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EXPLORING RESEARCH–POLICY PARTNERSHIPS IN INTERNATIONAL DEVELOPMENT

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Regional Research–Policy Partnerships for Health Equity and Inclusive Development: Reflections on Opportunities and Challenges from a Southern African Perspective*†◈

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Abstract This article critically reflects on the experience and lessons from a health-focused social policy research project (PRARI) involving a partnership spanning multiple countries across southern Africa and Europe. It asks what factors condition the efficacy of the partnership–policy nexus. The PRARI-SADC partnership case study used participatory action research (PAR) to create a regional indicators-based monitoring 'toolkit' of pro-poor health policy and change for the Southern African Development Community (SADC). The article addresses the partnership drivers, features, methodological context, and process of the project, and the wider implications for constructing partnerships for social change impact. Lessons drawn from this case study underscore the importance of PAR-inspired partnership structures and working methods while querying assumptions that the relationship between PAR and policy change is 'seamless'. We argue that greater focus is needed on the wider institutional context conditioning the work of partnerships when considering the efficacy of the partnership–policy nexus.

Keywords: regional integration, regionalism, international partnerships, Southern Africa Development Community (SADC), health, poverty, social policy, participatory action research, monitoring and evaluation systems.

1 Introduction

This article critically reflects on the experience and lessons of an international partnership established under the auspices of an ESRC-DFID-funded[5] international social policy research project that examined the scope for enhancing the effectiveness of regional integration

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processes in reducing poverty, and promoting social equity and inclusive development ('PRARI', 2014–15).[6] PRARI was inspired by the substantial and growing significance of multilateral cooperation on a regional scale in shaping development processes and their outcomes. The predominant share of attention accorded to trade, finance, and security by academic public policy analyses of the regionalism–development nexus had, however, significantly obscured the ways in which wider *social* policy mandates, goals, and programmes are pursued by multilateral regional partnerships. For example, many regional organisations around the world have developed institutional mandates on health, social protection, education, food security, and labour rights, yet little attention had been accorded to how these mandates are *in practice* being progressed through regional cooperation structures. In this context, the aims of PRARI as a whole were, first, to substantiate the relation between 'positive' regional integration measures and poverty reduction and, second, address the issue of how regional cooperation can be productively harnessed to reduce poverty and promote social equity.

A major plinth of the project was the creation of a regional policy monitoring 'toolkit' capable of tracking pro-poor regional health policy and change within the Southern African Development Community (SADC).[7] It is the experience of the international partnership established to create this 'toolkit' that is the subject of this article. The construction and working methods of the partnership are discussed later in the article, so suffice for now to highlight that this was a distinctive form of international partnership for social change in three respects.

First, it was extensively multinational and multi-institutional. It combined a North–South structure consisting of academic researchers from Europe (Belgium/UK) and government officials and non-governmental actors based in eight southern African countries including from the SADC Secretariat.

Second, the process of producing the 'toolkit' by the partnership was informed by the principles and tenets of *collaborative modes* of participatory action research (PAR). Methodologically, this work frames all participants from the policy and practice spheres – traditionally categorised as 'stakeholders' – as *co-researchers*. This framing and mode of research equally valued the knowledge and expertise of all partners during the toolkit creation process, and all partners – whether from academic, policy, or practice spheres – were equal to each other. All were actively engaged in the key decisions taken collectively about the research trajectory and research design as well as in all analytical components.

Third, the ambitions of the partnership were oriented towards socio-institutional change. The deliberate extension of the partnership into the practice and policy spheres, as highlighted above, was deemed essential to meet the goals of the partnership. The work of the partnership itself was also of direct policy relevance, aiming to lever a key innovation in policy practice. Thus, the academic partners' prior

research had highlighted the absence of a reliable basis for measuring the outcomes of regional processes as a significant obstacle to the prospective innovations that policymakers could make in tackling structural social and health inequalities on a regional scale.

PRARI accordingly sought to develop a policy monitoring tool that was context-specific, addressed a major priority regional social issue, was relevant to the work of diverse constituencies of state and non-state actors, and could subsequently be used by them to lever innovations in policy and practice. Although the 'toolkit' was the principal defined output of the partnership, it was not an end in itself. Indeed, it was envisaged as a step in the process of supporting regional policy development and, ultimately, greater democratic accountability for regional development outcomes.

It was envisaged that the 'toolkit' could be used to inform a regional strategy. Providing a means for identifying regional-level comparative evidence on the scale, scope, and depth of poverty-related health issues and their changing composition over time could, in principle, support the SADC to realise its pro-poor regional health mandate. An indicators-based regional tool with repeated rounds of data collection could, in time, help identify effective policies and programmes that make a real difference to population health, as well as those areas in which intended progress was not being made due to implementation challenges or failure. In this, it could be used by country-level and regional stakeholders to inform their policy formulation and delivery. It could help support improved efficacy of 'vertical' coordination (between local–national–regional), supporting better evidence for policymaking – nationally and regionally – and for better coordination among actors within the region. Ultimately, such a toolkit would be a shared resource, to be used by SADC states, the regional body, and other policy actors in myriad ways to refine, develop, strengthen, or even change their approach to tackling poverty-related health burdens.

