International Development Research Centre, Canada

External Review of the Governance Equity and Health Prospectus

Final Report

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It has been a privilege to work with IDRC on this review. We have been facilitated by Senior Management and guided by Kevin Kelpin of the Evaluation Unit. Participation by GEH staff has been exceptional, contributing to and answering our questions, making available all documents that we requested and creating them when they did not exist.

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Tables

Abbreviations

ACACIA	Communities and the Information Society in Africa Program
AHPSR	Alliance for Health Policy and Systems Research
ART	Anti-retroviral treatment
CAD	Canadian Dollars
CCGHR	Canadian Coalition for Global Health Research
CIDA	Canadian International Development Agency
CIET	Community Information and Epidemiological Technologies
CIHR	Canadian Institute of Health Research
CIII	Canadian International Immunization Initiative
CHF	Swiss Francs
CODESRIA	Council for Development and Social Science Research in Africa
CSPF	IDRC Corporate Strategies and Program Framework
DFID	Department for International Development, UK
DOHFS	Department of Health of the Free State, South Africa
EcoHealth	Ecosystem Approaches to Human Health
ESA	Eastern and Southern Africa
Equinet	Southern African Regional Network on Equity in Health
FTE	Full-time equivalent
GEGA	Global Equity Gauge Alliance
GEH	Governance, Equity and Health
GHRI	Global Health Research Initiative
HRP	Health Research Program for Development
IAVI	International AIDS Vaccine Initiative
ICT4D	Information and Communication Technology for Development
IDRC	International Development Research Centre
LAC	Latin America and the Caribbean
MAPHealth	Macroeconomic Adjustment Policies and Health
MIMAP	Micro Impacts of Macroeconomic and Adjustment Policies
PALSA	Practical Approach to Lung Health in South Africa
PAHO	Pan American Health Organization
PI	IDRC Programme Initiative
RM	Research Matters
SDC	Swiss Agency for Development and Cooperation
SEE	IDRC Social and Economic Equity Program Area
SEP	IDRC Social and Economic Policy Program Area
SIDA	Swedish International Development Agency
SSA	Sub-Saharan Africa
TDR	Special Programme for Research and Training in Tropical Diseases
TEHIP	Tanzanian Essential Health Interventions Project
UCT	University of Cape Town, South Africa
UFS	University of the Free State, South Africa
UK	United Kingdom
UNDP	United Nations Development Program
UNF	United Nations Foundation
UNICEF	United Nations Children's Fund
WHO	World Health Organization

1 Terms of reference and methodology

1.1 Terms of reference

We were asked to review the International Development Research Centre (IDRC) Governance, Equity and Health (GEH) program:

1 To assess the extent to which the program is meeting its objectives and aims, as set out in its prospectus, and identify any evolution in its objectives.

2 To document results of the program.

3 To offer reflections on the strengths and weaknesses of the program's thematic approach and strategies in relation to the current state of the field(s) in which the program is active.

4 To assess the composition and functioning of the program team as it relates to its ability to meet its objectives over the course of implementing this prospectus.

1.2 Methodology

The review team consisted of:

Norberto Dachs is presently a Professor at the State University of Campinas (Unicamp) in the State of São Paulo, Brazil, where he holds also a position of Senior Researcher at the Center for the Study of Public Policy. From April 1989 through March 2003 he worked at the Pan American Health Organization, first with the Program of Analysis and Trends of Health Situation and later with the Program on Public Policy and Health. In the past several years all Dr Dach's work has been in the area of Health Equity. http://www.ime.unicamp.br/~dachs.

Sarah Macfarlane spent her early career at the Liverpool School of Tropical Medicine as a Reader in Epidemiology and Statistics, teaching research methodology and collaborating with a number of African institutions. She was Associate Director, Health Equity, at the Rockefeller Foundation from 1998 to 2004 with responsibility for strategies to build capacity and support health research, particularly in sub-Saharan Africa and South East Asia. She is now Visiting Professor, Department of Epidemiology and Biostatistics, and Senior Advisor, Global Health Sciences, at the University of California, San Francisco.

Sally Stansfield is the Associate Director for Global Health Strategy of the Bill & Melinda Gates Foundation, where she shapes and manages programs and alliances to improve health outcomes in the developing world. She has over 30 years of experience in research and public health practice, including with the US Centers for Disease Control, the Agency for International Development, the International Development Research Centre and the World Health Organization. Dr. Stansfield has worked in more than 40 countries in Africa, Asia, the Americas, and the Middle East.

We bring a range of perspectives to this review, including experience of working in donor organizations (Rockefeller, and Bill and Melinda Gates Foundations, USAID, and IDRC), in international organizations (PAHO, WHO, CDC), in field projects in Latin America, sub-Saharan Africa and South East Asia, and in international programs within academic institutions in the US, UK, and Brazil.

Review team briefing and allocation of responsibilities The team was formed by IDRC and we first met in Ottawa Feb 3-7, 2005 where we were provided with an overview of the review by Kevin Kelpin, of the Social and Economic Policy Program Area by Brent Herbert-Copley, and of the GEH Program Initiative (PI) by Christina Zarowsky. We met with members of the GEH team and had informal meetings with IDRC senior management, in particular with Rohinton Medhora, Vice President for Program and Partnership Branch, Fred Carden, Director of the Evaluation Unit, Jean Lebel, Director, Environment and Natural Resources Management, Tim Dottridge, Director of the Special Initiatives Division, and Brent Herbert-Copley, Director of Social and Economic Policy.

During this visit, it was explained to us that the review would also be relevant to the Swiss Agency for Development and Cooperation (SDC) since they have collaborated in the launch and implementation of GEH through an agreement to contribute 1.7m CHF and considerable officer time over the four years of the GEH Prospectus. Although the GEH/SDC relationship has focussed on Research Matters (RM), we agreed that the report would be relevant in its entirety to the SDC, and that the RM project would not be singled out for extra attention but would be treated as an integral part of GEH strategy.

IDRC designated Sarah Macfarlane as team coordinator and we subsequently allocated responsibilities for grant reviews as follows: Norberto Dachs for Latin America and the Caribbean (LAC), and Health Equity as a cross-cutting theme; Sarah Macfarlane for Eastern and Southern Africa (ESA), African Health Research Forum, Global Forum for Health Research, and RM; and Sally Stansfield for West Africa and Canadian collaborations. Other global and secretariat grants remained the team's joint responsibility. We submitted a work plan and our travel schedules were approved by IDRC in the middle of March 2005. The target date for the final report was August 22, 2005, later revised to September 23, 2005.

Portfolio of projects reviewed. We were asked to review the grant portfolio for the fiscal years 2000 – 2005, consistent with the 2000-2005 IDRC Corporate Strategy. The 2002-2006 GEH Prospectus was approved in October 2002 and includes a retrospective component beginning April 1, 2002. There is some ambiguity about when GEH officially became a Program Initiative (PI), but for the sake of this review GEH considers that the PI began formally on April 1 2003[1] - making it a three-year PI due for completion on March 31, 2006.

Since we were only provided with information about one small research project grant[2] and a secretariat project grant for the International Initiative for Tobacco Policy Research (94-0200-01)[3] for the year 2000/01, we based the review on GEH Project Portfolios for the four years: 2001/02, 2002/03, 2003/04, and 2004/05.

[1] Email to the review team from GEH, dated July 7, 2005
[2] 100826: "AIDS Review, South Africa".
[3] 1726 "International Initiative for Tobacco Policy Research (94-0200-01)"

Of the 82 grants reviewed in the four-year period 45 were for research projects, 33 for research support projects, three for award projects, and one for a secretariat project. For the sake of analysis, we reclassified the three award projects[4] as research support projects and the secretariat project[5] as a research project, making 36 research support projects and 46 research projects. Of these 82 grants, 41 (51%) were made during the first two years (2003/2004 and 2004/2005) of the three-year GEH PI. One grant of 30,000 CAD was made for research support to Asia, which we classified as global.

Approach to the review process In view of the complexity of the GEH Prospectus and the heterogeneity of its grants, the team concluded that a quantitative survey instrument would not be a feasible or desirable approach to data collection. We developed a structured framework for our interviews but the questions we asked were often quite informal. We realised that the views we obtained were not representative but rather a range of perspectives that would give us and the readers of this report insights into issues for discussion. We decided to triangulate what we heard and observed with facts about GEH style of funding, for example through analysis of the allocation of funds: amount of GEH funds granted by region, by type of grant, by country; average length of grants and average amount granted per research project by region, and average amount granted by grant year; matching funds by region and year.

Review database We created an excel worksheet – "GEH Grantmaster 2001-2005" – from the information provided in the four annual GEH Project Portfolios for the 82 grants reviewed, and added some additional fields. A list of the fields used in the worksheet is provided in Attachment 2, and the complete worksheet is lodged with IDRC. Every effort was made to check the accuracy of this information and the GEH team assisted in checking the worksheet. There were small discrepancies between the overall allocation figures provided by IDRC and those resulting from our analyses the 82 grants reviewed.

Interviews During our briefing in Ottawa we met with representatives of the Canadian International Development Agency (CIDA) and the Global Health Research Initiative (GHRI). We all attended the GEH partner meeting on "Governance - intersections with health, equity and financing", in Saly Portudal, Senegal, from 25-30 April, 2005. This allowed us to: 1) work together as a team and evolve our methodology, 2) gain a more in-depth understanding of how issues of governance relate to GEH programming, 3) meet with grantees and other stakeholders, and 4) interact and meet with GEH team members. We attended some plenary sessions of the meeting but had to allocate most of our time to interviews and review team discussions.

In Saly Portudal, we interviewed grantees in project groups for approximately one hour each. We interviewed GEH team members individually for approximately one hour, and also held one group meeting in order to ascertain their views on the review and if there were any concerns. We had several meetings with Christina Zarowsky, and one longer interview with her at the end of the meeting. We also conducted interviews with Nadia Isler and Daniel Mausezahl of the SDC in regard to RM.

[4] 100443: "Relationship Building with Canadian Institutes for Health Research (CIHR)"; 100933: "Corporate Citizenship Grants 2001-2002"; 101365: "Governance, Equity and Health: CIHR Partnership 2002".
[5] 101346: "Promoting Essential Health Interventions in Tanzania".

Norberto Dachs and Sarah Macfarlane made the following field visits:

Bogotá, Colombia: Hosted by Francisco Yepez, Norberto Dachs visited the "Governance and Evidence Based Decision Making: a participatory formation process of health policies" project (102228) in Bogota.

São Paulo, Brazil: Norberto Dachs made a one-day visit to Instituto de Saúde (Health Institute) of the Department of Health of the State of São Paulo to discuss "Financing Municipal Health Systems and Equity" project (100095) and "Challenges for Health Equity in the Sao Paulo Metropolitan Region" (101876) with Luiza Sterman Heimann, and her team.

Dar es Salaam, Tanzania: Sarah Macfarlane met with Graham Reid and Harun Kasale to discuss TEHIP-related projects: REACH Policy: "Regional Capacity for Evidence-based Health Policy, East Africa" (102750), and "Promoting Essential Health Interventions in Tanzania" (101346). She also met with Pio Wennubst, SDC Country Director.

Johannesburg, South Africa: Sarah Macfarlane visited Ari Ho Foster and Judith Matthis of CIET, South Africa to discuss their role in the "Public Sector Anti-retroviral Treatment, South Africa" (102241, 102770).

Pretoria, South Africa: Sarah Macfarlane visited Diana Youdell and Jean-Didier Oth in the High Commission of Canada Office for Development, and later met with Nana Kgosidintsi, HIV/AIDS Advisor for CIDA.

Bloemfontein, South Africa: Sarah Macfarlane visited Ron Chapman of the Department of Health of the Free State, and Dingie Van Rensburg and his team at the University of the Free State Centre for Health Systems Research for Development, to discuss their role in the "Public Sector Anti-retroviral Treatment, South Africa"

Cape Town, South Africa: Sarah Macfarlane visited Eric Bateman of the University of Cape Town Lung Institute to discuss the "Practical Approach to Lung Health (PALSA)" and PALSA Plus work (101489, 102241, 102770), and their role in the "Public Sector Anti-retroviral Treatment, South Africa". She met with Uta Lehman of the University of Western Cape to discuss the "Impact of HIV/AIDS on health service capacity at primary care level project" (101938). She visited Di McIntyre at the University of Cape Town to discuss Equinet. From Cape Town, Sarah Macfarlane had an extended phone call with Lucy Gilson, University of Witwatersrand to discuss Equinet and the "Trust and Accountability in Health Service Delivery in South Africa" (102855).

A list of key contacts consulted during data collection is given in Attachment 4.

Case studies We selected the following projects as case studies: 1) "Public Sector Anti-Retroviral Treatment in Free State South Africa" (102770, 102241), 2) "Southern African Regional Network on Equity in Health (Equinet)" (004378, 100954,102041), 3) "Alliance/IDRC Competitive Grants for GEH Research in Eastern & Southern Africa" (101885 and 102079), 4) "Governance and Evidence Based Decision Making: a

participatory formation process of health policies (Colombia)", (102228), and 5) "Politiques Publiques et protection contre l'exclusion en Afrique de l'Ouest" (101160 and 102854). These projects were selected because they demonstrate different programming mechanisms, represent different geographic regions, illustrate a combination of regional and country programming, and because they appeared to be important to GEH strategy.

Documents reviewed The documents that formed the basis of the review (Attachment 5) consisted of GEH Project Portfolios and work plans for the four years under review, Project Appraisal Documents (PAD), project proposals progress reports, and project outputs such as publications, videos, transcripts of radio shows, and training materials, and conference presentations and reports.

Constraints Originally, IDRC invited a team of four reviewers. One potential reviewer declined at the last minute leaving a gap of knowledge of French, West Africa, and governance-related issues. The disparate locations and busy schedules of the review team and of the GEH team complicated review implementation. Although the GEH team is to be commended for its commitment to informing the review process, we would have wished to have had more face to face participation by them in the review, had this been physically possible.

2 IDRC: Governance, Equity and Health

The GEH PI straddles two IDRC Corporate Strategies and Program Frameworks (CSPF). The four-year GEH Prospectus, approved in October 2002, was designed to fit within the Social and Economic Equity (SEE) Program Area of the CSPF for 2000-2005. SEE supported research in SSA and LAC with the goal of increasing social and economic equity through four sub-areas, or foci: a) governance, peace-building and reconstruction, b) innovations in managing public goods, c) managing economic globalisation, and d) supporting economic livelihoods. In the 2005-2010 CSPF, GEH is located within the Social and Economic Policy Program Area (SEP) which aims to effect policy change by a) strengthening long-term capacities to carry out, manage and disseminate research, b) by supporting policy-relevant research on issues of immediate policy concern, and c) by assisting civil society organizations to facilitate public accountability by informing debates on key policy issues. Its programs are concerned with the "realities of institutions, governance, and power at the local, national and international levels". GEH is contained within one of four sets of issues addressed by SEP ie Equitable Access to Health and Social Security. The other three sets of issues are Peace, Conflict and Development; Globalisation, Growth and Poverty; and Gender Justice.

The GEH Prospectus grew from the findings of two explorations. One Centre-wide exploration into governance concluded "that research on governance issues related to the practical experience of the provision of public services would yield the most fruitful results in terms of contributing to improved policy and a greater understanding of the twin concepts of citizenship and of state legitimacy". The other exploration sought ways to increase the Centre's support for health and concluded that "linking political analysis

with health systems research and linking this in turn to policy and programming would be highly relevant to addressing many of the bottlenecks facing health systems and health sector reforms in the South". Programming under the GEH exploration was approved in March 2001.

One of SEE's goals was to "support research on the efficient and equitable provision of services, particularly for health and education". Health was selected as the sector "where IDRC could make the most difference" and where there "was the existence of a critical mass of suitable programmatic platforms and staff expertise". The GEH exploration set out to focus on health sector reform and to seek ways to link the Canadian experience in providing public goods and building citizenship in a multi-cultural environment with the challenges facing many Sub-Saharan African (SSA) countries. Consideration was also to be given to project support in LAC.

In October 2002, the Board approved the GEH Prospectus whose strategy is summarized in Table 1.1 Its three objectives are 1) to strengthen health systems, 2) promote civic engagement and 3) to make research matter. The prospectus lays out the axes and entry points for GEH programming and a set of expected outputs.

The prospectus highlighted a number of areas for immediate programming. In addition to developing, supporting, and monitoring GEH projects, these comprised 1) rolling out the longstanding Tanzanian Essential Health Interventions (TEHIP) project in Tanzania, phasing out of IDRC support for the project itself, and supporting the Duluti Lake Centre on Evidence for Health Policy in East Africa, 2) building on some other inherited projects, for example the Municipal Services Project in South Africa, and collaborations with the United Nations Development project (UNDP) in Latin America, 3) expanding pre-prospectus GEH work with continued support for the networking and "closing the loop" activities of Equinet and the African Health Research Forum, 4) developing two major new initiatives: GEH RM (corresponding to the third GEH objective); and Regional Research Funds for SSA and LAC, 5) collaborating with the CIHR-led inter-agency Request for Proposals on Global Health Research, 6) working closely with other IDRC programs and units, for example: MIMAP, EcoHealth, ICT4D, and the Evaluation Unit in the application of the Outcome Mapping approach to evaluation, , and 7) strengthening existing partnerships, particularly with SDC and forming new ones.

