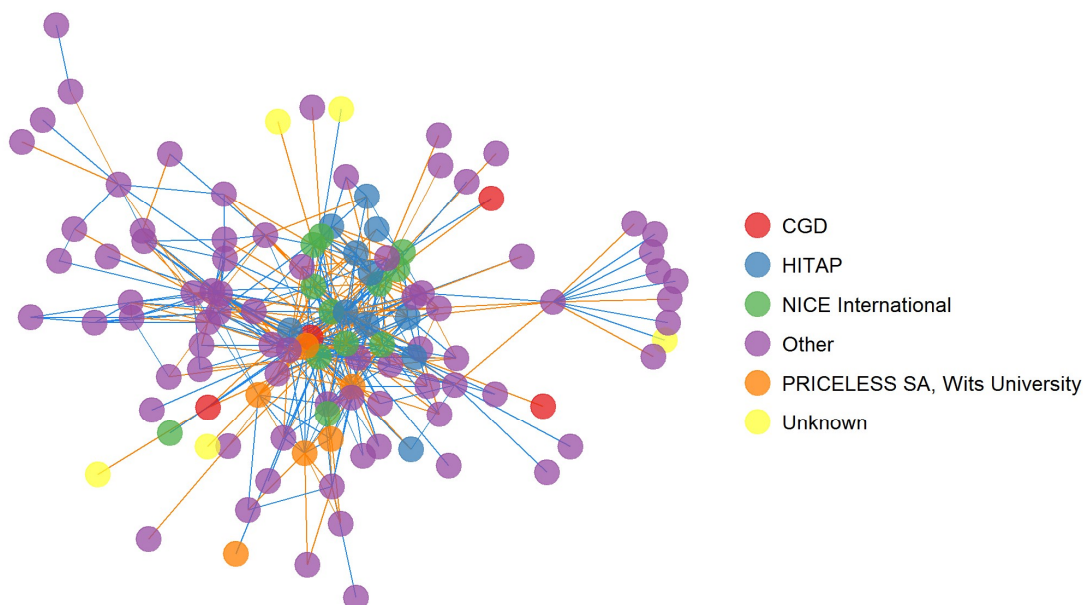
⁸⁷ See Annex C2 for a glossary of the terms used to describe network characteristics.

The characterisation of iDSI as having a dense, relatively closed core, is reinforced by the evidence that the current network is centred around the core partners with NI and HITAP playing the most dominant roles in collaborating with other partners. As shown in Figure 6, NI (green nodes) and HITAP (blue nodes) are clustered in the centre of the network with a high number of ties (connecting lines) going between them and other partners. This is because a high number of survey respondents identified representatives of NI and HITAP when asked to name who they had collaborated with on iDSI related activities in the past year. Over time, continuous assessment of the network structure may help track the extent to which iDSI is succeeding in its objective to increase collaboration, including South-to-South collaboration. Currently, as Figure 6 shows, a large proportion of collaboration within the network travels via HITAP and NI.

Box A: How to interpret the network diagrams

The iDSI collaboration network (Figure 6) was created based on iDSI network members' responses to a survey where they were asked to list the names of people they collaborated with in the past year on activities related to iDSI. Each node (coloured dot) represents an individual that was named in the survey, and the ties (lines connecting the nodes) show which individuals reported collaborating. For each collaborator named in the survey, the respondent was asked whether they knew them prior to the launch of iDSI (i.e. prior to 2013); those relationships that existed prior to iDSI are shown as blue ties in Figure 6 and represent a subset of all ties in the current collaboration network. The nodes in Figure 6 are coloured by their organisational affiliation, where CGD, HITAP, NICE International, and PRICELESS are the four core iDSI partners, and all other organisations are categorised as 'other' (i.e. non-core partners) in orange. The 'unknown' nodes are those where information about their organisational affiliation is missing or unknown (generally because those individuals were named as part of the network but did not participate in the survey).

Figure 6: iDSI core collaboration network



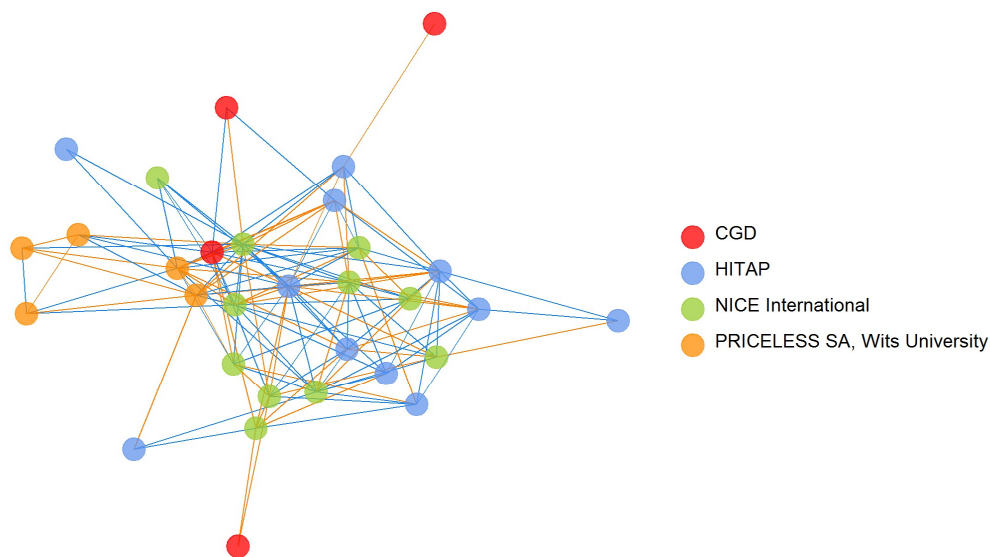
Partners who are further from the core tend to be less sure of how iDSI is being led. From the Network Health Survey, in response to the question “Since you started your engagement with iDSI, what is the biggest challenge or least positive thing about your involvement with the iDSI network”, one of the biggest challenges was a lack of clarity on the leadership of iDSI. Respondents commented that there was “no clear leadership”, that they are “unsure who is in charge”, and that they “[lack] understanding of who is leading the organisation”. All the respondents who identified this challenge are tier 2 (T2) and tier 3 (T3) network

partners.⁸⁸ Of all T2 and T3 respondents, a quarter (28% (n=33)) identified this as their biggest challenge to their involvement with iDSI.⁸⁹ While this may seem a small sample, it is worth considering since there was a high degree of commonality among the free-form responses.

Communication in the network

NI, HITAP, PRICELESS and CGD occupy different positions in the network. NI and HITAP are clearly the central brokers of the other partners, as can be seen in Figure 7 where the green and blue nodes are in the centre of the network and are highly connected. PRICELESS members are clustered (orange nodes), which may indicate that it is not as integrated into the network as other core partners. The pattern shows CGD on the margins of the network (red nodes) and this is consistent with occupying a strategic position in supporting information dissemination. Information disseminators are individuals who are linked to a large number of other networks, groups or individuals; they create bridges between them and facilitate information flow. It appears that CGD performs this function in the iDSI network.

Figure 7: Core partner collaboration network



The Network Analysis Survey demonstrates that the core partners have a high level of trust⁹⁰ and collaborate very closely. Trust has not grown as a result of creating iDSI but rather is holding more or less steady among core partners, which may be because core partners already had established professional relationships. As with the broader network, there is a high number of triangles (212) in the core network indicating a high level of collaboration. It is notable that the number of triangles increased by 9 times after iDSI was formed, indicating that core partners are collaborating much more due to iDSI. As noted above and shown in Figure 7, PRICELESS is less integrated than other core partners. This is not surprising since they are the newest core partner with HITAP, NI and CGD having worked together in iDSI 1 and even before that.

⁸⁸ All potential key informants were identified and grouped into three tiers depending on the depth and strength of their links to iDSI using criteria such as strategic funding relationship, co-authorship, joint working, etc. with tier 1 having the closest links to iDSI and tier 3 being less involved.

⁸⁹ Network health survey Qualitative Question Question 2: "iDSI challenge: Since you started your engagement with iDSI, what is the biggest challenge or least positive thing about your involvement with the iDSI network?"

⁹⁰ Mean trust score in the network based on responses to the question: "I trust this person to keep their word, do a good job, and respond to my professional needs" with a response scale of: (1) strongly disagree, (2) disagree, (3) neither agree nor disagree, (4) agree, (5) strongly agree.

Table 5: Metrics for collaboration among core partners

Metric	Pre-iDSI collaboration network (core)	Current collaboration network (core)
Nodes	22	31
Density	0.19	0.29
Triangles (n)	23	212
Trust (mean)	4.54	4.50

There is a high degree of collaboration within the wider network, and the core partners are appreciated for the support and opportunities they provide to the wider network. Core partners, particularly NI and HITAP, are appreciated for being very available and very responsive with Kalipso frequently identified as a key communicator within iDSI.⁹¹ Partners spoke about the availability of core partners in very positive terms both in terms of the technical, networking and social support they provide. One key informant expressed this as, “we know we are not alone in doing the often difficult, day-to-day work in our journey towards UHC”.⁹² This is supported by the Network Health Survey where 72% (n= 53) agreed or strongly agreed that partners had identified strategic goals for the network⁹³ Additionally, in response to the open response question about the “biggest success or most positive thing about your involvement with the iDSI network”, one of the main points independently mentioned was related to networking and being connected to resources and TA as a result of being part of the network.⁹⁴ Almost half (48%) of respondents (n=49) made a comment related to this, with comments that identified positive contributions of iDSI such as “increasing my professional network and contacts”, “collaboration between strong partners”, and “collaborating with people who are well-experienced and well-regarded in their field”.

Communication within the network is not identified as a strength and is not seen to be as effective as it could be. The responses to the network survey indicate that while 38% of respondents agreed or strongly agreed that the network’s internal communication systems work well, a total of 50% neither agreed nor disagreed, or actively disagreed.⁹⁵ The open-ended responses to the question about challenges faced working with iDSI provide more evidence of this as different aspects of communication were frequently mentioned (“communications has been a secondary focus”, “poor communication”, communicating with the ‘outside world’).⁹⁶ Specifically, 42% of respondents (n=47) identified communication challenges such as poor or burdensome general communications, or a lack of forums to communicate impact and updates within the network and beyond. Communication challenges are broad and include logistical challenges such as communicating across time zones, challenges communicating the value of iDSI’s work outside of iDSI, too much time consumed in calls and following email threads, poor communication of expected deliverables, e.g. “last minute requests for reports”, and difficulty engaging because of “lack of information or updates about the network”. These comments were spread across respondents from T1, T2 and T3. There was a more

⁹¹ KI02, KI07, KI10, KI11 KI13

⁹² KI13

⁹³ Network Health Survey Question 2: “Together, partners have identified strategic goals and objectives for the network”.

⁹⁴ Network Health Survey Qualitative Question 1: “iDSI success: Since you started your engagement with iDSI, what is the biggest success or most positive thing about your involvement with the iDSI network?”

⁹⁵ Network Health Survey Question Q13 “The network’s internal communication systems are working well”, 38% strongly agree or agree, 35% neither agree nor disagree, 15% disagree. Of all the questions in the Network Health Survey, this question had the lowest number of strongly agree/agree.

⁹⁶ Open-response answers from the Network Health Survey Qualitative Question 3: “iDSI use: Since you started your engagement with iDSI, can you provide an example of iDSI evidence being used to support policy development?”

positive response to how the network communicates more broadly with 68% of respondents agreeing that the way the network communicates with stakeholders builds support for the network.⁹⁷

The communications challenge is recognised by the core partners. It has been acknowledged by the Secretariat that communication was not sufficiently resourced (in terms of specialist skills or financing). A representative of the NI Secretariat reflected that “The biggest challenges has been coordinating our communications strategy and maintaining the website to make sure it is useful and engaging – I think all iDSI core partners (or iDSI as a whole) need dedicated communications support to be able to make this work”. iDSI has plans to address this including recruiting a communications specialist to join the Secretariat, working with DHA Communications to produce communications documents, and developing a communications strategy.