The central question we address in this article centres on the partnership–policy nexus, and asks: what are the factors conditioning the efficacy of partnerships for social change? As Georgalakis and Rose discuss in the introduction to this *IDS Bulletin*, critics claim that there is a lot of 'partnership rhetoric' in development (see also Morse and McNamara 2006). We aim to decipher such rhetoric by discussing this nexus through the lens of a 'deep dive' into context-specific analysis of the experience of, and lessons from, the PRARI-SADC partnership in southern Africa. We discuss how the partnership was constructed, the dynamics of the partnership, and the positive outcomes that can be attributed to this way of working, as well as some of the challenges. We position our reflections in relation to the theme of this issue's focus on partnerships for realising wider social change, explored here in relation to the interlinked research–policy challenges of realising health equity and inclusive development in a low-resource regional context comprising low- and middle-income countries.

The discussion is organised around five principal sections. We first review how the partnership was constructed – its key drivers (Section 2) – and how these shaped its aims, composition, scope, and methods of work (Section 3). The article then turns to the dynamics of the partnership in practice – its achievements and some key challenges. Section 4 considers linkages between the work of the partnership (including its ways of working) and its contributions to leveraging impact. We discuss the partnership in terms of different forms of impact commonly associated with partnerships, such as changes in capacity to use evidence, changes in critical relationships and connections, and changes in evidence-use behaviours within policy. Section 5 discusses some challenges of the partnership. In particular, we consider sources of tension as well as prospects that an institutional analysis of partnership work helps reveal. Section 6 concludes, returning to the overall question of the article, and considers implications of the experience of this partnership for realising policy innovations at scale that lead to sustained improvements in access to health care and associated social entitlements. In particular, it reflects on the implications of the learning for both how partnerships are understood and constructed for impact.

2 Drivers of the PRARI-SADC international partnership

The PRARI-SADC partnership and its work of creating the regional pro-poor health policy monitoring 'toolkit' responded to three sets of specific drivers. The first of these was the significant social and economic costs of the high disease burden within the region. SADC member states include low- and middle-income economies that face health and social development challenges experienced by many developing countries – namely a high burden of communicable diseases, and a growing non-communicable disease burden associated with urbanisation and lifestyle changes. The SADC region remains the epicentre of the global HIV epidemic with the highest HIV prevalence rates globally, and with over 15 million people living with HIV accounts for about 40 per cent of the global total of people living with HIV (authors' calculation based on WHO 2017 data; see also UNAIDS 2016, 2018). The epidemic is further compounded by its association with TB.

With the tropical and subtropical climate of the region, malaria is a major health challenge, responsible for a significant part of the disease burden in the region and is estimated to reduce economic growth by up to 1.3 per cent in affected countries (Gallup and Sachs 2001). Maternal mortality remains very high compared to the global average, despite a declining trend in a number of member states. High overall disease burdens are unequally distributed, such that social determinants of health, such as high levels of unemployment, income disparity, and gender inequality, are contributing factors that result in the poor, women and young girls, and other vulnerable groups being disproportionately adversely affected with respect to access to health services and health outcomes.

In addition to the high overall disease burden that has altered the trajectory of socioeconomic development in the region, the state of development and performance of health systems pose major challenges for the delivery of, and equitable access to, quality health services and the attainment of desired health outcomes. Even with the vastly different levels of health system development within the region, common challenges across the region include significant and often critical shortages of health workers, uneven distribution of scarce skills between the public and private sectors, weak health information systems, and poor health infrastructure (including equipment maintenance). All of these combine to present significant systemic challenges for effective service delivery. The wide variation in the strength and performance of economies in the region, ranging from low- to upper-middle-income, adds significant complexity to the context in which member states are able to address extant health challenges, including a high disease burden, within the context of a holistic regional integration agenda.

The second driver of the partnership and its work was the 'live' opportunities within the SADC region to address these major societal issues. Regional partnerships of nations, aligned around common visions and goals, are recognised as important institutional frameworks for mobilising financial and political resources capable of enabling collective responses to key development challenges that are beyond the scope of any one country to address unilaterally. Compared with global agreements, they involve fewer negotiating countries and they afford, in principle, the possibility both of raising social standards more quickly and in a way that is more attuned and responsive to the circumstances and needs of the member countries (Yeates and Deacon 2010; Yeates 2014, 2018).

The concerns of regional economic communities, such as the SADC and others across Africa are not limited to trade and investment (Yeates and Surender 2018). Indeed, ambitions to enhance social standards by extending social provision, strengthening health systems, and improving access to health and medicines, thereby boosting population-wide health outcomes, have been taken up as key regional social and economic development issues – albeit variably (Deacon *et al.* 2010; Taylor 2015; Yeates 2014, 2018; Penfold 2015). A concerted regional approach to health policy becomes especially salient in the light of Agenda 2063 which incorporates health as a key feature of sustainable development (African Union Commission 2015), and Agenda 2030 which envisages regional partnerships as a means by which health and related goals can be realised in context-specific ways (UN 2015; Yeates 2018). Given all of this, a key question is: how can regional partnerships contribute to realising tangible 'pro-poor' social change and in particular policy reforms conducive to health equity?