At the time of this review, the 2005-2010 CSPF has been approved in which there is some commitment to support research to increase access not only to health but also to other social services, for example education. GEH is evolving as a PI and has identified the following priorities for 2005/06, the last year of its prospectus: 1) financing and resourcing comprehensive and equitable health systems, 2) understanding and supporting more effective governance of multi-actor and plural health systems, and 3) capacity strengthening for the generation and utilization of GEH-congruent research.

Table 2.1 - Summary of GEH Strategy as described in the GEH Prospectus 2002 to 2006

GEH's work is guided by a vision for an equitable fair, and just provision of public services, particularly to the marginalized and excluded groups in developing countries

GEH Mission: strengthening health systems; promoting civic engagement; and making research matter: GEH aims to contribute to a shift in thinking and practice among key actors so that political and governance challenges, equity concerns, and technical health and health policy questions are increasingly considered as integrally related.

General objectives	Specific objectives	Axes The crux of GEH	Research areas/ Entry points	Methodological approaches	Funding mechanisms	Outputs
1. Strengthening Health Systems: To support applied research that will both strengthen and monitor the capacity of governments to ensure equitable financing and delivery of priority public health and health care services, especially to marginalized and underserved populations	i) Integrate political, social, economic, and policy analysis into research on public health systems and policy in order to (a) provide solid grounds for making informed and needs-based decisions on the equitable financing and functioning of health systems; and (b) examine the governance challenges critical for deepening democracy and increasing health and social equity	1.Politics and processes of service delivery (indicates a relative emphasis on health policy and system governance, and addresses the supply side of policy making and service provision). 2. Access and its effects on health and social equity (indicates a relative emphasis on citizen rights and engagement, thus addressing the demand side).	1. The policy process (e.g. formulating, implementing, and evaluating pro-poor policy for health; fair and sustainable financing; influences of donors and globalization on policy) 2. Health systems (e.g. effective delivery of quality services; human resources; transparency and accountability; corruption) 3. Priority conditions or interventions (eg TB, HIV as entry into broader governance, equity, health systems issues) 4. Civic engagement (e.g. mechanisms to promote effective and informed participation and inclusion; exercising the right to health; health and health care as an arena for democratization)	1. Policy and political systems analysis, addressing structures, actors and processes 2. Gender analysis 3. Particular attention to existence and mechanisms of inequalities 4. Participatory approaches Pay attention to: i) lines of potential social cleavage eg gender, socio-economic status, and ethnicity ii) opportunities to apply the findings to other sectors	1. Competitive requests for proposals, 2. Strategic or targeted programs and projects, 3. Support for networks, 4. Support for training 5. Support for synthesis 6. Support for "closing the loop"	1. A systematized body of research results and tools, available in usable and problem-oriented format, that demonstrably contributes to national and international policy dialogue regarding equitable access to health systems.
	ii) Build a systematised body of research results and tools, available in a usable and problem-oriented format that will inform national and international policy dialogue to reinforce political commitment to support equitable access to health systems.					
2. Promoting Civic Engagement: To support informed and effective citizen demand and participation throughout the policy-to-practice process	iii) Facilitate collaboration among researchers, NGOs, health practitioners, community and advocacy groups, and local/municipal/national governments in order to develop strategies to improve accountability, strengthen the rule of law, and create public spaces for policy dialogue that focuses on public services for health.					3. A record of experience with approaches and mechanisms that promote effective and informed participation of citizens in the policy and practice of service delivery for health, particularly among sub-groups which are now largely excluded from access to services and from policy consultations.
	iv) Identify and test mechanisms that promote effective and informed participation of citizens in the policy and practice of service delivery for health at local, national, and international levels, particularly among sub-populations which are now largely excluded from access to services and from policy consultations.					
3. Making Research Matter: To increase the effectiveness of research-to-policy linkages in promoting the dual goals of health and social equity	v) Systematically examine health sector reform experiences and results, in order to identify opportunities and challenges in translating lessons learned and policy recommendations on equitable access to health services among different countries and policy environments.					2. Strengthened capacity to transfer policy-relevant knowledge through comparative studies, synthesis and dissemination of findings and tools generated by individual projects, and linkages among researchers and decision makers at different levels. 4. Established research networks applying the locally relevant elements of the GEH approach in Africa and Latin America.
	vi) Build long-term partnerships with key like-minded actors, through linking research projects wherever possible to larger on-going development programs and through gradually building a critical mass of findings, networks, and tools around selected topical and geographic nodes. NB "GEH Research Matters" to be developed as a Knowledge Transfer Platform to complement project- and network-level "closing the loop" activities with a meta- project dedicated to catalyzing the synthesis and targeted dissemination of lessons learned from GEH and from other efforts in the health area.					

3 GEH project portfolio 2001 to 2005

3.1 Overview

Planned and actual appropriations in relation to the GEH Prospectus GEH allocated 12,491,318 CAD between 2001/2002 and 2004/2005 (note GEH was not a PI in 2001/02 and this is considered an exploration year). During the first three years of its prospectus GEH allocations were 10,709,323 CAD compared to the 10 million CAD planned in the prospectus. Allocations grew, in line with but higher than those planned in the prospectus, from 2,543,615 CAD in fiscal year 2002/2003 to 4,812,190 CAD in fiscal year 2004/2005. When funds from other PIs are included, the expenditure by IDRC on GEH projects totalled 11,496,638 CAD during the three-year prospectus period. GEH also leveraged 4,799,555 CAD in matching funds during the prospectus period, almost 1 million (actual 916,555) CAD higher than the 3,883,000 CAD anticipated in the prospectus.

The above figures were total figures provided by IDRC. All subsequent tables refer to our analyses of the 82 grants reviewed[6]. There are small discrepancies between these two sets of figures.

Expenditures and numbers of grants by region Of the 82 grants reviewed over the four-year period, 70% of GEH expenditure was accounted for by 42 grants to SSA, 17% by 14 grants to LAC, and 13% for 26 grants to global projects (Tables 3.1 and 3.2). Three percent of the grants to SSA were for research support, compared to 5% of grants to LAC and 50% of global grants.

Table 3.1 – GEH expenditures (CAD) on the 82 grants reviewed, by region

Fiscal Year	Global		Sub-Saharan Africa		Latin America and the Caribbean		Total
	Total	% yr total	Total	% yr total	Total	% yr total	
2001/02	211,400	10.3	1,614,289	78.7	226,729	11.0	2,052,418
2002/03	361,049	12.3	1,867,536	63.7	701,440	23.9	2,930,025
2003/04	873,698	25.4	2,366,560	68.9	192,660	5.6	3,432,918
2004/05	216,000	4.8	3,257,420	71.8	1,061,770	23.4	4,535,190
Total	1,662,147	12.8	9,105,805	70.3	2,182,599	16.9	12,950,551

[6] See section 2.1

Table 3.2 – Distribution of the 82 grants reviewed, by year and region.

Fiscal Year	Global		Sub-Saharan Africa		Latin America and the Caribbean		Total Number
	Number	% year total	Number	% year total	Number	% year total	
2001/02	6	40.0	6	40.0	3	20.0	15
2002/03	6	23.1	13	50.0	7	26.9	26
2003/04	10	45.4	12	50.0	1	4.5	22
2004/05	4	21.0	11	57.9	3	15.8	19
Total	26	31.7	42	51.2	14	17.1	82

3.2 Research projects

Of the 82 grants reviewed, GEH allocated 11,766,038 CAD in the form of 46 research projects (average size 255,783 CAD). Their distribution by region (Table 3.3) is described below.

In sub-Saharan Africa, GEH granted a total of 8,872,165 CAD in the form of 32 research projects (average size, 277,255 CAD). Three (791,350 CAD) grants were made to a Kenyan institution in support of the African Health Research Forum, two (626,670 CAD) to the Global Health Research Forum (based in Switzerland) as regional funds for research in SSA, and two (1,296,540 CAD) to a Zimbabwean institution for core support to Equinet, a Southern African regional network.

Two grants were made by way of follow up to TEHIP - one (176,260 CAD) to a Ugandan institution for an East African collaboration and one (398,851 CAD) to the World Health Organization (WHO), Tanzania, through UNF, to support TEHIP scale-up in Tanzania. Another grant (314,200 CAD) was made jointly to a Canadian, Tanzanian and Ugandan institution for collaborative research. Thirteen grants (4,013,076 CAD) were made to institutions in South Africa, two of which were for multi-country studies in Southern Africa.

Six grants (756,868 CAD) were made to institutions in four countries in West Africa – two to Burkina Faso (one for a multi-country program in West Africa), two to Senegal (one to the Council for Development and Social Science Research in Africa (CODRESIA), an Africa-wide institution), one to Ghana and one to Guinée. Three grants (498,350 CAD) were made to the University of Montreal, two for a multi-country collaboration in West Africa and the other for collaborative research in Guinée.

In Latin America and the Caribbean, GEH granted a total of 2,077,370 CAD (average size, 259,671 CAD) in the form of 7 research projects and for support of another IDRC project in which GEH invested only 10,000 CAD. Two of the research projects were developed jointly with the Pan American Health Organization (PAHO) and the investment in them was of 835,760 CAD (40.2% of the total) and a third one (404,810

CAD) has as grantee the United Nations Development Programme (UNDP) which will enable the UNDP and IDRC to finance several local studies, all in Guatemala. The remaining 40% of the resources were distributed evenly among four national projects, two in Brazil and one each in Colombia and México.

Globally, six research projects accounted for 816,503 CAD (average size, 136,084 CAD). Two of these grants enabled GEH to leverage larger matching funds for redistribution to grantees in developing countries. GEH provided one grant of 50,000 CAD towards CIII2 which, when matched with 2,500,000 CAD from CIDA, enabled IDRC to manage a research competition which awarded six grants to six countries. Another grant of 194,000 CAD was matched with a grant of 395,000 CAD from SDC in support of the GEH/SDC RM initiative.

GEH provided two grants (450,000 CAD) to the Global Forum for Health Research/ Alliance HPSR, one (66,503 CAD) to a South African and a Canadian institution to support the preparation of a report for the G8 Summit in Canada in 2002. A further grant of 56,000 CAD was made to a United Kingdom (UK) institution to support the writing of the first Global Health Watch Report.

3.3 Research support projects

Of the 82 grants reviewed, 36 research support grants were made between 2001/2002 and 2004/2005, totalling 1,184,513 CAD (average size, 32,903 CAD). Ten research support grants (average size, 23,364 CAD) made to SSA included proposal development, publications and attendance at meetings, and six (average size, 17,538 CAD) to LAC included participation in meetings and symposia, and a literature review.

Twenty research support grants (average size, 42,282 CAD) were classified as global in that the recipient institutions were not in developing regions. A grant (102689) for 30,000 CAD was given to an Asian institution for a “Health Rights, Women’s Rights” project. Seven research support grants to Canadian institutions were to build Canadian partnerships and to leverage Canadian research institutions to solve global issues. For example, the projects for “Relationship Building with Canadian Institutes for Health Research” (100443) and the “CIHR Partnership” (101365) provided support that has led to the development of a Canadian Coalition for Global Health Research (CCGHR). The 12 remaining grants include awards for workshops, GEH partner meetings and conferences, attendance by partners at meetings, preparation of papers (including some overview papers on governance, equity and health), consultancies, and for the early development of the RM project.

Table 3.3 – Distribution of grantees for the 46 research projects reviewed

Region	Grantee country or institution	No.	GEH (CAD)	% regional total	% grand total
Latin America and the Caribbean	Brazil	2	455,080	21.9	3.9
	Colombia	1	192,660	9.3	1.6
	Colombia, U of Montreal	1	10,000	0.5	0.1
	Guatemala (via UNDP)	1	404,810	19.5	3.4
	Mexico	1	179,060	8.6	1.5
	West Indies *	1	650260	31.3	5.5
	Brazil, Nicaragua*	1	185,500	8.9	1.6
	Regional total	**8**	**2,077,370**	**100.0**	**17.7**
Sub-Saharan Africa	Burkina Faso*	2	66,148	0.7	0.6
	Ghana	1	100,000	1.1	0.8
	Guinée	1	270,520	3.0	2.3
	Guinée (via U of Montreal)	1	25,000	0.3	0.2
	Kenya*	3	791,350	8.9	6.7
	Senegal*	2	320,200	3.6	2.7
	South Africa*	13	4,013,076	45.2	34.1
	Tanzania (via UNF)	1	398,851	4.5	3.4
	Tanzania, Uganda, U of Montreal	1	314,200	3.5	2.7
	Uganda*	1	176,260	2.0	1.5
	Zimbabwe*	2	1,296,540	14.6	11.0
	Sub-Saharan Africa** (via GFHR)	2	626,670	7.1	5.3
	West Africa* (via U of Montreal)	2	473,350	5.3	4.0
	Regional total	**32**	**8,872,165**	**100.0**	**75.4**
Global Projects	Canada **	1	50,000	6.1	0.4
	Global Forum for Health Research**	2	450,000	55.1	3.8
	South Africa, U of Montreal (G8)	1	66,503	8.1	0.6
	UK (Global Health Watch)	1	56,000	6.9	0.5
	Research Matters**	1	194,000	23.8	1.6
	Global total	**6**	**816,503**	**100.0**	**6.9**
Grand Total		**46**	**11,766,038**		**100.0**

***** Includes at least one regional grant

** Includes funds re-allocated to countries (may also include multiple grants within each)

4 GEH programming

4.1 Support for activities highlighted in the GEH Prospectus

GEH has followed through on the projects highlighted for early development in its prospectus (described in section 2 of this report).

GEH has created two major new initiatives:

1) The creation of a regional fund in ESA for competitive proposals to strengthen the capacity of institutions and researchers to integrate political analysis into health systems research. This fund has been set up through GEH support (101885 and 102079) of 626,670 CAD plus 100,000 CAD from SDC to the Alliance for Health Policy and Systems Research (AHPSR) – see Case Study 3.

2) The foundation of the RM project jointly with SDC is significant to GEH strategy to meet its own objectives. The project (102283) is funded with a grant of 194,000 CAD from GEH 395,000 CAD from SDC. Its secretariat is housed at IDRC and a SDC staff member works out of Mozambique – see Attachment 1.

GEH made a significant contribution to the CIHR-led inter-agency Request for Proposals on Global Health Research. GEH administered and implemented the CIDA funded competitive program for "Operational Research Grants of the Canadian International Immunization Initiative (CIII2)" (102107), through the GHRI partnership. – see Section 4.3.

GEH has built on ongoing activities:

1) Building on TEHIP, GEH made a grant (102750) of 176,260 CAD to the University of Makerere to support a series of research-to-policy case studies and a consultative process to develop an institutional mechanism for evidence-based health policy in East Africa between November 2003 and May 2004. GEH also made a grant (101346) to the United Nations Foundation (UNF) to support the scale-up of TEHIP tools within Tanzania. This catalyzed further support of 500,000 CAD from UNF for this purpose.

2) GEH has continued its long term support for the "Municipal Services and Health in Southern Africa" (MSP) II (101644) providing a three-year grant of 676,000 CAD to develop a better understanding of the complexities of the links between health and services, and explore the potential of different municipal service delivery models to be equitable, participatory and health-oriented. This project has been particularly productive in terms of outputs.

3) GEH continues to provide core support for Equinet providing grants (004378, 100954, 102041) totaling 1,296,540 CAD for Phase II and Phase III support – see Case Study 2.

4) GEH has supported the next stage in the development of the African Health Research Forum (102069, 102145) with grants totaling 791,350 CAD. This has included core support for its development and funds to create a leadership programme with support from a Canadian consultant.

5) GEH has developed LAC programming in collaboration with UNDP by providing a grant (102229) of 404,810 CAD to UNDP for a collaboration to produce a series of commissioned studies by local health specialists in Guatemala, on the current situation and foreseeable trends in the country's epidemiological profile, the social determinants of health, and the functioning of public and private institutions making up the national health system.

6) GEH has continued to work with PAHO (101107) by providing support (650,260 CAD) for research proposals from LAC countries to examine the impact of innovative strategies to expand social protection in health, stimulate research and promotion of relevant health policy research, in light of the weak research base of reform efforts during the 1990. Five new projects in Brazil, Argentina, Jamaica, and Colombia, are being funded. PAHO contributed a further 350,000 CAD to this project.

4.2 Strategies for funding research projects

Length and size of projects The average amount of money granted for research projects (project size) increased over the four-year period from 243,474 CAD to 310,106 CAD with an average of 255,783 CAD. These figures reflect the Centre's trend towards projects of increasing financial value, with the GEH figure for 2003/04 of 310,106 CAD being very close to the Centre's average of 300,000 CAD for that year[7].

