EXTERNAL REVIEW

IDRC GOVERNANCE FOR EQUITY IN HEALTH SYSTEMS PROGRAM

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SEPTEMBER 2015

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1 INTRODUCTION

The IDRC Governance for Equity in Health Systems (GEHS) program has the goal to strengthen research teams and institutions in low- and middle-income countries (LMICs) to build research capacities, methodologies and knowledge to influence policy and practice at all levels of the health system from local to global. The 2011-2016 Program Prospectus builds on two earlier phases, starting in 2002, to apply three effective principles – governance, equity and systems integration - to address "core challenges of decision-making, resource allocation and power distribution in health systems" and thereby to improve health outcomes.

This external review of the program is summative and serves the dual purpose of: 1) ensuring accountability to IDRC's Board of Governors for the implementation of the program prospectus and delivery of program results; and 2) providing input to programming for learning and improvement. Specifically, the review identifies key issues for consideration by IDRC's Board of Governors and senior management that derive from answers to three review questions:

1. How did the program perform in implementing its prospectus?
2. Was the quality of the research supported by the program acceptable?
3. To what extent are the program's outcomes relevant and significant?

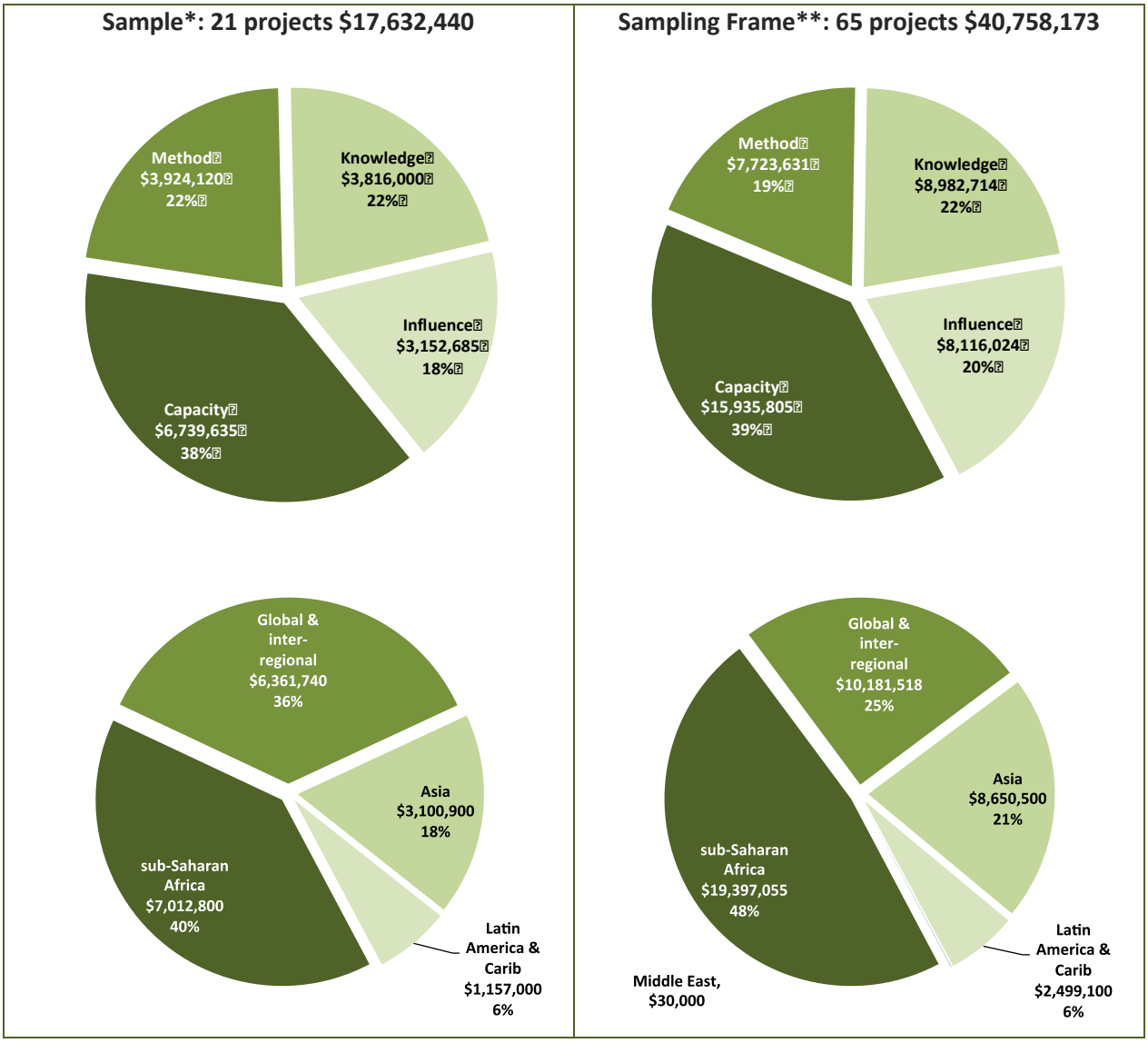
2 METHODOLOGY

Our review team comprised three senior professionals with extensive experience of international health each of whom contributed in equal parts to the analysis and findings, supported by a research assistant. (See Annex 2 for the team profile). We conducted the review by following the IDRC Scope of Work for External Program Reviews.

The core effort of the review centred on the analysis of the 2011-2016 GEHS Program Prospectus and of the Final Prospectus Report (FPR) of February 2015. In addition we reviewed program-related strategy and evaluation documents such as the report of the Evaluation of Influence and Outcomes of October 2014, the GEHS Real Time Learning and Evaluation Plan of June 2013, the GEHS Mid-Term Monitoring and Evaluation Self-Assessment Report of August 2013, and regional programming strategies for West and Central Africa and for Latin America. We also reviewed the project documentation available on the IDRC GEHS intranet site, and additional project documents provided by GEHS staff and grantees.

We selected a sample of 24 projects (22 research projects and two training awards) using a purposive sampling strategy (Annex 3) that provided us: 1) with a balance of projects with intended contributions to each of the program's outcome areas – capacity building, methodology development, knowledge generation and influencing policy and practice 2) favoured projects mentioned in the FPR; and 3) included as many projects as possible with products whose research we could assess with IDRC's Research Quality Plus Tool (RQ Plus Tool). We shared the selection with the GEHS team who suggested a small number of additions and deletions, some of which we accepted. Our final sample contained 21 (32%) of the 65 projects funded by GEHS between 2011 and 2015 and three legacy projects initiated before 2011. The FPR included references to fifteen (62%) of the 24 sampled projects. The sample of 21 projects (excluding the three legacy projects) was representative of the post 2011 GEHS portfolio of projects in terms of budget allocation to the four outcome areas and the geographic regions as illustrated in Figure 1.

Figure 1: Profile of sampled projects compared to GEHS projects initiated since 2011



** The profile does not include the 3 legacy projects*

*** 4 ICT4D legacy projects that were approved in 2011 are not included in the sampling frame*

We conducted semi-structured telephone interviews with 21 key informants using three specific interview guides. Interviews with six international health systems experts explored their views of the status of health systems research (HSR) in LMICs, knowledge about GEHS support for health system research, and assessments of the relevance and outcomes of this support. Interviews with five GEHS program officers explored the process of the development of the prospectus and their experiences in the implementation, as well as specific questions related to sampled projects within their portfolios. Interviews with 10 grantees of GEHS-funded projects explored their experience of working with IDRC and clarified the outputs and outcomes of their projects.

We developed a working spreadsheet in which we recorded critical information needed to answer each review question for each of the 24 sampled projects.

- For the first review question, we analyzed the GEHS Program Prospectus 2011-16, annotating the short- and medium-term objectives, the explicit and implicit long-term goals, and the proposed means to reach them. We compared the "intentional content" of the prospectus with the claims of accomplishments and the lessons presented in the FPR, and discussed changes in the program environment and strategic program adaptations made during the prospectus period with management and staff. We discussed the nature, reasons and consequences of these changes for the GEHS program, for its grantees and their constituencies: the health service providers, managers and decision-makers who are the users of research outputs.
- For the second review question, the assessment of the quality of the research supported by the program, we reviewed 67 project outputs (45 published papers and 22 technical reports). In order to assess the quality of each research project, we applied the IDRC Research Quality Plus Assessment Instrument (RQ+ Tool) to the aggregate outputs of each project component. This led to 14 quality assessments of eleven research projects. The quality of the remaining eleven research projects could not be assessed with the RQ+ Tool because they were too recent and had not yet produced any outputs, all of their outputs were written in Bahasa/Indonesian language, or the outputs could not be directly attributed to GEHS-supported research, as for instance the papers published in the two journal supplements in our sample.
- For the third review question, we extracted all statements from the FPR about any of the sampled projects that were mentioned in the FPR into the spreadsheet and verified their validity and accuracy by examining documentation, and talking to grantees and program officers. We assessed and classified the outcomes of each sampled project in terms of relevance and significance using the rubrics provided in the Scope of Work for External Program Reviews at IDRC. We classified outcomes of projects that were in an early phase of implementation as 'predicted outcomes' or we refrained from classifying them. To provide a program level overview, we assessed each project as a team and mapped its major outcome contributions to one (and occasionally two) of the cells in the Table of Expected Outcomes provided in the 2011-2016 GEHS Program Prospectus (Annex 6A).