The nature of the health challenges in the SADC region highlights the necessity of the SADC's regional health policy being demonstrably

'pro-poor'. This is an issue to which the SADC has responded for two decades. Since 1997, its health programme has recognised that a healthy population is a necessary catalyst for social and economic development in the region. It has collectively set common public health goals, defined strategic frameworks to improve the standard of health for all citizens in line with international health declarations and targets, and instituted a range of initiatives (SADC 1999; SADC Secretariat 2015). The SADC Secretariat has also taken a keen interest in research to better understand how poor health and poverty coincide, are mutually reinforcing, and are socially structured (Amaya, Kingah and De Lombaerde 2015; Amaya *et al.* 2015a).

SADC health frameworks provide important normative and institutional structures for the development of pro-poor health policy, but there remains somewhat of a 'disconnect' in implementation. In theory, regional instruments are operationalised through the national-level policy frameworks of member states. However, the existence of regional health policy frameworks and protocols do not necessarily generate enhanced regional and institutional capacity for policy initiation and implementation; nor do they guarantee compliance by all member states. This is by no means a problem unique to the SADC, but the perceived efficacy of the SADC *is* an issue, insofar as the pace of the domestication of SADC policies has been slow and a region-wide mechanism to monitor this has been absent. There is insufficient evidence either way about the impacts of SADC regional policies on pro-poor health change. Consequently, progress in dealing with diseases predominantly affecting poor and disadvantaged populations in the SADC (notably HIV) is often attributed more to national and international investments than regional ones.

The third driver of the PRARI-SADC partnership was the prospective value of creating and instituting a *regional* indicators-based monitoring mechanism. National approaches invariably suffer from lack of comparability across countries, whether due to inadequate mechanisms for data sharing, monitoring and evaluation of health activities, or due to different national priorities as to what should be monitored. This is a problem when it comes to region-wide action, as national mechanisms do not serve well the realisation of a common (regional) health strategy.

PRARI's analysis of previous experiences of regional monitoring systems highlighted two key points. First, was the potential of metrics and indicators in monitoring initiatives to provide additional precision, transparency, and policy relevance. In a context where all too often, progress in regional integration is restricted to measures of economic (market) integration (De Lombaerde, Estevadeordal and Suominen 2008; De Lombaerde *et al.* 2011), the use of social indicators-based policy monitoring instruments can capture the characteristics and effects of 'positive' regional integration policies, such as in relation to health and social protection policies, and the extent to which regional-level policies are impacting upon social (in)equity in practice.

Second, local and regional ownership is essential to the success in developing embedded regional monitoring policies and instruments that are durable. Previous efforts funded and developed by donors and actors external to the regions using conventional research methods had invariably not taken hold.

3 Structure, goals, composition, and working methods of the partnership

As a project concerned with the scope for greater cooperation and coordination on a *regional scale* to address serious health challenges as matters of common concern to all members of the regional community, the structure established to create the toolkit was also necessarily international in its goals, scope, and composition.[8] The Open University, working in close collaboration with the SADC Secretariat and others in southern Africa (notably the Botswana Institute for Development Policy Analysis) from the outset, led the application to secure DFID funding to initiate and manage the project, and, in collaboration with research consultants from the United Nations University Institute on Comparative Regional Integration Studies, to organise the logistical aspects of the partnership and work with the partners over the two-year lifetime of the project (2014–15).

All parties agreed from the earliest stages of the research cycle (prior to the formal grant application) on the potential benefits of a modest but potentially impactful initial project on the measurement and metrics of regional pro-poor health policy success and change. The scope of the work of the partnership was defined as identifying what input, process, output, and outcome indicators could effectively capture regional policy change and especially pro-poor regional health policy success and failure. It had four principal broad goals. First was to support the SADC countries and the regional Secretariat to identify gaps in their action on the poverty–health nexus. Second was to help strengthen the link between the regional body and member states to help facilitate integrated policy change in the region. Third was to help identify better mechanisms for data sharing, and monitoring and evaluation of regional health activities. Fourth was to enhance efforts to hold political actors accountable for realising regional commitments on the health–poverty nexus.

During the early stages of the 'live' project, partners were recruited from southern African state and civil society organisations. The core academic partners deliberately extended the partnership into the practice and policy spheres as this was deemed essential to meet the goals of the partnership. Partners from these spheres were equal members to each other and to academic partners. The partnership was not a representative structure, and partners were not deemed to be national representatives. Rather, they brought complementary expertise and diverse perspectives on health systems, the health–poverty nexus, monitoring and evaluation, and/or regional governance in the context of the SADC region.