The average length of a research project increased for global grants and for grants to LAC, but decreased by 1.16 years for grants to SSA from 2.79 years in 2001/2002 to 1.63 years in 2004/2005) (Table 4.1). At the same time, the average amount of money allocated per project year (amount granted divided by the length of the project) increased for SSA from 119,619 to 172,303 CAD over the four years. The average CAD/year for 2004/2005 has to be interpreted with caution as it included GEH's largest ever single grant of 1,129,750 CAD (102241) to four institutions to work on the Free State project. This grant was for fifteen months.

Grantees from more than one project in SSA commented that they had been asked, after proposal submission, to cut their budgets and to reduce the lengths of their projects in order to accommodate GEH budget restrictions indicating that these had resulted in reduction in sample size, change in project location, reduction in the project length, use of less qualified fieldworkers, inadequate overheads, and added pressures on the principle investigators. One grantee described this as "forcing tariffs below realistic levels". These comments are borne out by the increasingly short average grant length in Table 4.2. In the case of the Free State (102241), we observed that in the bringing together by IDRC of

[7] IDRC CSPF 2005-2010

several institutions[8], each had been required to reduce its budget and the overall length of the project in order to accommodate the inclusion of four partners in the grant. While this ensured a rounded approach to the research problem being explored, the downside of this strategy is: 1) the risk that the project is under-funded to achieve its goals, 2) funding for the completion of the project is uncertain and 3) each of the partners may feel short changed by the other.

Table 4.1 – Average GEH allocations and length for the 46 research projects reviewed.

Fiscal Year	Global			Sub-Saharan Africa			Latin America and the Caribbean			Total		
	Average grant size	Average length (yrs)	No.	Average grant size	Average Length (yrs)*	No.	Average grant size	Average length (yrs)**	No.	Average grant size	Average length (yrs)***	No.
2001/02	150,000	1.60	1	320,458	2.79	5	97,750	1.86	2	243,473	2.44	8
2002/03	-	-	-	282,544	2.32	6	211,380	2.57	3	258,823	2.41	9
2003/04	152,626	2.63	4	234,419	1.72	10	192,660	2.00	1	209,823	1.98	15
2004/05	56,000	2.00	1	293,675	1.63	11	527,535	2.50	2	310,106	1.75	14
Total	136,084	2.35	6	277,255	1.96	32	259,671	2.35	8	255,783	2.08	46

* 5 missing values ** 2 missing values ***7 missing values

Funding mechanisms In its prospectus, GEH described a number of funding mechanisms that it would use to pursue its objectives. These included: strategic or targeted programs and projects, and support for competitive requests for proposals, networks, training, synthesis and "closing the loop".

The grants (101885 and 102079) to the AHPSR for a joint AHPSR/IDRC **competitive request for proposals** from SSA were designed to obtain an impression of the interest and capacity of researchers in the GEH thematic approach. It was also intended to build research capacity and a body of knowledge around governance, equity and health. This was modelled on experience in EcoHealth and is intended to be the forerunner of a similar approach for GEH in West Africa and LAC. The CIDA funded operational research immunization grants program is another example of a competitive set of awards this time administered by GEH.

GEH encourages **networking**, for example it has provided core support to Equinet during the entire review period. GEH is also nurturing other younger networks with very different structures. For example, the African Forum for Health Research (102069), which grew out of the Bangkok conference on Health Research for Development, is run from Kenya but has yet to demonstrate that it can successfully network. "Politiques publiques et protection contre l'exclusion", a unique multi-country project in West Africa

[8] Referred to by one of the institutions as "an arranged marriage" and by another as a "forcing partnership in this project - with unwelcome consequence"

supported through the University of Montreal, is beginning to emerge as a West African network. Many other GEH supported projects have networking activities or are multi-country collaborations. GEH partner meetings, such as the one in Saly Portudal in April 2005, are intended to facilitate networking among GEH partners and to form a GEH community of practice.

GEH does not usually provide grants for **training** per se, with the exception of some small research support grants, but there is no doubt that the GEH strategy is about capacity building, particularly with its focus on support for developing country researchers. Support for Equinet is an excellent example of longstanding support for capacity building in Southern Africa. GEH also supported the African Forum for Health Research (102069) to develop a leadership programme. GEH encourages grantees to include support for young researchers, and some Master and PhD students are already emerging as a result of GEH funded projects, for example in the Free State project.

Support for **"closing the loop"** is fundamental to GEH strategy forming one of its objectives. GEH encourages all grantees to conduct research that addresses questions and answers that interest policy makers. The GEH strategy in this regard is demonstrated by the RM project. Support for **synthesis**, on the other hand, is less than we might have imagined given the early stage of gestation of the overall theme of governance, equity and health. The "AIDS Review" (102676) is the clearest example of support for synthesis.

We understand **"strategic or targeted programs and projects"** to mean grants that were made strategically to match grantee interests with GEH objectives. Many of GEH's current projects/grantees were inherited, for example, TEHIP, MSP, Equinet, and the AIDS Review. RM is novel to GEH, as is support for the leadership program of the African Health Research Forum, and the joint AHPSR/IDRC competitive grants program.

The "Public Sector Anti-Retroviral Treatment in Free State, South Africa" (Case Study 1) is an outstanding example of new GEH strategic programming. The decision to roll-out ART in South Africa, with the highest HIV/AIDS prevalence in Africa, signalled the need for immediate research. Given its in-depth knowledge of South Africa and its confidence in some familiar institutions, GEH supported a collaboration to monitor ART roll-out in the Free State. We understand this project to meet all three GEH objectives. As such, we would expect long-term follow-up and learning from this project into the next prospectus.

A review of the 18 grants made in 2004/2005, the second year of the GEH PI (the third year of the prospectus), revealed that most were to established projects or to previous grantees. There were only two projects/grantees for whom we could not identify earlier association with GEH: These were to the West Africa Rural Foundation for "Conception et gestion decentralisees d'un programme d'intervention en santé maternelle et infantile dans une sous-préfecture de Guinée" (102805), and to Basic Needs, an NGO in Ghana for "Equitable Economic Access to Treatment for People with Mental Illness in SSA" (102835).

Geographic focus The CSPF identified SSA as the area where new governance and health systems work should focus, with a secondary focus on LAC. This is reflected in GEH investments to date, with 75% of grants for research projects going to SSA and 18% to LAC during the four-year period under review. One strategy employed in LAC in order to maximize the small funds available is to leverage matching funds from, for example, PAHO, the Brazilian Ministry of Health, and SDC. In LAC, GEH obtained 1,250,698 CAD in matching funds, or 60% of the total 2,077,370 CAD invested by GEH in research projects in the region. Whereas GEH obtained 1,673,563 CAD in matching funds in SSA, this represented only19% of the total 8,872,165 CAD invested by GEH in research projects in the region.

Within SSA, GEH invested 1,255,218 CAD in research projects in West Africa compared to 7,616,947 CAD in ESA. Grants totalling 4,013,076 CAD were made for research projects to institutions in South Africa - 44% of all research project grants to SSA, and 34% of all research project grants. South Africa was not identified in the prospectus as a country for GEH primary strategic focus.

Almost seven percent (816,503 CAD) of GEH expenditures on research projects were classified as "global". Of the remaining 10,949,435 CAD allocated for research projects, 48 % was spent in support of networks or multi-country studies. Of the grants for research projects to institutions working in one country (Brazil, Colombia, Guatemala, Mexico, Ghana, Guinée, South Africa, and Tanzania) grants to South Africa accounted for 64% of GEH expenditures.

GEH relationships with grantees[9] Wherever we went, we received praise for the GEH team and much less often there was criticism[10]. Grantees and partners commented on the importance of the GEH theme, the integrity and professionalism of the officers, and their commitment to support the grantees. Several commented that the GEH modus operandi was exceptional among donors and that they appreciated IDRC's flexibility in funding. Some grantees asked for more dedicated officer time in order that the GEH team would better understand the circumstances in which they operate, and a few would have preferred less direct intervention. There was some concern about the length of time between submission of proposals and ultimate funding (the review team did not examine these statistics), and some consternation about the reasoning behind some proposal revisions required. One thoughtful grantee - generally positive about GEH - offered his/her opinion without being prompted by us because s/he thought improvements could be made: "the process of negotiating took a while …. not clear how the process was managed …. what the criteria were…. we didn't know what was going on ….comments on the project were mostly legitimate but not clear why they were raised" . The implied solution was clearer guidelines about what GEH funds, and how and when decisions are made.

[9] In response to the first draft of this report, we were asked by IDRC to give a flavour of views expressed during our interviews. The following list gives an indication of the range of terms used to describe GEH, but not their frequency. Some respondents have been quoted more than once in this list, and many have been omitted because there were no retrospectively quotable terms in our notes. As observed above, comments were mostly favourable. Terms (in no specific order) included: *open-minded, more involved, real communication, very present, hierarchical, could spend more time with us, one-way communication, involved internationally, responsive to emerging issues, sincere, imperialistic, not transparent, unresponsive to our views, one of the best funders, less bureaucratic, chronic incapacity to focus, feel valued and supported, they facilitate, too hands on, refreshing, smart, terrific value, catalytic, unique.*

4.3 Partnerships

GEH has invested substantial effort and funds in building and managing partnerships. The GEH Prospectus (2002 – 2006) specifies that GEH will "solidify key partnerships … with SDC and in Canada, with CIDA, Health Canada, and CIHR through a memorandum of understanding (MOU) for global health research". GEH has fully delivered on this commitment.

These partnerships have yielded important gains through leveraging other donor funding and expanding commitments to global health. During the four-year period under review GEH obtained 6,29,528 CAD in matching funds (Table 3.3) of which 58% were for global projects, with 20% for LAC and 22% for SSA.CIDA and SDC contributed the major proportion of these matching funds. Other donors included PAHO, Ford, UNF, Canada Health, UNICEF, the Brazilian Ministry of Health, Netherlands Ministry of Foreign affairs, and the World Bank.

PAHO and SDC have been particularly important partners for GEH. With these agencies, GEH has not only benefited from co-funding of its projects but has shared responsibilities for ongoing decision making in the management of projects and programs. In LAC, two large projects have been developed jointly by IDRC and PAHO.

Table 4.2 – Distribution of GEH matching funding (CAD) for the 46 research projects reviewed, by region

Fiscal Year	Global		Sub-Saharan Africa		Latin America and the Caribbean		Total
	Total	% yr total	Total	% yr total	Total	% yr total	
2001/02	45,000	3.0	893,155	80.6	541,818	36.6	1,479,973
2002/03	247,586	35.5	240,408	34.5	208,880	30.0	696,874
2003/04	3,132,681	89.7	210,000	6.0	150,000	4.3	3,492,681
2004/05	230,000	37.7	30,000	4.9	350,000	57.4	610,000
Total	3,655,267	58.2	1,373,563	21.9	1,250,698	19.9	6,279,528
% of GEH expenditure	202.4		10.6		57.3		48.6

One of the most important investments that enabled achievement of the GEH objective for partnerships was the Canadian Coalition for Global Health Research (CCGHR). The CCGHR was created informally in the fall of 2001 as a network of researchers, donors, non-governmental organizations, and other stakeholders committed to global health research. Soon thereafter, GEH was also instrumental in the formation of the Global

Health Research Initiative (GHRI), which is a partnership of the Canadian Institute for Health Research (CIHR), Health Canada, CIDA and IDRC. Through the GHRI, these four agencies collaborate to provide coordinated parallel funding of global health research activities, joint reviews of projects and programs of mutual interest, and co-funding of global health research projects. GHRI partners have jointly funded WHO's Research and Training in Tropical Diseases (TDR) Programme, the Health Research Program for Development (HRP), the International AIDS Vaccine Initiative (IAVI), and the Canadian International Immunization Initiative (CIII). The GHRI is directed by representatives of the four partner agencies and managed through a small secretariat housed at CIHR in Ottawa. The GHRI "liaises closely" with the CCGHR, which provides a mechanism for participation of non-donor stakeholders in the dialogue regarding global health research.

The members of the GHRI are clearly enthusiastic about the benefits of coalition membership and report that member agencies have increased their commitment and support for global health research and other initiatives through GHRI activities. The partnership is strategic in that it exploits the comparative advantage of each agency. For example, the GHRI-led competitive program for operational research for the "Canadian Immunization Initiative – Phase II (CIII2)" leveraged CIDA's funding power, CIHR's expertise in peer review, and IDRC's comparative advantage in administering research programs in developing countries. CIHR, in particular, has become deeply engaged in developing and managing global health research, including through the administration of two RFP's to date. The review team focused primarily on the IDRC-managed portions of the work of GHRI, so the report does not fully reflect the substantial work and achievements contributed by other agencies.

The development and joint support of CIII2 has been one of the most important collaborative activities of the GHRI partners. CIII2 builds upon the achievements of the first phase of the project, which was a five-year $50 million activity that was completed in 2003. CIII2 is funded largely by CIDA, which contributed $80 million for this current phase of the project. Although the bulk of this funding is committed to the support of the Vaccine Fund and the Global Alliance for Vaccines and Immunization (GAVI), substantial funding is reserved for operational research which complements GAVI activities by focusing on innovations to increase access to and quality of immunization services. Recipients may include CIDA focus/priority countries and Canadian researchers. The operational research program has resulted in an allocation of 200,000 to 425,000 CAD to 6 teams of low- and middle-income country researchers in partnership with Canadian researchers to use research to increase access to and enhance immunization services. The CIII has funded researchers in Canada, Chile, Paraguay, Peru, Bolivia, Cuba, Nicaragua, Pakistan, Burkina Faso, Mali, Benin, Georgia, and India.

The partnership with the Social Development Division of the SDC has been particularly important for GEH. Initially negotiated in October 2001, this partnership has focused primarily on strengthening research-to-practice linkages. SDC has contributed CHF 1.7 million for MAPHealth II, GEH Research Matters, and other jointly developed projects related to health equity, access and governance. SDC and IDRC also collaborate directly through their respective Evaluation Units, which work together on Outcome Mapping activities.

GEH also exerts leadership through less formal partnerships with other agencies and initiatives in global health. Several of the most prominent contributions are though collaboration with the Global Forum for Health Research, the Global Fund (GFATM), the World Bank's "Reaching the Poor" initiative, and the Rockefeller Foundation's Global Health Equity Initiative. Additional linkages are under consideration or under development with UK's Department for International Development (DFID) and the Wellcome Trust (for research capacity strengthening), the Alliance for Health Policy and Systems Research, the Canadian Health Services Research Foundation, PAHO (on social protection in health), Council on Health Research for Development (COHRED), and the Commission on Social Determinants of Health.

IDRC and CIDA have a natural alliance as the research and operational arms of Canada's international development capacity. But GEH collaboration with CIDA has been limited to date, both at the global and country levels. GEH is, however, considering joining the CIDA Nigeria Partnership, which proposes to adapt TEHIP and other GEH lessons and tools to the Nigerian context. In addition to CIDA, the World Bank and DFID are contributing to this effort in Nigeria's health sector. Whereas the Nigeria partnership deepens the natural partnership between CIDA and IDRC if introduces risks of overstretching the already thin human resources of GEH. It should also be clear that it is a development project and cannot be characterized as a research project.

Some of these partnerships are reflected in commitments of funds and/or staff from other donors to work with IDRC (e.g., SDC's support to Research Matters) or at the country level (e.g., CIDA's proposed support for work in Nigeria). Some of GEH's most important partnerships, however, have been developed and managed solely by core IDRC staff from the GEH team. These partnerships, which include CIIP and the GHRI, are more resource-intensive but have yielded substantial benefits in credibility and visibility for IDRC as well as increased momentum within Canada for global health. Another example lies in the GEH-managed Partnership for Global Health Equity competition, which demonstrated the substantial domestic demand for global health research funding in Canada. This effort was instrumental in securing broader commitment among Canadian government institutions to support research on global health.

GEH activities in development of these partnerships are a key component of efforts to achieve objective 3, "to increase the effectiveness of research to policy linkages in promoting the dual goals of health and social equity". These partnerships are envisioned as being effective in achieving the objective "through linking research projects wherever possible to larger on-going development programs and through gradually building a critical mass of findings, networks, and tools around selected topical and geographic nodes". Although not articulated in the GEH Prospectus, the review team found ample evidence that these partnerships have also been effective in expanding IDRC's constituency both within and outside Canada. It is also evident that these partnerships have been instrumental in leveraging new commitments of resources for improving global health.

5 Meeting GEH objectives, outputs and outcomes

5.1 Objectives and intended influence of the program through its outcomes

GEH has three objectives: 1) "strengthening health systems", 2) "promoting civic engagement" and 3) "making research matter". Additionally, there are two axes: 1) "politics and processes" and 2) "access and its effects on health and social equity", and four entry points: 1) "policy and political systems analysis", 2) "health systems", 3) "priority conditions", and 4) "civic engagement" (Table 1.1).

In addition to these dimensions for intervention and evaluation, the GEH prospectus identifies six "specific objectives". Each of these objectives is compound, implying intermediate and ultimate outcomes and, thereby, a "theory of change". However even these "specific" objectives are not adequately specific or measurable to permit a quantitative assessment of progress of the GEH PI. There are no linked indicators, milestones, or other metrics to enable objective measures of success. And there has been no plan or effort to test the implied "theory of change" to determine whether the delivery of intermediate outcomes will, indeed, induce the expected ultimate outcomes promised in the specific objectives.