Capacity of partners to deliver the strategy

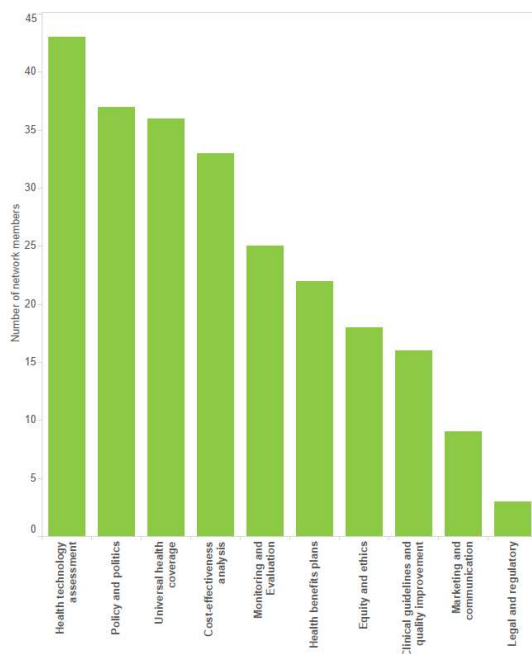
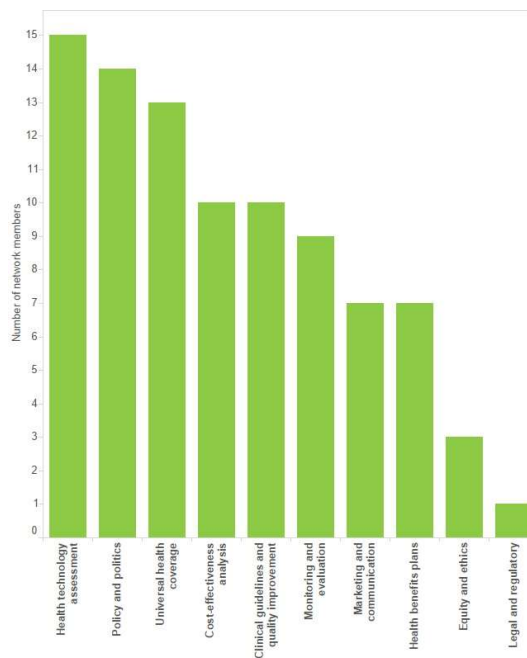
iDSI brings together core partners with significant skills, experience and a strong reputation in many of the areas necessary to deliver on its strategy. There was evidence of this breadth of skills from several sources. For example, the country case studies found evidence of HTA, clinical guidelines, capacity building, research, training, policy formulation and advocacy among others. Many network partners clearly have experience supporting and influencing priority setting in the countries where they are based (UK, Thailand, South Africa) as well as experience supporting other countries. Across the country case studies and in the global interviews, there was strong recognition of and respect for the technical expertise that the iDSI core partners bring to the network⁹⁸. This was also reflected in the responses in the Network Health Survey with 75% of respondents strongly agreeing or agreeing that “partners have the skills they need to advance network goals”.⁹⁹ However, looking across the skills iDSI identifies as vital to the full range of priority-setting support, there are some notable gaps. For example, Figures 8 and 9 show the self-reported expertise of respondents where respondents could select multiple areas from a pre-determined list¹⁰⁰. There were few individuals who identified themselves as being experts in legal and regulatory aspects of priority setting. Marketing and communications is low as well and as we have seen (and will note again in the technical analysis below), communications and marketing (and knowledge management) are less developed areas of expertise in the iDSI network. Understanding, promoting and integrating equity and ethics into priority setting is another notable gap.

⁹⁷ Network Health Survey Question 5: “The way the network communicates with stakeholders builds support for the network”

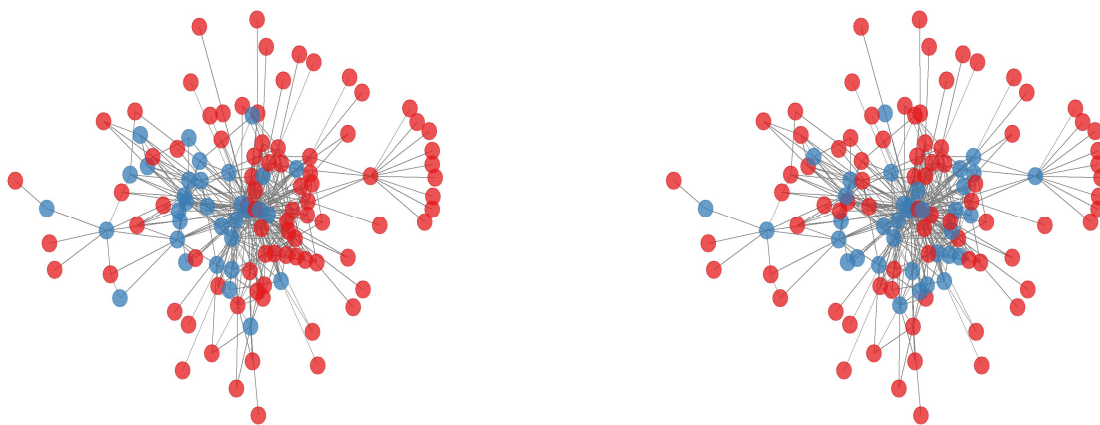
⁹⁸ India country case study, Indonesia country case study, KI02, KI07, KI11, KI13, KI05, KI15, KI19.

⁹⁹ Network Health Survey Question 19: “Partners have the skills they need to advance network goals”

¹⁰⁰ Figures 8 and 9 are derived from responses to Question 4 in the Network Survey (see Annex C2). The question was: “Please indicate your area(s) of expertise. Select all that apply.” Respondents could choose from a list of: Cost-effectiveness analysis; Policy and politics; Equity and ethics; Health technology assessment; Universal health coverage; Health benefits plans; Clinical guidelines and quality improvement; Monitoring and evaluation; Marketing and communication; Legal and regulatory.

Figure 8: Self-reported expertise in the iDSI network**Figure 9: Self-reported expertise among core partners**

When this expertise is visualized within the network, we see that expertise in cost-effectiveness, a highly specialised area, is clustered while expertise in UHC, a more multi-disciplinary area, is dispersed throughout the network. This is not surprising but it signals to iDSI that it will need to be more intentional about connecting up network partners with those who have expertise in specialised areas as this expertise is concentrated in a smaller number of people who tend to collaborate more frequently with each other rather than the broader network.

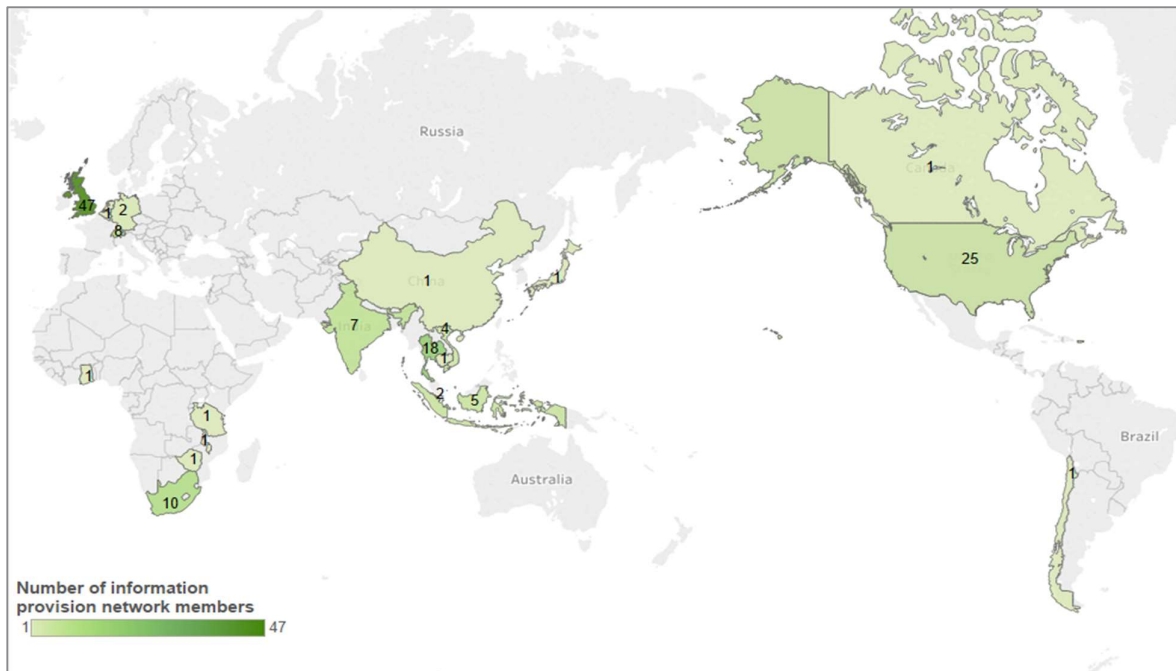
Figure 10: Self-reported expertise in the iDSI network

Key: Blue nodes indicate self-reported expertise in the network (red indicates all other nodes that did not self-report expertise) [left = cost-effectiveness analysis; right = universal health coverage]

The geographic reach of iDSI's capacity does not extend significantly into LMICs where iDSI envisions effecting change. Members of the iDSI collaboration network are based across fourteen countries (see Figure 11 below),

with the largest proportion (42% of members) in the UK. While there is a presence in Asia (Cambodia, Indonesia, India, Thailand), very few network partners are based in Africa, apart from PRICELESS in South Africa. Concern was raised by informants about iDSI's experience working in LICs/LMICs and its ability to provide practical support in low-income and less developed contexts, where the needs and challenges are different than in middle-income or more advanced health systems.¹⁰¹ It has been suggested previously that iDSI works through global funders and global players such as the Global Fund, Gavi and WHO in LIC/LMICs¹⁰². However, as identified in Section 4.1, these relationships need to be developed further at the global, country and regional levels in order to do this. Relationships also need to be developed to bring more LIC/LMIC partners into the network and to share information and build collaboration with LIC/LMIC partners.

Figure 11: Map showing the distribution of iDSI partners



Partners' perceptions about the network

Being a part of iDSI creates value for partners and constituents, and partners add value to the network. Key informants, for example, spoke about the technical value of the practical support and social support that iDSI provides to in-country partners.¹⁰³ The questions with the most positive responses from the Network Health Survey related to the benefits gained by partners from being a part of iDSI or contributing to the impact of iDSI's work. The combined value of the network is perceived to be greater than the sum of its parts. Among network survey respondents, more than 80% agreed that the network creates value for its constituents, 85% agreed that partners can achieve more together than they could alone and 90% thought that partners were creating new knowledge. On the other hand, partners were much less certain that the network processes were as sound as they could be (Table 6). For example, only 55% agreed that the network was able to promote accountability among partners. Fewer than half (47%) were clear about what was expected of them

¹⁰¹ KI10, KI02, KI07, KI15, KI13

¹⁰² iDSI Business Case

¹⁰³ Indonesia country report, India country report, KI10, KI11, KI13.

as partners and only about 40% of respondents agreed that the network addressed conflict when it arose and that the communications in the network were working well.

Table 6: Partners' perceptions of accountability and communications in the network

Q#	Question	Strongly Agree / Agree	Neither agree nor disagree	Disagree / Strongly Disagree	No answer
17	The network has mechanisms in place to promote accountability among partners (e.g. agreements, memorandums of understanding, etc.)	55%	23%	5%	18%
15	Network partners are comfortable with the level of engagement expected from the network	47%	30%	8%	15%
12	The network addresses conflict when it arises	41%	24%	8%	27%
13	The network's internal communications systems are working well	38%	35%	15%	12%

Resource management

iDSI has established systems and processes to manage its grants, and funders are satisfied with contract management. Each core partner has day-to-day responsibility for managing its grant and budget, with oversight from the Secretariat, as do consultants (individuals or organisations) that are funded through iDSI's grants. The Secretariat has established tools and processes for reporting from partners to NI, to track technical and financial progress against the grant, and for reporting to donors. Donors and the Secretariat both said that there is flexibility in the funding, as reasonable to achieve objectives or respond to changes, and that this is discussed and agreed as needed. All donors were satisfied with the contractual management of the grant.

iDSI is currently funded by a narrow group of donors but is actively identifying and pursuing alternative sources of funding. Funding for iDSI's core activities is dominated by the BMGF grant. Members of the Secretariat have raised concerns about the overdependence on this funding. iDSI is actively addressing this with funding recently secured from a new funder, several other proposals submitted or in the process of being finalised for submission, and proactive efforts in progress to build relationships with new funders.¹⁰⁴

There are also countries that may want capacity building and may have local financial support to contract iDSI to help strengthen capacity and improve institutional arrangements for priority setting. Singapore was mentioned in this capacity. This would create an opportunity for iDSI to create an income stream. Additionally, there are positive examples of in-country partners (including national governments) funding key components of priority-setting work,¹⁰⁵ which demonstrate iDSI's ability to leverage funding from other sources to support the priority-setting agenda and contributes to sustainability. Opportunities for iDSI to

¹⁰⁴ A proposal for FCO Prosperity Fund project in China was recently awarded to iDSI (including NICE International, CNHDC and Capita), and launched at FCO event in China w/c 25 July 2016. iDSI is awaiting decisions on other proposals and/or scoping out opportunities with new funders for practical support in Africa and Asia, as well as advancing global public goods. Information on these funding opportunities was provided on 27/07/16 in a document compiled by Ryan Li titled "iDSI Learning Review: Additional Evidence".

¹⁰⁵ For example: (1) The Government of India has recently committed to funding two staff positions for the medical technology advisory board (MTAB), which will provide strategic oversight and support in establishing a fully functional system into which HTA can be embedded. Initially, iDSI was going to fund these positions. (2) In Vietnam, resources have been mobilised nationally to support the work of iDSI which was previously being covered by iDSI's funding. (3) In Indonesia, the roadmap for institutionalising HTA stipulates that the budget will increasingly be funded from national resources.

diversify its funding include “[producing] global public goods that are in demand,” and linking its ‘offer’ to the priorities of both funders and countries.¹⁰⁶

Although key informants from the Secretariat said that there was some flexibility in the funding sufficient to achieve iDSI objectives or respond to changes, iDSI has little capacity to manoeuvre the sub-grants and commitments to consultants in the next couple of years. Its grant has been largely allocated and there are few resources available to reallocate to emerging issues, significant new research, opportunistic projects or problem solving. This aspect of iDSI performance is discussed further in the section on recommendations.

4.3. Technical component

4.3.1 Summary of main points



- iDSI supports the production of a wide variety of high-quality materials. The majority are peer-reviewed journal articles (63%) while others include reports from workshops/meetings, internal strategy documents, manuals and guidelines, and resources to support policy makers. What iDSI considers a knowledge product is not always clear.
- iDSI’s overarching research strategy is not explicit or visible to many partners in the network. There was a range of views about the objectives and products that iDSI could focus its support on through its research programme.
- There was agreement that iDSI’s focus include support for capacity building and knowledge production in LMICs.
- iDSI does not currently have a platform(s) that allows for knowledge to be strategically “pushed” out to relevant audiences or to link knowledge management to its high-level strategic and advocacy goals around evidence-based decision making.