We conducted the review in accordance with a work plan approved by the IDRC Policy and Evaluation Division in April 2013. We discussed the preliminary findings of our review with the IDRC Policy and Evaluation Unit and in two dynamic validation sessions with the GEHS program team.

LIMITATIONS

We did not undertake as many interviews with external experts as initially planned. We contacted twelve internationally known researchers and managers of programs supporting health research in low and middle-income countries. Six of them did either not reply or were not available at a feasible time. The six experts interviewed represented a range of experience and expertise that complemented our own. After completion of the sixth interview, we assessed that the collected information had reached saturation and additional interviews were unlikely to add new perspectives.

We were unable to conduct as many research quality assessments as we had projected. From our initial scan during project sampling, we had anticipated conducting 19 assessments. In five cases, however, the outputs could not be assessed for a variety of reasons detailed in Annex 5.

While the 2015 FPR formulated achievements as outcomes, the evidence provided in the FPR was mainly in the form of outputs. For example, GEHS reported numbers of people trained without information about what had changed as a result of the training. We discussed this with the GEHS team which responded positively by providing a set of outcomes (Annex 6D).

3 CONTEXT

Discussions of health systems in international development date back to the launching of the Alma Ata Declaration on Primary Health Care in the 1970s. They received new emphasis in the beginning of the 21st century through publications, seminars and declarations by international institutions such as the World Bank, World Health Organization (WHO), and the G8. The focus on health systems increased after the 2012 World Health Assembly, when the WHO Director General announced that Universal Health Coverage (UHC) was "the single most powerful concept that public health had to offer".

With growing investments in health systems strengthening programs by development agencies and global health initiatives, the need to generate evidence for effective approaches grew. In 2004, the Summit on Health Research in Mexico called for increased research support to strengthen health systems and improve the equitable distribution of health services.

The GEHS program started in 2002 in recognition that research to strengthen health systems was a new field, especially in LMICs, with a very limited number of capable institutions and researchers. IDRC was, and remains, one of few donors who support HSR in LMICs. During two program periods (2002-2006 and 2006-2011) the program supported research, capacity development, and South-South networks to develop health systems. In 2010, the first Global Symposium on Health Systems Research was held in Montreux, Switzerland and is now a rapidly growing biannual conference.

By 2011, GEHS and other stakeholders had made considerable progress in establishing the legitimacy of the field, developing methodology and building a critical mass of international health systems researchers. The 2011-2016 Prospectus identified four outcomes towards the goal of improved health in LMICs through strengthened equitable health systems:

1. development of capacities of LMIC researchers and institutions
2. development of a knowledge base of research methodologies
3. generation of a body of knowledge and evidence-base of research findings
4. influence of policies, practices, agendas and funding priorities to strengthen health systems

During implementation, the program underwent a number of significant institutional changes including:

- In 2011, IDRC closed the Information and Communication Technologies for Development (ICT4D) program and integrated staff and projects into the GEHS program. Eight projects with a combined budget of about $6 million were added to the GEHS portfolio. Following the merger, GEHS further developed the support of research on information technology in health within the framework of the GEHS principles of governance, equity and systems integration. The eight projects of the former ICT4D program were, however, excluded from our review because they were not developed under the 2011-2016 GEHS Program Prospectus.
- In 2012, IDRC closed the Regional Office in Dakar covering the West African sub-region. West Africa was a priority program area for GEHS, as recommended by the preceding program review. GEHS mitigated the effects of the decreased presence in the region with the assistance of new and existing partners, ensuring that the focus on West Africa was not lost.
- In 2013, the GEHS program merged with the Global Health Research Initiative (GHRI). The GHRI partnership program closed in 2015, concurrently with a process of institutional restructuring and the adoption of a new corporate strategy by IDRC. These institutional changes had significant effects on the management of the GEHS Program.

Since the start of the prospectus period in 2011, GEHS approved 65 projects with a total budget allocation of approximately $41 million (Figure1).

4 FINDINGS

4.1 IMPLEMENTATION OF THE PROSPECTUS

- Appropriate spread of project topics, settings, research partners (e.g. old versus new), size and cost. Additional external funding did not distort the approach or the focus of the GEHS program.
- The GEHS team worked hard to develop and support projects in under-funded and challenging areas which previous reviews and evaluations had identified as priorities.
- The GEHS program demonstrated strong resilience and high adaptability in the face of significant external challenges, some of which hit precise priority arenas of GEHS activity

APPROPRIATENESS OF OVERALL PROGRAM INVESTMENTS

The GEHS program database provides a useful departure point for analysing the fit between the aims of the 2011-2016 Prospectus and the budget investments made by the GEHS program in the portfolio of 65 projects approved between 2011 and 2015. Program investments across the four intended outcome areas were well distributed (Figure 1). We observed that:

- The preponderance of capacity-building, representing 39% of GEHS investments in 2011-15, is in keeping with the relatively early stage of development of HSR, compared to most health research, in LMICs. Despite IDRC's 13 years of investments in GEHS projects to build HSR as a field, interviewed experts considered the field to be still in its infancy, especially in the poorest countries. In these settings, where health services are often delivered by an uncoordinated mix of private, voluntary-sector, and underfunded public-sector providers, "research to action" is necessarily high-risk.
- GEHS allocated 48% of its resources for new projects during the 2011-2016 Prospectus to research institutions in sub-Saharan Africa (Figure 1), plus additional resources for their participation in global and inter-regional projects. In light of the well-documented weak health system performance in this region we view this distribution of resources as appropriate.
- The majority of projects initiated during 2011-2015 (57%) had budget allocations ranging between $200 thousand and $1 million. Only 10 projects (15%) had budget greater than $1 million. Most of the 44 research projects approved during this period had durations between two and five years. A number of very productive GEHS projects had several phases that cumulatively amounted to ten or more years of funding (i.e. the legacy/flagship projects). These amounts and durations are appropriate in a field that is typically still at the stage of demonstration projects and pilots aiming to show "proof of principle" for health service and system innovations. Such projects normally take a number of years to properly implement and robustly evaluate, let alone lead to wider use of their findings. Some of our key informants pointed out that IDRC stands out among international funders of HSR for its willingness to fund projects for longer periods. Interviewed experts concurred that worthwhile HSR projects, especially in challenging settings, require a longer duration of funding to have a reasonable chance of generating conclusive findings and to translate them into policy and programs.
- About two-thirds of the GEHS grant recipients during 2011-15 were based at previously funded institutions and about one third were new institutional recipients. We view this as an appropriate balance in a relatively new field, with few internationally recognized centres of excellence within LMICs. Over time, the proportion of new institutional recipients of GEHS grants has steadily grown, as should be the case in a field still establishing its status.

In sum, we view the distribution of project investments as appropriate across all these dimensions, and in keeping with the intent of the 2011-16 Prospectus.

PROGRAM RESPONSIVENESS TO PREVIOUS EXPERT/STAKEHOLDER ADVICE ON PRIORITIES

Because GEHS is completing its third five-year program, it is relevant for this review to ask whether GEHS project investments between 2011 and 2015 addressed the topics and issues which the program was advised to prioritize in previous reviews, evaluations and stakeholder-consultations, such as the program reviews of previous prospectus periods, as well as consultations with health systems researchers and research users during the IDRC-supported 2nd Global Symposium on Health Systems Research in 2012. Annex 4 lists how GEHS addressed these suggested priorities in the projects sampled for the review. It clearly documents that the program has been responsive to advisory inputs, and the opinion of experts in the field.

PROGRAM ADAPTABILITY (RESPONSES TO EMERGENT CHALLENGES AND OPPORTUNITIES)

1. Identification and Management of Program Risks:

GEHS demonstrated the capacity to identify and mitigate risks during program implementation by applying the IDRC 'Grants Plus' approach[1]. When data management in one component of the high-budget Nigeria Evidence-based Health System Initiative (NEHSI) by the University of Calabar threatened to fail, GEHS mobilized a partnership with the University of Maine on short notice. This resulted in a re-engineering of the mobile data collection and management software-platform and a change to an open-source format with major technical advantages, and a much better potential for adaptation in other settings. We noted similar timely risk mitigation interventions in other projects, documenting flexibility and quality oversight by the program, for instance in the Nigeria component of the West African Initiative to Strengthen Capacities through Health Systems Research and the Evaluation of Rajiv Aarogyasri Health Insurance Scheme in India.

GEHS invested considerable time and resources in strengthening research proposals and teams prior to funding, through project development workshops and up-front technical support. GEHS consistently strengthened the methodology and relevance of the research in terms of the three GEHS principles of governance, equity and systems integration. Several projects, for instance the Network in Equity in Health in East and Southern Africa (EQUINET), benefited from additional support to improve the gender analysis. Our interviews with principal investigators confirmed that such early input from GEHS significantly strengthened their research projects. None of the interviewed Principal Investigators felt that GEHS was in any way interfering with their prerogatives as researchers.

In terms of management risks, the number of overall project failures experienced by GEHS during the review period was remarkably low. Only one of the projects in our sample failed to implement the activities agreed under the grant to the point that disbursed funds had to be reclaimed by IDRC. According to information available to us, this failure could hardly have been foreseen. One of the members in the review team who is widely experienced in grant-making judged a project failure rate at this level to be impressively low. It clearly suggests strong program planning, project selection and support, as well as intensive and skilled monitoring of project implementation. The low failure rate is particularly impressive

[1] The 'grants plus' approach was defined in the IDRC Strategic Framework 2010-2015 as follows: "… IDRC is not just a research funder offering financial support to create new opportunities for research. The Centre is also a research partner and adviser that engages with its recipients throughout the research process as a mentor, but increasingly on a peer-to-peer basis. In addition, IDRC acts as a research broker that furthers networking among its various grantees, helps strengthen research-to-policy linkages, and facilitates access to research materials and other services."

for research funding in an emerging field with high risks in the data environment, the research environment, and the political environment.