Nevertheless, qualitative information gleaned from both grantees and other partners provides evidence for some progress toward the specific and general objectives identified in table 2.1. With regard to the first specific objective, for example, GEH has clearly been successful in efforts to "integrate political, social, economic, and policy analysis in research". However it is difficult to attribute any resulting success in delivering the expected outcomes of "equitable financing and functioning of health systems" or "deepening democracy and increasing health and social equity".

The second specific objective promises "a systematised body of research results and tools" to "inform national and policy dialogue to reinforce political commitment to support equitable access to health systems". While the GEH-funded research and resulting tools may not be fully "systematised", the program has clearly been effective in transforming the policy dialogue on equity issues at both global and country levels. IDRC's work in the area of equity, through Equinet and other projects, has contributed to recent increased consciousness of and commitment to improving equity, especially in access to health systems and services.

There is solid anecdotal evidence of success in "facilitating collaboration", as specified in the third specific objective in the GEH program prospectus. The stated purpose of this collaboration is "to improve accountability, strengthen the rule of law, and create public space for policy dialogue that focuses on public services for health." While the causal link between collaboration and the expected result may be questioned, several GEH-funded projects have contributed toward achieving the expected outcome.

The fourth specific objective, "to identify and test mechanisms that promote effective and informed participation of citizens" is designed to favour "sub-populations which are now largely excluded from access to services and from policy consultation". There are a few examples of GEH-funded projects that have been successful in both promoting civic

engagement and in targeting previously marginalized populations. However there has not been a clear identification and testing of "mechanisms" or tools that can be used to replicate these results across geographies.

The fifth specific objective promises to "systematically examine health sector reform experiences and results" to "identify opportunities and challenges in translating lessons learned and policy recommendations on equitable access to health services among different countries and policy environments". While there are examples of such translational work by GEH, this analytic work has not yet been "systematically" produced or catalogued for publication and dissemination.

The sixth of the specific objectives cites a plan to "build long-term partnerships with key like-minded actors". As noted in section 4.3 above, there has been substantial progress in achieving this objective. This impressive success, however, is not due solely to the interventions cited in the objective.

We appreciate that GEH faces the challenge that Christina Zarowsky put to the partner meeting in Saly Portudal: "How do we hold the complexity of these issues and yet act in a targeted and focussed way?" It is evident that the GEH PI has provided important contributions to global knowledge and commitment to explore the nexus among governance, equity, and health. But the articulation of the objectives, axes, and entry points is a constraint to the assessment of success of the program.

To complement the data collection from grantees and other external stakeholders, we asked the GEH team to retrospectively rate their research project grants by the extent to which they reflected each of the three objectives. In total 33 projects were rated out of a possible 46. Of these 33 projects, all were considered relevant to the "strengthening health systems" objective and 20 to the "promoting civic engagement" objective. Eleven were very relevant to "strengthening health systems" and 6 were very relevant to "promoting civic engagement". No projects were strongly relevant to both objectives. Twenty-one projects were considered relevant to the third objective, "making research matter", five of them being very relevant.

Using the PADS, we also made an effort to map how responsible officers justified support for each of 28 currently active research projects in terms of GEH objectives and expected outcomes. We found substantial variability in how the terms in the prospectus are used to justify support for proposed projects. Some PADs framed the "relation to centre objectives" based on the general objectives, some linked these to the GEH-specific objectives, while others cited only the axes or entry points in the GEH Prospectus that would be addressed in the project.

Table 5.1 – Relevance of research projects to GEH objectives

Promoting civic engagement (Objective 2)	Strengthening health systems (Objective 1)				
	Not relevant	Relevant (1)	Quite relevant (2)	Very relevant (3)	Total
Not relevant	0	3	3	7	13
Relevant (1)	0	1	2	2	4
Quite relevant (2)	0	2	6	2	10
Very relevant (3)	0	3	3	0	6
Total	0	9	13	11	33

Of the 28 active projects, 20 cited (either specifically or by implication) "strengthening health systems" as an objective, nine "promoting civil engagement", and eight "making research matter" as GEH objectives that would be met through the efforts of the project. Of the 20 projects justified under the first GEH objective ("strengthening health systems"), only seven indicated specifically what that the outcome might be, and only one of these was objectively quantifiable. Of the 9 projects justified under GEH's second objective ("promoting civic engagement"), only three articulated a specific expected outcome. Of the 8 projects justified under the third GEH objective ("making research matter"), only two were able to offer specificity about likely outcomes.

Nine of the 28 active GEH projects mentioned in the PAD that one or, often, "all three" of the entry points would be "addressed" by the project. Those projects that focused on the entry points generally did not also specify expected attainment of GEH objectives. Only one project specified an outcome aligned with one of the three GEH objectives that was potentially measurable.

5.2 The role of Research Matters[11]

GEH, in partnership with SDC, launched the RM project around the time it became a PI. RM is one component of objective three "making research matter" but its activities cut across the GEH theme. Its aim is **"**to increase policy dialogue and promote policy change and implementation towards a GEH vision, through increasing the policy and practice applicability and utilization of research".

The structure of the RM project is complex, like the PI in which it is embedded having itself, five "objectives", three "approaches", two "themes" and four "modalities" (Table A1.1). However, the RM proposal summarizes in one paragraph what we understand to be the essence of the initiative as a GEH programming mechanism: "RM complements, builds on and informs the programming of GEH, beginning where individual GEH projects normally leave off, and in turn suggesting new approaches or areas of research to GEH but without itself undertaking new research. It brings together the common threads

[11] Please refer to Attachment 1: launched as part of the IDRC/SDC four year collaboration (1.7m CHF) and with provision of one full time SDC program officer based in Mozambique.

among projects, and links GEH projects and the GEH programme's findings and partners to a broad range of research users."

RM's activities[12] have been focused around: 1) developing tools for dissemination of research results, by working with researchers and others to produce films and radio programmes, 2) encouraging and facilitating dialogue by supporting researcher exchange and organizing meetings to develop a community of practice around GEH, and 3) working with researchers to share their research results with research users.

All three categories of activities are well demonstrated in RM's implementation of its first theme: **Strengthening health systems through ART**, culminating in the ART Conference in the Free State Province, South Africa (March 30-31 and April 1, 2005). RM organized the conference in order to showcase the work IDRC is supporting in the Free State to a broad range of players in the Free State, South Africa, Africa and internationally. It also included the airing of two films, one based around the ARVs project in the Free State ("Making Research Matter") and another produced by Makerere University's Child Health and Development Centre, highlighting the Ugandan dilemma of accessing antiretroviral therapy for women and children, called 'The Neglected Child''. RM also provided: a research support grant to the Medical Research Council to produce a Special Edition of the AIDS Bulletin: Strengthening Health Systems through Anti-retroviral Therapy, to highlight the experiences and research of leading thinkers in this field in South Africa; support to ensure coverage of the conference by local and national media; and a grant to the Health Systems Trust to write up and disseminate the findings presented and the discussions.

RM indicated that it would collaborate with Equinet in the development of the "strengthening health systems through ART" focus theme, and, for this purpose, provided Equinet with a research support grant of 70,000 CAD (in addition to its core grant) to produce policy briefs that demonstrate good practice for use at regional meetings of ministers and global meetings of multilaterals, and to establish a review panel of major bilaterals, civil society, and regional partners to champion RM/Equinet work in this area. To our knowledge the review panel has not been formed.

A major product of this partnership was the preparation of a paper on expanding treatment access and strengthening HIV/AIDS programmes in ways that also strengthen the broader health systems agenda, and, at the request of CIDA, four two-page briefing papers for consideration by the joint CIDA, DFID, GTZ, and SDC representation on the Board of the Global Fund to fight AIDS, TB and Malaria: Equity issues and the provision of ART; Black market distribution of ART; ART and its broader impacts on health systems; and drug resistance and ART. This was a clear demonstration of how RM can play a strategic role in bringing field research and literature reviews undertaken by GEH partners to the attention of potential research-users.

There is less evidence of RM's work in the **Financing for health and social equity** focus theme, reflecting that GEH itself has not, so far, provided major support in this area. A post-conference report for the Saly-Portudal GEH partners meeting, written by a

[12] Some of RM' s activities were undertaken by an SDC officer in Mozambique. We were unable to include an assessment of this work as part of this review.

consultant supported by RM, suggested the following possible entry points for GEH: (1) How the donor agenda and national priorities/ownership interact? (2) Success as well as failure stories of recipient governments' attempts to coordinate donors (and eventually the private sector) and pool re-sources specifically in the area of HIV/AIDS. (3) Evidence around the pooling of funds; (4) ART and rationing of service provision; (5) Evidence that ART may contribute to health systems strengthening, for example through the integration of ART services; and (6) Effects of PEPFAR and other Global Health Initiatives on health systems

There was RM presence at the Tanzanian Ministry of Health hosted workshop, May 3-6, 2005, on: Health financing options in Tanzania: Attaining financial sustainability for an equitable access to essential health care - defining the way forward in Tanzania. Some entry points for GEH, based on the needs expressed at the workshop for GEH identified were: tracking resource flows; effects of Aids, TB and Malaria on the health sector; what would an essential health package comprise and how much would it cost; why people are not joining community health financing schemes; how to regulate health insurances; why exemptions/waivers are not working, and the cost of covering them.

5.3 Outputs to date

GEH products GEH funded projects and activities have produced considerable outputs, including papers, reports, pamphlets, presentations, workshops, conferences, websites, videos, radio programmes, and CDs. The GEH team prepared a list of outputs for the review team and this contained 241 items ranging from papers published in peer-reviewed journals to presentations in meetings. A separate list was provided from the University of Cape Town Lung Institute for the "Practical Approach to Lung Health in South Africa (PALSA)", and PALSA Plus projects totalling 57 different items. Our comments are based on this information, although by no means complete, and supplemented where relevant with our personal observations through site visits[13].

Of the 241 items in the main list, 14 were papers, reports and booklets available at IDRC´s website, 38 were papers, reports and presentations produced by the MSP and available on its website (hosted by Queens University in Canada), and 81 were papers, reports, booklets, and leaflets produced by Equinet (004378, 100954, 102041) (a little over 25% of all the items listed) and available either through their website or on a CD. Thirty-two of these items were reports, papers or presentations by one single Canadian researcher. These three cases (MSP, Equinet, and the Canadian researcher) represent almost 63% of all the items in the output table. Most of the publications were published internally, for example by Equinet or by IDRC, and only a few were peer-reviewed publications.

For 151 of the items there was a web link (two were cold). All of these were scrutinized to determine if the grantees had acknowledged the support received from IDRC. Almost all of the publications (reports, papers, booklets, leaflets, etc.) produced by Equinet formally cited the support received from IDRC. IDRC support is not acknowledged for the products of the MSP, although the overall grant support from IDRC is acknowledged

[13] Some outputs from RM are described in section 5.2

at the entrance to their web portal. Most of the other products do not mention IDRC support, one important exception being the Global Health Watch book, 2005 edition.

The output from the University of Cape Town Lung Institute for the PALSA and PALSA Plus projects includes 12 papers (one already published, four submitted and/or under review, and 8 in preparation) one report and 39 presentations at conferences and academic meetings. Four doctorates are being undertaken with support from GEH.

RM supported the production of a range of media products (videos, radio programmes, production of SMS messages). In addition to two excellent films based around the Free State work, and Ugandan film, “The Neglected Child”, the RM team produced a film at the 2004 Global Forum for Health Research in Mexico (“Does Research Matter?”). RM also supported grantees to produce a number of radio programs, for example, the recording by the MSP and Workers World Media Productions of six feature radio slots for the Labour-Community Radio Project labour radio shows. These were based on MSP research and are featured on the IDRC RM Website. These captivating and informative programmes, in several languages, are critical of South African municipal issues, and reach an audience of 2.2 million people in South Africa. Another radio program, heard by one of the reviewers, was produced on the basis of community-level research conducted by CIET in the Free State to encourage discourse on and stimulate community mobilisation around ART implementation.

Methodological approaches In its prospectus, GEH anticipated that the research methodology used by the projects it would support would be trans-disciplinary in nature "... characterized by linking measures of well-being with processes by which key actors (the state, NGOs, user/citizens, the private sector) supply and demand public services for health", including: “policy and political systems analysis, addressing structures, actors and processes”; “gender analysis”; “participatory approaches”; and that “particular attention would be given to the existence and mechanisms of inequalities”. The most consistent of these broad types of approach that have been used has been the analysis of political systems and policy mechanisms. There has been relatively less evidence of gender analysis and not as much equity analysis as might have been expected.

Our reviews of the PADS indicated a variety of methodologies with frequent mention of the use of a combination of qualitative and quantitative methods, and phrases like “a strong participatory dimension” or “a participatory methodology will be encouraged”. Gender analysis is mentioned infrequently. Other methods mentioned include quarterly population based surveys based on demographic surveillance systems, literature reviews, interviews with selected key informants, synthesis, data base analysis and fieldwork-based studies, and the “development of conceptual and methodological approaches to more effective integration of technical public health and health services research with political science, human geography, and economic analysis of municipal services” (MSP). The Free State project demonstrates a variety of types of methodology ranging from social science through epidemiology, political analysis and a pragmatic controlled trial. One PhD student is researching gender analysis across the project. When questioned, these researchers could not provide specifics about any equity analysis.

5.4 Evolution of GEH strategy

GEH has identified as priorities for 2005/2006: 1) financing and resourcing comprehensive and equitable health systems, 2) understanding and supporting more effective governance of multi-actor and plural health systems, and 3) capacity strengthening for the generation and utilization of GEH-congruent research. The first priority on financing corresponds closely to the first RM focus theme. It will be important to synthesise the work GEH is currently supporting that relates to all these areas and to consolidate funding choices. The third priority appears to be supporting the development of GEH as a field of research and building capacity towards that end.

6 Management of GEH

6.1 Team composition and responsibilities

The GEH team comprises five programme officers, who provide 3.1 GEH full time equivalents (FTE), and one full time research officer (Table 6.1). Only the team leader works 100% for GEH. Three of the programme officers (including the team leader) and the research officer are based in Ottawa, one (30% GEH)) is based in Montevideo, and the other (80% GEH) in Dakar. Andrés Rius, an economist working in Montevideo 20% of his time for GEH has left the team, and will be replaced by a newly appointed economist in Ottawa, bringing the total GEH FTE to 4.1 through 6 officers. In addition Graham Reid is a senior program specialist based in Dar Es Salaam working on the roll-out of TEHIP.

The officers bring an appropriate and impressive range of expertise to the evolution and implementation of GEH, covering between them the disciplines of medicine, anthropology, social science, epidemiology, public health, health administration, law and economics (until recently Andrés Rius, with an economist soon to be appointed). Their combined relevant expertise includes: development, population and reproductive health, humanitarian aid, environmental management, urban development, poverty reduction, social policy, health reform, health policy and planning, prevention of sexual violence and HIV/AIDS, governance, judicial reform, and constitutional and legal provisions in Africa.

GEH operates as a team and although certain officers take responsibility for developing specific grants and projects, final decisions are taken at team meetings. There appears to be more autonomy in LAC programming, than in SSA, with LAC grantees used to working through Roberto Bazzani, and until recently Andrés Rius, in the regional office. All other officers work in SSA. Moussa Samb works from the Dakar office and has established projects in French-speaking West Africa. Jean Michel Labatut works across Africa and aims to capitalize on contacts and travel between EcoHealth and GEH. Christina Zarowsky took the lead in establishing many of the early projects in ESA, especially during the incubation of GEH, and continues to play a strong role in program development in this region. Sharmila Mhatre, appointed since the prospectus, programs in West Africa and South Africa and has responsibilities for GEH exploratory activity and MIMAP related projects in South Asia. Christina Zarowsky takes the lead globally in

representing IDRC with other donors and major international stakeholders. Christina Zarowsky and Sharmila Mhatre share responsibility for Canadian partnerships, and, with Moussa Samb, for the development of the CIDA project (102064) in Nigeria.