4.3.2 Main findings

Outline of the section structure, overview of the evidence base, response to the EQs

The findings in this section focus on the critical aspects of iDSI’s knowledge generation programme. Along with country operations, knowledge generation is presented as a major element of iDSI core business. iDSI strategy documents refer to its aim to deliver “high quality, policy relevant research”, contributing to global public goods and furthering its larger goals linked to expanding the role of evidence-based decision making in health. Furthermore, iDSI aims to pursue “... *Topics linked to the needs of policy makers in LMICS including work on appropriate decision thresholds and on incorporating supply side constraints in economic evaluations.*”¹⁰⁷ Several key informants also referred to iDSI’s knowledge products as global public goods.¹⁰⁸ In order to assess whether iDSI’s knowledge production is policy relevant, it is first necessary to be explicit about the framework for measurement.¹⁰⁹ Using the iDSI’s own aims and approach to its research programme, an assessment framework has been developed (Figure 12) to guide and structure the learning review. The framework pares down iDSI knowledge generation to five main points for review starting with who is engaged

¹⁰⁶ Interview KI19

¹⁰⁷ iDSI Grant Proposal, Bill and Melinda Gates Foundation, July 2015.

¹⁰⁸ The World Bank defines a global public good as: “those goods that are both ‘non-rival’ (you or I or both of us can consume the good without affecting the utility either of us derive from its consumption) and ‘non-excludable’ (once the good is produced, no one can be prevented from enjoying it).”

<http://web.worldbank.org/WBSITE/EXTERNAL/EXTOED/EXTANNREVDEVEFFE/EXT2008ANNREVDEVEFFE/0,,contentMDK:21903365~menuPK:5397143~pagePK:64829573~piPK:64829550~theSitePK:4683541,00.html>

¹⁰⁹ Various frameworks exist for assessing the research process and products, including uptake. See for example, DFID, Research Uptake Guide, London, April 2016, available here:

https://www.gov.uk/government/uploads/system/uploads/attachment_data/file/514977/Research_uptake_guidance.pdf

in identifying research topics, how relevant research is to LMICs, the capacity to deliver quality research, the communication of results, and – critically – how the uptake of research is monitored.

Figure 12: A framework for assessing iDSI's contribution to priority-setting knowledge production



Description of iDSI knowledge products

iDSI counts a wide variety of printed materials in its collection of knowledge products. These include peer-reviewed journal articles, reports from workshops/meetings, the iDSI business case and stakeholder report, manuals and guidelines, books and resources to support policy makers. The sample shown in Table 7 is drawn from the knowledge library on iDSI's website, listed as iDSI Products under the Resource Type filter.¹¹⁰

Table 7: The distribution of iDSI knowledge products by type of product and audience

Type of product	Number of examples	Audience/dissemination
Research (includes journal articles and policy documents)	23	Academic research channels, print and online journals and platforms
Resource or Guidance document	4	Unclear apart from iDSI website
Event/Workshop Report	5	Unclear apart from iDSI website
Newsletter	2	Website of hosting organisations (HITAP and HTAsiaLink)
Books	2	Specialists and policy makers
Total sample	37	

It is not clear how decisions are taken to include a product in the knowledge library, or how and when it is branded as an iDSI product or not. Of the sample of 37 products identified on the website as iDSI publications, 17 reference iDSI either through explicit branding or through acknowledging iDSI support for research production. The other 20 products made no acknowledgement of iDSI either as a contributor, funder or publisher. Currently, the majority of knowledge products (62%) are original research articles published in peer-reviewed journals, online journals or academic research platforms. These are developed mainly by

¹¹⁰ The website lists 31 iDSI Products under the Resource Filter. However, several of the links contain multiple products which is why the samples considered for this report comprises 37 products. The website distinguishes between iDSI resources and "External Resources". The latter were not analysed for the report. However, it is worth noting that some of the products listed as iDSI Products are also listed as External Resources, e.g. "Priority-setting for achieving universal health coverage" by Chalkidou, Glassman, et al.

members of iDSI's current or previous core partners (e.g. University of York), or close partners such as Imperial College. The topics covered among these 37 products are mainly advocacy, manuals and guidance (25%) and economic evaluations (33%). The rest are UK focused, ethics and equity discussions, and documents of a more general nature such as newsletters.

Stakeholder engagement and the process of selecting research (and researchers)

The process to select what individual knowledge products to support and develop has not been clear to all stakeholders but it is being formalised/standardised under current governance and management processes.

Key informants in the iDSI Secretariat pointed to an objective gap analysis process undertaken during iDSI 1 including through a survey on priority research topics for the iDSI Reference Case,¹¹¹ a commissioned paper on research priorities¹¹² and the HITAP-led survey of LMIC researchers to identify priority economic evaluation research questions.¹¹³ Based on discussions with several of those involved in developing knowledge products, it appears to some that there has not been a consistent process articulated for how decisions have been made about what products to support and the allocation of necessary resources. When asked about how iDSI decides what KPs to develop, comments included, that "there was a process" which involved "a lot of different actors" although the details were difficult to grasp.¹¹⁴ Respondents to the survey and key informants expressed a desire to understand how iDSI decides what is in the research scope and there were questions over whether or not iDSI accepts proposals for research.¹¹⁵ There was some evidence that some respondents had had chance or informal conversations with core partners that led to a request to participate in developing a knowledge product, or where a brief discussion about an idea for research they wanted to do was subsequently taken forward (presumably without a formal application process).¹¹⁶ There were some suggestions that research topics were identified based on the views of individual experts rather than through an objective gap analysis.¹¹⁷

Partners had differing views about iDSI's current and ideal role in developing knowledge products and identifying what research to commission with some thinking that the current arrangements are not responding sufficiently to country needs. iDSI's global public goods are intended to be useful to countries and to support countries to develop their own version ('domesticate' the approach).¹¹⁸ As the country case studies identified, countries seem to rely on their own data and to want cost-effectiveness analyses done using their own data and related to their own settings and contexts. They may draw down on examples from elsewhere (including from the iDSI website) but where they are able, countries will re-do an economic evaluation using domestic data before using that evidence for decision making.¹¹⁹ Country engagement in developing knowledge products is largely considered to be a part of the country practical support provided by iDSI.¹²⁰ Yet, for those in countries undertaking knowledge production, this distinction may not be clear to them. One example of a knowledge product that been used by different countries is the Quality Standards Process

¹¹¹ Qualtrics survey, October 7 2014.

¹¹² Paul Revill, Beth Woods, Mark J. Sculpher, (no date) Economic Evaluation of Health Care Programmes and Interventions in Low and Middle Income Countries York University, Directions for Future Methods Research, Centre for Health Economics, University of York.

¹¹³ Alia Luz, Benjarin Santatiwongchai, Juntana Pattanaphesaj, Yot Teerawattananon (2016) Health Intervention and Technology Assessment Program (HITAP), Identifying Priority Methodological Issues in Economic Evaluation in Low- and Middle-Income Countries: Finding the Holy Grail, HITAP.

¹¹⁴ KI26

¹¹⁵ KI12, KI103 for example.

¹¹⁶ KI22, KI15

¹¹⁷ KI24

¹¹⁸ KI09, KI11

¹¹⁹ The country case studies suggest this as do several key informants who report that knowledge products are not always seen as relevant to countries where the context is another geographical setting.

¹²⁰ For example, the budget for care pathways or standard treatment guideline development is from the country operations budget, not the research budget.

Guide.¹²¹ This guide, developed in 2015 using Kerala (maternal health) and Vietnam (stroke care) as examples of how to identify and agree quality standards, has also been used in other settings (China, South Africa) and for other conditions (antibiotic use in acute respiratory conditions).

There is a lack of clarity among stakeholders about what types of products were most relevant for iDSI to produce. Some network responders were unclear about the role of iDSI in research – its overarching research strategy – while others were concerned that the research agenda was set without sufficient consultation. Respondents did not know how the decisions around specific research were taken, how to get into the research network (and apply for funding) and who was in the leadership role.¹²² On the other hand, several respondents to the network survey and key informants believed that getting the balance right between research and practical capacity building support was an ongoing point of discussion. For example, one of the core partners thought that donors would like to see iDSI publish more in peer-reviewed journals, but the several donors interviewed were largely interested in iDSI's work to provide examples of process or "how-to" pieces that would be useful to policy makers at the country level, especially among LMICs. They did not immediately identify iDSI's role to commission academic research as very high among its main priorities (as opposed to developing knowledge products). Some of the non-executive Board members were also not clear on the decision-making process around iDSI knowledge products. Several key informants, including many Board members and other partners thought the knowledge programme should be linked to an overarching iDSI research strategy that was developed through consultation and approved by the Board. They felt that the decision about what research to pursue and the associated resource allocations was not currently taken through a clearly defined process.

iDSI has started to address the lack of a formalised process by initiating a research proposal and application process moving away from an ad hoc approach. This process is centred on a structured form that prospective researchers complete. The process enables decision makers to assess the value of the research, the potential impact, whether the audience is clear, and so on. This is an important step forward and starts to make the research identification and funding process more clear. However, if iDSI were to decide to expand its research agenda and had additional resources to do so, there is more it could also consider to ensure that the iDSI research programme is more accountable in terms of the strategic research plan, and more transparent in terms of process and decision making.

Relevance to LMICs

It is difficult to assess the extent to which iDSI knowledge products are relevant to LMICs as iDSI does not currently have a process to identify priorities or monitor needs. Furthermore, as the evidence of uptake by country and global informants shows, country-based stakeholders make the most use of the products they themselves develop. iDSI is supporting the development of a database, however, that may help strengthen the visibility between country priorities and iDSI investments into knowledge production. The Guide to Economic Analysis and Research GEAR database is currently being developed by HITAP. GEAR will work by enabling actively engaged researchers to pose questions which someone in the GEAR process will try to respond to using available knowledge. Where there is no evidence to support a response, that question would then constitute an identified research gap. Looking at research gaps identified this way may enable iDSI to respond better to demand for specific knowledge products (or at least topics). As unanswered questions build up, iDSI partners will decide if they are questions of interest to them as research questions, in which case they will develop research proposals and, in due course, conduct the research. The GEAR project also aims to link up researchers and policy makers across geographies. The GEAR database is in its very earliest stages and

¹²¹ Ryan Li, Francoise Cluzeau et al Principles for developing clinical quality standards in LMICS, NICE International, UK, http://www.idshealth.org/knowledge_base/principles-for-developing-clinical-quality-standards-in-lmics/

¹²² Responses collected through the network survey.

learning review was not able to assess how well it will facilitate the identification of LMIC needs.¹²³

Capacity building through iDSI research

The current iDSI vision around capacity building for knowledge provision and consumption is not likely to be achieved without additional investments in knowledge management. The iDSI vision is to grow the capacity of policy makers to consume and use quality research while at the same time producing more relevant knowledge through engaging country-level academics in research as a capacity-building exercise. Capacity needs to be built at the country level to strengthen local, quality academic research (iDSI is aware of and is working on this); and equally, capacity needs to support decision makers to use that research for policy making. Sound research helps to build the credibility of decision makers. Ensuring that research is undertaken to support specific policy making needs also helps to ensure both that the most relevant research is undertaken and that the research is more likely to be used.¹²⁴ However, it has been challenging to convince academics in high-income countries to undertake this role because there is a perception that this will create a tension between publishing in leading journals and building capacity.¹²⁵ It is difficult to establish the link between the iDSI global knowledge products and the ambition to build capacity in countries (capacity to plan and undertake research, to demand and then use research in policy making, to adapt global research to local settings, etc.), because the way countries download knowledge products and use them is not systematically tracked.

Quality assessment of the process to develop specific KPs

Those involved in producing research products were generally confident that the process for ensuring their quality was sufficiently rigorous. Knowledge producers described similar processes of engaging with iDSI as they did with broader partners from academia and policy backgrounds to get useful feedback in workshops or written feedback. In some cases, there was no formal “QA” event but consultations with stakeholders satisfied that process.¹²⁶ Additionally, as a large proportion of products are published in peer review journals, it was felt that the peer review process and publication by respected journals provided quality assurance.¹²⁷ As a recent Cochrane Review found, however, relying on peer review for quality assurance is not necessarily a rigorous process: “We could not identify any methodologically convincing studies assessing the core effects of peer review.”¹²⁸ In addition, given the range of partners engaged in research, the variability in topics and the range of research methodologies, it would be an important contribution to building accountability and transparency for iDSI to establish a more robust form of quality assurance that takes account of relevance and response to identifiable knowledge gaps as well as the quality of the research itself.

Communicating research

iDSI does not currently have a platform(s) that allows for KPs to be strategically “pushed” out to relevant audiences. iDSI does not have the technology or processes in place to promote or communicate its knowledge. Knowledge product users can find products by proactively accessing the website and searching the library, or by a connection through iDSI, e.g. being invited to an event where a KP is launched/referenced, a conversation with a network partner who has direct knowledge of a specific product or finding a product through a non-iDSI source. There is acknowledgement among core partners and in the iDSI Secretariat that

¹²³ Additionally, there are knowledge products relevant to iDSI’s strategic aims, most notably the Cochrane EPOC reviews (<http://epoc.cochrane.org/>) and McMaster’s <https://www.healthsystemevidence.org/> which can help identify gaps as well. It is not clear how iDSI incorporates evidence from these sources.