2. Ability to Capitalize on Emergent Opportunities:

Two examples illustrate the capacity of the GEHS program to capitalize on new opportunities:

- Under its previous prospectus (2005-2010), the GEHS program supported several research projects that addressed financial barriers to equitable access to health care. During the same period, UHC emerged as a central theme of international development advocacy. GEHS was well positioned to contribute to this global policy initiative, by building on its earlier project investments, and expanding them into an important portfolio of research on UHC. Perhaps the most influential among these projects was the Global Network for Health Equity through its leadership in generating evidence to support international UHC strategies.
- In 2014, on IDRC's request, GEHS acted as the lead program in IDRC to participate with the Canadian Institutes for Health Research (CIHR) and the Department of Foreign Affairs, Trade and Development (DFATD) in the development of a co-funded initiative for maternal and child health under the title of "Innovation for Maternal and Child Health in Africa" (IMCHA). The seven-year program was launched in 2014 with a funding envelope of $36 million. GEHS was well positioned to provide the HSR evidence to assure that IMCHA built on a solid foundation of health systems strengthening.

PROGRAM EVOLUTION OVER TIME

The capacity to implement HSR is still weak, including in high income industrialized countries. All experts we interviewed confirmed that there are few international institutions with the structure and capacity to provide financial and technical support for HSR in LMICs. One senior official of an international research funding agency stated that any major change in focus of GEHS would leave a large gap. The GEHS program evolved considerably during the period under review, for instance by integrating the issues of eHealth and UHC in its HSR portfolio. The main strength of the GEHS program, however, has been its ability to maintain its original focus -- i.e. strengthening LMIC health systems through increasing local research capacity to analyse, evaluate, and improve their performance. This long-term consistency is important in a field that continues to be highly relevant for the achievement of the Millennium Development Goals by 2015 and the health-related Sustainable Development Goals of the post-2015 agenda.

PROGRAM RESILIENCE (CONTEXTUAL CONSIDERATIONS)

During the 2011-2016 Prospectus period, GEHS had to contend with significant external and internal contextual challenges: 1) regional office closures, especially in West Africa which was a priority program implementation region; 2) the merger with GHRI at the end of 2013; 3) internal restructuring of IDRC and major budget reallocations; 4) more recent changes in the IDRC corporate direction and planning process; and 5) the Ebola outbreak in West Africa. Our review did not find any evidence that these challenges impaired the performance of GEHS in implementing the 2011-2016 Prospectus. The quality and the scope of activities funded and supported by GEHS during this period were fully in line with the expectations raised by the Prospectus, and actually exceeded expectations given these challenges. GEHS's capacity to rise above these challenges since 2011 has in no small measure been facilitated by its strong internal "learning-based approach" to project development and support, with regular reflective practice and collective discussion of what the team has learned about portfolio implementation.

4.2 QUALITY OF RESEARCH SUPPORTED BY THE PROGRAM

- The GEHS program supports research in new and emergent fields, accompanied by significant effort in capacity strengthening.
- The quality of outputs of GEHS-supported research projects was generally good, and often very good. Very few sampled research outputs were of less than acceptable quality. In most cases these were early outputs of projects that had potential to improve with ongoing program support.
- The risks of funding health systems research in LMICs are considerable. There was, however, no correlation between research risks as assessed with the use of the IDRC RQ+ Tool and research quality, attesting to effective risk mitigation by GEHS.

RESEARCH ENVIRONMENT AND CONTEXT

We examined the quality of research conducted by the sampled projects by applying the RQ+ Tool which was developed by IDRC to assess different dimensions on quality across different types of development research as well as to capture contextual factors that either enable or constrain the implementation of research. The RQ+ Tool includes three parameters to characterize the research context:

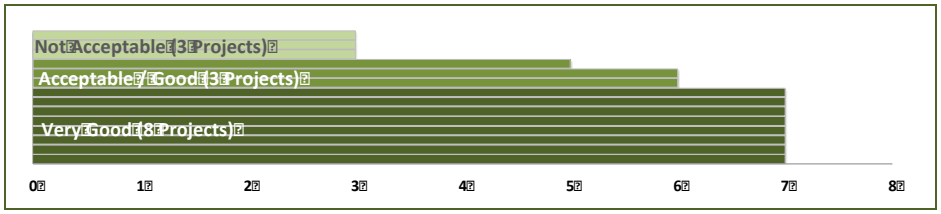
1. Maturity of the research field: Most of the assessed research projects (9/14) worked in emergent or new fields and only five projects conducted their research in an established field. GEHS-supported research entered into new territories in: the examination of the fairness of the UHC roll-out in Uganda and Zambia; the evaluation of a rights-based health program using a natural experiment design in Guatemala; the development of a national health service performance framework through a participatory community-based approach in Burkina Faso; and in a range of equity research projects in Africa.

2. Research capacity strengthening: Strengthening research capacity in GEHS-funded projects takes two forms that are not mutually exclusive: the capacity-building of research partners through additional inputs, and the support of partners to transfer their capacity and skills to emergent researchers and institutions. Most sampled projects included capacity strengthening activities. The research project for health rights and equity in Maharashtra and the West African initiative to strengthen HSR capacity stood out for their support to build capacity of the research partner. NEHSI in Nigeria and EQUINET in East and Southern Africa, on the other hand, were among the projects that included significant funding for the research partner to provide training and skills transfer to emergent institutions.

3. Research risks: The research risks assessed with the application of the RQ+ Tool include three dimensions: the data environment, the research environment, and the political environment. Many projects worked with household survey data in a rich data environment. A number of projects, particularly those working with qualitative data, however, collected and analyzed data using less well established instruments and methodologies and therefore incurred a significant data risk. The risks in the research environment were considerably higher owing to the nature of HSR as a new field with weak support in LMICs. Political risks were the highest, with at least half of the sampled projects implemented in countries with considerable political volatility and weak governance.

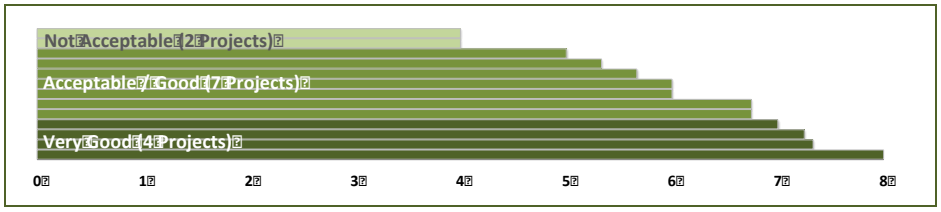
RESEARCH QUALITY

Figure 2:
Research Integrity



Research integrity, rated by the IDRC RQ+ Tool on a scale of one to eight, includes the technical quality, appropriateness, and rigor of the design and execution of the research as judged in terms of commonly accepted standards for such work. It is a key quality parameter, to the extent that in our view the quality of a research output cannot be assessed unless there is sufficient information to assess its integrity. Adherence to standards of research ethics, was part of our assessment of research integrity, although it is also partially covered under the parameter of research legitimacy. Of the sampled projects, eight generated outputs with very high levels of integrity that could serve as examples of what it means to achieve this criterion. Among the three projects that failed to reach acceptable standards, two assessments were of technical papers published by research groups in an early phase of a capacity building program. The weaknesses of these research outputs were being addressed by the capacity-building component of the projects.

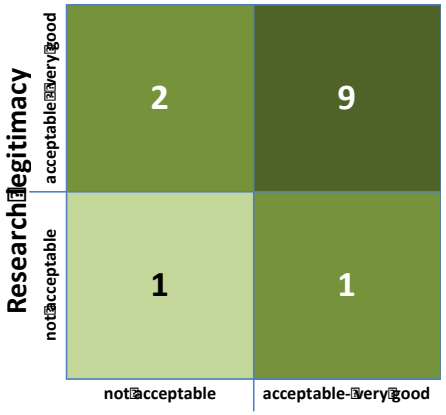
Figure 3:
Research Legitimacy[2]



To reach the highest level of research legitimacy, projects are expected to show a systematic effort to mitigate potential negative consequences, a high level of gender sensitivity, the prioritization and safeguarding of the interests of vulnerable populations and an engagement with local knowledge. These are high standards that were only reached by four of 13 projects. The main reason for most projects not reaching the highest level were weaknesses in addressing gender dynamics.

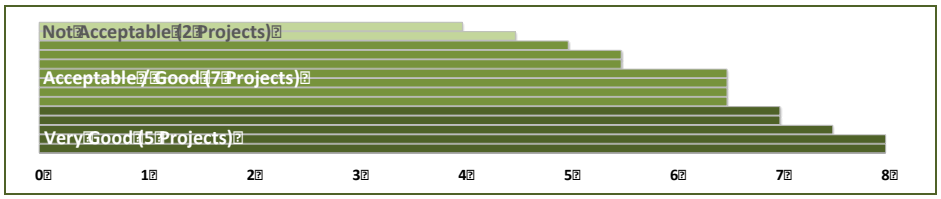
Among all quality parameters examined across the outputs of the 14 projects, gender responsiveness had the lowest mean score. The outputs of three projects were found to be very weak in terms of analysing and reporting on the gender dimensions of the research area. This indicates that gender responsiveness continues to require further strengthening in HSR. Nevertheless, the majority of projects (11/13) produced outputs with an acceptable to high level of legitimacy. There was a reasonable correlation between the integrity and legitimacy scores of evaluated research outputs.