Table 6.1 - Team composition and changes over the review period

Name	Position	Location	% time GEH	Changes
The current GEH team				
Christina Zarowsky	Team Leader	Ottawa	100	None
Roberto Bazzani	Senior Program Specialist	Montevideo	30 (70% EcoH)	None
Jean-Michel Labatut	Senior Program Specialist	Ottawa	30 (70% EcoH)	None
Sharmila Mhatre	Senior Program Specialist	Ottawa	70 (30% MMP)	Started: Nov 2003
Graham Reid	Senior Program Specialist	Dar-es-Salaam	Dedicated to TEHIP	
Moussa Samb	Senior Program Specialist	Dakar	80 (20% PCD)	None
Nasreen Jessani	Research Officer	Ottawa	100	Started: July 2004
Research Matters Project				
Sandy Campbell	Project Coordinator- GEH	Ottawa	100 (RM)	Started: Aug 2003
Nadia Isler	Project Coordinator- SDC	Mozambique	60 (RM)	Started: Oct 2003
Marianne Villaret	Consultant	Lugano		Jan to Dec 2004
New GEH team member to be appointed later in 2005				
Health Economist	Senior Program Specialist	Ottawa		OPEN
GEH team members who have left over the review period				
Andrés Rius	Senior Program Specialist	Montevideo	20 (80% TEC)	Left: Feb 2005
Martha Melesse	Research Officer	Ottawa	50 (50% MMP)	Left: Apr 2004
Matthew Sanger	Prof. Dev. Awardee- 1 yr	Ottawa	100	Left: Nov 2003

Sandy Campbell, based in Ottawa, works 100% for the RM project under the supervision of Christina Zarowsky. He travels extensively to support GEH grantees prepare dissemination materials, although a recent decision has been taken to focus RM only in ESA. Nadia Isler is a SDC officer working for RM from her base in Mozambique.

6.2 Team management

GEH team members travel extensively, host workshops, work with grantees in project and proposal development, work with other partners to develop alliances and attract additional funding for GEH type activities, advise the Centre on global health-related issues, write trip reports, project documents, develop strategies and associated program documents, and monitor the GEH PI with outcome mapping. In addition they keep abreast of their field, write papers, attend and present at conferences, supervise staff, interns and, occasionally postgraduate research theses. All but the Team Leader and the Research Officer also works for another PI with parallel demands on their time.

GEH's achievements are quite remarkable given the limited total FTE of its officers. We observed first hand the pressures that the external review requirements imposed on the team, and its ability to respond despite already heavy workloads. It became apparent to us that the research officer spends much of her time on administrative issues, rather than research, as she was instrumental in organizing the information that we required for the evaluation. The GEH PI is now two and a half years into its three-year duration, with the preparation of a new prospectus imminent. GEH has considerable internal synthesis to conduct in order to prepare the groundwork for the next prospectus, and will require a full-time research officer for this purpose, and beyond.

GEH implementation of the Operational Research Grants of CIII2 has increased the workload for both administrative and programming officers in managing the program and administering and supervising six additional multi-year grants. Three of these grants are in countries that fall within GEH regional focus but the others are in Pakistan, Georgia, and India, well outside GEH geographic focus. Additionally, the management of 17 research support grants averaging 16,930 CAD for RM has significantly increased GEH's administrative workload. The proposal to work with CIDA in Nigeria could impose an additional workload on programming staff stretching both technical expertise and field experience, at the expense of programmatic and geographic focus.

6.4 Use of evaluation

GEH has adhered to and promoted the use of outcome mapping to evaluate the GEH PI and IDRC-funded research projects. The Review team was not aware of any external evaluations of GEH projects[14].

From the start of the PI, GEH committed to a monitoring and evaluation plan in order to monitor progress, identify unexpected changes, reassess the objectives, ensure timely results and to develop tools for learning. A plan for outcome mapping was laid out with the following challenge statement:

" GEH intends to see researchers who share a holistic and inter-sectoral approach to integrating governance and equity concerns into health policy and systems research. From the outset, they work with other stakeholders – to promote health and social equity and to ensure civic engagement. Based upon a trans-disciplinary and participatory methodology, they produce solid findings, tools and strategies accessible to the various stakeholders and packaged differently for different audiences, As a result of this process, they have strengthened their credibility and built a relationship of trust among researchers and with decision makers and the community. They provide credible evidence to allow decision makers (and donors) to make informed decisions on equitable financing and functioning of health systems."

In March 2004, one year into the PI, GEH reported on an internal program review. Its objectives were to provide an overview of achievements to date, assess what has worked and what has not worked, and to assess strategies. The review was based on the administration of a questionnaire and review of technical reports for 12 research projects. The review made the following suggestions as to how GEH could enhance the effectiveness of its one-year old program: 1) help establish linkages between relevant research organizations and facilitate a "community of practice", 2) assist with finding additional funds, 3) work as a global advocate for research findings and use the findings

[14] We subsequently learned that there had been an external evaluation of Equinet by Blair Rutherford.

to inform donor decisions and priorities, and 4) continue to provide moral and technical support.

GEH has clearly followed through on the findings of this review. RM, in particular, has been effective in encouraging dissemination and in bringing GEH researchers together – as demonstrated by the partner meeting in Saly Portudal. A GEH community of practice is certainly evolving. GEH has also been extremely successful in promoting its theme among other donors. The team is exceptional in the moral and technical support that it provides to grantees. The one weakness of the review was that it did not address the relevance of the projects in the context of the GEH strategy and so it did not provide evidence to assess what has worked and what has not worked nor to inform strategic direction.

Two research support grants were made to facilitate Outcome Mapping by grantees: a global grant (102133) to "Enhancing Partners' Capacities for M&E using Outcome Mapping" and a regional grant 102776) to train grantees in "Outcome Mapping for Social Protection in Health in LAC". There was evidence in several PADs that grantees had committed to the use of outcome mapping in the proposals they had submitted to the IDRC.

A form has been prepared for individual project monitoring and GEH officers use it regularly. We did not ask to see any of the completed forms as it is their aggregate that is of relevance to this review. The overall GEH Outcome Mapping was revisited in July 2005, and was thoroughly completed. It appears that the process is helpful to the GEH team to monitor its progress with various aspects of the strategy.

GEH has a keen interest to reflect and review its strategy but there does not appear to be an organizational template against which to assess progress, and with which to refine strategy. We found it useful to summarize the GEH strategy in the form of Table 2.1. It immediately demonstrated that there are overlapping terms and content, and that the prospectus did not provide a sufficient framework for a thorough evaluation of strategy and achievements.

7 Synthesis of the review findings and recommendations

7.1 Strengths and weaknesses of the program's thematic approach and strategies in relation to the current state of the field

7.1.1 Governance, Equity and Health, as a funding theme, fills a unique gap and claims a novel space for IDRC's leadership in research to strengthen health systems.

The emergence of equity in health as an issue for research and action is fairly recent. The Declaration of Alma Ata with the adoption of the strategy of Health for All by the World Health Organization in the late 1970's was a strong equity statement, but interest in social justice in the provision of health care services and in equity in health status escalated after publication of the UK Back Report in the early 1980's. Canada has led by example, ranking high in

UNDP's Human Development Index, and recognized internationally for promoting social justice in general, and in health and health care in particular.

Over the past decade, several multilateral and bilateral institutions, as well as private foundations, have begun investing in health equity related research to promote knowledge to action in decreasing unfair inequalities in health and health care, for example: the Division of Human Development and Health of PAHO (1996-2002) had a strong equity focus, from 1998, the Rockefeller Foundation has promoted a number of equity-led research initiatives (for example the Global Equity Gauge Alliance (GEGA)), and the Swedish International Development Agency has been a front runner integrating health equity into its development strategies. The World Bank and WHO have not yet launched specific initiatives in this area although they have been building momentum in their construction. WHO has launched a new set of programs and projects around the theme of social determinants of health inequalities at a global level that could lead to greater interest and possibly lead to innovative public policy interventions to increase health equity in the world. Much of the work to date has focussed on measurement with varying success in implementation.

With the launch of the GEH Prospectus, IDRC arrived as a welcome new player, not only because it supports research around equity in health but also because it has added the dimension of governance, hitherto not considered in health research circles. GEH has been extremely successful in promoting consideration of the "interplay of governance, equity and health" in research to strengthen health systems, and has influenced global agendas to consider these issues, for example of the CIHR, the Global Forum for Health Research, the Alliance, regional agendas, for example PAHO, UNDP in LAC, Equinet, CODRESIA, and the agendas of numerous research partners in SSA and LAC.

More donors are now beginning to support developing country institutions but IDRC GEH and SDC are ahead of the game in this regard. In some ways, the 2000 International Conference on Health Research for Development - supported in part by SDC and IDRC and to which Christina Zarowsky made significant contributions – was a turning point. Developing country researchers put on the table their concerns about inequities in external funding of research in their countries and international agencies have begun to respond.

FOR CONSIDERATION BY IDRC
Issue 1

The IDRC investment in Governance, Equity, and Health is worth sustaining. The PI has supported research and raised consciousness about GEH issues among policy makers and researchers in developing countries, donors, and Canadian institutions. The number of actors in this area is still small and IDRC, through GEH's lead, is achieving high visibility, and having an important impact on the type of health research is conducted.

7.1.2 The research projects supported by GEH address issues of local relevance and of international interest. This has been an important factor in promoting the linkage to change in policies and practice. Examples are easy to find:

In South Africa, the “Public Sector Anti-retroviral Treatment” project in South Africa, one of the first and probably the most comprehensive piece of research to monitor the roll-out of ART, will provide vital information to the Department of Health in the Free State, to other states in South Africa and will contribute to wider international synthesis. The MSP has received considerable media coverage contributing to national, regional and international debate around service delivery and pro-poor policies, influencing, for example, the recent decision of the South African Government to introduce the lifeline free water policy. By exploring the links between HIV-related attitudes and practices and sexual violence through a national base-line survey in South Africa (101477), researchers have obtained evidence to support the development of interventions by local government agencies and non-governmental agencies. The lessons learned have been shared internationally through publication in the British Medical journal.

In Benin, Burkina Faso, Côte d'Ivoire, Mali, and Sénégal, the “Politiques publiques et protection contre l'exclusion” project is conducting research that contributes to the formulation of public policies designed to promote reasonable and fair access to health care particularly by the poorest section of society. The research process and results have been effective in improving both the equity and quality of health services in the participating countries. New interventions have been designed, based on the evidence from the research, to better address the special needs of indigent populations. Although there is no population-based data to document the results, there is strong evidence that the poor are now more likely to access care when needed and less likely to encounter financial barriers to utilization. Publication of these research finding will soon expand the impact of this research through dissemination to audiences in other countries.

In Latin America, the commissioned studies for the Building the future for better health in Guatemala project (102229) will inform the future of the national health system and may create the conditions for a "national health pact". The joint IDRC/PAHO project “Building and Bridging Health Services Research and Health Policy in the Americas”, has generated knowledge to bridge research and practice, promote equity, and expand social protection in health in the region. These partnerships have been instrumental in making it possible for GEH to have more research projects in the Region, considering the small number of staff involved in the process, and the limited existing financial resources. The joint work with PAHO has the potential of having great impact in the development of new forms of public policy to address some of the large inequities in access and utilization of health care in Latin America.

7.1.3 GEH's thematic approach is broad and does not provide sufficient boundaries with which to delineate what GEH funds and what it does not fund.

The GEH Prospectus lacks a conceptual framework against which to understand clearly why one project might be funded and another not. As an emerging PI, it was essential that there be room to evolve ideas, but our review of grants made during 2004/2005 did not reveal any greater clarity of focus than in the prospectus itself. One of the possible reasons for this could be the fact that there is so little work already done in the broad area of governance and health. It is surprising, therefore, that, while promoting its theme, GEH has built up very little supporting synthetic material or conceptual thinking. The recent GEH partner meeting in Saly Portudal stimulated many new ideas through some innovative presentations around the theme, for example: by Ernesto Báscolo on Governance and Equity in Health Systems, Mary Caesar Katsega on Governance and HIV/AIDS, Slim Haddad on the interplay between financing, equity and governance, and Marc Hufty on a conceptual approach to governance and equity in health systems research.

It became clear, too, during the Saly Portudal meeting that researchers were all struggling with common problems in operationally defining key parameters and documenting changes in outcomes for health, equity and governance[15]. While researchers were able to recognize the issue and compare notes informally with other researchers, the meeting was a missed opportunity to facilitate a more focused dialogue and technical progress on this common issue.

FOR CONSIDERATION BY IDRC

Issue 2

It would be advisable for GEH to conduct a systematic review of the lessons learned from its projects and to support some in-depth social and political science reviews around the theme. The next prospectus could benefit from the results of this work, and a gap-analysis, defining priorities for driving progress in the field.

Issue 3

At this stage in the evolution of GEH, there is a need and opportunity to clarify and tighten the conceptual framework for the PI. Articulation of measurable objectives and selection of success metrics that can be tracked across geographies will stimulate research, accelerate global learning, and enhance progress toward the goals and objectives. It is recommended that the extension into non-health social sectors be deferred until this enhanced clarity is achieved.

[15] We have not seen the participant evaluation of the Saly-Portudal meeting. Participants appreciated being able to draw connections between their disparate research projects, and many gained from the process. One, however, referred to the discussions as being within an "empty framework".

7.1.4 The balance of GEH's investments in research projects reflects IDRC's overall geographic priorities. Current programming needs some geographic rationalization before being extended to other geographic regions. GEH spends 75% of its budget on research projects in SSA and 18% in LAC. In SSA, most of its country support has been to South Africa, and in LAC, to institutions in richer countries. GEH should explore the possibility of extending its support to new countries in SSA and to poorer countries in LAC such as Nicaragua, Bolivia, Honduras, and Ecuador. There are few donors supporting health research in French-speaking West Africa. GEH's current portfolio of grants in West Africa, with an 80% GEH program officer based in Senegal, provides IDRC with a strong and unique platform to develop a coherent portfolio of grants, particularly to support French-speaking institutions in West Africa. In developing its next prospectus GEH could articulate mechanisms and criteria for widening its support to new institutions in new countries. GEH has otherwise maintained a balanced portfolio of regional and global grants.

FOR CONSIDERATION BY IDRC

Issue 4

While maintaining its focus on SSA and LAC, GEH might consider extending its programming to new institutions and countries in both regions, and building on IDRC's strategic advantage in French-speaking West Africa. While the focus on South Africa has yielded impressive results, programming in both SSA and LAC could be extended to countries and institutions that are less affluent.

7.1.5 GEH has shown flexibility in its use of funding mechanisms and is now in a position to make some strategic choices based on the lessons learned. GEH has been skilled in leveraging additional funds towards its goals and has experimented with a number of funding mechanisms, for example, using calls for proposals, competitive grants, support for networks, and strategic programming. The average amount awarded per research project grant by GEH is near the IDRC average, but in SSA the average length of grants decreased from 2.8 years in 2001/2002 to 1.63 years in 2004/2005. There was evidence that grantees had been requested to reduce budgets to accommodate GEH available budget.

Support always leads to expectations of further funding. Some GEH grantees have received major external funding from IDRC for several years and the recently funded ART project in the Free State, for example, will inevitably expect follow-up funding. At the same time, GEH should also consider extending its work to new institutions and countries. In preparing for its next prospectus, GEH will need to make hard choices between support for longstanding projects and support for new projects that more closely reflect its conceptual framework, objectives and

geographic focus. GEH could also review its experience with different funding mechanisms and find the most efficient means of disbursing its funds to achieve its objectives by, for example, making more use of competitive calls for proposals.

FOR CONSIDERATION BY IDRC

Issue 5

Based on the analysis of priorities recommended above (Issue 2), IDRC will be able to target the allocation of GEH limited resources to achieve higher impact. GEH should consider a linked analytic exercise to assess experience to date with different funding modalities, and identify the highest priority opportunities to solve GEH problems. GEH will then be enabled to choose funding modalities (such as umbrella contractors or RFPs) that would better create a critical mass of knowledge designed to achieve constructive change.

7.1.6 GEH has been successful in forming strategic global and regional partnerships. GEH has been able to make major contributions through these partnerships, bringing the comparative advantages of IDRC in global health and in management of research in developing countries. IDRC has also derived benefits from these partnerships, including growing Canadian commitments mobilized for health research.

These successes and benefits of partnerships come at a substantial cost, especially in terms of staff time. Partnerships should be undertaken only when there is a clear shared goal and when careful analysis indicates that the transaction costs of developing and maintaining the partnership will be fully offset or exceeded by the expected benefits. The partnership with SDC has great potential to meet these criteria, but requires some further investment, as noted in 7.3.3 below.

IDRC is uniquely well-positioned to broker partnerships between researchers and users of research. IDRC, for example, could establish alliances with parliamentarians, ministries of health, health donors (such as the World Bank, regional development banks), and/or regional organizations (such as SADEC, NEPAD, or ECA). Through such alliances IDRC could assist these potential "users" of research results to identify research priorities, seek competitive proposals, and fund highly targeted research to inform and shape projects, policies, and legislation.

The work done with some academic Canadian institutions has been successful in several instances and it might be expanded to give GEH more technical capacity in preparing proposals and in collaborating technically in developing the projects.

FOR CONSIDERATION BY IDRC

Issue 6

Avoid compromising GEH objectives when leveraging external funding. GEH has been successful in mobilizing additional sources of funding for its programs but should avoid becoming a "grantee". GEH needs to be strategic in using co-funding to focus other donors on GEH issues. There is a danger, for example, that collaboration with CIDA over the Nigeria project will detract GEH limited human resources from more targeted programming.

7.2 Extent to which the program is meeting its objectives and aims, as set out in its prospectus, and any evolution in objectives.