¹²⁴ Views expressed in the network survey and interviews KI09, KI06, KI17

¹²⁵ KI09, KI12

¹²⁶ KI22, KI12, KI24

¹²⁷ KI15, KI23

¹²⁸ http://www.cochrane.org/MR000016/METHOD_editorial-peer-review-for-improving-the-quality-of-reports-of-biomedical-studies

the website needs to be more accessible and that knowledge products need to be positioned differently for different audiences with a clear dissemination strategy. Several informants who had been involved in the production of knowledge products were not aware of a dissemination strategy beyond the product being put on the website. They reported disseminating knowledge products through their own networks or at key events but also were of the opinion that iDSI was better placed to lead on wider dissemination rather than the KP production partner.¹²⁹ The new proposal process that iDSI has recently started implementing will help identify the target audience upfront as the research is being designed and planned. This would create an important opportunity for a more upfront discussion about communicating results before the research is actually undertaken.

Uptake of research

Network partners cited many positive examples of iDSI evidence being used to influence policy. Of those who responded to the Network Health Survey Question “Since you started your engagement with iDSI, can you provide an example of iDSI evidence being used to support policy development?”, 77% (n=44) cited positive examples. Specific knowledge products (such as the Cost-Effectiveness Thresholds work and the Reference Case) were cited by 8 respondents (18%). Additionally, several key informants referenced the Cost-Effectiveness Threshold work specifically as having positively influenced the WHO to review its position on thresholds.¹³⁰ As one person put it, this piece alone did not solve the problem but it sparked a much needed debate.¹³¹ The majority of the responses, however, included evidence which iDSI would currently categorise as practical support to countries, e.g. country-level HTA, clinical guidelines, health benefits packages processes and support engaging with country-level policy makers. Research into the factors that make it more likely that evidence is acted upon by policymakers has identified elements such as regular interactions between policymakers and those who generate the evidence, timeliness of evidence products, having evidence “presented in a way that allows for rapid scanning for relevance and then graded entry (such as one page of take-home messages, a three-page executive summary and a 25-page report)”¹³² and others. It is not clear how iDSI ensures that its research is selected, managed and marketed in ways that increase the likelihood of its uptake.

For most respondents, the knowledge products they most often cited were those they worked on in their own countries rather than global research products pulled from the iDSI website or introduced to them by an iDSI partner. These are products that iDSI actually considers “capacity development products” and which are not classified as knowledge products. However, they were most often named as the most useful products by key informants and in country interviews. This triangulates with evidence from the country case studies which also identified most country stakeholders’ views that the knowledge products most useful to them were their locally developed products while few were able to cite global research that is on the iDSI website.¹³³ The confusion between global knowledge products and capacity development products may just be one of semantics and thus an issue for communications. However, there may also be a missed opportunities to leverage and showcase global knowledge products and capacity development products. For example, are country capacity development products shared with other countries and are countries offered the possibility of linking their products to the iDSI knowledge library? It could strengthen the learning/knowledge potential, if the knowledge library could package together the “Principles for developing Clinical Quality Standards” guide together with three or four examples of its use by countries around different conditions.

¹²⁹ KI12, KI28

¹³⁰ KI22, KI24, KI12, KI26,

¹³¹ KI22

¹³² Lavis J, et al. Towards systematic reviews that inform health care management and policy-making. *J Health Serv Res Policy* 10: S1:35–S1:48

¹³³ See the Country case studies, especially India, Annex C4.

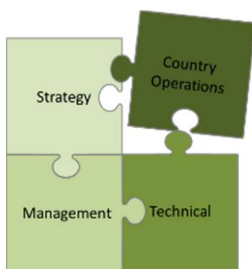
It is not possible to track uptake of research methodically or to follow-up with knowledge product users because processes are not in place to support this. Currently, iDSI is not able to systematically track downloads of knowledge products from the website nor is it able to gather data on who is downloading what, where they are based, or to follow up with users to see if they found the research useful. Conversations are ongoing with F1000 research website to create a gateway where iDSI can showcase its outputs. This will be an important step forward to enabling iDSI to assess the relevance and uptake of its knowledge products. It will also enable it to more efficiently take remedial action if products are not used as much as they are intended to be used and to help clarify links between specific knowledge products and other advocacy and technical assistance processes.¹³⁴

One of iDSI's own funded pieces of research identifies the challenges:

“Research organisations working in the field of HTA have to do so much more than conduct high quality research: they also have to engage with a complex array of stakeholders, network closely with a number of other research organisations, build partnerships with different levels of government and train the future generation of HTA researchers and policy-makers.”¹³⁵

4.4. Country Operations component

4.4.1 Summary of main points



- iDSI partners provide a range of technical and capacity-building support in the countries where they work linked to the full process cycle of designing, building, implementing and refining national capacity to institutionalise priority setting in a UHC context (end-to-end process);
- iDSI's approach to technical assistance at country level is an important feature of its niche, and its ability to pace its support to genuine country-led demand is a distinguishing quality worth safeguarding.
- iDSI partners have an established track record and experience in several countries but more clearly around advocacy and individually focused capacity building than around the establishment of priority-setting institutions (as yet);
- iDSI partners are viewed as credible, experienced, respected and, most importantly, worthwhile engaging with in support of country goals;
- Country-based informants were unfamiliar with iDSI knowledge products and/or did not use them to inform their work;
- iDSI has uneven experience working with other priority-setting partners at the country level such as WHO.

4.4.2 Main findings: Country Operations

Outline of the section structure, overview of the evidence base, response to the EQs

One of iDSI's principal areas of engagement is to provide practical support to countries to strengthen and integrate priority-setting capacity and institutions into their health systems. iDSI's approach to identifying suitable country partnerships was set out in Section 3 above. In order to understand how iDSI operates in

¹³⁴ K105

¹³⁵ Jane Doherty, Effective capacity-building strategies for Health Technology Assessment: A rapid review of international experience, School of Public Health, University of the Witwatersrand, South Africa, June 2015.

country, case studies in India and Indonesia were undertaken (summarised in this section and included in full in the annexes). Additional evidence was gathered from key informant interviews, the network survey and from the document review. The findings below consider the range of iDSI support to countries; the relevance of that support both to country priority-setting goals and to iDSI's own strategy; iDSI's adaptability and responsiveness to country needs; how it positions itself in countries to promote results; and end with a review of iDSI's partnerships with others in country and how others view it.

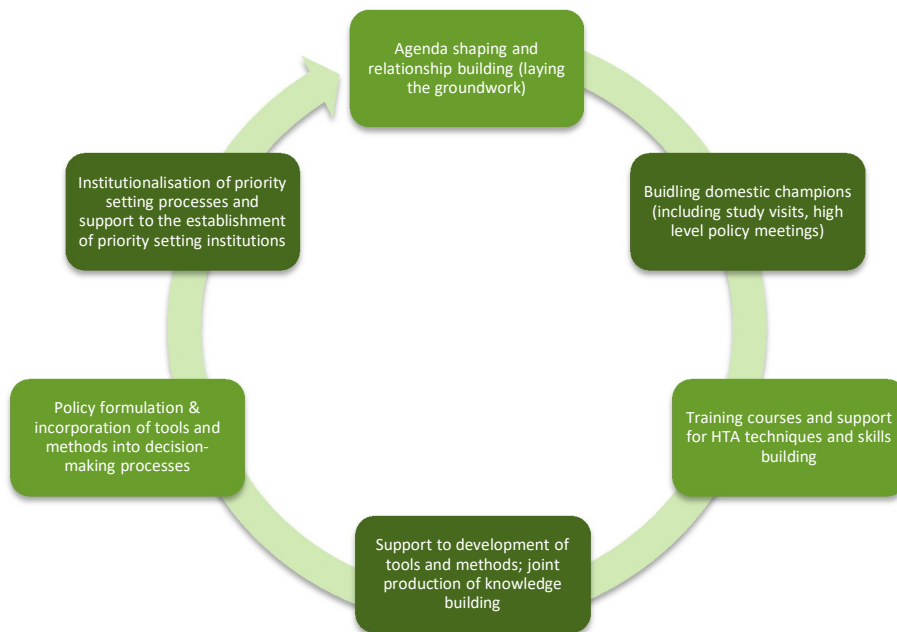
Range of iDSI country support

iDSI core and delivery support partners provide a range of technical, capacity building and process-based support in the countries where they work. This support can take many forms but typically it follows a number of steps which include: (a) building a discussion around priority setting in order to create a common understanding about its value and role in the health system; (b) deepening knowledge in general and specific ways including through skills training, practical tools development and consensus building around methods and processes; and (c) supporting the processes and institutions needed to integrate priority setting in a sustainable way. This **end-to-end process** takes time and patience to play out fully and there are no examples yet of where it has been fully supported at country level, although India and Indonesia are well advanced. This mix of technical and institutional support was valued by countries.¹³⁶

iDSI demonstrates the flexibility needed to respond to the variability of country needs. The way that priority setting is integrated into national health policy varies by country and depends to some extent on where they are in their UHC journey and the range of iDSI responses reflects this. For example, in India, where UHC is still a fairly vague political aim, priority setting will be used to standardise health care largely purchased out of pocket from the private sector “in such a manner that for a particular type of condition, patients in different places should receive similar care and pay similar amounts. Guidelines for treatment in the public domain will curb over-treatment and over-prescription by private facilities.”¹³⁷ Elsewhere in India, other partners are working on maximum retail pricing to help individuals determine how much they should be paying for certain tests, prescriptions, consultations, etc. In other settings, such as in the Philippines or Indonesia, priority setting may be used to determine the most cost-effective way to manage a particular disease burden such as diabetes or stroke or to define how public resources should be used. iDSI aims to support countries at all stages of developing priority setting irrespective of their health systems. Figure 13 identifies the most common stages of support.

¹³⁶ Interview KI13, KI11, KI03

¹³⁷ DNA e-Paper, New Delhi, July 23 2016, <http://www.dnaindia.com/india/report-health-department-to-launch-new-board-to-standardise-health-care-reduce-private-malpractice-2237093>

Figure 13: Support provided to countries by iDSI partners

Relevance of iDSI country support

With experience in several countries, iDSI partners have been able to establish a sound track record of supporting most elements of the end-to-end process. This includes strengthening priority setting from problem identification to training and methods development, to process and institution building. Examples of assistance from iDSI identified in positive terms through the review include study tours, attendance at PMAC, support to advocacy in country, formal training courses and ongoing mentoring and coaching.¹³⁸ These are consistent with most of the six elements of the priority-setting process, as summarised in Table 8. Country work was also seen as “important, to the extent that it provides credibility to [iDSI] and lessons to apply in other countries.”¹³⁹

Table 8: Elements of the priority-setting process supported by iDSI partners in a sample of countries¹⁴⁰

	Agenda shaping (Visits to country/ joint visits to 3 rd countries)	Building domestic champions (Study visits, PMAC attendance)	Training courses (Economic evaluations)	Development of tools and methods (HTA, CPs, STGs)	Policy & process support (Integrating STGs, CPs into practice)	Institution building support (Establishment of institutions & systems)
India	✓	✓	✓	✓	✓	✓
Indonesia	✓	✓	✓	✓	✓	✓
Viet Nam	✓	✓	✓	✓	✓	✓

¹³⁸ Interview KI11, KI13, KI10 and both India and Indonesia country case studies.

¹³⁹ Interview KI15

¹⁴⁰ The sample of countries was selected because these are both amongst the countries that iDSI lists on its website as its main partner countries and the countries referred to by the key informants. The remaining countries (Myanmar and the Philippines) were not mentioned in interviews.

China	✓	✓				
Ghana	✓	✓	✓	✓		
South Africa	✓	✓				

Key informants mentioned a wide range of capacity strengthening needs stretching across the priority setting end-to-end process. Examples of needs expressed by or in relation to different countries¹⁴¹ in the course of the review include:

- * A middle-income country overwhelmed with new technology that, to fully integrate into the health service, would require trade-offs with services for the poor. What should be covered and where in the system should it be offered?
- * Another country started with a growing health problem – cardiovascular disease or diabetes – and wanted to know what to do about it.
- * A middle-income country transitioning out of aid needs to establish and sustain capacity to achieve maximum impact from health resources. It aims to build a more structured and transparent priority setting approach and is looking to develop skills, understand related policy and institutional processes, and find champions within government.
- * A low-income country aims to understand priority setting in order to build the capacity to ask the right questions, challenge donors and the global health funding organisations, and to be in a position to set its own priorities.
- * Other needs included rationalising the drugs list, creating a benefits package, de-listing services, change management for institutions, the economic benefits associated with allocating resources between levels of care like primary and promotive rather than selecting individual services (see below), initiating and managing cultural shifts for evidence-informed decision making, governance and institutional development.
- * Several countries expressed a desire to be in touch with others, to share lessons and learn from other countries engaged in similar challenges.

There was significant engagement in the ongoing development of the benefits package but some informants also identified the need for more support around rational allocation *between* levels of health service delivery (primary, secondary and tertiary, etc.) especially in LMICs. For example, several LMIC-based health survey respondents mentioned the benefits package when asked to identify ways that iDSI supported the link between research and policy.¹⁴² Many respondents also linked different kinds of iDSI support together. For example, “... methods on cost-effectiveness thresholds is informing the essential health package.”¹⁴³ However, while these were endorsements of ongoing and highly relevant iDSI support mainly by those involved in the processes, one observation from a key informant not directly engaged suggested that iDSI could consider helping countries strengthen high-level decision-making processes that lead to the initial allocation of sufficient funds (relative to all available funds) for primary level care (related

¹⁴¹ The examples come from across the documentary and interview evidence including KI03, KI10, KI01, KI13, KI11

¹⁴² Others were the thresholds piece, the reference case, the Chinese HTA hub, the MTAB in India, and quality standards for stroke in Viet Nam).