Figure 4: Correlation between legitimacy and integrity



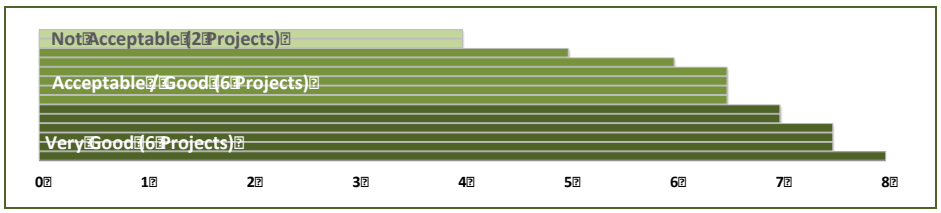
[2] The assessment criteria for legitimacy were not applicable for one project

Figure 5:
Research Importance



Under the heading of research importance, we applied the RQ+ Tool to assess the originality and the relevance of research outputs. While most outputs provided relevant knowledge about health systems, either locally, nationally or globally, we considered fewer outputs to be original. As expected, early technical outputs by inexperienced research teams tended to score at the lower end of the scale. There were, however, exceptions. One early preliminary report of a baseline study to evaluate the impact of a community- and rights-based primary health care intervention was among the two projects that achieved top scores in terms of relevance and originality.

Figure 6:
Positioning for Use



Under the heading of 'positioning for use', we assessed the efforts by the research teams to make knowledge available to the relevant audience, and the extent to which researchers reflected on the receptivity of research users in the design of their project. Many projects scored highly on this parameter reflecting on the importance of the 'influence' outcome of HSR. Several of the projects involved their key audience early in the research process.

HSR is an action-oriented field. This is well reflected in the outputs generated by the GEHS-supported research projects. We found that those projects that we excluded from the quality assessment because their outputs were not suitable for the application of the RQ+ tool were often particularly strong in their 'position for use'. Those were the projects whose primary outputs were policy papers, training manuals, editorials and advocacy material.

Our analysis of the relationship between research quality and risks in the data environment, research environment and political environment found that there was no correlation. This indicates that GEHS was able to support quality research, even in difficult contexts. The main mitigation strategy used in all projects was the IDRC Grants Plus approach which relied on a close working relationship between the grantees and the GEHS officers. It allowed early detection of potential risks and rapid action through administrative or technical support.

4.3 RELEVANCE AND SIGNIFICANCE OF PROGRAM OUTCOMES

- The achievements described by GEHS were generally accurate for the sampled projects and demonstrate positive influence of the program on the way in which HSR is undertaken in LMICs.
- Nineteen of 24 sampled projects contributed outcomes that are, or are likely to be, relevant or significant to the strengthening of health systems and are consistent with the program prospectus.
- GEHS's achievements in the 2011-2016 Prospectus period were above expectations. To our knowledge, there is no similar research funding program in this field that has accomplished as much given the time elapsed and available resources.

GEHS summarised its outcomes by providing evidence for nine statements of achievement (Annex 6B) that broadly correspond to the expectations laid out in the prospectus (Annex 6A): demonstrating progression in creating capacity, developing new methodologies, generating knowledge, and influencing policy and practice at the individual, institutional, national, regional and global levels. Our analysis of available documents and our interviews with program officers and grantees about the sampled projects led us to conclude that the examples given by GEHS to support these statements were generally accurate and illustrative of the program's significant achievements across its outcome areas.

Table 1 summarises our program level assessment of the expected major outcome contributions of each of the sampled projects (see Annex 6C for our allocation of specific projects). The distribution of projects across outcome areas is consistent with GEHS's allocation of investments (Figure 1 and Section 4.1). Importantly, the projects demonstrate a progression from "building" at the local level, through "influencing" at the regional level to "achieving a critical mass". Whereas we would expect an early stage program to focus on building the capacity of individuals and institutions, the program showed its maturity by supporting projects that were locally relevant as well as projects that influenced the way in which HSR is informed and practiced regionally and globally. We illustrate below how the program achieved this progression of outcomes for the projects as they are highlighted in Table 1[3].

Table 1: Distribution of the 24 sampled projects by expected major outcomes

OUTCOME AREA	PROGRESSION OF OUTCOMES			Total
	"Building" Mainly local	*"Influencing"* Mainly regional	*"Achieving critical mass"* Mainly global	
Creation of capacity	6 projects	2 projects	2 projects	**10 projects**
Development of methods	1 project	3 projects	2 projects	**6 projects**
Generation of knowledge	1 project	7 projects	2 projects	**10 projects**
Influence on policy and practice	4 projects	1 project	2 projects	**7 projects**
Total	**12 projects**	**13 projects**	**8 projects**	

Fifteen projects were allocated to one cell, and nine to two cells in the table
This table follows the format of the 2011-2016 Prospectus Table of Outcomes

[3] We restrict our examples to the major outcomes for each project as categorized in Table 1.

CREATING CAPACITY:

The GEHS program has: built capacity; influenced capacity development at national and regional level; and begun to build critical mass of capacity to undertake HSR. We highlight ten projects that exemplify these outcomes.

Building capacity: GEHS supported curriculum development, training and mentoring programs in Africa and Asia. We noted a particularly high output from such activities in Africa, including at least 30 masters graduates in policy analysis in Francophone Africa, 40 policy analysts in health financing analysis across sub-Saharan Africa, and 150 African doctoral dissertations as indicated in the FPR. We concluded that these projects are relevant and significant to the development of a critical mass of health system researchers and policy analysts in Africa. The GEHS program's long-term support for the African Doctoral Dissertation Research Fellowships project, for example, addresses a critical bottleneck: the failure of enrolled PhD students at African universities to complete their theses, and/or publish their research, usually due to lack of funds. We would like to see IDRC insisting that their grantees keep records of the types of dissertations and publications arising from these activities and more systematic career follow-up of the trainees. It would be advisable to request grantees to be prepared to show how they intend to provide such outcome information when they develop their proposals.

GEHS also supported projects aimed at strengthening capacity to undertake research on governance for equity in health systems strengthening. The West African Health Systems Research Initiative has established a regional consultative committee to build a critical mass of researchers and other stakeholders able to influence policies and prioritize HSR in the region. After two years of funding, we were unable to find much evidence to demonstrate outcomes. On a smaller scale, a project in Maharashtra State in India aimed to build research capacity within an advocacy NGO. We note that it takes time to build such research capacity and advise that support of this kind be very carefully targeted and linked over a longer term to mentoring institutions with sufficient capacity. The African Doctoral Dissertation Research Fellowships project provides an excellent example of a model that builds capacity of individuals and their institutions. Many of its PhD graduates are working productively in African research settings.

Influencing capacity at national and regional level: GEHS has successfully supported networks that aim to increase coordination and cooperation among researchers, and stakeholders. Although its outcomes are as yet not well documented, the Collaboration for Health Systems Analysis and Innovation (CHESAI) is strengthening capacity to conduct health policy and systems research in South Africa towards achieving a critical mass. The Indonesian Network on Equity and Social Protection brought together researchers and practitioners, involving 17 universities to work on issues of equity and health financing. Given the challenges in Indonesia of scaling up health insurance and striving towards UHC, this work is highly relevant.

Achieving a critical mass of capacity: Two projects exemplify long-term GEHS support for projects that have built collaborations between LMIC researchers and institutions. The outcomes of EQUINET are highly relevant and significant since it has carefully built local, national and regional capacity to analyze the equity of health systems and to critically evaluate and improve the use of national and local health systems data by partnering across institutions and countries. The Global Network for Health Equity has effectively built capacity in research on health financing by linking three networks of researchers in Africa, Asia and Latin America.

DEVELOPING RESEARCH METHODOLOGIES:

The GEHS program is (i) bringing together researchers from various disciplines to build their common understanding of appropriate methods, to ensure that research findings are robust and replicable, and can be generalized to some extent; (ii) influencing the development of scientifically sound and consistently used research methods through innovation, application, and consolidation; and (iii) beginning to achieve a critical mass in HSR methods. We highlight six projects that exemplify these outcomes.

Building an understanding of methods: The Strengthening Equity through Applied Research Capacity building in eHealth (SEARCH) project stands out for its activities to build methodologies through collaboration across disciplines and institutions using eHealth. Although there has been an explosion of research projects on the use of information technology in health, very few of them are studying the implications of the technology on the equity and governance of health systems. Under the SEARCH program seven research teams on three continents are linked in an interdisciplinary mutual learning network to exchange experiences and findings as they address these issues. The project is in an early phase and has not yet produced any outputs that could be reviewed.

Influencing the development of methods: Three of the sampled projects demonstrated that researchers and institutions are systematically applying, innovating and creating new methods: the Rajiv Health Insurance Scheme project developed and published a methodology for the use of National Sample Survey data in public health research in India. The Indigenous Equity in Health Systems project is highly relevant, both in terms of influencing governance and quality of health services at the local level through community action, and potentially through documenting evidence for the effectiveness of rights-based approaches to health systems strengthening. The Strengthening the Evidence Base for Integrating Gender and Equity in Health Research and Policy in India project developed an innovative triangulation approach to improve the validity of information obtained through verbal autopsies of maternal deaths.