In addition to the PRARI team, the partnership consisted of an extended multinational team (17 partners in total) spanning eight SADC member countries, including the SADC Secretariat and two international organisations operating within the SADC region. Partners comprised officials and senior officials in the health division within their organisation (national ministries of health and/or social development; research institutes; international organisations) or working in health organisations (e.g. health-focused non-governmental organisations (NGOs)). The partnership's work progressed through three face-to-face research workshops in different SADC country venues over a 15-month period during 2014–15. International conferencing and documentary facilities in between the meetings were used extensively to overcome geographical separation and maintain work progress.

Although the key goals, outputs, and broad impact of the project – namely, to create an indicators-based regional monitoring system which could catalyse support for larger-scale work – were necessarily decided at the point of the project funding application, no specific design was imposed *ex ante* on the indicators toolkit/s. This decision was made in advance of the 'live' project, at the point of application for funding, on the basis that the specific content and form of the partnership's work should maximally respond to the needs of key stakeholders and be defined in collaboration with them. In this, the partnership structure and methods of working were inspired by the tenets of PAR.

As an *orientation* or *approach* to research rather than a specific method, PAR is based on a commitment to egalitarianism, pluralism, and interconnectedness in the research process (Yeates and Amaya 2018).[9] PAR affirms the value of research participants ('stakeholders') in bringing diverse knowledges and experience as well as commitment to research findings and policy change (Yeates and Amaya 2018; Amaya, Yeates and Moeti 2015; Greenwood, Whyte and Harkavy 1993; Cornwall and Jewkes 1995; van Niekerk and van Niekerk 2009). The distinguishing features of PAR centre on the intrinsic and instrumental value of co-created research and the 'virtuous' relationship between knowledge, ownership, and action. PAR affirms all stakeholders in the research process as equal agents bringing diverse knowledge and techniques. This affirmation is both instrumental and outcome-oriented: in theory, participation on the basis of inclusiveness and equality brings a commitment to the research and its findings. Because participants are more likely to take 'ownership' of the research findings, its outputs are more likely than 'conventional' research using consultative processes to be translated into concrete action, which in turn helps effect social change in ways that are empowering (Bergold and Thomas 2012; Loewenson *et al.* 2014).

In the PRARI-SADC partnership, the full participation of a wide range of partners from the outset and throughout the development of the regional monitoring instrument was vital to realising a high-quality toolkit and in fulfilling its wider impact potential. Indeed, this would,

in principle, bring many benefits: share information, pool skills, and bring together diverse knowledge and expertise which, in turn, could uncover extant good practices, generate awareness of the need for socially equitable health policies, and incentivise the development of significant regional initiatives in the interests of inclusive development. Furthermore, a regional monitoring instrument designed through inclusive participatory methodology and data gathered through it that are widely accessible would be an important means for holding political actors to account for the progress (or lack of it) in realising the regional health mandates, goals, and plans to which they had formally committed.

Because all partners needed to ensure that the eventual toolkit would be feasible in supporting the region to address its health challenges and institutional priorities, it was important that officials from key SADC member states, the SADC Secretariat, and NGO service providers and advocacy actors in the health sector worked together from the start and throughout the process. The co-created monitoring toolkit, and its effectiveness as a tool for levering policy (and wider social) change, required 'regional ownership'. In the context of the project, this meant active participation, not just of national experts within the region, but also of regional-level actors. In this regard, the SADC Secretariat's (through the Social and Human Development Directorate) membership of the partnership was key.

Indeed, the project was seen by the Secretariat as well aligned with its programme of work on poverty-related ill-health (Amaya, Kingah and De Lombaerde 2015; Amaya *et al.* 2015a). In this, the institutional leadership from the SADC Secretariat and the support from its member states was a vital plinth of support for the partnership, its work, and working methods throughout the duration of the partnership. After all, the strength of a regional body lies in the relevance that member states see in it addressing their needs, including addressing major social disparities. Having the means to 'measure' policy change and success (for example, in terms of the domestication of regional initiatives which leverage improvements in health) could be an important 'tool' by which to demonstrate the 'value added' by regional social (health) policy cooperation. This could, in turn, help garner support for greater regional health investment and policy innovation.

The PRARI-SADC partnership deployed a mode of participation most closely correlating to the *collaborative* mode of PAR (Cornwall and Jewkes 1995), with significant elements of the collegiate mode also present.[10] This is the case insofar as academic researchers, public officials, and NGOs across the SADC worked together as colleagues, based on equality in a process of mutual learning, to co-create the regional monitoring toolkit using methods and techniques negotiated within the partnership. We hesitate to identify the partnership as having operated purely in the collegiate mode because although participation extended throughout the research cycle in all the components of

analysis and determination of proposed solutions and actions, the broad goals, outputs, and desired impacts were pre-defined by the terms of the grant, while the work of the partnership was initiated, coordinated, and managed by PRARI academic researchers.