¹⁴³ From the Health Survey.

to Quadrant 3 in Figure 1 above).¹⁴⁴ For many countries, becoming overly focused on a benefits package before the fundamentals of primary care are addressed risks an overarching distortion in the use of available resources. A critical presumption of UHC is the reduction of the preventable burden of disease and this occurs fastest and most efficiently at community and primary level as well as through investment in the social and economic determinants of health. So far, iDSI partners have focused less on these levels of decision making.¹⁴⁵ Clearly, iDSI cannot do everything, everywhere and given that its niche is to build long term partnerships with countries, it can only engage in a limited number of countries (even with additional financial resources). However, as it moves into new countries, and bearing in mind that opportunities to engage at country level are sometimes restricted, iDSI partners might find it worthwhile to engage in political economy analysis across the four quadrants to assess where to engage for the greatest impact on health outcomes.

Investments in priority setting need to be well beyond capacity and skills to have sustained impact.

Evidence from the country case studies and from key informants suggests that the obstacles to making progress with priority setting are beyond capacity and skills deficits, and rather include a lack of resources, insufficient evidence about the potential health value to be gained from different decisions, the need for technical support, and a lack of political and policy commitment. The limitations of the tools and methods were also highlighted by a number of key informants who said that in general terms, they need to be used in the right way. The value of HTA generally “needs to be framed correctly to identify where it can help and where it can’t.”¹⁴⁶ There are a lot of instruments and they each have suitable (and unsuitable) contexts. Another informant suggested that policy makers are especially in need of guidance about the limitations of HTA and how it can be used as HTA “is not a decision in itself. Priority setting does not create answers but helps policy makers to make informed decisions.”¹⁴⁷

When asked about iDSI global knowledge products, few country-based informants either in India or Indonesia or from among the country-based key informants were able to name one that they were familiar with or had recently used. Knowledge products and documents of most value to country participants were cited by them as those developed actually in country where iDSI supported them to strengthen their skills and capacity in order to develop them (for example, to complete cost-effectiveness analyses with local information in Indonesia).¹⁴⁸ iDSI does not classify these as knowledge products but rather as capacity-building products which are part of country-level practical support. Some interlocutors mentioned that they were aware that there were iDSI global knowledge products on the website but had not accessed them.

¹⁴⁴ KI08

¹⁴⁵ For example, in India, NI supports the development of standard treatment guidelines (STG) focused on specific disease conditions. While there may be some aspects of these conditions (such as hypertension) that have primary care elements, the purpose of the STG is to identify medical interventions appropriate to disease progression. In Indonesia, HTA focuses on economic evaluation of new therapies, commodities and procedures.

¹⁴⁶ Interview KI08

¹⁴⁷ Interview KI03

¹⁴⁸ Interview KI03, KI10, KI13, KI11 and interviews conducted to complete the country case studies

Box B: Summary of the India Country Case Study

The case study aims to better understand the **scope of the support that IDSI is providing at the country level, how that support responds to country-specific needs and how it contributes to IDSI's Theory of Change.**

Context: Health outcomes in India are improving, but they lag behind countries of a similar economic size and development. Public expenditure on health is currently one of the lowest in Asia.

Scope: Stakeholders are familiar with the support that is being provided through its partners, NICE International and HITAP. Building on quality standards support to Kerala, key areas include support to standard treatment guidelines, the development of the Medical Technology Advisory Board and cost-effectiveness training.

Effectiveness: The NICE brand brings high credibility in India, and this has been effectively combined with interpersonal relationships and a presence on the ground in India to ensure that NICE International has been able to build partnerships with some key organisations and individuals in India.

Relevance: IDSI's support to priority setting is focusing attention in India. NI and HITAP support is considered to be highly relevant in terms of increasing the prominence and awareness of the priority setting agenda, as well as supporting increased technical expertise and capacity to deliver on that agenda. IDSI could expand the scope of its support to ensure that the evolving Indian model is based on global best practice.

Contributing to stronger country institutions: NI has been able to work with a wide range of partners despite the fragmented health system and is in a good position to provide credible assistance to the establishment of the new medical technology assessment board (MTAB). This will be a new role for NI and will require new skills and expertise.

Conclusions and issues arising

The NICE brand, combined with a presence on the ground and the development of strong interpersonal relationships, has been a powerful combination in India. ★ IDSI does not yet have a strong footprint in India, but there are existing institutional relationships with NICE International and HITAP that might be leveraged. ★ The work of NICE International and HITAP adds value in India, and stakeholders see a role for their support going forward. ★ The establishment of the MTAB requires additional skills and or modes of technical assistance that are arguably distinct from the type of practical support that NICE International and HITAP have provided to date in India.¹⁴⁹ ★ The development of robust and evidence-informed products needs to be balanced with work to ensure that there are mechanisms and pathways for implementation and use of products. ★ Given the complexities of the Indian health system and its decentralised arrangements, there is a need for NICE International, HITAP and others to be flexible and engage with stakeholders beyond those that have historically been engaged in dialogue around priority setting.

Considerations for IDSI going forward

NI has built a very solid foundation in India. It is widely respected and has developed a reputation for careful, appropriate, patient and technically rigorous work, as has HITAP. Given the context in India, IDSI will need to consider carefully how to brand its activities at country level and navigate the introduction of a global network into a country where a presence on the ground and personal relationships are critical for working effectively. IDSI partners that want to deepen their engagement in India could look for opportunities to increase their presence on the ground. NICE International is well placed to use its position and relationships to help shape the priority setting agenda in India, ensuring priority is given to serving the needs of the people rather than an over-focus on health care funders. IDSI should increase the focus it gives to the mechanisms through which treatment guidelines will be implemented. IDSI and NICE International, in helping to shape the MTAB, may find it beneficial to invest further in their own health systems knowledge beyond the establishment and operation of immediate institutions linked to priority setting either directly or through expanding partnerships.

IDSI adaptability and responsiveness

Each stage of the priority-setting process involves different levels of the health system and differently paced reforms that depend on factors beyond the control of IDSI partners. Investments may be short or long

¹⁴⁹ For example, it would be prudent to ensure that MTAB has the capacity, scope and flexibility to adapt to imminent and substantial health systems changes India by including an analysis of health systems reforms on institutional arrangements, including on recommended structure, skills and processes.

term in nature. Process elements of priority-setting reforms are particularly challenging as they require the convergence of political commitment, institutional reforms, financing, human resources training or contracting and very often legislation. To fully support countries, iDSI partners need to either have these skills in-house or be in a position to access them reliably when needed. Table 9 sets out the skills most typically required at different stages of priority setting and identifies those which are assessed as strong in iDSI as well as those which, across the core partnership, are weaker or less systematically available.¹⁵⁰

Both the country case studies raised a risk inherent in depending on the political will and capacity of individuals to achieve iDSI's strategy. Capacity and political will of individuals is portable or mobile. Engaging at the institutional level thus helps ensure that actions can be taken to retain capacity, that the institutional strategy embraces a longer-term view, and that the country itself is leading, making key decisions about pace and strategy and investing sufficient domestic resources, with the iDSI partner taking an important but supportive role. This is a difficult balance to achieve and there are risks associated with not getting the balance right. For example, where national leadership wanes (as it did in one case following the internal transfer of a priority-setting champion), iDSI may find momentum has stopped. There is little that can be done then until country leadership picks up again other than to continue to build individual capacity. iDSI's ability to progress its strategy can thus be limited by national leadership commitment; political decision making is an inherent part of the country-focused operations.

There are illustrations from partner countries including, most recently, from India, of how political decision making has both accelerated and stalled iDSI supported progress to priority setting and it underscores the vital role of country-based priority-setting champions. It also raises operational and methodological challenges for iDSI in terms of the range and number of countries it can support, how it can always be ready to scale up or scale back in response to country demand, and when it is the right time to promote or push the next stage of priority setting in a given setting. For example, iDSI partners engage with a limited number of countries at any one time because the partnerships are technically intense and require focus. Pacing and ensuring the optimal use of iDSI technical assistance resources could be a challenge then. Where a country is having a slower phase, should iDSI take on a new partner? In one country recently, the slow-down in institutional commitment lasted more than 18 months. Yet, this careful, genuinely country-driven support is iDSI's real niche and is a valuable part of its offer (and what distinguishes it from other priority-setting groups). As one respondent in the network survey framed it, "iDSI excels at one on one support to ministers, strategic guidance and technical support".¹⁵¹ In relation to its technical assistance capacity and engagement, iDSI partners need to continue to pace themselves in the shadow of the institutions they are supporting therefore.¹⁵² An iDSI-funded review of global experience in supporting capacity building suggested that when embarking on *"the development of an effective HTA-informed priority-setting process that is sensitive to societal and government needs and priorities ... it is important to start small, building on existing capacity and opportunities through the development of sound partnerships"*. This is exactly what iDSI has done. The challenge is to identify where it goes from here.¹⁵³

¹⁵⁰ This assessment is based on an analysis of current and previous technical support to countries and drawing on the views of key informants including iDSI core partners.

¹⁵¹ Network Survey responses.

¹⁵² The evidence for this observation is drawn primarily from the two country case studies (Annex C4) and from a range of interviews at global and country level.

¹⁵³ Jane Doherty, Effective capacity-building strategies for Health Technology Assessment: A rapid review of international experience, School of Public Health, University of the Witwatersand, South Africa, June 2015.

Table 9: Skills and expertise needed at each stage of the country focused priority-setting end-to-end process

	Agenda Shaping	Fostering Champions	Training courses	Development of tools and methods	Policy & Process support	Institution building support
Priority setting technical knowledge	✓	✓	✓	✓	✓	✓
Economic analysis expertise			✓	✓		
Teaching and capacity building skills		✓	✓	✓		
Diplomacy and negotiation skills	✓				✓	✓
Political economy analysis skills	✓				○	○
Developing a priority setting institution						✓
Health systems strengthening expertise	✓				○	○

✓ indicates iDSI expertise identified by key informants ○ indicates expertise less clearly evident in the partnership

iDSI's positioning in country processes

In most countries where iDSI partners work, the primary country client is a government entity or some branch of the national health authority which positions iDSI exactly where it can have the greatest impact.

In India, NI shifted from working with the Kerala state health authorities to national level institutions within the Federal Ministry of Health for example. HITAP provided HTA skills training support to a network of universities hooked loosely into the WHO collaborating centre, itself based in a national institution. In Indonesia, support to HTA and the inclusion of HTA in health decision-making processes was linked to national authorities and a network of universities. Looking at most of iDSI partners' contacts, this is the case. However, there are exceptions. In South Africa, iDSI's core partner is embedded within a university rather than a government entity. In Ethiopia, iDSI was originally linked in through DFID rather than through national entities.¹⁵⁴ Others pointed out that where priority setting is still at early stages there are often non-government partners ready to start building appropriate interest and skills, and if iDSI waits for national authorities to indicate their commitment, especially something in writing, this may create delays.

The question arises, therefore, as to whether iDSI is in fact a government-to-government partner as suggested in one iteration of its strategy (see Section 4.1) or a practitioner-to-practitioner partnership (as suggested elsewhere), and whether and how this matters to the way that iDSI is structured. Where national authorities lag behind non-government actors in a high priority country, is iDSI pragmatic about linking up where it finds common ground? In practice, this seems sometimes to be the case. As iDSI partners become increasingly separated from government entities themselves, this aspect of the approach might be worth thinking through again and articulating slightly differently. In relation to country operations, it would certainly seem that what is valued from iDSI is the technical assistance they offer rather than the actual production of economic analyses. Their own knowledge products developed at the global level are not what is most valued or recognised. Some informants were clear in their view that iDSI should provide technical assistance and promote the "institutionalisation of HTA rather than function first as a research platform," except to the extent that research serves the above purpose.¹⁵⁵

¹⁵⁴ iDSI has now signed a MOU with the Ethiopian Public Health Institute.

¹⁵⁵ Interview KI02, KI07

A common finding from the country case studies was the important role of continuous in-country technical support. In India, the presence of a credible, knowledgeable and respected resident technical adviser was raised by many of those interviewed across widely varying roles as a critical condition for success. Even those who felt more ambivalent about iDSI's work more generally nonetheless recognised the value and role played by the resident technical adviser. In Indonesia, despite the 500+ days of technical support provided by iDSI, there were still requests for more continuity through the appointment of resident (or at least more resident) technical assistance.¹⁵⁶ This suggests that the process elements of positioning evidence-based decision making are one of the challenges countries face and this is closer to what one iDSI partner called the “hand-holding function” of iDSI.¹⁵⁷ It is the policy, process, institutionalisation end of the priority-setting chain.

Box C: Summary of the Indonesia Country Case Study

The case study aims to better understand the **scope of the support that iDSI is providing at the country level, how that support responds to country-specific needs and how it contributes to iDSI's Theory of Change.**

Context: Indonesia has taken major strides in its pathway towards UHC integrating several public insurance schemes with a view to achieving universal coverage by 2019. Given the burden of disease trends, the size of the Indonesian population, and the contextual constraints, this undertaking is ambitious. In 2014, the government mandated an HTA Committee by Presidential Decree and there are a number of governmental and non-governmental organisations working on priority setting. Supporting better decisions for better health within this context is highly relevant and timely.

Scope: Stakeholders are familiar with the support that is being provided through its partners, HITAP and NICE International. HITAP, as the lead for iDSI in Indonesia, is more widely recognised for concrete outcomes but there is also a high level of familiarity with NI, particularly with key individuals from NI. Key areas of practical support include technical support to conduct HTAs including economic evaluation, and policy and advocacy work to advance the institutionalisation of priority setting.