Achieving a critical mass of methods: Two of the sampled projects developed and applied rigorous research methodologies that have become a reference in their field. The Alternative Public Service Delivery Models in Health, Water, and Electricity project built strong links between different sectors at the local, national and international levels on three continents, generating evidence that informed resistance to privatization of public services using participatory action research methods. It created tools for objective analysis of various ownership and governance models for local services in all sectors (led by water and health). In 2014, in collaboration with the Alliance for Health Policy and Systems Research, GEHS supported the publication of a journal supplement on applying systems thinking methodologies to HSR. This supplement is the most complete and detailed reader for complex systems analysis in health. Together with an associated training package it will have a significant impact on methodological development in HSR.

GENERATING KNOWLEDGE

The GEHS program has: built knowledge to influence local health policies and practices; *influenced knowledge by opening and deepening the HSR knowledge base; and begun to build a critical mass of knowledge about HSR. We highlight ten projects that exemplify these outcomes.*

Building local knowledge*:* One project clearly demonstrates that GEHS supported research is applying its effective principles to address local priorities and influence local health policies and practices. Groups of researchers in Uganda and Zambia prepared national case studies demonstrating ethical and equity choices in expanding UHC, with a focus on fair financing.

Influencing the availability of knowledge: A project to strengthen primary health care and social protection in Pakistan is in its early stages but aims to expand and apply a health financing model from

tertiary to primary health care facilities using a technology interface to assess the poverty status of patients. If the approach is successful, it has the potential to reduce catastrophic expenditures borne by extremely marginalized people.

At least six other sampled projects from several geographic regions are likely to influence or are influencing national and regional policies, practices and priorities. In India, the evaluation of the Rajiv Health Insurance Scheme project has generated knowledge about the role of hospital insurance in achieving UHC and its shortcomings at the primary health care level. Another project is starting to develop evidence to facilitate the roll out of UHC at the state level. In Indonesia, grantees have published three volumes of an on-line journal in Bahasa that focus on key health policy issues, especially regional inequities and financing challenges faced by the effort to scale up national health insurance. An evaluation project in Chile found that the current approach to providing early childhood development services in the health sector was not effective, a finding that may result in changes in how the program is being delivered. Methodological issues make it less clear how the work in Uruguay under the same project will have an impact on breastfeeding policy. In Nigeria, NEHSI has provided extensive and exemplary evidence of a model approach to health system improvement. Finally across Africa, the African Health and Policy Association is preparing policy analysts in methods of health financing in order that they can build and monitor UHC.

Achieving a critical mass of knowledge: GEHS supported the publication of a journal supplement on sexual and reproductive rights and health in an open access journal. The contributions reflected on progress achieved since the 1994 International Conference on Population and Development in Cairo and looked ahead to the international development agenda after 2015. The papers published in this issue of the journal are highly accessed online. The Global Network for Health Equity is influencing policy, practice, agendas and funding priorities globally, by promoting UHC from the country perspective.

INFLUENCING POLICIES AND PRACTICES

The GEHS program has: influenced local and national changes; influenced regional changes; and begun to achieve a critical mass of influence at the global level. We highlight seven projects that exemplify these outcomes.

Building activities that influence national changes: GEHS supported research is impacting and informing local and national policies and practices. NEHSI commissioned an independent "Proof of Influence" evaluation which identified almost 300 outcomes that demonstrated "proof that sustainable changes can be influenced to generate evidence and use evidence for decision-making and actions across multiple levels of responsibilities". CHESAI has influenced the development of the health strategy in the Western Cape Province of South Africa, although we could not find evidence for the assertion of the FPR that the project informed "the decentralization process in South Africa resulting in more informed implementation of services". A project in Guatemala is influencing the governance and quality of health services at the local level through community action. This project includes a randomized community intervention trial which, once completed, will potentially contribute significantly to global knowledge about the effectiveness of rights-based approaches to development in the health sector. In India, a project is improving primary health care by mentoring and providing information about maternal safety and maternal rights to NGOs and government agencies that work with communities and local advocates.

Influencing regional changes: EQUINET has generated a range of knowledge products of high quality that are taken up widely throughout Eastern and Southern Africa. With GEHS support, EQUINET has developed into the most sophisticated and influential network for health equity research and evaluation in Africa.

Achieving a critical mass of influence at the global level: The institutions and researchers participating in the Global Network for Health Equity are global leaders in research on financing options for the implementation of UHC in LMICs. They have published many high-quality papers in top-impact journals, and prepared policy-relevant reports governments and international development agencies focussing on how to finance more equitable access to health services in LMICs. Country reports generated by a project in Ethiopia, Uganda and Zambia contributed to the WHO report 'Making Fair Choices on the Path to Universal Health Coverage'.

RELEVANCE AND SIGNIFICANCE OF THE OUTCOMES

Table 2 summarizes our assessment of the relevance and significance of the sampled projects. We rated most of the projects as good or very good on both criteria. We had to predict the significance of some of the projects not only because they were in their early stages but also because there was not sufficient emphasis on outcomes as opposed to outputs in project reporting. We have also indicated in Annex 6C the nine projects we assessed as very relevant and very significant

Table 2: Relevance and significance of the outcomes of the 24 sampled projects

Relevance \ Significance	N/A	Not acceptable	Less than acceptable	Acceptable /good	Very good
N/A	1				
Not acceptable					
Less than acceptable			1		
Acceptable /good	1		3	4	
Very good	2			3	9

Four significant scores and one relevance score were "predicted"

The ultimate goal of the GEHS program is to improve health outcomes. This is an appropriate program vision, but changes in health outcomes are difficult for a research program to demonstrate. Under Achievement #9, GEHS reported that, through the implementation of the NEHSI research initiative in Nigeria, "maternal mortality rates were reduced in the focus Local Government Area". The team supported this with a footnote comparing maternal mortality ratios and infant mortality rates in the intervention area with other Local Government Areas. However the size of the population on which these calculations were based was insufficient to document a statistically significant difference at the reported level, especially in the maternal mortality ratio. Even if the differences in rates and ratios would have reached statistical significance levels, attribution of the difference to the research initiative would be very difficult and the intention to infer causation would have to be built into the design of the study from the start.

The achievements of the GEHS program since 2011 need to be considered in the context of the challenging and changing environment of HSR, especially in sub-Saharan Africa, recent regional emergencies, and the reorganization of health-sector development-oriented research in Canada described earlier in this report. Given these contextual factors, the achievements of GEHS are above expectations. To our knowledge, there is no similar research funding program in this field that has accomplished as much given the time elapsed and available resources.

5 KEY ISSUES FOR IDRC'S BOARD OF GOVERNORS AND SENIOR MANAGEMENT

The GEHS program performed at a high level, with strong fidelity to the 2011-2016 Prospectus, especially in view of some of the external and internal challenges it faced. GEHS capitalized successfully on emergent opportunities that arose during this period, such as the increasing prominence of the theme of UHC in international public health and, more recently, the new Canadian international development focus on maternal and child health in Africa. The program supported new and emergent aspects of HSR and contributed to development of methods and generation of new knowledge, all of which was accompanied by significant capacity strengthening. With the support of GEHS, institutions and networks in LMICs have grown to occupy strong positions to influence local, national, regional and global policy agendas.

We raise the following issues for consideration by the IDRC Board of Governors and Senior Management:

1. ***Maintain leadership in this field***: Through its focus on governance and equity in strengthening HSR, IDRC has, through GEHS, played a critical role among funders of health research for development. Although GEHS is at the end of three funding phases, the momentum gained by the program could be lost unless IDRC maintains its unique leadership in this field. International experts in HSR to whom we spoke clearly stated that IDRC, and GEHS in particular, is widely viewed as a key player in developing and supporting HSR capacity in LMICs, and in ensuring that HSR influences global health policy and practice.

2. ***Increase global visibility***: While GEHS's leadership in global HSR is well recognized by its grantees and other investigators in this field, as well as among its funding partners, our discussions with international experts indicated that the program is not as visible globally as it might be. We suggest that IDRC further publicize and disseminate its work in HSR widely and ensure IDRC representation on relevant advisory and implementation bodies. This can readily be done within the IMCHA portfolio, for example, given that strengthened health systems are a key prerequisite for progress in reproductive, maternal, neonatal and child health.

3. ***Rethink LMIC research leadership:*** A major element of GEHS's success in recent years has been its focus on "growing" a cadre of HSR experts in LMICs, now spanning a range of career stages. The next phase of IDRC support should seek to refine this approach, learning from extensive past experience, to invest in the most effective and efficient approaches to capacity building. We recommend that IDRC:

    a. ***Support experienced researchers to network and mentor the younger generation:*** The maturity of the GEHS program has resulted in a rich mixture of experienced and less experienced grantees in several regions. Some senior HSR researchers are now so successful that they do not need IDRC funding for research *per se.* Those senior researchers could instead be funded by IDRC to continue building the capacity of early-career researchers and less accomplished institutions in their regions, through creative mentoring programs. Such activities are essential to building the field, yet they are not well funded by other international agencies.

    b. ***Target effective capacity building models:*** GEHS has explored several approaches to capacity building. While the outputs are impressive, we suggest the program systematically reflect on which models have been most successful, including additional approaches to building a critical mass of researchers within regions - for example the support of centres of excellence – to guide further investments.

    c. ***Achieve impact in West Africa:*** Establishing and sustaining capacity for HSR and its translation into policy and program action is a particular challenge in West Africa. We suggest that after evaluating capacity building approaches, GEHS form long-term partnerships with other funders to

implement a coherent institution-based model in West Africa, in order to allow larger-scale investments to overcome longstanding challenges and achieve sustained impact.