Nevertheless, the role of the academic researchers was defined – and actually operated – in a way that sets the working methods and nature of interactivity within the partnership apart from 'weaker' (contractual, consultative) modes of PAR and the hierarchical relationships between academics and participants seen in conventional academic research. Academic researchers' role was limited to managing the logistical and processual aspects of workshop organisation, providing specific technical expertise (e.g. identifying data sources and gaps), suggesting potential solutions to specific problems encountered by the partners during the construction of the toolkit, coordinating the completion of the toolkit within the project's lifetime and, where requested by the partners, to take specific follow-up actions in terms of its wider institutional interfaces. For all intents and purposes, however, the 'centre of gravity' of the partnership was decidedly southern African, and the determination of every component of the toolkit, from its concrete focus to its presentational form, across all stages of the research cycle was the outcome of myriad decisions taken collectively by all of the partners. In this, the partnership structure was decidedly southern African in its composition and dynamics. It shifted the locus of power to determine the process and outcomes away from (European) academic researchers to southern African colleagues.

The confluence of drivers of the partnership's work, the mutuality of agendas among the different partners and the participatory principles underpinning the partnership's work were in theory auspicious circumstances for this initiative. The next section turns to discuss the dynamics of the partnership as they played out in practice. In particular, we identify the positive outcomes achieved and consider how the interactive social processes generated by and through the partnership contributed to realising the project goals and other impacts.

4 Encounters, contributions, and impacts

The written outputs of the partnership were a Policy Brief (Amaya *et al.* 2015a) and the monitoring toolkit (Amaya *et al.* 2015b). These were borne of participatory working methods and consensual approaches to collective decision-making among the partners. The strengths of the partnership and its working methods were seen in that, through an interactive and iterative process unfolding over 15 months, there was agreement among partners on the key issues that: the major health issues prioritised within the SADC regional health agenda were those that most significantly affected those living in poverty; full implementation of extant SADC regional health policies had the potential to improve access to health services and medicines by disadvantaged majorities in the countries of the region; there was considerable scope to demonstrate the positive impacts of SADC

regional initiatives, especially in relation to maternal and child health, effective health service policy implementation, and health systems-strengthening; and there was a real potential to significantly strengthen regional capacity to improve health outcomes.

The impacts of the partnership were seen in changes in capacity to use evidence and in evidence-use behaviours within policy. The project's evaluation highlighted that, on the first of these, a key learning benefit was the sensitisation of participants to the prospective value of strengthening the regional dimensions of pro-poor health policy. Government officials in the partnership highlighted that the deliberative process around the poverty–health nexus and the policy and planning implications was an invaluable 'take away' of the project. They highlighted how this process supported their decision-making and planning capacities, and helping to expand domestic and regional capacity in monitoring and evaluation. They also highlighted that the process helped them to think more analytically about the purposes of, and scope for, regional-level action on health, as well as the distinctions between the regional and national scales of governance and policy – and the relation between the two (issues of 'vertical coordination').

The partners more generally emphasised that the partnership of regional-level actors, country officials, civil society, and academic researchers to discuss regional organisations' contribution to successful health policies was invaluable, suggesting that this mix of partners working together in a deliberative process was intrinsically valuable. The consensus-based decision-making and joint collaboration on publications generated trust and was seen as an opportunity for self-reflection by the regional organisation and governments alike regarding the efficacy of their health programmes. The deliberative process also stimulated better understanding of the need for better mechanisms for data sharing, and monitoring and evaluation of regional health activities. Collective authoring was particularly mentioned as a source of the learning, and the written outputs stand as a lasting legacy of the collective endeavour.

What happened after the creation of the toolkit had been completed was always going to be a key indicator of the success of the partnership as far as policy impact and changes in evidence-use within policy are concerned. In this, the toolkit proved to be a major stimulus in the SADC Secretariat's Results-Based Regional Monitoring and Evaluation (RBME) initiative. Introduced two years after the completion of the PRARI-SADC work, this takes up PRARI's indicators-based regional monitoring toolkit. The RBME initiative includes health and poverty, but actually is progressively extending to *all* areas of SADC priority areas.[11] In this respect, we can confidently assert the tangible policy-level impacts of the PRARI-SADC partnership.

The Secretariat is currently rolling out the RBME system amongst the SADC member states, and has just finalised the translation

of the system into French and Portuguese. By March 2019, eight member states will have completed their on-boarding (SADC 2017, 2018). The RBME system is aimed at enabling real-time tracking of performance, the documentation of results at member state level and the facilitation of evidence-based decision-making and learning. In this, it is an important initiative to strengthen regional–national links that the Secretariat has long been keen to see progressed. Making the results of RBME widely available and strengthening the capacity of the SADC as a whole, as a regional body, to use those results to inform policy formulation, will be important steps towards greater democratic accountability.

5 Constraints and challenges

There were a number of factors possibly militating against the partnership initiative reaching greater potential earlier on, during its active lifetime. One factor is to do with timing. The toolkit work was of great interest to SADC officials at the timing precisely because they were engaged with prospective revisions to the Regional Indicative Strategic Development Plan (and the SADC Health Programme), but in practice the toolkit work was too late to enable it to meaningfully inform and be integrated into the key regional policy instrument for which it would have been relevant: the SADC Revised Regional Indicative Strategic Development Plan (R-RISDP).[12] The work of the partnership got underway at the end of 2014 whereas the RISDP was already at a very advanced stage by 2015. There was insufficient opportunity to formally introduce the project through the rounds of SADC regional meetings and for it to be officially supported as a SADC project. The SADC Secretariat's own capacity to make use of the learning and work of the partnership was also hampered by uncertainty arising from the planned reorganisation of the Secretariat as part of the revised regional development strategy.