Effectiveness: The HITAP and NI brands brings high credibility in Indonesia. This has been effectively combined with building interpersonal relationships on the ground as well as HITAP's geographical proximity and cultural similarity. HITAP and NI have been able to build partnerships with some key organisations and individuals in Indonesia.

Relevance: iDSI's support to priority setting is focusing attention in Indonesia. HITAP and NI support is considered to be highly relevant in terms of increasing the prominence and awareness of the priority setting agenda, as well as supporting increased technical expertise and capacity to deliver on that agenda. iDSI could expand the scope of its support to respond to the demand in Indonesia for more on-the-ground support.

Contributing to stronger country institutions: HITAP and NI have been able to work with a wide range of partners and build consensus during a time when the UHC/priority-setting agenda is in a rapid stage of development and under close political scrutiny. HITAP and NI are in a good position to provide credible assistance to the Health Technology Assessment Committee as it formalises and strengthens its structure and remit. Going forward, the need and demand for iDSI is to focus on institutionalising priority setting in Indonesia, rather than targeted and intense HTA mentoring and technical support.

Conclusions and issues arising

The HITAP and NICE brands, combined with demand-driven practical support in HTA and the development of strong interpersonal relationships, have been an effective combination in Indonesia. ★ The iDSI brand does not yet have a strong footprint in Indonesia, but there are existing institutional relationships with HITAP and NI that can be leveraged. ★ The work of HITAP and NI adds value in Indonesia, and stakeholders see a role for their support going forward. ★ Moving from focused support to conduct HTAs to support for Indonesia to be able to take forward the findings of HTAs, requires a skill set and a mode of technical assistance that is arguably distinct from the type of practical support that HITAP and NI are recognised for to date in Indonesia.

¹⁵⁶ Country case studies (India and Indonesia, comments from iDSI and consultants' reply)

¹⁵⁷ Interview KI04, KI09

Considerations for iDSI going forward

HITAP and NI have built a solid foundation in Indonesia. They are widely respected and have developed a reputation for careful, appropriate, patient and technically rigorous work. If iDSI wants to promote the iDSI brand, it will need to consider carefully how to do this as its current reputation is built on respect for and familiarity with the HITAP and NI brands. There is demand in Indonesia to tap into iDSI's global offer and leverage global goods for the country benefit. The global offer of iDSI could be an attractive entry point to introduce the brand more prominently in Indonesia. iDSI partners that want to deepen their engagement in Indonesia may find it useful to be aware of the demand from Indonesia for an increased presence on the ground.

Perceptions about iDSI at country level

iDSI core partners are viewed as credible, experienced, respectful and, most importantly, worthwhile engaging with in support of country goals.¹⁵⁸ We found strong evidence from the country case studies, triangulated through key informant interviews, that countries considered iDSI core partners as knowledgeable about exactly the questions and challenges they faced. They were considered the right partner to accompany and support country processes and were valued especially for their experience and their approach to working in support of country capacity building.¹⁵⁹ In-country partners appreciated the support from iDSI partners on several levels. All valued the knowledge, technical capacity and experience¹⁶⁰ that iDSI partners bring to the field and all recognised the worth of being 'accompanied' through the process of developing priority-setting tools or procedures especially the first time round. Some felt there had been limited engagement so far and more technical assistance would be useful to improving results.¹⁶¹ Others saw the assistance in more ephemeral terms, something more like creating solidarity among a geographically group of like-minded policy makers and academics with common interests and challenges.¹⁶² Policy makers in countries were particularly interested in acquiring the tools to *make* decisions on their own rather than to be provided with the *decisions* themselves.¹⁶³

A few key informants diverged a little from the otherwise fairly consistent and positive assessment of iDSI's country-level practical support. Some, for example, thought that it would be beneficial for iDSI partners to be able to provide assistance across a range of methodologies and approaches to priority setting including from a range of country experiences (Canada, Australia, Mexico and Brazil were named specifically).¹⁶⁴ Although iDSI partners may themselves feel that they are flexible and open about methodology, they may not always transmit this openness or encourage exploration of alternatives.¹⁶⁵ While the numbers may be small, the degree to which it matters to iDSI what a minority thinks about them depends to some extent on how iDSI decides to develop its approach to partnerships. For example, if iDSI aims to be a 'one-stop' shop for priority setting or to be able to support demand-driven processes in a wider range of countries, it will be important to be as methodologically open as possible (and be seen to be so) while still adhering to its guiding principles. In relation to partnerships, it would be strategic for iDSI to nurture its reputation wherever opportunity arises and while it is never possible to meet all needs, at least understanding where the dissent is would be politic. This point will be discussed further in Section 5.

¹⁵⁸ This assessment is based on evidence gathered for the two country case studies and information from global level key informants.

¹⁵⁹ The country case studies from India and Indonesia both make this point quite thoroughly.

¹⁶⁰ Interview KI13, KI10, KI07, KI03, KI05, KI11

¹⁶¹ Interview KI10 and evidence from India and Indonesia country case studies.

¹⁶² Interview KI13

¹⁶³ Indonesia country case study.

¹⁶⁴ This point is raised in the India Country Case Study.

¹⁶⁵ This observation emerges from the India and the Indonesia country case studies and some of the key informants KI17, KI07.

iDSI's partnerships at country level

iDSI partners were able to effectively form and maintain the right partnerships needed to support high-quality country operations. This included identifying and responding to opportunities, building well-functioning partnerships with a range of organisations, and supporting processes with a flexible, adaptable approach. For example, in India, the NICE brand, combined with personal relationships established between NICE International and Indian stakeholders, facilitated effective relationship building in India. The NICE brand had high credibility in India, and meant that many organisations saw the value in working with NI especially given their link to NICE UK, the Royal Colleges, and other UK-based organisations. Their reputation, together with a recognition of the NI team's technical skills, strengthened NI's convening power, which was seen as exactly what was needed to support the development of standard treatment guidelines.¹⁶⁶ In Indonesia, similarly, HITAP first identified relevant opportunities and then, building on its reputation, used its knowledge about the HTA process and its funding flexibility to siphon off an important segment of the programme approach that complemented the contributions of others and had a significant incremental impact on the overall process and results.¹⁶⁷

Given the fragmented nature of priority setting in India, stakeholders saw value in the fact that NICE International was able to work with a number of organisations. Priority setting in India was increasingly complex and there were a number of different priority-setting programmes under way. These stretched across different organisations (including various government bodies simultaneously undertaking different priority-setting activities, non-governmental organisations and other international development partners) and at different levels (centrally and at state level). There were a range of technical areas supported including standard treatment guidelines (STGs), care pathways (CPs) and other HTA methods. NI was seen by the Indian government as the right partner to help it integrate different priority-setting efforts into a single institution.

Working constructively and systematically with WHO and other global organisations represented in country was identified as a major priority for iDSI across all its country operations. For example, one key informant suggested that, "iDSI should work with WHO and other international players. This will give more leverage to iDSI and brings synergies to the country; iDSI can help WHO move forward the commitments to HTA emerging from UHC commitments."¹⁶⁸ Another said that iDSI should focus on supporting health "decision-makers to have the information needed to move forward with UHC and to look at how to apply cost-effectiveness analysis to LMICs and primary care interventions (rather than to high-income countries and drugs)."¹⁶⁹ Among other views expressed, and considering iDSI's own strategy and approach to country operations, it was suggested that iDSI prioritise:

- Working with the Global Fund and Gavi to build on existing country-level prioritisation processes
- Working with WHO and the World Bank specifically on aligning with their priority-setting assistance in countries and ensuring iDSI support is complementary
- Fostering South-South partnerships by connecting countries with each other

Indonesia is an example of where iDSI is working constructively and closely with WHO, and this could be reviewed as a positive model for working with WHO in other countries.

iDSI focused on health assessments that support diagnosis and treatment of specific diseases or health conditions. Some informants pointed out that there are critical priority-setting questions across all the four

¹⁶⁶ See India Country Case Study, Annex C4.

¹⁶⁷ See Indonesia Country Case Study (Annex C4). HITAP support to the HTAs in Indonesia was through training and ongoing mentoring to the two dedicated staff whose salaries were funded by DFAT and seen as an essential factor in completing the HTA activities. In this case, the relationship was symbiotic: HITAP would have found it difficult to support the HTAs without having the two dedicated counterparts to do the work while the two counterparts would have been much less useful without additional training and mentoring from HITAP.

¹⁶⁸ Interview KI13

¹⁶⁹ Interview KI15

quadrants (Figure 1). For example, helping countries take a systematic approach to allocating resources to other sectors like water, housing or nutrition to address the social and economic determinants of health or to identify the best allocation of resources between disease prevention and detection and treatment would also be an important line to pursue.¹⁷⁰

iDSI as a brand

iDSI as a brand had limited visibility in both India and Indonesia. In both countries – and probably elsewhere as well – stakeholders are more familiar with an iDSI partner rather than iDSI. While some country-based stakeholders had heard of iDSI and had a general sense of its “global” nature, the majority associated activities in Indonesia with HITAP and those in India with NI. Among those in-country stakeholders in Indonesia that had heard of iDSI, for example, it was understood in general terms such as “an umbrella organisation” or “it has a global presence”. Awareness of iDSI in both countries was more concentrated among other development partners and some high-level Ministry of Health officials. This is recognised by HITAP and NI, who noted that there are plans to increase the visibility of iDSI but also acknowledged the value of the HITAP and NI brands especially when first building a partnership with a country.

At this stage, there is no evidence to suggest that the lack of iDSI brand recognition has impacted on the effectiveness of the practical support nor will it likely do so in the future. The brand profile is well recognised by iDSI partners, who note that over time there may be plans put in place to increase the prominence of iDSI and its brand (for example, by labelling convening events as iDSI events rather than NI, or HITAP). However, it will be important for iDSI to consider how it wants to position the iDSI brand in countries, the purpose of the brand, and the potential risks of a change in the branding and, above all, the extent to which it matters to the outcomes of the partnership’s work.

The use of iDSI resources at country level

iDSI resources are spent in support of country operations but generally speaking there are few sub-grants made to country-based partners. Core partners have contracts with iDSI and “get reimbursed on deliverables” but for others, “It is not clear how resources are channelled through iDSI for support to [my country]. The study tour to NICE was paid for but I am not sure of the source of funding.”¹⁷¹

Sub-granting to and within countries engaged in priority-setting activities is a sensitive issue. India-based researchers and policy makers all emphasised the importance of using public funding for economic evaluations, guideline development and other interventions that were going to lead to health resource allocation decisions to safeguard objectivity and prevent accusations of bias. For example, Dr Soumya Swaminathan, the Health Secretary overseeing the establishment of the Medical Technology Assessment Board (MTAB) in India stated that *“the board will not have members from the private health industry so as to be above all conflict of interest.”*¹⁷² Others echoed this and one country-based partner said they did not see funding as the key element of the relationship. Rather, “the key element is jointly developing conception framework and changing attitudes (creating a culture) around evidence-informed priority setting.”¹⁷³

¹⁷⁰ Interview KI06

¹⁷¹ Interview KI10, KI13

¹⁷² Reported in: DNA e-Paper, New Delhi, July 23 2016, <http://www.dnaindia.com/india/report-health-department-to-launch-new-board-to-standardise-health-care-reduce-private-malpractice-2237093>

¹⁷³ Interview (KI11)

5. Conclusions

This is a formative or learning review aimed at identifying lessons. The timing of the review is intended to support tactical and organisational adjustments, and strengthen iDSI's ability to better deliver its objectives and to be adaptable and responsive. This review was framed around four components and a series of 0 questions. Based on the findings set out in Section 4, this section draws out conclusions by presenting answers to the evaluation questions. The final section of the report draws on these conclusions to lay out priority recommendations to help iDSI determine its next steps.

iDSI is in the right place at the right time for steady growth in interest, commitment, investment and experience around priority setting at both global and country levels. The coming decade will probably be accompanied by a fast-changing expansion in priority-setting knowledge and capacity among other organisations as well. There is scope for leadership and direction in this field and it is likely that at some point, a particular approach will emerge to fill this gap. Therefore, iDSI needs to consider how it wants to evolve. It has many of the components of what would be needed to provide a leadership role, but is hindered by a lack of precision and clarity in its strategy, and a management approach that seems to be constraining growth (in size of the network, influence and knowledge). Its core partners have solid reputations and as a partnership it has built a reputation for integrity, commitment and capacity-building support. However, based on the findings of this review, if iDSI wants to become the go-to network for priority setting for UHC, there are some strategic, governance, networking, and knowledge management shifts for it to consider.

Strategy

What is the context in which iDSI operates and what is the strategic positioning of iDSI in this context?

The context is fast evolving given the rapid growth in commitments to advance UHC in all countries. The environment is ideal for organisations like iDSI as there is an increased focus on spending resources for health effectively. In the near future, in light of the WHO 2014 HTA resolution combined with the acceleration of interest in and commitment to UHC, there is likely to be a growth in expertise focused on priority setting.

iDSI has a very solid position on which to build in the coming decade and as yet, there are few other organisations able to deliver the same combination of capacity building and technical support with long-term commitments to process-related governance and institutional support at country level. iDSI does not bring a lot of funding to countries but what it does bring is knowledge, credibility and expertise. There are a number of questions it needs to resolve in order to fully take advantage of this position, including how best to reach low-income countries, how to strengthen its relationship with the WHO, and how to balance the slower more incremental work at country level with its ambition to influence and shape priority setting at the global level.

To what extent do the activities that iDSI is implementing contribute to its strategy?

Everything that iDSI is engaged in contributes to its strategy in a positive way. However, it is unlikely that iDSI will fully achieve its strategy if it continues along the current path. To accelerate progress towards its strategic objectives, iDSI may need to address questions related to the scale of its operations, its current approach to building relationships especially with other priority-setting actors not fully integrated with the partnership, its slightly disconnected strategy, and its network structure and governance. These areas are explored more fully in the next section.