7.2.1 GEH has achieved most of the activities that it highlighted in its prospectus, for example by creating: a regional fund in East and Southern Africa for competitive proposals (101885 and 102079); creating Research Matters (102283) and housing the secretariat; implementing the CIDA funded competitive program for "Operational Research Grants of the Canadian International Immunization Initiative (CIII2"), through the GHRI partnership; building on the TEHIP (102750, 01346); continuing long term support for the MSP; continuing to provide core support for the Equinet (004378, 100954,102041); supporting the next stage in the development of the African Health Research Forum (102069,102145); developing LAC programming in collaboration with UNDP (102229); and continuing to work with PAHO (101107).

7.2.2 The GEH Prospectus does not articulate sufficiently specific objectives, outputs and outcomes whose achievement can be readily evaluated. The GEH vision is for "equitable, fair and just provision of public services" and we interpret the overall theme to be researching approaches to strengthen health systems using the parallel lenses of governance and equity. Where possible, GEH has intended to support research that coherently reflects this theme, ie "the interplay between governance, equity and health" but the three objectives categorize the theme slightly differently and serve more as strategies than as objectives. It is not clear how these three objectives, while important and relevant, actually combine to represent the theme. The specific objectives do not actually clarify the objectives, in fact specific objective 2 is the same as output 1. If the objectives were clear and some implementing strategies or mechanisms well articulated, the additional overlapping categories (entry points and axes) might not be required.

The terminology used for the outputs does not invite evaluation ie 1) "a systemised body of research and tools"; 2) "strengthened capacity", 3) "a record of experience with approaches and mechanisms", and 4) "established research

networks". No measurable outcomes are specified in the prospectus. It would be advisable for GEH to build clear terminology into its new conceptual framework with measurable outputs and outcomes. It would then be possible to translate this into some general guidelines for wider discussion with grantees and other stakeholders.

7.2.3 Support for research projects has been justified on the basis of different combinations of GEH objectives, entry points and axes. Appropriately all projects relate to health system strengthening but with less focus on civic engagement. In principle all projects have some relevance to "making research matter" but some of them are funded specifically because a component complements other objectives by fulfilling this objective. Equity is a common thread although not always highlighted in the PADS. There appears to be a strong "governance" component in most projects but we had difficulty interpreting the many dimensions of "governance". Without further clarification (see Sections 7.1.3 and 7.2.2) the term "governance" is too wide a filter against which to decide whether or not to fund a project. There was considerable variety in the use of terminology in the PADS which could be tightened when the objectives, outputs and outcomes have been further clarified.

The GEH objectives and success metrics are not now sharply enough articulated to provide leadership and to accelerate progress in the new and exciting "field" of governance, equity and health. While the staff are understandably reticent to be directive, the PI could be designed to reflect the consensus among scientists working in the field regarding the technical state-of-the-art, rather than the shared opinion of staff. Such shared ownership of the design of the PI with stakeholders would undoubtedly also serve to galvanize the field.

FOR CONSIDERATION BY IDRC

Issue 7

Develop a one page tabular presentation (similar to a log frame) of the strategic framework, objectives, outputs and outcomes. This would enable greater program efficiency as well as more effective evaluation.

7.2.4 GEH is sensitive to changing contexts. GEH programming is extremely flexible. The main evolution in the strategy, articulated at its retreat in February 2005, is to give priority to: 1) financing and resourcing comprehensive and equitable health systems, 2) understanding and supporting more effective governance of multi-actor and plural health systems, and 3) capacity strengthening for the generation and utilization of GEH-congruent research. It would be advisable to fine tune and consolidate these ideas within the new framework and objectives to avoid broadening the strategy.

7.2.5 GEH is committed to evaluation GEH has adhered to and promoted the use of outcome mapping to evaluate the GEH PI and IDRC-funded research projects. GEH has also followed through on the findings of an internal progress review in March 2004. Once the issues raised in 7.2.2 are resolved, the overall strategy will be easier to evaluate.

7.3 Quality of the outputs and the influence of the program's outcomes to date.

7.3.1 GEH has generated considerable volume and variety of outputs, including papers, reports, pamphlets, presentations, workshops, conferences, websites, videos, radio programmes, and CDs. We did not assess the quality of individual outputs produced through GEH grants, but it is clear that a number have been influential. Some have been published in major peer-reviewed journals including the British Medical Journal, International Journal of Occupational and Environmental Health, and Social Science and Medicine. The quality of the research being supported in LAC is of high quality, for example the projects in Colombia and São Paulo and in South Africa, the MSP, the work of CIET, and the PALSA projects are also of high quality.

In the Free State, there was evidence of the value of radio programs prepared by the research teams to inform the public of their findings. The PALSA and PALSA Plus projects have developed algorithms for diagnosis and treatment and through their pragmatic trials they are able to insure relevance and ease of use of their guidelines and to build the capacity of health workers to implement them. The MSP has used diverse means to influence policy including gaining national media attention.

The methodological approaches used by GEH projects are varied and rather broad. Insufficient attention has been given to methodologies to define, and measure indicators of governance, and equity over time and between projects. There was little evidence of the integration of gender analysis into the research projects.

7.3.2 GEH research projects have been influential in many contexts but it is too early to assess the overall outcomes from GEH as a PI. Our comments in section 7.2.2 about the need to clarify outcomes in development of the coming prospectus will facilitate long-term review of the outcomes and impact of the GEH PI.

FOR CONSIDERATION BY IDRC

Issue 8

Strengthen the linkages between GEH investments and expected outputs, outcomes and impacts**.** Require grantees to measure change in governance, and equity in access to health care and health status resulting from project interventions, and provide methodological guidance to enable them to measure changes over time and across projects. Make an effort to plan and track outputs and outcomes, and require that all IDRC support be acknowledged.

7.3.3 Research Matters has been extremely active in its short lifetime, and has produced some significant products. The project team has worked well with grantees, many of whom expressed their appreciation to us. The team has balanced tool development with capacity building for grantees hitherto unfamiliar with multi-media, and has started to build a GEH community of practice. RM's focus on "strengthening health systems through ART" has made a strong contribution to GEH programming, clearly fulfilling GEH's third objective to "make research matter". Its second focus on "financing for health and social equity" is less developed but corresponds to one of GEH's three priorities for the coming year.

RM's role in the GEH strategy could be tightened as GEH develops its conceptual framework and clarifies its objectives, outputs and outcomes. RM also suffers from lack of focus with ambitious objectives and few clear milestones. It would be advisable for RM to focus on a single theme and to harness all its activities with researchers and research-users around making an impact within this theme. There is also a need to work more closely with policy makers to judge their needs for research results rather than starting with the interests of researchers.

Geographically, RM has been stretched, attempting with a small staff to cover both GEH regions. The RM SDC officer is based in Mozambique, an African country in which GEH has no projects and in which the language is neither French nor English. We support the recent decision to relocate the SDC officer to Tanzania and to focus RM's activities in East and Southern Africa, a region where both SDC and GEH have strengths.

7.3.4 Research Matters has potential to serve as a much-needed vehicle to link research to practice and transform the value and effectiveness of health research. The promotion of the early results of the Free State project and the preparation and presentation of papers for the joint CIDA, DFID, GTZ, and SDC representation on the Board of the Global Fund to fight AIDS, TB and Malaria both demonstrated RM's strategic intention to bring research results to the attention of research users. But a dedicated evaluation of the RM project would be required to assess whether these activities have had or are likely to have demonstrable impact.

There is widespread international recognition of the need for initiatives to stimulate the translation of research results into policy. The 2004 Global Forum and Summit on Health Research in Mexico, attended by both researchers and policy makers was held for this reason, and the World Health Assembly has committed to follow-up action. GEH/RM had a significant presence at that meeting, bringing Dr Ron Chapman, Director of Health Services in the Free State to the meeting to highlight the way in which his department works with researchers in the ART project.

The RM concept is enlightened and holds considerable potential to influence policy, especially if the ownership is widened beyond IDRC/SDC.

The RM project is implemented by the IDRC/SDC team and supervised by the GEH team leader. GEH partners serve as voluntary advisors and although the proposal indicates that an Advisory Board would be formalized in early 2004, this has not been set up. Although a project, the RM team serves grantees, in effect, as additional supportive IDRC/SDC GEH officers. To the outside world, the distinction between being a project and being part of GEH is thin, with the RM project team making grants using the same procedures to the same grantees, organizing GEH meetings and producing GEH products. One grantee, for example, was skeptical about the independence of the films produced and the degree to which they promote IDRC.

More inclusive ownership of RM with broader partnerships would open possibilities for contributions from other donors and wider potential for innovative approaches. This might be achieved by setting the initiative up in collaboration with a grantee institution, and complementing its activities through other GEH grants. Whether or not the project remains with IDRC, it requires full-time dedicated senior leadership.

FOR CONSIDERATION BY IDRC
Issue 9

Consider innovative options for realizing RM goals including, for example:

- Engaging policy suggesters and policy makers in identifying research questions for which the research findings would be immediately actionable;
- Providing a source of funding for competitive grants to policy makers to use local research expertise for assessment of the local landscape and formulation and testing of new policies to improve governance, equity and health;
- Creating a source of funding for research targeted to solve problems for which funding is available for implementation of interventions (e.g., through collaboration with CIDA, SDC, the Global Fund, and/or the World Bank);
- Seeking proposals from countries to identify and test the effectiveness of other strategies to transform research results to actions; and,
- Providing support for formation of alliances between researchers and advocacy groups that need and/or can use research findings.

Issue 10

GEH and SDC should consider providing a joint grant to an external institution for the Research Matters project, and establishing an advisory group of donors, policy makers and researchers whose common interest is to increase the relevance of research and synthesise and disseminate research findings. This would widen the pool of projects that would both inform and benefit from RM. There might be more possibility of catalysing additional donor funds if RM were less closely aligned to GEH.

7.4 Composition and functioning of the program team as it relates to its ability to meet its objectives over the course of this prospectus.

7.4.1 The GEH team is dedicated, visionary, innovative and a credit to IDRC Christina Zarowsky's leadership is outstanding. She is recognized by her peers, respected by her grantees, valued for her perspectives, and acknowledged for her achievements. She leads a team that has succeeded in putting the GEH perspective into the international arena in a very short period of time. Each of the Senior Program Specialists is recognized in her/his own right, entirely committed, innovative and open to new ideas. Between them, they bring to the table an impressive and appropriate array of disciplines, skills, talents and experience. The research and support staff has demonstrated to us first hand their efficiency, productivity, enthusiasm and dedication to the GEH team. The overall team spirit that we witnessed is exceptional. During our interviews, we gained very positive feedback about team members (including the RM project team) from grantees.

Throughout this report, we have emphasized the need to articulate a conceptual framework based on growing knowledge and synthesis of the GEH field. This is inevitably time-consuming. The IDRC library has contributed very positively to GEH development and to keeping officers and grantees up to date. Research Matters has a very important role to play here too, but GEH requires some dedicated internal research time.

7.4.2 The GEH programming team is stretched to accomplish the work set out in its prospectus. Although there are currently 5 Senior Program Specialists, they are only equivalent to 3.1 FTE. This is a very small group to manage the wide variety of activities and responsibilities undertaken by GEH. It is a credit to the entire team that they are able to achieve so much. The forthcoming appointment of an additional Senior Program Specialist to be based in Ottawa but also to work in LAC is timely, and that person's skills as an economist will maintain an appropriate skill balance.

We recognize the potential for cross-fertilization between PIs (for example, with EcoHealth and MIMAP), and the efficiency of field staff covering two PIs, we question whether one officer based in LAC working only 30% on GEH is sufficient. We also suggest that at least three Ottawa-based officers should be 100% dedicated to GEH.

The downside of the enthusiasm and dedication is that staff members are needlessly stretched. If program activities were more focussed and hard decisions made about what to do and what not to do, then workload might be reduced or easier to handle. There is a call for more disciplined team management and for clearer definitions of responsibilities. One clear example of delegated responsibilities is that, although there is team agreement about direction, programming in LAC seems to operate fairly independently and successfully.

7.4.3 There is opportunity to re-organize geographic responsibility among GEH team members. The choice of field projects by the GEH team needs local knowledge of research gaps, and of the activities of other stakeholders and their implementation requires technical insights and supervision. GEH work in LAC and in West Africa demonstrates the value of having officers located near to the institutions supported or potentially supported. One reason why there is a preponderance of projects in South Africa is because of some officers' familiarity with grantees and institutions there.

The coverage of programming in SSA is varied and could be rationalized. There is potential for GEH to meet considerable unmet need for research support in French-speaking West Africa but this would require the officer based in Dakar to take less responsibility for the rest of SSA (which currently accounts for 70% of total GEH support for research projects). Responsibility for Eastern and Southern Africa needs to be clarified and it would be advantageous if there were an officer located in the Kenyan office in view of the need to extend GEH programming to new institutions and countries beyond South Africa.

FOR CONSIDERATION BY IDRC

Issue 11

Consider recruiting additional administrative support to ease administrative burden and to free up the Research Officer's time for research to support GEH synthesis work, and to conduct exploratory research for the development of the conceptual framework and preparation of the next prospectus.

7.4.4 Global programming and partnership building is essential but time-consuming. Global programming, and building Canadian partnerships has taken a considerable amount of GEH officer time that inevitably competes with time-demands for international programming. GEH implementation of the "Operational Research Grants of the Canadian International Immunization Initiative CIII2", has increased the workload for both administrative and programming officers in managing the program and administering and supervising six additional multi-year grants. The proposed project in Nigeria is already demanding considerable officer time and widening geographic focus to a new country in West Africa. Although the RM coordinator is project-based, the project itself makes heavy demands on administrative time and depends on Christina Zarowsky's time for its leadership.

FOR CONSIDERATION BY IDRC

Issue 12

Rationalize the responsibilities of Senior Program Specialists. Strengthen the implementation of GEH by ensuring that three Ottawa-based officers work 100% on the GEH PI (this calculation includes the economist about to be appointed), and agree upon clear geographic responsibilities. Implementation of Issues 2 and 7 could also free some officer time for synthesis and ongoing program development. We suggest that responsibility for SSA be given to two officers, one for West Africa and the other for Eastern and Southern Africa. We do not recommend more global expansion of programming activities outside SSA and LAC, for example to Asia, until the current human resource constraints are eased.

We suggest that there be some rationalization of global projects taken on. Although it is natural that officers based in Ottawa should handle some Canadian projects, relationships with CIDA, for example, could benefit from greater field presence. We also suggest that all Senior Program Specialists start to represent GEH globally in some way, so that all are equally recognized at the international level.

Attachment 1: IDRC/SDC collaboration and Research Matters

IDRC GEH /SDC agreement to collaborate GEH was launched in collaboration with the SDC, which has contributed 1.7m CHF over the four years of the GEH Prospectus. This collaboration features support for GEH's third objective, "to increase the effectiveness of research-to-policy linkages in promoting the dual goals of health and social equity", in the form of 250,000 CHF for the RM project, complemented by 470,000 CHF from IDRC[16]. According to the agreement the contributions of SDC to GEH were also to include: a socio-economist (20%) and a health specialist (10%), access to relevant data from other SDC sponsored activities in the health domain, access to the SDC "floor" for special events, a future SDC secondment to GEH to be discussed according to the evolution of the programme.

Evaluation was to be as laid out in the GEH Prospectus with participation of the SDC in selected monitoring activities and in yearly IDRC programme reviews, and with support from the SDC Evaluation Unit. It was planned that the external evaluation scheduled for prospectus year three would evaluate the SDC/GEH partnership as well as the progress of the overall GEH programme.

In its agreement, IDRC and SDC did not anticipate any major difficulties in implementing the work but highlighted that it would be subject to the "development challenges which led to the formulation of GEH", that is the sensitive nature of governance issues, and the major risk that research results would be ignored. RM was "aimed at lowering this risk by consolidating and disseminating research findings to targeted audiences".

The Research Matters project itself was launched in May 2003 with the aim to "increase policy dialogue and promote policy change and implementation towards a GEH vision, through increasing the policy and practice applicability and utilization of research" with the objectives, approaches and modalities described in Table A1.1.

Between January 2004 and May 2005, RM disbursed 287,816 CAD in the form of 17 research support grants, $134,656 for consultants and $105,500 to support travel. The major categories of expenditure for the research support grants were for dissemination, and researcher exchange.