A second factor relates to resources. The modest project budget and grant conditions could not have supported the series of discussions and meetings across diverse SADC structures necessary, either for the formal adoption of the toolkit and/or to facilitate its roll-out, even on an initial basis. The post-grant 'impact acceleration' funding mechanism of the ESRC did not support the modest initial post-toolkit developmental work that the SADC Secretariat required to take the toolkit forward at that time. The Secretariat was not in a position to fund the much-needed follow-on technical assistance work from its extant budget, and it could not sponsor (financially or otherwise) the work of securing SADC's formal support for the toolkit.

We conclude that the mutuality of agendas, including demand for the programme of work by the regional organisation (the SADC Secretariat), and the interactive processes engendered during the partners' work, were clearly important conditions for realising the policy impacts that the partnership did achieve (albeit with a two-year time-lag before demonstrable results were seen). However, they were insufficient

in and of themselves in propelling the impact dimensions of the work of the partnership. The research–impact relation – and the role of the partnership as a 'bridge' between the two – was far from seamless. In this regard, we now turn to identify some critical challenges.

One challenge revolves around the extensity of the 'ownership network'. Ownership of the collective work by the partners directly involved is clearly essential, and this was partially achieved in the PRARI-SADC partnership structures for the duration of the work. The partnership had support from the regional Secretariat through the Social and Human Development and Special Programmes Directorate, and tried to mirror SADC structures through inclusion of participants from the Troika countries as members of the partnership. However, the somewhat informal nature of PRARI partnership in relation to SADC structures[13] was not in itself sufficient.

Given the highly formalised institutional setting and the policy-oriented goals of the partnership's work, a more expansive ownership network, extending beyond direct participants in the partnership structure to also include wider networks of allies, such as senior policy stakeholders nationally (in the SADC member states) and regionally might well have been beneficial to the uptake of the toolkit at the time. That said, securing formal sponsorship of a regional 'toolkit' among all SADC countries in parallel with the process of co-researching the toolkit would have placed significant additional (and largely unattainable) demands upon a modest research budget, as well as on participants' capacities and resources – demands which, realistically, could not accommodated. Choices were made interactively and iteratively with the information available at the time according to the priorities of the partnership.

A second challenge concerns the necessity of locating partnership work in relation to the wider institutional structures governing policy formulation. Engagement with these structures is essential if the work of the partnership is about addressing structural social inequalities and the political governance of them. In the SADC context, like other regional groupings around the world (whether in low-, medium-, or high-income settings), such engagement involves pluralistic multi-level policy and governance structures which make up complex dynamics of regional policymaking and reform. Although the regional policy process and routes by which new initiatives may be proposed or introduced is generally well defined,[14] the 'informal' (tacit) rules and structures conditioning the regional dynamics of regional policymaking in practice are not always necessarily well understood.

There is also an issue about the efficacy of regional policy structures through which initiatives may be proposed. It is recognised, for example, that the SADC National Committees[15] are functional to greater or lesser degrees across the region, and that many member states are still struggling to fully embrace non-state actors in these committees.[16] Substantially engaging with institutional structures of

regional policy formation spanning numerous countries in ways that also take account of the international dynamics of regional integration and development requires having a 'big picture' view, especially in a context where 'vertical' coordination (between national and regional governance) is a known problem and non-state actors' involvement in SADC policymaking is a highly contentious political issue.

This 'big picture' view also extends to having a longer-range time frame. A third challenge thus arises from managing the tension between, on the one hand, the necessity of 'deep engagement' with institutional structures and formal policy formulation processes over time and, on the other hand, the (comparatively) short-term nature of projects (and partnerships for change). The PRARI-SADC partnership did so by limiting itself to the creation of a specific policy product – the toolkit – as a means of catalysing policy change processes. But however useful the toolkit (and the process of creating it) was deemed to be, achieving institutional impact on such a large (regional) scale is realistically beyond the scope of what any single partnership operating over such a short timespan can achieve within its lifetime. In the PRARI-SADC case, it was two years after the end of the project and completion of the partners' work that the most tangible and prospectively durable impacts were manifested.

There are three principal corollaries of this. One is that, as far as partnerships seeking policy impact are concerned, unless these are established by state structures to undertake specific work helping to resolve a state policy problem and are formally 'owned' by them, these need to be planned and resourced over durations exceeding what is standard for most funded research projects. In the PRARI-SADC partnership, follow-on resourcing to support embedding the toolkit in policy and practice within the region would have enabled the partnership to continue, gain further momentum, and respond in a timely way to windows of opportunity as and when they become available.

A second corollary is that concrete and tangible policy impacts of partnerships, especially those on a larger scale and/or in complex institutional environments, are (probably) going to be, at best, most fully evidenced over the medium term, typically after the end of the research grant. A third corollary, and perhaps most importantly, is that access to the spaces and resources from which policy innovations can emerge probably requires, in practice, a different kind of entity than an international donor-funded partnership structure of the PRARI-SADC kind.