Management

How effective and efficient are the iDSI governance arrangements?

iDSI's governance and management arrangements are becoming progressively more professional and formal, and contain many of the structures expected in a Board and oversight bodies. However, the small number of directly people involved in oversight and strategic decisions exposes iDSI to potential conflict of interest and a

lack of independence between the Board and core partners. Additionally, the Board is currently more focused on information sharing and is not yet operating at a strategic decision-making level.

Is iDSI's global structure fit for purpose to deliver iDSI's strategy (in terms of member size, composition of disciplines, connectedness, centralisation and median trust)?

iDSI brings together a respected, skilled and committed group of individuals and organisations at the forefront of evidence-informed priority setting globally, primarily based in the UK, USA and Asia with emerging partnerships in Africa. There is a high level of collaboration, trust, social and technical support generated by the network. iDSI's ability to deliver its strategy will be constrained if the currently dense and relatively closed core is not able to expand out to meaningfully engage a broader group of partners and foster innovation, and if it does not more effectively communicate impact and progress with the network and stakeholders. Additionally, the limited reach of iDSI into LICs/LMICs inhibits its ability to achieve its objectives to support LICs/LMICs in their journey towards UHC.

How effectively is iDSI managing/coordinating the core partners (optimising the value of each individual partners and the collective)?

Core partners collaborate closely and work well together, building on a foundation of long-standing relationships between NI, HITAP and CGD. Each core partner has a defined area of work, with clear objectives to fulfil. However, they also work together closely through the governance and management structures on day-to-day delivery of broader network activities. This familiarity among the core partners has positive and negative attributes. They are aligned behind a common approach and share similar values which builds cohesion. However, it also potentially leads to management and decision-making processes which can be perceived by those outside the core as unclear and not transparent. The closely bonded group may also be less open to challenge.

How effective and efficient is resource management across the network?

Core partners and broader network partners are satisfied with how their grants, sub-grants and MoUs are being managed by the iDSI Secretariat. Funders are also satisfied with grant management and compliance. Core partners have acknowledged that the communications function was under-resourced and have put plans in place to address this to the extent possible with current funding. As funds were all allocated at the point of agreeing the grant with BMGF, iDSI has little room to respond to opportunities that arise, or to rethink its approach. While iDSI is focused on and making progress in raising additional funds and leveraging funds from in-country partners, iDSI could consider ensuring an explicit component of flexible funding for future grants. This will place iDSI in a better position to drive the global agenda more proactively.

Technical

What knowledge products (KPs) have been produced by iDSI?

iDSI has either directly produced or supported/ assisted with the production of a wide variety of knowledge products at both global and country level. The products range from original academic research to guidelines and methods papers, to workshop reports and summary papers. iDSI partners are highly engaged and active in the development of research and a significant portion of iDSI funding is used for research or knowledge production¹⁷⁴.

What is the process through which knowledge products are identified and produced?

¹⁷⁴ We have estimated that at least 40% of iDSI's budget is dedicated to knowledge products. This is based on an assumption that the following percentages of partners' allocations are committed to knowledge products: 100% of the allocation for the four academic partners (York, Imperial, LSHTM, Glasgow), 50% of the allocation for NI's (excluding dedicated programme management and administrative functions), 50% of the allocation for HITAP, 25% of the allocation for PRICELESS, and 80% of the allocation for CGD. This recognises that all core partners have deliverables related to knowledge production and that there is intentionally not a firm division between knowledge products and country practical support. Source: Email exchange with NI Secretariat on 23/08/16 and 24/08/16.

The process is currently shifting from one that was fairly ad hoc or opportunistic (and thus lacked transparency) to one that is more rigorous and methodical. There is still a lack of clarity within the network around the higher-level iDSI research strategy, as well as around aspects of the selection process including who can apply and how decisions are taken. Knowledge products are developed at global level and at country level but there is a distinction between these in terms of iDSI funding processes and how they are categorised (i.e. global products are categorised as knowledge products while country products are categorised as practical support).

What is the relevance of the research that iDSI produces?

The majority of the research that iDSI produces is relevant to informing global policy and processes around priority setting for health. Based on analysis of iDSI knowledge products, research products have limited relevance for LICs/LMICs, particularly in their current form as academic journal articles rather than “how-to” guidance. iDSI has no structured system of tracking how its knowledge products are used and by whom and thus the relevance of its research is difficult to fully ascertain. Key informants from both the country case studies and the global interviews had limited awareness of global (website based) knowledge products and had rarely accessed them (except for those who were involved in the commissioning and production of knowledge products).

Have the quality standards for producing and disseminating research products been followed?

iDSI’s quality standards for producing and disseminating knowledge products are evolving, and, to date, a common QA process was not identified by those involved in producing research. However, overall, those involved in knowledge production were confident that the quality of the outputs was assured by a mix of methods, including consultation with and comments from relevant experts, publication in peer-reviewed journals, and structured workshops to review and refine knowledge products. Dissemination plans have been ad hoc and processes are not in place to monitor how and to what extent knowledge products have been disseminated to their intended audiences.

What is the uptake of knowledge products?

It is difficult to systematically assess the uptake of knowledge products since the processes are not in place to track downloads of publications from the website or other dissemination channels. Network partners are able to identify iDSI-associated evidence and support which has positively influenced policy. However, specific products (as per iDSI’s definition of knowledge products) were rarely mentioned except by those involved in the commissioning and production of knowledge products.

Country Operations

What is the scope of iDSI’s practical support at country level?

iDSI partners have experience in several countries supporting most elements of the priority-setting process. This includes agenda shaping and problem identification, specific training and methods development, and, to a lesser extent, systems and institution building. Examples of assistance from iDSI identified in positive terms include study tours, attendance at PMAC, joint development of authored manuscripts, support to advocacy in country, formal training courses, and ongoing mentoring and coaching. Typical engagement at country level is long-term accompaniment and advice around a specific area of priority setting. There was a preference expressed by countries for more long-term in-country technical assistance.

Most of iDSI’s support has been focused on providing practical guidance and building specific skills (economic evaluation) and processes (such as Standard Treatment Guidelines, Care Pathways, etc.). As countries advance their institutional arrangements, they need increasingly specialised health systems and institutional development expertise. At present, iDSI capacity is less evident in this regard.

How effectively is iDSI working with other actors at country level?

iDSI adopts an approach to country operations that combines targeted assistance, opportunistic and responsive technical guidance, and credible advice and support. This approach is appreciated and valued by

countries, and it is largely effective. iDSI does not have the scope or capacity to take on the whole priority agenda in any given country but rather works on components that are strategic to the context and are within its area of expertise. The advantage of this approach is that what iDSI partners do, they do very well. The disadvantage is that they seem to have less focus on the full priority setting landscape in a particular country, especially at the higher resource allocation level or in relation to allocating resources between burdens of disease including taking account of the social and economic determinants of health. Building more strategic partnerships with others working at global and country level may be a practical solution to this challenge since it is not iDSI's intent, nor would it be feasible with existing funding and resources, to cover all aspects of priority setting in every country where they work. Linked to this, as the technical support requirements of countries move closer to governance and institution building, some critical systems expertise might be missing in some contexts, notably low income settings where priority setting tends to be less advanced.

Is country support relevant?

iDSI work in partner countries is considered, on the whole, to be responsive, technically credible and high quality. It addresses critical needs in the countries concerned. Some countries would have preferred more consistent technical support in the way that India experienced. However, there is clearly a balance to be struck between 'supporting' and 'doing'.

How is the work that iDSI is doing at country level set up to deliver stronger country institutions?

iDSI takes a long-term approach to country partnerships and capacity building. To the extent that institutions rely on cadres of experienced, confident and appropriately skilled people, iDSI partners seem to be able to deliver the right kind of support in the right way. What iDSI does, it does very well. However, iDSI can only move at the pace of country leadership and this may result in periods of both intense engagement and gaps with little activity. iDSI efforts at country level focus primarily on national (usually government) actors. Although there is evidence that iDSI is making efforts to expand its field of operations to include working relationships with other priority-setting partners such as WHO, there is more uneven evidence of success here. A question for reflection is whether iDSI partners are so dependent on what is prioritised by national or sub-national authorities, that they are overly constrained in relation to advancing the dialogue or shifting the conversation about evidence-based decision making in a country context.

How effective and efficient is resource management for sub-grants to in-country partners?

Resource management at the country level is effective and efficient to the extent that it takes place. Most in country partners benefit from technical support, capacity building, trainings and study tours (which iDSI often provides the budget for) rather than receiving sub-grants. Among country-based partners, agreements linked to funding from iDSI presented no challenges and the approach to reimbursement of deliverables was acceptable.

6. Recommendations

Based on the findings in Section 4 and the conclusions in Section 5, the key recommendations from this learning review are set out below. The recommendations are high level for the most part and aim to help iDSI consider options as it continues to develop. The recommendations take as a starting point the idea that iDSI is more than its current grant and that it aims to diversify funding as well as increase its institutional presence in the future. The recommendations are designed to help iDSI to strengthen its strategic, operational and technical arrangements in light of fast-changing global and country contexts. Recommendations are organised in a suggested categorisation in terms of their (a) priority, (b) relative complexity and (c) resource implications.

Table 6: Summary of recommendations

Recommendation	Priority	Complexity	Resource implications
1. Clarify the partnership's strategy, vision and operational priorities.	1	3	3
2. Continue to make progress strengthening governance arrangements to provide greater transparency and legitimacy of decision making and to access additional expertise.	1	3	3
3. Develop and appropriately resource a global engagement strategy including the identification and engagement of priority partners.	2	3	3
4. Review iDSI's approach to country operations at both technical and operational levels to ensure it is adaptable and remains fit for purpose.	3	3	2
5. Identify the full range of skills and expertise needed and proactively seek these out specifically including political economy analysis, health systems strengthening and public institutional reform skills.	2	3	3
6. Reassess the current knowledge generation strategy to ensure that knowledge products relate clearly to other pillars of iDSI activity (including its country support and advocacy for priority setting for UHC); and build on recent developments to ensure the process of selection, quality assurance and uptake is transparent and robust.	1	3	2
7. Develop a knowledge management strategy that works in the service of the iDSI strategic objectives by promoting priority setting in health, supporting technical knowledge and building a broader understanding of the role of evidence-based decision making in health.	1	3	2
8. A vision for future discussion - Consider how the organisational structure within the partnership might be reshaped in order to better support its core business and make its products more accessible to a wider range of practitioners, policy makers, affiliates and beneficiaries.	2	2	2

Key to the table:

1 = Highest priority, high complexity such that additional support would be required, significant costs involved;

2 = medium priority, more complex (such as being a multi-stage process), and has cost implications (more than one meeting or could not fit into current job descriptions);

3 = lower priority, least complex, low or no cost.

1. Clarify iDSI's strategy, vision and operational priorities

In light of the fast changing environment (both within iDSI and globally), iDSI partners might consider it a good time to clarify the partnership's strategy, vision and operational priorities as a first step to ensuring they are fit for purpose for the next phase of iDSI development. The re-defined strategy could take into consideration:

- What part of the priority-setting process and landscape the partnership aims to focus on;
- How the different components of iDSI's work fit together and support each other, in particular the knowledge generation, country operations, agenda shaping and communications elements;
- Who iDSI's key partners are and how to build meaningful partnerships based on articulated, common objectives including partners at global and country levels.

The strategy could deal with three inter-related but parallel objectives:

1. Support to knowledge generation
2. Advocacy for evidence-based decision making in health systems
3. Technical assistance to countries

Re-connecting with the iDSI strategy as a partnership and crystallising how iDSI will operationalise it (and both communicate and track its operationalisation), is considered in this review as a priority recommendation and one that could be undertaken with minimal resources. It would inform many other elements of iDSI's institutional development over the coming two to five years, however, so is probably more urgent than many of the other recommendations here.

2. Strengthen iDSI governance arrangements

iDSI has made sound progress advancing its governance and management arrangements to promote institutionalisation in the network. Continuing the evolution of this process would be helpful to embed a more explicit pattern of internal decision making and to introduce the additional expertise needed to tackle some of the challenges iDSI faces in achieving its strategy. Depending upon iDSI partners' views, this could be done in a number of ways including by:

- Further institutionalising Board meetings with explicit decision points for the Board to oversee the direction of the partnership, appraise risks, consider and ratify, including further defining the remit of the Board to make strategic decisions around resource allocation, knowledge products and practical support strategies including who delivers these activities.
- Strengthening controls and reducing potential conflict of interest by:
 - Appointing a Board chair who is independent from iDSI in that s/he is not involved in the delivery of iDSI outputs.
 - Ensuring that those who are making the decisions about resource allocations are sufficiently independent from those who are directly involved in and/or receiving funding for delivery of iDSI's work (although it is recognised that given the small size and nature of the iDSI partnership, there will never be complete separation of decision makers and implementers).

- Ensuring the Board members bring a mix of skills necessary for a professional Board – including relevant technical expertise, external relations and connections with key stakeholders – and demonstrate experience with standard governance processes such as compliance, financial and risk management, contracting, and organisational structure.
- Ensuring that the Board includes representatives from one or more relevant global partners (e.g. Global Fund, Gavi, UNITAID, WHO) with whom it is strategically important to build strong relationships, particularly to expand its reach into LICs/LMICs. See Recommendation 5 for suggested criteria for identifying global partners.