16 See agreement between IDRC and SDC

Table A1.1 Summary of Research Matters as summarized in its proposal dated September 2003.				
Aim: to increase policy dialogue and promote policy change and implementation towards a GEH vision, through increasing the policy and practice applicability and utilization of research				
Five objectives	**Three approaches**		**Four modalities with activities**	
1. to consolidate existing evidence as well as help identify key gaps in evidence on GEH themes,	1. Exploring focus themes (the leading thread)	**2004 theme: Strengthening health systems through ART**. RM will collaborate with Equinet, a Zimbabwe-based southern African health equity network and key GEH-partner, building on and complementing this regional network's efforts at consolidating and moving the evidence for an integrated approach into policy and practice. Equinet has already established strong channels of communication with key policy and practice actors in health and finance ministries, parliaments, and civil society. What it lacks is a consolidated and user-friendly evidence base to support the health systems focused work—a base this network has already expressed a desire to create.	1. reflecting on research and policy needs	1. workshops and exchanges 2. supporting knowledge brokers 3. moderated e-discussions
			2. consolidating the evidence	1. developing a database on the web 2. commissioning papers to synthesize published and unpublished research and development reports 3. producing briefing papers, briefing notes, and other tools to reach various audiences
		2004 theme: Financing for health and social equity will be more directed by RM and will address the key challenge—highlighted by but by no means limited to ARVs—of how to scale up health system financing which protects against both "medical" and social exclusion.	3. strengthening know-how	1. workshops highlighting synthesis work at important events 2. targeted dissemination of briefing notes 3. media interviews 4. Creating alliances between RM, GEH, SDC, and/or research teams and policy makers, scientific- and lay-journals 5. editing and translation support (under consideration – subject to appropriateness and resources)
2. to enable research teams and research users to interact more effectively in order to increase the applicability and utilization of GEH research at national, international and global levels	2. Responding to windows of opportunity	RM will provide small grants to support proposals from GEH teams (and eventually other researchers and research users) through which research on specific GEH problems can be moved further into concrete policy or practice. Keeping a door open to new opportunities is also a way of identifying topics that are high on the agenda and that could become potential focus themes for RM's future activities. Possible activities include: workshops, producing targeted synthesis documents or videos, joint activities such as priority setting or pilot projects involving researchers and research users, etc. RM expects to support 5-10 small projects of $5000 to $10000 each in year one.		
3. to support targeted and problem-oriented transfer of GEH and related evidence to policy makers and other research users at country, regional, and global levels, both proactively and in response to demand			4. advancing the evidence and agenda.	1. supporting the development of knowledge translation (KT) skills by researchers and research-users through exchanges, training in policy analysis or research interpretation etc 2. developing inventories of tools for GEH research and, especially, for engaging policy and practice communities 3. strengthening writing and communication skills through training 4. supporting journalists to communicate health research more effectively 5. communicating and possibly developing opportunities to deepen the mutual understanding of researchers, policy makers, civil society, donors etc 6. training modules: facilitating access to existing and new modules or activities, but situating these within a knowledge translation process.
4. to advance consolidation of evidence and advancement of policy dialogue on two themes: strengthening health systems through anti-retroviral therapy, and financing for health and social equity; and	3. Supporting a community of practice	to strengthen a) the relevance and impact of individual teams' research in their own contexts and policy environments, and b) the capacity of individual teams to recognize and respond to opportunities to act together to move a broader governance, equity and health agenda forward, at national, international and global levels.		
5. to pilot test the devolution of a significant component of the programme to a Southern partner while maintaining close collaboration with the RM and GEH teams.				

Attachment 2: Case studies

Case Study 1: Public Sector Anti-Retroviral Treatment in Free State South Africa
Projects: 102770 and 102241, total 1,403,170 CAD (Phase I – March 2004 to September 2004 - and Phase II - September 2004 to December 2006).

Case Study 2: Southern African Regional Network on Equity in Health (Equinet)
Projects: 004378, 100954,102041, total 1,296,540 CAD (Phase II - June 2001 to October 2004, Phase III – January 2004 to January 2006).

Case Study 3: Alliance/IDRC Competitive Grants for GEH Research in Eastern & Southern Africa Projects: 101885 and 102079, total 626,670 CAD plus 100,000 from SDC (Phase I – May 2003 to May 2004 - and Phase II - March 2004 to March 2008).

Case Study 4: Governance and Evidence Based Decision Making: a participatory formation process of health policies (Colombia) Project 102228, total, 192,660 CAD (February 2004 to February 2006).

Case Study 5: Politiques Publiques et protection contre l'exclusion en Afrique de l'Ouest – Phase II : 101160 and 102854, total CAD 523350 (Phase 1November 2001 to November 2004 – and Phase II – February 2005 to December 2006.

Case Study 1: <u>Public Sector Anti-Retroviral Treatment in Free State South Africa</u>
Projects: 102770 and 102241, total 1,403,170 CAD (Phase I – March 2004 to September 2004 - and Phase II - September 2004 to December 2006).

Background The Free State, one of South Africa's nine provinces, has a population of 2.8 million. At the start of this project, it was estimated that 500,000 people were HIV infected and 30,000 were eligible for ART. Distribution of anti-retroviral drugs started in May 2004 with a target of 2,127 patients on treatment by March 2005. The Department of Health of the Free State Free State (DOHFS) approached research partners and IDRC to set up comprehensive research, monitoring and evaluation from the beginning. GEH responded positively on the basis that 'experience in the Free State can inform other provinces, and potentially other countries in Southern Africa, providing evidence for effective, efficient, evidence-based and monitored national and regional ART rollouts'.

The objectives of the project are to inform and strengthen public health sector capacity to implement an effective, accountable and equitable ART rollout in the Free State and potentially other provinces and other parts of Southern Africa by 1) supporting the government's effort to strengthen the primary health care system to deal with the HIV/AIDS burden in the Free State, 2) building accountability and improving the effectiveness of the service offered to citizens through evaluating training of health workers and documenting the impact of the ART roll out at the institutional and community level.

Why GEH chose to fund this project The project grew out of an earlier GEH grant (101489) to the UCT PALSA (Practical Approach to Lung Health, South Africa) research group for work with the DOHFS and the UFS Centre for Health Systems Research and Development (CHSTD) in the development of respiratory disease case management tools for front line healthcare providers. When faced with provincial roll-out of ART, the DOHFS invited PALSA to assist in related research and evaluation, and the two institutions approached GEH. CIET had simultaneously approached GEH about support for a nationwide project to explore community-led solutions to increase health service effectiveness. GEH encouraged and facilitated UCT, UFS, and CIET to work with DOHFS to develop a joint project in the Free State.

In regard to GEH's objectives, the Project Approval Document (PAD) reads: 'The research programme supports GEH objectives of strengthening health systems and making research matter. The community based component, linked to the institutional and policy component addresses GEH's objective of promoting civic engagement'.

Outputs, reach and outcomes The project is producing a large amount of quantitative and qualitative data. Each research team maintains it own databases, but, with assistance from UCT and the South African Medical Research Council through an ICT4D/ ACACIA grant, patient data collected by the DOHFS are being made available to the stakeholders including the researchers through a password protected database. There will be short-term reports and publications and, by the end of the project and beyond there are likely to be some significant peer-reviewed publications.

Much of the UFS and UCT work involves staff and patients. The researchers are making every attempt to provide and discuss feedback as the project progresses. The CIET group has already prepared a radio broadcast to popularize their findings and provide health education about HIV/AIDS and ART to the wider community

UFS and UCT each has a close reciprocal relationship with the DOHFS whereby short-term research findings are fed back into implementation, and management challenges and successes are relayed to the researchers. CHSRD hosts weekly ART Task Team meetings, chaired by the Director of the DOHFS, and attended by representatives of all key institutions – DOH, UFS and NGOs. UCT prepares regular reports for the DOHFS.[17]

Observations

1. This project makes a timely and significant contribution to health systems research around the roll-out of ARTs. It is likely to provide a unique record that will be relevant not only to the Free State but to other provinces in South Africa, and to other countries. It was a strategic investment by GEH, and in line with all its objectives.
2. GEH was candid in the PAD about the risks associated with this project and these included concerns about relationships between the research teams. Lack of trust is demonstrated by close protection and possession of data collected. Without some wise intervention, an ethical situation could arise. The data are obtained from overworked stressed health workers, and from long interviews with seriously ill patients. It is imperative that the complete dataset is maintained and analysed efficiently and effectively by the entire research team.
3. GEH supports a multi-disciplinary approach. The project includes a range of disciplines but there is little cross-fertilization between methodologies. The CHRSD takes a social science perspective, UCT is more clinically focussed on guideline development and pragmatic trials, and CIET applies its signature epidemiological methods. Each could benefit from learning about each other's approaches.
4. GEH has encouraged the involvement of younger researchers. UFS has appointed several interns and is providing many young staff with invaluable research experience, but there is room for more capacity development at CHRSD. The UCT component seems to be the responsibility of one or two people and would benefit from wider participation and improved team relationships.
5. All the institutions have had to compromise their proposed research in order to meet GEH budget restrictions. Each is seeking complementary funding but a question for the GEH team to consider is whether or not the research suffers or capacity is undermined by supporting this combination of projects with a limited budget.
6. The technical contribution of GEH staff was welcomed by most of the people interviewed but there was a sense that longer visits would be appreciated.
7. The project ends in December 2006. There is no doubt that it will make significant contributions to research, policy and implementation locally and internationally. Now is the time to consider where the project might go after 2006, the capacity that it will leave behind in the Free State, and GEH's role in this given its foresight in backing the project so far.

17 For example: Implementation of the Comprehensive Care, Management and Treatment of HIV and AIDS patients – Outcomes of the first year, 2004.

Case Study 2: <u>Southern African Regional Network on Equity in Health (Equinet)</u>
Projects: 004378, 100954,102041, total 1,296,540 CAD (Phase II - June 2001 to October 2004, Phase III – January 2004 to January 2006).

Background The Southern African Regional Network on Equity in Health (Equinet) is a network of professionals, researchers, civil society members and policymakers who have come together to promote equity in health in the Southern African Development Community (SADC). The third phase of work aims to advance social justice and improve the health of the poorest by promoting the "Millennium 2015 Agenda." “Unfair and avoidable inequalities in health will be exposed in a manner that strengthens community voice, mobilizes public debate, encourages claims for health rights, attracts the attention of policymakers and prompts evidence-based action to improve health equity at the household, community, national and international levels”.

The objectives of the project are to: 1) generate evidence and analysis within priority areas of health equity work towards building a common framework of analysis and identifying strategic goals for network-wide action; 2) build and support the information base, institutional competencies, action and networking across different stakeholders needed to take forward the equity agendas, and 3) strengthen the capabilities and internal cohesion of the network.

Equinet's work covers ten theme areas: health rights; building civil-society and parliamentary alliances for equity in health; strengthening policy analysis; macro-economic policy, trade and health ; integrating equity and deprivation into health resource allocation; human resources for health; health sector responses to HIV/AIDS; poverty, equity and health; strengthening community voice and agency in health governance; strengthening policy analysis and intervention across all areas of work and monitoring equity in health and benefit incidence of health inputs.

Why GEH chose to fund this project Equinet is a GEH flagship project because its work is fundamental to GEH strategy. IDRC has been a major donor to Equinet since its inception in 1998. Equinet has emerged as one of the strongest South-based and South-led networks supporting research and the development and assessment of policy on equity in health. Its loose organization as an "expert lobby" with strong links to many research institutions across Southern Africa, its formal recognition by the SADC Health Desk as the channel for health equity issues to this regional body, and its partnerships with - but independence from - more clearly activist organizations, allow it to generate and promote rigorous and strongly pro-equity research that is credible to policy, academic, and activist communities.

Outputs, reach and outcomes Equinet has produced a significant body of both original empirical research and synthesis of existing work across a number of theme areas: capacity building in community health governance, integrating equity into resource allocation, and policy analysis were particularly strong in Phase 2, through competitive grants programmes combined with training workshops and mentoring by senior researchers. One of its major principles is to strengthen collaboration with and mentoring of emerging scholars and research users throughout SADC, and collaboration with other health equity networks and programmes.

These have specifically been reflected in the GovERN and Resource Allocation sub-networks, the policy analysis work led by a Southern African Researcher, and the Centre for Health Policy at Wits, and co-sponsoring of new initiatives in HIV/AIDS, Human Resources, Parliamentary Alliances, and student research programmes with Oxfam, Health Systems Trust, GEGA, edACT, DfID, Canadian researchers, and others. The new work extends and deepens the network's activities in a number of areas including both substantive research on several key aspects of health equity, and the functioning and impact of the network itself.

Equinet's website and CD demonstrate the productivity and range of products and activities undertaken. Of immediate relevance to GEH was the EQUINET Regional Meeting on Fair Financing for Health in April 2005 attended by participants from Namibia, South Africa, Tanzania, Zimbabwe and from IDRC. This helped to initiate thinking both for an Equinet fair financing research agenda for research, and for development of the GEH focus in this area.

Observations

1. Equinet is recognized as one of the most important institutions in the world dealing with equity in health. Achieving this status has been made possible due to the funding by IDRC.
2. A large part of the funds for Equinet are used to finance specific studies in different countries, which is excellent. It would be important for GEH to keep track of these, not only to guarantee that they have the necessary "quality" and focus but also to be able to use the results of the studies in other projects and as information on its achievements.
3. One of the consequences of the previous point is that most of the publications that result from Equinet's activities do not acknowledge the fact that it was possible due to IDRC funding.
4. GEH has worked with Equinet as a partner in several ways. Importantly, Equinet prepared a paper and policy briefs to inform members of the GFATM Board about opportunities research around GEH (see Attachment 1). The collaboration between GEH/RM and Equinet in the development of the fair financing focus theme is likely to be productive for both organizations.
5. It would be worth GEH exploring further ways of working with Equinet, for example in taking on the regional fund idea. Equinet has some experience with small calls for proposals, and might be able to take a leading role for GEH in this regard. Equinet is worth considering as a possible institution to which to devolve RM.
6. GEH has provided core funding to Equinet from its early days, and, although they have other donors, for example the Swedish Development Agency, SDC and the Rockefeller Foundation, they are now dependent on IDRC support for their future. It would be worth GEH spending time with members to vision its future over the next five years and to look for ways of creating long-term sustainability.

Case Study 3: Alliance/IDRC Competitive Grants for GEH Research in Eastern & Southern Africa Projects: 101885 and 102079, total 626,670 CAD plus 100,000 from SDC (Phase I – May 2003 to May 2004 - and Phase II - March 2004 to March 2008).

Background There is a dearth of funding made directly available to research institutions in ESA particularly to address issues around health systems performance. This joint project with the Alliance for Health Policy and Systems Research (AHPSR) represents a strategic investment by GEH to catalyse the interest of stakeholders in health systems research and accelerate research within its program objectives

The objective of the project is to establish a regional competitive grants program which will support a set of high quality research projects 'solid grounds for making informed and needs-based decisions on the equitable financing and functioning of health systems. Innovative, evidence-based thinking and explicit attention to governance challenges such as accountability, transparency, corruption and civic engagement, are considered important means to deepen democracy and strengthen health and social equity. Relevant and scientifically sound research can promote effective citizen engagement and help target interventions toward helping the marginalized and under-served populations - in the development of health policy and the delivery of public services for health' (the Call for proposals).

Why GEH chose to fund this project Building on experience with the EcoHealth PI, the GEH Prospectus envisaged creating a regional fund for ESA to 'strengthen the capacity of Southern institutions and researchers to integrate political analysis into health systems research', to lead collaboration among donor organizations, and to build 'fairly rapidly a critical mass of projects' in the region. GEH has provided core support to the Global Forum for Health Research for several years, and more recently through it to the AHSPR (which has 310 in over 70 developing countries). GEH, therefore invited the AHSPR to collaborate in the design and implementation of the fund.

In regard to GEH objectives, the reasons for funding given in the PAD include: 1) to enable GEH to assess the scale of interest in its strategy and the relevant resources and capacities in ESA, 2) to regroup researchers, decision makers and other actors that share the same interests into a community of practice, 3) to inform and complement RM, and 4) to build long-term collaboration with the AHSPR to enable GEH to delegate some of its administrative and training responsibilities. Although the project addresses all four GEH research entry points, overall it is linked most strongly to the GEH objective to strengthen health systems.

Outputs, reach and outcomes The outputs so far have included a training workshop for seed-funding to five research teams, the preparation and submission of 34 proposals (24 of which were deemed to lie within the scope of the Call) and the award of two grants of $150,000 CAD: 1) to the Centre for Health Policy, School of Public Health, University of the Witwatersrand, South Africa for a project entitled: 'Market-led public hospital reform in South Africa: the equity and governance implications of public-private interactions within the public health system', and 2) to the Multiface Development And Research Centre, Kenya for a project entitled 'Enhancing Governance for Improved Access to Tuberculosis Services in Western Kenya'. An additional grant of 150,000 CAD is being

made by GEH to the Health Economics Unit, University of Cape Town, South Africa, for a project entitled 'Fiscal Federalism, Equity and Governance in the Financing of Primary Health Care in South Africa'.

Observations

1. This is an example of GEH experimenting with a funding mechanism, based on the experience of another PI. The underlying principle is a good one, i.e. to throw a line out and see which researchers and institutions are interested in or doing work around the GEH theme. The lessons learned from this project can be incorporated into future decisions about efficient funding mechanisms.
2. Some of the questions that might be asked are: Did the call identify new institutions in new countries or were the respondents in institutions already familiar to/with IDRC/GEH[18]; did GEH feel comfortable giving a grantee the choice about projects; was the grantee able to act fairly as a "donor"[19]; are the grantees and workshop participants being adequately supported in their ongoing work; was this an efficient way of operating fro IDRC; how much funding would this require to take it to scale as a regional research fund; is the project relevant to other regions?
3. One of the intentions was to raise other donor awareness and buy-in to GEH work. Some were invited to the workshop but more work is required to attract other donors to the (excellent) idea of having a regional research fund available for investigators from the south to apply for projects that meet their own priorities. There may be issues for other donors because the call was so closely aligned to GEH priorities.
4. There is a question as to whether the awards will have sufficient impact unless more rounds are funded.