4. ***Ensure that future strategies define measurable outcome targets and monitor progress towards their achievement:*** We advise that future programs define more specifically how achievements towards outcome targets will be measured, beyond the monitoring of inputs and outputs. Recipients of HSR grants should be encouraged and supported to monitor more distal (downstream) outcomes of their research and capacity-building projects. However this effort has to be within the range of feasibility. We note that changes in health outcomes can rarely be attributed directly to research or research strengthening projects.

6 ANNEXES

Annex 1. List of Abbreviations and Acronyms

CHESAI	Collaboration for Health Systems Analysis and Innovation
CIHR	Canadian Institutes of Health Research
DFATD	Department of Foreign Affairs, Trade and Development
ECSA	East, Central, and Southern African
EQUINET	Network in Equity in Health in East and Southern Africa
FPR	Final Prospectus Report
GEHS	Governance for Equity in Health Systems
GHRI	Global Health Research Initiative
GNHE	Global Network for Health Equity
HSR	Health Systems Research
ICT	Information and Communications Technology
ICT4D	ICT for Development
IMCHA	Innovation for Maternal and Child Health in Africa
LMIC	Low- and Middle- Income Country
NEHSI	Nigeria Evidence-based Health System Initiative
NGO	Non-Governmental Organization
RQ+	Research Quality Plus
RSP	Research Support Project
SEARCH	Strengthening Equity through Applied Research Capacity building in eHealth
UHC	Universal Health Coverage
WAHO	West African Health Organisation
WHO	World Health Organization

Annex 2. Profile of the review team members

Josef Decosas is a Canadian-trained public health physician and health service administration specialist. He is a partner in **hera**, an international cooperative health consulting company with headquarters in Belgium. He worked during most of his career as program manager and technical advisor for international health development projects in Africa.

John Frank, a physician-epidemiologist, has worked in 20+ countries, and is currently founding Director (2008) of a research-to-policy centre at the University of Edinburgh -- the third such Directorship in Canadian/UK start-ups since 1991, dedicated to knowledge transfer and exchange in public health.

Sarah Macfarlane is a professor in Epidemiology and Biostatistics, and in Global Health Sciences, at the University of California San Francisco. Earlier she worked at the Liverpool School of Tropical Medicine and at the Rockefeller Foundation. She has collaborated in many countries in Africa and South East Asia.

Grace Sheehy recently completed a Master of Health Sciences from the University of Ottawa where she undertook thesis research on reproductive health in Myanmar. She is a former summer student of the GEHS program, and was the research assistant to the review team.

Annex 3. Project sampling strategy and sample profile

Our sampling frame was the GEHS project database (version of February 2015) which included 96 projects. Eight of these were legacy projects of the ICT4D Program and were removed from the sampling frame.

We sampled GEHS projects primarily on the basis of a strategy to answer Question 3, and to a lesser extent Question 1. We then examined whether the sample was satisfactory to answer Question 2. The strategy aimed to provide us with between 20 and 25 projects with sufficient diversity to represent the GEHS portfolio.

For Questions 3 and 1, it was important to include as many of the projects that were mentioned in the GEHS FPR so that we could compare what the program *intended* to achieve as published in the prospectus with what the program team *reported it had* achieved as published in its FPR.

We decided to include all three GEHS "legacy" flagship projects initiated before the prospectus period began in 2011, but no other continuing projects (21) initiated before 2011. We then excluded all RSPs (20) and, after that, projects (3) of less than $100,000. We also excluded ICT legacy projects (4) initiated during the prospectus period. This left 45 projects from which to sample.

Using the GEHS program dashboard spreadsheet, we stratified projects by whether or not their outcomes were intended to be largely in terms of "capacities" (over 50%), "methods" (over 35%), "knowledge" (over 50%) or "influence" (over 35%), or if the outcomes of the projects were intended to be mixed across these categories -- i.e. five levels. We then selected three to six projects from each category. When there were too many projects in a particular category, we selected all flagship projects, and projects mentioned in the GEHS FPR. This resulted in 23 projects (combining two phases of the African Dissertation Initiative into one project) including all 12 flagship projects.

To address the question of research quality (Question 2), we reviewed the project portfolios of the selected 23 projects and only found 10 suitable products for the RQ+ assessment. We searched the database for additional research projects that had intended knowledge production of greater than 35% and found 11 only four of which had products for the RQ+ assessment. This amounted to a total of 27 projects (taking the original 23 and adding the four RQ+ projects).

We consulted with GEHS who suggested: 1) removing five projects (105727, 106973, 103858, 104373, 104960) - with which we agreed; 2) adding two projects to the main sample (106949, 106969) - with which we did not agree; and 3) adding seven projects (105309, 105053, 107022, 106683, 106502, 107501, 107532) for the purposes of RQ+ assessment – we agreed to add three of these (105053, 106683, 106502). We further decided to remove one of the RQ+ additional sample (107532). This resulted in a total of 24 projects to be included in the review. During the review itself we removed one project proposed by GEHS (105053) and replaced it with another proposed by GEHS (107501). Of the 24 projects sampled 22 were research projects and two awards.

Table 3A provides the full list of 24 projects. This sample was representative of the GEHS portfolio of projects in terms of budget allocation to the four outcome areas based on the estimated percentage contribution to each outcome provided in the project approval documents (Figure 3A).

Annex 3A: Projects sampled for the review

104613	Nigeria Evidence-based Health System Initiative: Implementation
105141	Understanding Successful Alternative Public Service Delivery Models in Health, Water, and Electricity: Sub-Saharan Africa, Latin America and Asia
105675	EQUINET: Reclaiming the resources for health
106229	Strengthening Equity through Applied Research Capacity building in eHealth (SEARCH)
106400	Setting Priorities in Health - a reasoned approach
106439	Research, Capacity Building and Policy Response for Equity in Health and Health Financing: Building and Strengthening Developing Country Networks
106502	Research, advocacy and capacity building for health rights and equity oriented health system change in Maharashtra, India
106683	Strengthening the evidence base for integrating gender and equity in health research and policy in India
106751	Evaluation of Rajiv Aarogyasri Health Insurance Scheme: Towards improved access to quality healthcare services in Andhra Pradesh, India
106788	Collaboration for Health Systems Analysis and Innovation CHESAI
106815	Enhancing participation of indigenous people to address discrimination and promote equity in health systems
106817	Strategies to improve the quality of health care - Learning from experiences in Uruguay and Chile
106920	Strengthening the Indonesia Health Policy Network to Promote Equity and Social Protection
106948	The West African Initiative to Strengthen Capacities through Health Systems Research
106970	United Nations Commission on Commodities for Women's and Children's Health
106975	Advancing knowledge and practice for using systems thinking for equitable health systems strengthening
106977	African Health Economics and Policy Research Capacity Building and Dissemination
107129	Strengthening Primary Health Care and Social Protection: Universal Coverage in Pakistan through Heartfile Health Financing
107304	Community health learning program for health equity in India
107313	Preparing states in India for universal health coverage
106206	African Doctoral Dissertation Research Fellowships Program - Phase III
106129	Projet de renforcement des capacités en analyse des politiques et systèmes de sante en Afrique Subsaharienne
107501	A fair path towards universal coverage: National case studies for Ethiopia, Uganda and Zambia
107248	Special Issue of a journal on Sexual and Reproductive Rights and Health (SRRH) Beyond 2014

Annex 4. Evidence of responsiveness to identified priorities

The table refers to Section 4.1 of the report and lists the projects sampled by the review that responded to recommendations to GEHS about program priorities and advice from expert and stakeholders

Priority Topics/ Areas	Sampled GEHS Projects (2011-2015)
Francophone West Africa	• Policy Analysis Africa (106129) • SEARCH (106229) • West African Health Systems Research (106948) • African Doctoral Dissertation Research Fellowships (106206; 107508)
eHealth / mHealth	• SEARCH (106229)
Human resource bottlenecks for research in LMICs	• African Doctoral Dissertation Research Fellowships (106206; 107508) • AfHEA (106977)
Regional/global networks to allow cross-setting/project learning	• EQUINET (105675) • Municipal Services Project (105141); • GNHE (106439) • CHESAI (106788) • African Doctoral Dissertation Research Fellowships (106206; 107508)
Gender-focused work	• Health Rights and Equity - Maharashtra (106502); • Municipal Services Project (105141) • NEHSI (104613) • Gender and Equity in India (106683) • SRRH Journal Supplement (107248)
Tracking 'hot' topical policy issues (e.g. Universal Health Coverage)	• GNHE (106439); • Rajiv Aarogyasri Health Insurance (106751) • Heartfile (107129); • UHC India (107313); • Towards Universal Coverage (Ethiopia, Uganda, Zambia) (107501)
Improved methodologies and innovative applications of existing methods in LMIC settings	• SEARCH (106229) • UHC India (107313) • GNHE (106439) • Rajiv Aarogyasri Health Insurance (106751) • Municipal Services Project (105141) • EQUINET (105675)

Annex 5. Results of the RQ+ assessment

We sampled projects for the review to maximize the applicability of the RQ+ tool by preferentially selecting research projects that, according to the GEHS database, listed at least one and if possible more academic publications among their outputs. We did this under the assumption that an academic publication would, in the majority of case, be a research report in a format accepted by a scientific journal.