3. Develop a structured, resourced global engagement strategy

In order to advance its global agenda, iDSI could aim to articulate its global agenda, including priority global partnerships, and develop an appropriate proactive engagement strategy. This strategy might include both broad and specific goals, outline clear objectives and identify a series of actions to be undertaken based on a set of criteria to identify priorities linked to iDSI's strategy.

Global partners with whom iDSI might prioritise its engagement could be identified using criteria such as their global and country presence; their leadership in UHC; their leadership in health systems strengthening; their positioning and influence in relation to iDSI's country counterparts; and their knowledge and role in priority-setting processes. Specifically, for each priority partner identified, iDSI might then develop an engagement strategy which includes:

- ✓ Identification of objectives and results of engagement
- ✓ A plan of action and potential joint activities
- ✓ Success criteria
- ✓ Funding and designated tasks

As in Recommendation 2, consideration could be given to **inviting at least two global partners to sit on the Board of iDSI** (probably WHO and the World Bank to link up with the two main agencies promoting UHC globally but others might also be considered including the Global Fund particularly in light of its on-going shift to support health systems development). It is noted that there have been attempts in the past to engage WHO and World Bank more formally in the governance of iDSI but on reflection the Board decided that this was not the right platform to engage WHO and World Bank.

4. Review options for engaging and supporting countries

Given that iDSI's core business is its country operations work and in order to ensure that as a partnership iDSI remains fit for purpose, it is recommended that partners set aside time to review and develop their thinking and approach to how they first offer and then deliver technical assistance in their priority partner countries.¹⁷⁵ Given that iDSI's support to countries is an intensive, long term and substantial commitment, iDSI decisions about what countries to support, when and with what level of resource can have a defining effect on the partnership for years at a time. There are a limited number of countries to which iDSI can offer this kind of support and ensuring that the criteria are fit for purpose in a changing environment would be a valuable exercise. The existing partnerships with countries like India and Indonesia, China and Vietnam have each evolved differently. As the first stage of partnerships advance and iDSI partners give thought to another set of countries to support (especially where these are low income countries), it may be helpful to reflect on how to ensure the skills and expertise can be accessed in order to:

¹⁷⁵ The recommendations contained in the country case studies supplement these overarching recommendations.

1. Position technical guidance to have impact on the larger health systems context especially, in the least developed countries, around promoting resource allocation for health and the horizontal decisions within health systems.
 2. Include (and be seen to be including) different options suitable to the evolution of the health system in the country
 3. Map out where the technical advice fits in the health decision-making process (Figure 1) and how partnerships with others may help strengthen elements of the decision-making process that iDSI will not specifically target
 4. Identify ways to support countries to incorporate public views/patient representation
- 5. Seek out and/or cultivate skills around political economy analysis, institution building, and health systems strengthening**

Linked to Recommendations 4 and 5, it is recommended that iDSI partners could identify the skills and expertise they need more of and proactively seek these out. While one option would be to build these skills in one of the core partners, there are other ways as well. For example, iDSI could aim to fill gaps through expanding the core partnership or to include skills gaps as a criterion for global partner selection onto the Board. Creating platforms to engage and work cooperatively with some of the right partners may require negotiations and compromise around engagement to maximise their comparative advantage.

6. Develop a knowledge generation strategy that works in the service of the partnership and links knowledge to country and global needs

iDSI could further formalise its knowledge generation processes by developing a research strategy that includes an opportunity for the Board to review and approve it. The strategy would be strengthened with the inclusion of a commissioning process that builds on that which is already under way, and which creates scope to link knowledge products with capacity building. It could also be strengthened through a quality assurance process and a post-research communications and uptake plan.

Currently, knowledge generated by iDSI partners does not have a clear enough link to its technical assistance at country level, its advocacy or its other activities. Many of the knowledge products are unsuitable for the non-specialist public policy maker. Yet, knowledge generation is a significant part of iDSI's role. It also largely underpins the extended network and absorbs a large share of iDSI resources. The knowledge generation platform is an excellent opportunity to extend the network to a wider range of practitioners working across the globe. In addition to defining a Board-approved research strategy, there are two specific ways the knowledge generation strategy could be strengthened:

1. **Use future iDSI funds to commission knowledge generation based on more transparent or explicit criteria linked to an overarching plan.** One criterion could be the presence in the bidding group of academic partners from iDSI countries or from a subset of priority countries. Another criterion could be related to specific subject or methodological areas of focus that iDSI identifies as priorities in any given year. For example, it may identify a need to increase knowledge about priority setting in support of a particular disease burden, or level of health care delivery, or influencing expenditure in a country by the Global Fund, etc.
2. **Create a community of practice that is not explicitly linked to a pot of iDSI funding.** Linked to the idea above of developing a broader practitioners' network, members could be considered affiliates. While not an *open* or public network, it could become a much wider group of like-minded practitioners working in a common field and sharing best practices etc. enabling iDSI to advance its goal around fostering knowledge for evidence based decision making. In other words, with relatively few resources, iDSI could demonstrate intellectual leadership and use the platform as a meeting place for practitioners to exchange ideas, share work and showcase interesting articles. It

would also be an excellent way to communicate across a large network, sharing information about funding opportunities and so on.

7. Strengthen knowledge management and communication

iDSI could define and implement a comprehensive, proactive knowledge management strategy that incorporates the knowledge development programme but also fuels the network of partners, providing information, lessons learned, and communications about priority setting theory and practice that seeks to profile progress and support learning. Such a knowledge management strategy would look at how to push out products as well as facilitate how partners can access and use resources on the website. This recommendation is linked to the suggested open access website (knowledge centre) outlined in recommendation 2 above. It could encompass options for supporting the knowledge to policy transition (for example, how to adapt technical or academic knowledge products to be user-friendly or accessible to a wider audience).

In particular, the knowledge management strategy could usefully separate out the strands that deal with the following:

- a) **Knowledge generation:** Academic-based work aimed at publishing the results of priority setting analysis including cost-effectiveness analyses.
- b) **How-to and public goods:** Developing and publishing tools and methodologies that users can identify and use in order to get started doing priority setting work in their own environments (from agenda shaping to HTA to policy).
- c) **Policy implications and implementation:** Supporting the development of policy implications and findings (by country or region, or by sub area if preferred) that are 'digestible' by policy makers.
- d) **Priority setting in practice:** Examples of priority setting in practice.

This recommendation would require some resources in order to reshape the website, set up and manage knowledge communications and related tasks. Given how much iDSI does that is currently difficult to access and how important information and knowledge are to advancing the role of priority setting for UHC, this recommendation is considered higher priority. It has a medium complexity level as it would require some specialist support.

8. A final overarching recommendation for further thought: Consider whether iDSI could become a 'one-stop shop' for priority setting and adjust its structure to support this goal

As a unique partnership focused on priority setting, iDSI could develop into a 'one-stop shop' for evidence-based decision-making. In this case, it will need to be clearer about meeting the needs of different stakeholders and groups. At the moment, the different pillars of iDSI activity are not as clearly linked to one another operationally (for example, country operations, knowledge generation) from the outside of the partnership as they may seem to those working in the partnership. Furthermore, the less immediately tangible goals, including capacity building and broadening commitment to priority setting, are difficult to track systematically. Many of the key informants and respondents to the network surveys (i.e. iDSI's partners and stakeholders) expressed a sense of feeling outside the network itself or unable to communicate across the partnership without going through a centrally positioned individual. The findings also suggested that the iDSI website contains a range of material that may not be accessible those who are interested in priority setting.

This recommendation centres on the idea of re-thinking how the main activities of the partnership are organised and structured in order to make both its core business and its products more appropriately accessible to a wider range of practitioners, policy makers, affiliates and beneficiaries and progressing towards a 'one-stop shop approach'. In re-thinking the structure of the partnership, iDSI partners could address the multiple aims of the partnership, including the following:

- ✓ Generate knowledge through high-quality, peer-reviewed research
- ✓ Build a community of practice among like-minded practitioners working on similar questions
- ✓ Foster a wider understanding of priority setting for UHC
- ✓ Support countries to analyse the political economy of priority setting in their health systems
- ✓ Support countries to integrate evidence-based priority setting into their health delivery systems
- ✓ Increase the explicit use of evidence-based decision making in the global health funding organisations both at global and at country levels.

What would this look like in practice?

In practice, this recommendation sounds more far reaching than it is likely to be in reality. In taking forward all the other recommendations, the key elements of this recommendation would be considerably advanced. iDSI could articulate three interlocking platforms that together meet the needs of different stakeholders and achieve different partnership objectives but which are managed separately. Although coordinated, each platform would have its own processes and budgets and annual work plans (and reports) which could be discussed and approved by the Board and clearly linked into the iDSI's overarching strategy (Table 10). Each platform could work at its own pace. Creating three separate but interlocked platforms would also enable the partnership to distribute management and leadership roles and responsibilities, creating posts that can be rotated and ensuring fresh talent is continually introduced into the network and building institutional capacity across a wider group of individuals.

Table 10: Three proposed iDSI engagement platforms

	Platform 1: An affiliated practitioners' network	Platform 2: Advocacy & learning open resource centre	Platform 3: Technical assistance
Focus	Knowledge generation	Development of guidance, tools and policy analysis	Practical and institutional support
Purpose	This track aims to foster and support a community of practice around priority-setting knowledge specifically at the academic or economics end of the chain. It is for practitioners and would be open to screened affiliates.	The resource centre aims to (a) promote the best knowledge and practical experience to develop a set of peer-reviewed, regularly updated resources to support priority setting; (b) capture policy implications, lessons and guidance to enable policy makers to understand the role of priority setting, what works where, how to move forward; and (c) proactively distribute and communicate these resources to an open network of interested organisations and individuals including policy makers, managers and UHC leaders.	This aims to build country and global partnerships to support practical delivery and application of priority-setting techniques and processes in health settings. It focuses on iDSI partners and the countries in which they are providing practical support at various stages of priority-setting development. It would include more demand-driven links between the countries themselves.
How does it differ from the current situation?	This approach would differentiate audiences/stakeholders and enable practitioners to "meet" and collaborate even where they work in countries beyond the iDSI network. It is partially advanced by Recommendation 6.	This would be the main open end of the partnership and its public face. It might aim to meet the needs of policy and decision makers and support those working on universal health coverage reforms. It would help position priority setting in a health systems context (especially around UHC). It is partially advanced by recommendations 3 and 7.	This approach would be less visible on a website and would encompass the practical support iDSI undertakes with countries. It is advanced through recommendations 3, 4 and 5 and selected outcomes, progress or products might be shared on the Open Resource Centre or through the practitioners' network.

The affiliated research practitioners' network:

An affiliated network of individuals (mainly academics, but others relevant disciplines as well) working on priority setting knowledge through the completion of priority setting research. Creating a more open yet still prescribed network would enable iDSI to proactively foster partnerships between individuals working on HTA especially including those from institutions in the global south.

Some funding could be made available to groups of researchers within this track (through a transparent bidding system) with priority given to bids that include both a core partner and a partner from a global south institution. There is scope for the practitioner's network to be semi-autonomous, and potentially groups within this network could bid for non-iDSI funds.

This approach would encourage collaboration beyond that created by iDSI funding. It would increase collaboration with a wider network of practitioners and non-iDSI partners while at the same time enabling iDSI to maintain/assure quality and methodological rigour. The network could prioritise and facilitate research partnerships with global south institutions, for example by requiring collaboration as a funding criteria.

The Advocacy and Learning Resource Centre:

This platform could be a virtual resource centre based on a website as it is at present, building on iDSI partners' experience and knowledge to support priority setting within the context of UHC. It would be entirely open access and would be aimed at policy makers, UHC leaders and others with an interest in priority setting. The resource centre would identify best practice, focus on agenda shaping, and promote links to other sources of support as well such as in WHO or the WB. It would be linked to the affiliated research network and be fed knowledge from the network but would ensure those materials were translated to meet the policy makers' needs. The resource centre would house vetted, tested methodologies, guides and manuals to support new and existing users to:

- a) Understand priority setting
- b) Develop their own priority-setting approaches and strategies
- c) Understand and undertake cost-effectiveness analysis and other HTA techniques
- d) Assess the current state of health priority setting in their organisation or country.

Creating a virtual resource centre will help iDSI take forward its advocacy goal, centred on increasing the role and function of priority setting in health, and can be an entirely open part of the network. Although the resource centre might draw on the academic work produced by the practitioners' network, it would be less technical, more accessible and focus on policy. Separating the policy platform from the practitioners' platform makes it easier to ensure that both groups get the level of engagement they need to meet their needs.

Technical assistance:

Providing practical, hands-on support to countries is a core element of iDSI. It generates learning and experience that is valuable for informing both the practitioners and the policy platforms but it is operationally very different and requires a different pace, budget, planning process and monitoring framework. This pillar would be focused – as it is now – on long-term technical assistance to, and partnerships with, a selection of countries. Technical assistance from the iDSI partnership would support specialised, results-oriented practical support and partnership, technical and operational in nature, focused on a selected group of countries and global partners.

Communications about both global and country experience and progress (where appropriate), including lessons learned, could be showcased in a clearly identifiable section of the resource centre. This platform could also incorporate defined, results-driven partnerships with global priority setting and UHC focused organisations. Partnerships could also be accelerated for specific joint results with global and regional partners, in particular WHO and the World Bank.

Annexes

Annex A: Key Informants and persons interviewed

Annex B: References and list of documents consulted

Annex C: Detailed results and additional analysis:

- C1 Network analysis survey Analysis
- C2 Network analysis survey
- C3 Management review (systems and processes)
- C4 Knowledge products review
- C5 Country case study reports

Annex D: Evaluation Questions

Annex E: Terms of Reference