The list of proposals are worthy of analysis as they represent the interest of those who heard about the call and their interpretation of what GEH is about (from the call). We were curious to see if there was some agreement among the reviewers about their understanding of the relevance of the proposals to GEH. Table A2.1 compares their ratings. There was a fairly good agreement between the two reviews (kappa for agreement = 0.250 P<0.1)[20].

Table A 2.1 – Ratings of relevance for 24 IDRC/AHSPR proposals by different reviewers

Reviewer 1	Reviewer 2				Total
	0	1	2	3	
0	0	0	0	0	0
1	1	3	2	4	10
2	0	2	1	5	8
3	0	0	3	3	6
Total	1	5	6	12	24

18 Two of the top-rated proposals were from South African institutions already associated with IDRC. One was given an award, and the other has subsequently been given a grant from GEH (2005/2006)

19 There is now some question marks about the future funding and therefore existence of the ASPHR as an organization

20 The weights used were 1 for perfect agreement, 0.889 for a difference in one, 0.556 for a difference of two and zero for a difference of three.

Case Study 4: <u>Governance and Evidence Based Decision Making: a participatory formation process of health policies (Colombia)</u> Project 102228, total, 192,660 CAD (February 2004 to February 2006).

Background In 1993, Colombia launched a profound reform of its social security system with a view to attaining universal coverage within a set period of time. The reform radically altered the health system but failed to fully deliver on its promise. Today, only 50% of the population is covered by the health insurance scheme, leaving an estimated 15 million without coverage. For a developing country facing many urgent social and economic challenges, it is critical that debates aimed at reducing inequalities in health are informed by the best knowledge available. This action-research project aims to develop a participatory process of policy formulation that makes use of state-of-the-art analytical tools and solid evidence. The project will build on ongoing dialogue within two groups that bring together a cross section of interests and positions. It will develop a computable general equilibrium model to produce evidence-based responses to key questions arising from those groups. And, it will enrich the groups' discussion by giving them access to simulations of alternatives for pro-equity reform of the health sector. The process of deriving evidence-based recommendations will be monitored in order to draw lessons for other countries or communities interested in replicating the project design

The objectives of the project are to develop a participatory process of evidence-based public policy formulation, which utilizes analytic tools to support recommendations on health sector reforms for Colombia produced by relevant stakeholders. More specifically:

1) To create spaces of informed analysis of public health policies by the civil society.
2) To develop and consolidate dialog spaces between organized actors and government decision makers, with the participation of the civil society.
3) To evaluate the effectiveness of mechanisms for research-policy articulation, in terms of their acceptability to the stakeholders, usefulness of the technical tools, and pertinence and relevance of the resulting recommendations.

Why GEH chose to fund this project This project directly addresses the GEH PI's objectives of increasing the effectiveness of research-to-policy linkages in promoting the goals of health and social equity, and of supporting informed and effective citizen engagement in the policy process. The two objectives are simultaneously tackled with a strategy that entails model building and simulations designed to address specific policy questions identified through a multi-stakeholder consultative process. In turn, the results of the analytical exercises and simulations will be the bases of further deliberations of the two multi-stakeholder bodies, aimed at drawing recommendations to policy making entities and inputs to public policy debates. In this sense, the project is an experiment in research-to-policy articulation and the lessons derived by the built-in evaluation mechanism are expected to be of use to others in the region besides the direct participants. The project directly addresses the Centre's regional objective of encouraging and supporting quality research that is usable and actually used, specifically in the area of health equity as a key element of the broader concern with promoting social and economic equity. This will all be done through collaboration among ASSALUD, the School of Economics, Universidad del Rosario, and the Université de Montreal, which

will allow research capabilities in the Southern institutions to be strengthened and developed.

Outputs, reach and outcomes The project is still under way. A visit to the two groups that carry out the research has demonstrated that it is very likely that this project will produce policy recommendations that will be taken very seriously by government officials, analysts, civil society organizations, and health sector actors. That high probability is determined by the track record of the proponents, in terms of producing quality knowledge outputs, by the membership of the two multi-stakeholder groups that will be key actors in the project, and by the project design that combines policy dialogue with evidence-based analysis in an interactive process.

To some extent, the success of the project will be measurable by the degree to which participants share an awareness of the real constraints that any policy change will have to take into account and that the modeling should help uncover, even if they continue to disagree on the preferred solutions. In the medium term, the project will make available a tool, the computable model, that will be of use to the broader research community in the future. To the extent that it produces viable recommendations to enhance equity in financing and in access that take into account both the economic, social and political dimensions, the project may have a positive impact on the livelihoods of vulnerable populations that, for instance, lack health coverage at present. However, it is understood that actual changes in policies in the directions that may be recommended by the participants is a second order process to which the project will only make one significant but far from sufficient contribution.

Observations

1. This is an excellent example of success among GEH projects.
2. Technically it is flawless.
3. Moreover, the research group has been extremely lucky in the fact that the government decided to send to Congress in Colombia a project of a new law to change many of the central aspects of the regulations of the Health Security System.
4. The research group is participating in discussion with lawmakers and government officials the main aspects of the new legislation.
5. The participation of leaders of civil society and representatives of the media in the meetings promoted by the project team increase the potential of including the main findings of the research in the new legislation being considered for the Health System regulation in Colombia.

Case Study 5: <u>Politiques Publiques et protection contre l'exclusion en Afrique de l'Ouest – Phase II</u> : 101160 and 102854, total CAD 523350 (Phase 1November 2001 to November 2004 – and Phase II – February 2005 to December 2006.

The objective of the project is to "consolider les travaux du Réseau dans la Phase I en notamment permettant aux équipes de finaliser les protocoles de recherche et en particulier les dimensions méthodologiques de six projets de recherche dans trois domaines thématiques définis (analyse d'implantation et gouverne, équité et programmes de santé maternelle, gouverne et impact des mutuelles de santé).

This phase II grant supports work consolidating the results from the research network (Senegal, Côte d'Ivoire, and Burkina Faso) from phase I and preparing for the planned phase III, which will establish the evidence of the effects of health policies on equity, use this evidence to encourage the adoption of "pro-equity" policies, and build capacity for health systems research. These studies have been supported through "RM".

Why GEH chose to fund this project This project supports research that strengthens the capacity of the health system to provide equity in access and quality of care, with special attention to poor and socially marginalized populations. The promotion of civic engagement in enhancing the demand for health equity is an important theme for this project. The project also contributes to the GEH objectives of enhancing the capacity for and use of research in strengthening the health system. The second phase of this project, which is now being implemented, will prepare for a third phase that will focus on transfer of this knowledge. This third phase will be supported through the "RM" project.

Outputs, reach and outcomes
The project, now in its second phase (phase I was completed in 2003), has outputs that result both from country-level activities and from the regional activities of the network.

At the regional level, there were important lessons learned regarding strategies for identifying and ensuring access to care for indigent populations. Based on these findings, specific tools (including training materials for health workers) were developed and put to use to ensure access for these populations. Representatives from the three countries (Senegal, Côte d'Ivoire, and Burkina Faso) took part in the Equinet meetings in Durban in June 2004, where there was an opportunity to share the results of the first phase of the project. At this meeting, members of the network were also able to share best practices in management of networks of researchers and strategies for ensuring linkages of the research to policy and practice. The members of the network also participated and shared findings in meetings of the International Society for Equity in Health and the Global Equity Gauge Alliance. The results of the network's research are well-recognized in the equity "subculture".

In Senegal, the Ministry of Health organized and financed a workshop to present the findings. The effects of health insurance in improving access to care were reported to donors, including the ILO, World Bank, and African Development Bank. In November and December of 2004, the reports of the quantitative and qualitative findings from the first phase were distributed to more than 250 users.

In Côte d'Ivoire, it was documented that the exemptions for indigents were applied based on the predispositions of the managers rather than any transparent, replicable, and equitable set of criteria. A partnership was formed with the National Institute of Public Health to conduct operational research to test the implementation of recommendations designed to improve the equity and transparency of policies based on the research findings. The Ivoirian team was also able to introduce a new theme on equity and health into the curriculum at the University of Cocody in Abidjan. A journal article reporting the lessons learned from the Ivoirian project in likely to be published soon.

In Burkina Faso, the results of the study were shared with the major partners engaged in delivering or strengthening health services, in meetings with the Directorate for Hospitals of the Ministry of Health, and in National Health Days in Bobo Dioulasso in May 2004. Based on the research findings, new norms and programs were developed to improve the quality and equity of emergency obstetric care. Based on the results, the regional hospitals requested and received increased numbers of social workers to implement the improvements to assure access to indigent populations. There was a documented need to develop a cost-sharing strategy in order to reduce the burden of potentially impoverishing health expenditures, such as `for Caesarian section, on poor households. The Directorate for Hospitals has revised its policies for exemption from payment for indigents based on the findings of the research.

Observations

1. In addition to the direct outputs and impacts, both the researchers in the network and the broader regional research community acknowledge that the research has resulted in strengthening of the capacity and momentum for research in the participating countries.
2. The researchers were successful in sharing ownership of the research process and outcomes so that some of the "champions" for policy change based on the results of the research were decision makers who were not directly affiliated with the research teams.
3. The workshops and meetings funded through this project and its predecessor were clearly instrumental in enabling this capacity building and the strengthening of the network.
4. The role of the University of Montreal was important in providing continuity in the technical and methodological support for the country teams.
5. The natural cohesion of the technical and the scientific communities in francophone West Africa makes networks a strategic choice for programming research support in the region.
6. The teams and research would have benefited from more resources for travel and for networking among the projects. There is also a need in this project, as in others, for a source of technical support for writing and publishing project results, including after the completion of the research project. This assistance will be especially important if reports are to be optimally targeted to decision makers who are positioned to make the changes that can be recommended based on the research results.

Attachment 3: Details of the review database

This is an Excel spreadsheet, "GEH Grantmaster 2001-2005" ,with the following fields completed from the GEH Project Portfolios for the years 2001/2002, 2002/2003, 2003/2004, and 2004/2005:

Type of grant: research project, research support
Region: Global, sub-Saharan Africa, Latin America and the Caribbean
Sub-regions: Global Canada, Global other, West Africa, Eastern and Southern Africa, Latin America and the Caribbean
Country of grantee
Financial year in which grant was made
Status: active, closed, pending
Grant number
Project name
Grantee institution
Project officer
Whether the project fell within the GEH health system strengthening objective, (provided by the GEH team)
Whether the project fell within the GEH community empowerment objective, (provided by the GEH team)
Whether the project fell within the GEH research matters objective, (provided by the GEH team)
Whether the project fell within the GEH contains capacity building, (provided by the GEH team)
Countries included in the project
Start date
End date
Length years (calculated)
GEH $ invested
Other IDCR $ invested
Total IDRC $ invested
CIDA $ invested
SDC $ invested
Other external $ invested (calculated)
All external $ invested (calculated)
Total $ invested (calculated)
Abstract

Attachment 4: Key contacts interviewed

IDRC
Christina Zarowsky, GEH Team Leader
Moussa Samb, Senior Program Specialist (Dakar)
Roberto Bazzani, Senior Program Specialist (Montevideo)
Jean-Michel Labatut, Senior Program Specialist
Sharmila Mhatre, Senior Program Specialist
Nasreen Jessani, Research Officer
Sandy Campbell, Program Coordinator for Research Matters
Danielle Reinhardt, Program Assistant
Margaret Emokor, Grant Administrator

Marie Elizabeth Turpin, Program Assistant (Dakar)
Heloise Emdon, Senior Program Specialist, ICT4D (Johannesburg)

Fred Carden, Director, Evaluation Unit
Kevin Kelpin, Senior Program Specialist, Evaluation Unit

Brent Herbert-Copley, Director of Social and Economic Policy

Jean Lebel, Director, Environment and Natural Resources Management
Tim Dottridge, Director of the Special Initiatives Division

Rohinton Medhora, Vice President for Program and Partnership Branch

SDC
Nadia Isler, Program Officer, Health Domain, Swiss Corporation Office, Mozambique
Daniel Mäusezahl, Senior Scientist, Swiss Tropical Institute
Pio Wennubst, SDC Country Director, Tanzania

Canadian Partnerships
Alita Perry, Global Health Research Initiative, Canadian Institutes of Health Research
Roberta Lloyd, Global Health Research Initiative. Canadian Institutes of Health Research
Garry Aslanyan, Senior Health Advisor, Canadian International Development Agency
Nana Kgosidintsi, HIV/AIDS Advisor,Canadian International Development Agency, Pretoria
Diana Youdell Counsellor (Development), High Commission of Canada, Pretoria
Jean-Didier Oth, Second Secretary (Development), High Commission of Canada, Pretoria

Other
Clive Emdon, Media consultant, Johannesburg

Table A4.1 - Interviews conducted with grantees

Project	Title	Persons interviewed
101644	Municipal services in health in Southern Africa	Greg Ruiters, Rebecca Pointer
101862	Equity, financing and decentralization in Mexico	Emanuel Nunez
101939	Private health care sector and STI quality of care and control in Southern Africa	Rita Sonko, Abdul Elgoni
100954 102041	Equinet	Godfrey Musuka, Hon Blessing Chebundo, Clara Mbiwili, Itai Rusike, Di McKintyre, Lucy Gilson
1020609	African Health Research Forum	Mutuma Mugambi
102283	AIDS Bulletin	Jo Stein
101477	Sexual violence and HIV risk	Ari Ho-Foster, Ncumisa Ngoxwa Thami Mokoena
102770	Public sector anti-retroviral treatment in Free State South Africa, II	Dingie Van Rensburg, Ron Chapman, Eric Bateman, Lara Fairall, Gloria Rembe, Christo Heunis, Chantell De Reuck, Judith Matthis
101465	Decentralisation in Guinee	Adama Ndiaye, Ngagne Mbao
101340	VCT in Burkina	Pascal Niamba, Jean Marie Tapsoba
102228	Governance and evidenced based decision-making	Francisco Yepes, Zayda Ardila, Claudia Garzon, Manuel Ramirez, Hearnán Jaramillo, Claudio Karl, Andres Zambrano
102107	Extending social protection in health in LAC – bridging research and practice, phase II	Alvaro Cardona, Ernesto Biscola
101914	Corruption and good governance	Abdou Salam Fall
102172	Immunization project, Curatio International	Kaki Zoidze
102854	Politique publiques et lutte contre l'exclusion, Phase II	Slim Haddad, Pierre Fournier, Idrissa Diop, Hoyce Dogba, Salimata Ouedraogo, Auguste Blibolo
101595	Access to health care and basic minimum services in Kerala	D. Narayana
100095, 101876	Financing Municipal Health Systems and Equity project and Challenges for Health Equity in the Sao Paulo Metropolitan Region	Luiza Sterman Heimann, Iracema Ester do Nascimento Castro, Lauro Cesar Ibanhes, Olinda do Carmo Luiz, Roberta Cristina Boaretto and Renato Barboza
102750, 01346	Tanzanian Essential Health Interventions Projects	Graham Reid, Harun Kasale
101938	Impact of HIV/AIDS on Health service capacity at primary care level	Uta Lehmann
101885 102079	Alliance/IDRC Competitive Grants for GEH Research in Eastern & Southern Africa Projects	Ashok Yeseudian
101042	Global Forum for Health Research	Mary Ann Burke

Attachment 5: IDRC documents reviewed

- IDRC Corporate Strategy and Programme Framework 2000-2005, January 2000
- IDRC Programme Framework 2005-2010, November 2004
- IDRC Corporate Strategy 2005-2010, November 2004
- IDRC Program Framework 2005-2010, November 2004
- IDRC Website: http://web.idrc.ca/
- Governance Equity, and Health Prospectus 2002-2006, September 2002
- Governance, Equity and Health project portfolio, 2001/2002
- Governance, Equity and Health project portfolio, 2002/2003
- Governance, Equity and Health project portfolio, 2003/2004
- Governance, Equity and Health project portfolio, 2004/2005
- Governance, Equity and Health workplan, 2003/2004
- Governance, Equity and Health, 2004/2005
- Project Appraisal Documents for most of the 46 project grants reviewed
- Project proposals and reports for selected projects
- IDRC individual project monitoring matrix: an outcome mapping approach
- Memorandum of Understanding in support of : Better health for the Poor A Canadian Collaboration for Better Health between The Canadian International Development Agency, Canadian Institutes of health research, health Canada and the International Development centre
- Canada: demonstrating national leadership for international health by The Honorable Carolyn Bennett and the Canadian Health Research Initiative.
- Governance, Equity and Health: A Swiss-Canadian partnership on equitable access in health
- GEH Guidelines for project ideas/proposal review
- Integrating learning and reflection into the GEH program an outcome mapping approach
- The challenges of assessing development impacts: Outcome mapping building learning and reflection into development programs. Sarah Earl, Fred Carden and Terry Smutylo