Addressing the deep-rooted, structural causes of high disease burdens and societal impacts requires responses that are more akin to a regional coalition campaign for regional health policy reform founded on social equity. A longer-term research–policy *programme* that can sustain the interest and support over time of myriad partners within and across different countries that are members of the regional development

community may well prove very effective for achieving long-term social change of the kind that this partnership was ambitiously concerned with highlighting.

6 Conclusions

Through a 'deep-dive' case study of the PRARI-SADC partnership, this article has considered the range of factors conditioning the efficacy of this partnership in terms of realising its social (policy) change ambitions. We highlighted the distinctive features of this partnership including auspicious circumstances for successful partnership work. This work was from the outset fully aligned to the key policy priorities of the regional grouping, which are addressed to the challenges of health inequity adversely impacting upon the region's social and economic development. There were clear opportunities – and demand – supportive of a strengthened regional approach in addressing severe health and wider social challenges. The mutuality of agendas – arising from academic policy research, regional and national imperatives to respond to key health issues, and demands by engaged communities of policy practitioners from the state and non-state sectors – combined with the beneficial interactive social processes arising from the PAR-based working methods were conducive to realising the goals and work of the partnership. Yet these were in themselves insufficient for 'predicting' how the partnership–policy nexus would manifest itself in this instance.

Amongst the many valuable lessons that emerged, we have drawn attention to the critical importance of the wider institutional context in which the work of partnerships is embedded, including the necessity of engaging with policy formulation structures and processes throughout the research process. One difficulty is that the timing and nature of tangible policy impacts, including institutional changes in evidence-use within policy, tend not to be within the control of any of the partners or the partnership as a whole. This is an inescapable truth. It was certainly the case for the PRARI-SADC partnership, however inclusive and ethical, and whatever the amount and quality of social learning gained. This difficulty shines a light on endemic dilemmas facing partnerships seeking to effect social change, such as the balance struck between looking 'inwardly' to realise work on time and to budget versus pursuing the costly, 'messy' work of looking 'outwardly' to influence policy formulation where results and outcomes are uncertain. In a results-based research funding culture, this is a generic issue.

Despite the constraints and challenges facing the PRARI-SADC partnership in realising these in practice, there were nonetheless real achievements. The partnership innovated the use of PAR in a multinational policy-oriented partnership involving government bodies, civil society organisations, and academics working together on the basis of inclusiveness, equality, and deliberative methods among all partners at all stages of the research process. The work of the partnership proved to be a catalyst in learning and reform within regional policy

communities, most tangibly in informing the intersectoral regional indicators-based RBME system as part of the revised regional development strategy. Learning from this case study can create opportunities for the implementation of initiatives with modest budgets and high return on investment for all parties involved.

To conclude, what are the implications of the experience of the PRARI-SADC partnership for constructing future partnerships aiming to catalyse or actually realise policy impact at scale in ways that lead to sustained improvements in access to health care and associated social entitlements?

First, we underscore the importance of PAR-inspired partnership structures and working methods but at the same query assumptions that the relationship between PAR-inspired partnership working methods and policy change is 'seamless'. This article has gone beyond the skills and knowledge of individual participants in analysing the efficacy of the partnership–policy nexus to emphasise the necessity of attending to the institutional framework in which partnerships are embedded. We have highlighted how opportunities for impact are conditioned by engagement with policymakers *and* policy cycles (and the 'windows of opportunity' that these generate) from the outset and throughout the lifetime of the partnership. Our experience firmly underscores these institutional aspects as a principal determinant of whether any single partnership realises its policy impact goals. In essence, whether the work of such partnerships take hold, institutionally, is *contingent*, and highly context-specific. Good impact design can be structured into the partnership, but actual impact is ultimately as likely to be by a serendipitous coincidence of mutual interests and opportune timing.

This conclusion is not a fatalistic one. One of the implications of this case study is that it is incumbent on each of those involved in the research partnership to engage with their respective communities. This includes identifying and leveraging opportunities and openings throughout the research process, rather than waiting until the research is completed. In this, the *action research* segment of PAR is worth emphasising because it highlights the mutually constitutive relation between research–social change during a research project's lifetime. The importance of structuring resources to match this alternate conception of the research–policy nexus cannot be overestimated. We have to recognise that this carries significant risks that research funders, looking for demonstrable results and impacts within finite time periods, may not be willing to bear.

Second, it may be important to re-conceive the very idea of partnerships if the goal is to make significant in-roads into the sources of structural social and health inequalities. Partnerships working on specific projects cannot substitute for long-term resourcing and investment of the kind that states have a monopoly over. International donor funding through applied research projects taking up particular

issues can support capacity building and catalyse changes within policy, whether in expanding the horizons of policy actors, supporting the development of new initiatives, or stimulating changes in evidence-use, as the PRARI-SADC partnership did. However, the question of what happens after donor priorities change or project funding ends remains a live one.