However, on a review of our initial sample, we found that we did not have a sufficient number of outputs that could be assessed. The outputs found in the project files included, among others:

- Published viewpoints and editorials
- Training manuals and methodology guides
- Policy papers based on critical reviews of available evidence, however without a description of how this evidence was collected and analyzed
- Publications by researchers of studies they had conducted prior to initiating the project or with funding that was not related to the IDRC grant
- Papers that were commissioned under a GEHS-supported project, and often also written for publication with financial and technical support of GEHS, for instance to be included a special journal supplement, but that described research that was not part of the GEHS portfolio of funded projects
- Outputs that posed special challenges such as one project with publications written in Bahasa/Indonesian and another project with outputs of ethnographic citizens' research in the form of video footages

Among these products were outputs of high quality, and sometimes exceptional quality, some of them with a high potential to generate impact in terms of influencing policy and practice. However they could not be assessed in terms of the integrity of GEHS funded research.

We discussed the problem of identifying a sufficient sample of assessable outputs with the GEHS team, with individual project officers, and in some cases with grant recipients. These discussions resulted in some changes in our sample as described in Annex 3. In some instances it also led to receiving additional documents that had not yet been filed in the project folders on the IDRC SharePoint site. These additional documents were useful and helped to increase our sample, however in most cases they were initial or preliminary technical reports. In terms of the parameters of the RQ+ tool, they were often of relatively low quality, especially if they were generated by projects with a major objective of capacity building.

In our final sample, we identified 11 projects that had generated outputs of research funded by GEHS in the 2011-2016 Prospectus period that could be assessed with the RQ+ tool. Some of these projects had produced many outputs. However the objective of the review was to assess the quality of the supported research on the basis of their outputs rather than the quality of each output. In three instances the projects had distinct components with funding of different

Table Annex 5A: Number of outputs reviewed

Project	Academic papers published in a peer reviewed journal	Technical reports and unpublished papers
1		2
2	3	1
3	1	
4	3	1
5		1
6-1	2	
6-2	1	
7-1		1
7-2	1	1
8-1	8	5
8-2	2	
9	8	2
10	8	8
11	8	
Total	**45**	**22**

research teams. This increased our sample of RQ+ assessments to 14. We aggregated all outputs that were generated by each research team working in the same location in a single RQ+ assessments, taking the quality of all outputs into consideration. Overall, we reviewed 67 outputs as presented in Table Annex 5A.

The results of the individual RQ+ assessments are presented in Table Annex 5B. The five contextual parameters on the left side of the table are assigned scores ranging from 1 to 3, the research quality parameters on the right side are scored from 1 to 8. The meaning of the scores is explained in the IDRC RQ+ Tool. The information gained through the scoring exercise is presented in the main body of this review report.

Table Annex 5B: RQ+ Scores

Project	Maturity	Research capacity strengthening	Risk in data environment	Risk in research environment	Risk in political environment	MEAN	Research integrity	Potential negative consequences	Gender responsiveness	Inclusiveness of vulnerable populations	Engaged with local knowledge	Originality	Relevance	Knowledge and sharing	Timeliness and accountability	MEAN
1	3	1	2	N/A	1	**1.75**	7	N/A	5	6	6	6	7	8	8	**6.63**
2	1	3	1	2	1	**1.60**	3	7	6	8	6	4	7	8	7	**6.22**
3	1	1	2	1	1	**1.20**	6	8	8	8	8	8	8	6	7	**7.44**
4	1	2	1	2	3	**1.80**	7	N/A	6	8	7	7	7	4	6	**6.50**
5	3	1	1	1	3	**1.80**	7	6	N/A	8	8	8	8	N/A	6	**7.29**
6-1	1	2	1	1	1	**1.20**	7	N/A	2	6	8	5	8	6	7	**6.13**
6-2	1	2	1	1	1	**1.20**	6	N/A	N/A	4	N/A	6	5	4	4	**4.83**
7-1	3	3	3	2	2	**2.60**	5	N/A	1	6	8	4	5	8	7	**5.50**
7-2	2	3	1	2	2	**2.00**	3	3	3	4	6	4	4	8	5	**4.44**
8-1	2	3	3	3	3	**2.80**	7	6	7	7	7	6	7	8	7	**6.89**
8-2	2	3	3	3	3	**2.80**	3	N/A	8	6	4	2	8	4	4	**4.88**
9	2	2	3	3	3	**2.60**	7	7	7	7	8	7	7	8	6	**7.11**
10	3	3	2	3	3	**2.80**	7	N/A	6	N/A	N/A	6	7	6	7	**6.50**
11	2	2	1	1	3	**1.80**	7	N/A	N/A	N/A	N/A	7	8	6	7	**7.00**
MEAN	**1.93**	**2.21**	**1.79**	**1.92**	**2.14**	**2.00**	**5.86**	**6.17**	**5.36**	**6.50**	**6.91**	**5.71**	**6.86**	**6.46**	**6.29**	**6.24**

Annex 6. Relevance and significance of project outcomes

Annex 6A: Summary of expected program outcomes (GEHS Program 2011-2016 Prospectus Table 1)

	Current trend	Minimum	Medium	Maximum
1.Developing a critical mass of LMIC researchers and institutions	There is a growing number of LMIC researchers and institutions influencing policies and practices at local, national and global levels. However, there is strong variation in capacities, lack of coherence in and collaboration around priorities. In addition there is limited and inappropriate funding to strengthen this outcome.	***Strengthening capacities to undertake and use research*** Fund curriculum development, training and mentoring programs Capacity strengthening to undertake research on governance for equity in health systems strengthening	***Influencing at national and regional level*** Increased coordination and cooperation among researchers, relevant stakeholders Publications and engagement in relevant national and global fora to influence national and regional policies and practices	***A critical mass aligned for maximum influence*** Vibrant collaborations of LMIC researchers and institutions aligned around the effective principles influencing global policies and practices Building the field of governance for equity in health systems strengthening
2.Enabling the innovation, use and promotion of appropriate and rigorous methodologies	GEHS supported researchers have developed a growing body of methods that use effective principles of governance, equity and integration to strengthen health systems. The challenge lies in the internalization and widespread adoption of these methods and their translation into funding decisions and practices to strengthen health systems.	***Exposure and dialogue*** Researchers from various disciplines discuss research methods to deepen and consolidate their understanding of appropriate methods	***Innovation, application, and consolidation*** *Researchers and institutions are systematically applying, innovating and creating new methods*	***Recognition of credible body of research methods*** Recognition and use of a rigorous and appropriate body of research methodologies to influence and be the 'mainstream' approach
3.Building a body of knowledge and evidence-base of research findings on governance for equity in health	Strong research findings exist, but there are differing understandings of the methods and concepts. This fragments the knowledge base, divides the research community, and sends conflicting messages to decision makers and practitioners. The challenge lies in synthesizing research findings into a coherent body of knowledge that can have greater influence**.**	***Building GEHS knowledge base and research findings*** GEHS supported research is applying and confirming the effective principles and addressing local health systems priorities and influencing local health policies and practices Coordination with the methods dialogue (above)	***Opening and deepening the GEHS knowledge base*** GEHS supported research is growing and consolidating with a deepened application of the effective principles, integrating social and gender analysis, and innovative ICTs Influencing national and regional policies, practices/ priorities	***Affecting research paradigms and their influence*** Coherent and recognized body of knowledge applying the effective principles Critical mass of researchers and institutions are influencing global policies, practices, research agendas and funding priorities
4.Influencing policies, practices, agendas and funding priorities	GEHS supported research has had varying influence on policies and practices at local, national, regional and global levels. There is a need for more coherence and collaboration among and with LMIC researchers, relevant stakeholders and institutions to have a more significant influence not only on policies and practices but also on research agendas and funding priorities.	***Influencing local and national changes*** GEHS supported research conducted by skilled researchers is influencing and informing local and national policies and practices	***Affecting regional changes*** A growing critical mass is producing a relevant body of knowledge and evidence-base Informing and influencing regional policies, practices, and priorities Setting regional agendas in selected areas	***Taking leadership for global changes*** A critical mass of researchers and institutions leads the body of knowledge, research findings and research methodologies Informing and influencing policies, practices, agendas and funding priorities at global level, including at the WHO and Northern agencies

Annex 6B: GEHS achievements as reported in the 2011-2016 Final Prospectus Report

1. Increasing number of skilled health system researchers and institutions across LMICs consider the effective principles in health system research
2. Increased alliances and collaboration between researchers, policy makers, health providers, civil society organizations and knowledge brokers to address health systems issues are creating a vibrant community and building a critical mass for health system research adopting the effective principles
3. Deepened the foundation of health systems research methodologies including innovations in research design
4. Increasing recognition, impact and adoption at scale of health systems research methods
5. A growing body of knowledge with scientific merit that is applying the GEHS effective principles
6. The growing body of knowledge applying the GEHS effective principles is both legitimate and important to key stakeholders
7. A recognised body of quality GEHS knowledge is well positioned for use and has had impact, particularly at the community level
8. Progressive influence in key policy areas and primary health care delivery by 'being there and staying there'
9. Measurable change in the health of individuals and communities

Annex 6C: Sampled project outcomes allocated by the review team to the Prospectus Table of Intended Outcomes[4]