At best, partnerships (whether PAR or non-PAR-inspired) can address themselves to concrete projects to offer a solution to specific problems. All the partnership working in the world, even with the concrete aims and work of the PRARI-SADC one, cannot substitute for state responsibility. An important implication may be that in future, collaborative initiatives of this kind are led by coalitions of Southern actors in their implementation, if not in their funding. In low-resource contexts, this does not get around the question of long-term resourcing, but it does open up questions about the degree of openness and closure in (regional) policy formulation processes, and the kinds of institutionalised forms of participatory policymaking that will support partnership for development initiatives in contributing to make universal access to high-quality affordable health care and better population health outcomes a reality.

Notes

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4 All authors were directly involved in the PRARI-SADC partnership that is the subject of this article. Dr Luwabelwa was not a SADC Secretariat official during the period of the project.

5 Economic and Social Research Council-Department for International Development.
6 Poverty Reduction and Regional Integration: www.open.ac.uk/socialsciences/prari/.
7 SADC is an inter-governmental organisation whose overall goal is to further socioeconomic cooperation and integration as well as political and security cooperation among 16 southern African states (Angola, Botswana, Comoros, Democratic Republic of Congo, Eswatini, Lesotho, Madagascar, Malawi, Mauritius, Mozambique, Namibia, Seychelles, South Africa, Tanzania, Zambia, and Zimbabwe).
8 Anonymised data from this toolkit project are available from the UK Data Service (Yeates 2017). This data set provides further details about specifics of the work and processes by which it was realised.
9 www.open.ac.uk/socialsciences/prari.
10 Participatory research maps across a continuum of different modes and sorts of participation. Cornwall and Jewkes (1995) distinguish between four principal types of participation in research projects: contractual, whereby people are contracted into projects directed by researchers to take part in their enquiries or experiments; consultative, where people are asked for their opinions and consulted by researchers before interventions are made; collaborative, where researchers and local people work together on projects designed, initiated, and managed by researchers; and collegiate, where researchers and local people work together as colleagues with different skills to offer, in a process of mutual learning where local people have full control over the process. Each mode implies different degrees of participation in a given research project, and, with it, different degrees of researcher control and ownership.
11 The SADC RBME is informed by a number of indicators that have been selected in line with the Revised Regional Integrated Strategic Development Plan (R-RISDP) at intermediary and short-term outcome levels to assess improved human capacities for socioeconomic development, improved and integrated regional infrastructure, and sustainable industrial development, trade integration, and financial cooperation. Poverty indicators are mostly cross-cutting under the issues from employment; food security; education and literacy levels; and employment and labour issues. The SADC Statistics Unit also produces poverty-related information. Health indicators are monitored under Health and Pharmaceuticals, under the intermediate outcome of 'Increased availability and access to quality health and HIV and AIDS services and commodities'. There are in total 12 intermediary indicators on health issues. All indicators have been uploaded into the M&E system and will be informed by reports from the member states. The first report on the indicators was prepared and submitted during the August 2018 Council and Summit Meetings.
12 The Revised Regional Integrated Strategic Development Plan (R-RISDP 2015–20) aims to integrate health as a priority within the context of social and human development, poverty, and food security

(SADC Secretariat 2015). Member states continue to implement the SADC Protocol on Health (SADC 1999) with special focus on the agreed priority areas of disease control, child and reproductive health, health education and communication, and health systems strengthening.

13 There was no formal expectation by SADC structures for a report from the PRARI-SADC partnership that would have created accountability at the level of the Secretariat for the project and its outcomes.

14 They emerge from political or developmental issues of concern to the entire grouping, individual member states' needs that potentially impact on or are a concern to the entire bloc, or significant groupings of its membership. Alternatively, regional or international initiatives may be taken up within the bloc as part of the region's commitment to development for the benefit of their citizens or to meet global obligations. The perceived ownership of such initiatives in terms of the member states of the grouping, recognised constituencies in the member states or the Secretariat fulfilling its role to advance the regional agenda are often important approaches to ensuring that new initiatives take hold and secure member states' support. In terms of formal processes, the main actors in health policy formulation within the SADC region and its institutions are the member states of the SADC represented at various levels of the policy and strategy development process through SADC structures, beginning with SADC National Committees and extending through a hierarchy of structures including the Standing Committee of Senior Officials, the Sectoral and Cluster Ministerial Committees, the SADC Council of Ministers, to the Summit of Heads of State or Government as the supreme policymaking body.

15 Article 16A of the SADC Treaty defines the role of the SADC National Committees as providing inputs at national level in the formulation of regional policies and strategies, to coordinate and oversee the implementation of programmes at national level, and initiate SADC projects and issue papers as an input to regional strategies. To ensure broad ownership and multi-sectoral input, the National Committees comprise key stakeholders from government, private sector, and civil society in each member state.

16 There is renewed hope for support for the National Committees with particular emphasis on including non-state actors as provided for by the Treaty. So far, seven member states have functional National Committees, with three of them being fully functional and four nearing the stage of functionality. The plan is to extend to ten by the end of 2019.

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