1.Developing a critical mass of LMIC researchers and institutions			
Current trend	**Minimum** *Strengthening capacities to undertake and use research*	**Medium** *Influencing at national and regional level*	**Maximum** *A critical mass aligned for maximum influence*
There is a growing number of LMIC researchers and institutions influencing policies and practices at local, national and global levels. However, there is strong variation in capacities, lack of coherence in and collaboration around priorities. In addition there is limited and inappropriate funding to strengthen this outcome.	**Fund curriculum development, training and mentoring programs:** 106129 Policy Analysis Africa 107304 Community Health Training Program 106206 *African Doctoral Dissertation Program 106977 AfHEA **Capacity strengthening to undertake research on governance for equity in health systems strengthening:** 106948 West Africa 106502 Health System Change in Maharashtra	**Increased coordination and cooperation among researchers, relevant stakeholders:** 106788 CHESAI 106920 Indonesian Network **Publications and engagement in relevant national and global fora to influence national and regional policies and practices:**	**Vibrant collaborations of LMIC researchers and institutions aligned around the effective principles influencing global policies and practices:** 105675 EQUINET* **Building the field of governance for equity in health systems strengthening:** 106439 Equity in Health Financing
2.Enabling the innovation, use and promotion of appropriate and rigorous methodologies			
Current trend	**Minimum** *Exposure and dialogue*	**Medium** *Innovation, application, and consolidation*	**Maximum** *Recognition of credible body of research methods*
GEHS supported researchers have developed a growing body of methods that use effective principles of governance, equity and integration to strengthen health systems. The challenge lies in the internalization and widespread adoption of these methods and their translation into funding decisions and practices to strengthen health systems.	**Researchers from various disciplines discuss research methods to deepen and consolidate their understanding of appropriate methods** 106229 SEARCH	**Researchers and institutions are systematically applying, innovating and creating new methods** 106751 * Rajiv Health Insurance 106815 * Indigenous Equity in Health Systems 106683 Gender and equity in India (verbal autopsies)	**Recognition and use of a rigorous and appropriate body of research methodologies to influence and be the 'mainstream' approach** 105141 * Municipal Services Project 106975 * Equitable HSS: Journal Supplement on Systems Thinking in Health Systems Research

[4] Projects assessed as both very relevant and very significant are marked with an asterix (*)

3.Building a body of knowledge and evidence-base of research findings on governance for equity in health systems			
Current trend	**Minimum** *Building GEHS knowledge base and research findings*	**Medium** *Opening and deepening the GEHS knowledge base*	**Maximum** *Affecting research paradigms and their influence*
Strong research findings exist, but there are differing understandings of the methods and concepts. This fragments the knowledge base, divides the research community, and sends conflicting messages to decision makers and practitioners. The challenge lies in synthesizing research findings into a coherent body of knowledge that can have greater influence.	**GEHS supported research is applying and confirming the effective principles and addressing local health systems priorities and influencing local health policies and practices** 107501 * Fair path to UHC **Coordination with the methods dialogue** (above)	**GEHS supported research is growing and consolidating with a deepened application of the effective principles, integrating social and gender analysis, and innovative ICTs** 107129 Heartfile **Influencing national and regional policies, practices/ priorities** 107313 Preparing States in India for UHC 106920 Indonesia Network 104613 * NEHSI 106817 Uruguay and Chile Health Care Quality 106751 * Rajiv Health Insurance 106977 AfHEA	**Coherent and recognized body of knowledge applying the effective principles** **Critical mass of researchers and institutions are influencing global policies, practices, research agendas and funding priorities** 106439 Equity in Health Financing 107248 * SRH Supplement
4.Influencing policies, practices, agendas and funding priorities			
Current trend	**Minimum** *Influencing local and national changes*	**Medium** *Affecting regional changes*	**Maximum** *Taking leadership for global changes*
GEHS supported research has had varying influence on policies and practices at local, national, regional and global levels. There is a need for more coherence and collaboration among and with LMIC researchers, relevant stakeholders and institutions to have a more significant influence not only on policies and practices but also on research agendas and funding priorities.	**GEHS supported research conducted by skilled researchers is influencing and informing local and national policies and practices** 106788 CHESAI 104613 * NEHSI 106683 Gender and Equity in India 106815 * Indigenous Equity in Health Systems	**A growing critical mass is producing a relevant body of knowledge and evidence-base** **Informing and influencing regional policies, practices, and priorities** **Setting regional agendas in selected areas** 105675* EQUINET	**A critical mass of researchers and institutions leads the body of knowledge, research findings and research methodologies** **Informing and influencing policies, practices, agendas and funding priorities at global level, including at the WHO and Northern agencies** 106439 Equity in Health Financing 107501 * Fair Path to UHC

Annex 6D: GEHS reflections on reflections outcomes after discussion with the review team[5]

Outcome 1: A critical mass of LMIC researchers and institutions

The GEHS investment in strengthening the capacities for researchers, policy analysts and health providers, CSOs, and policy makers have resulted in concrete changes in the state of health systems research in LMICs as well as the behaviour of researchers.

Achievement	Example
An increased profile and understanding of HSR with an emphasis on the effective principles in LMICs	• The Grants + model through projects' approval processes and calls for applications through GEHS supported projects (e.g. ADDRF, ISSP, University of Gadjah Mada) strongly contributed to raising the interest in, the profile of, and skills in health systems research with emphasis on equity, governance and systems integration principles in Africa and Asia. • Topics and approaches of the proposals received for the fellowship programs have significantly evolved from clinical to health systems research. • CSOs and health providers understanding and embracing the importance of evidence-based decision-making at their level. • The CHESAI platform now attracting researchers from other regions. (Expert residents from Ghana, India, Argentina) • The RCC increasingly connecting researchers in West Africa and providing a platform to engage regional entities and policy makers. (Dialogue and planning grant issued to University of Ghana after submission of concept note)
HSR has been institutionalized and the institutional capacity improved which is contributing to the sustainability of HSR capacity in LMICs	• The first ever health policy and systems module (series of courses) being institutionalized in a masters' degree in Francophone West Africa, capturing the effective principles in the training content. • Alliances and networks between institutions have allowed strengthening the capacity for and uptake of HSR (Indonesia, GNHE, ISSP and ADDRF). • The institutionalization of equity analysis by Equinet (at national and regional levels) and change in evidence-based decision-making • Mainstreaming of curriculum of SOCHARA and SOCHARA expert council members on existing institutional advisory committees.

[5] Text of document prepared by the GEHS team and submitted to the review team during final validation meeting

Achievement	Example
increased leadership in HSR from LMICs with a strong voice and impact at local, national, regional and global	• Improved capacity of African training and research institutions in health systems research by retaining and attracting skilled researchers who are now attracting funding to their institutions (ADDRF, ISSP). • Increased alliances and collaboration between researchers (senior and/or juniors), researchers and policy makers, and researchers, policy makers and health providers has provided a stronger voice and improved presence from LMICs at the global, regional and national levels (GNHE, Equinet, AfHEA). • Research by LMIC researchers is increasingly being published in peer reviewed journals, especially research by young researchers. (Systems thinking supplement; people-centred supplement and the SRH supplement) • On the first elected Board of Health Systems Global, the first and unique international society for health systems research, a significant number of members (including the Chair) were GEHS research partners. Currently, on the HSG Board of 11 members, eight are from LMICs and half of them are GEHS research partners.
A vibrant critical mass of health systems researchers in LMICs	• The new and existing networks (e.g. CHESAI platform, regional networks forming a global network for health equity, Health Policy Network in Indonesia, and the RCC and WAHO) collaborating and sharing experiences. • Regions are also learning from each other and synergies between projects are established, improving south-south collaboration – ADDRF experience informing the Asia Pacific initiative, GNHE • GEHS was part of the small group that let the establishment of Health Systems Global (HSG), bringing together the broad community of health systems researchers. GEHS influenced the HSG design and regulations, ensured a strong role and leadership of LMIC researchers for its governance and activities, and contributed to its ongoing vibrancy through activities during and between symposia.

Outcome 2: Enabling the innovation, use and promotion of appropriate and rigorous methodologies

Achievement	Example
Multi-disciplinary teams crossing disciplinary boundaries to work together at national/regional/global levels have fostered dialogue, peer-learning, cross-national knowledge exchange and review of strategies used in varying policy contexts to address similar health challenges.	• MSP (105141) researchers and activists had cross-disciplinary teams who worked on alternative to privatization of services in health, water and electricity sectors. Consequently, the idea of 'publicness', which is key in striving towards national health systems, has been developed and various regional partners in Africa, Asia and Latin America are using it to assess services in health and other sectors. • The publication of a journal (106975) from abstract concepts to actual applications and experiences of systems thinking in health in LMICs. The impact on the health systems research community is such that 11 of the 14 articles have been categorized as highly accessed. Also, 6 of the articles have already been cited in other peer-reviewed publications. • A state-level health insurance Rajiv Aaogyarsi Health Insurance scheme in India was evaluated (106751) and gaps identified in the design of the scheme in terms of addressing equity issues. • SEARCH (106229) this project has convened researchers from different disciplines to discuss the GEHS effective principles as they deal with integrating

Achievement	Example
	ICTs into health systems. The dialogues fostered through face-to-face and online exchanges (supported through a learning-oriented Development Evaluation) help catalyze and nurture innovation in how this area is conceptualized and how research methods can be applied.
Projects have framed health challenges due to structural inequities, speaking to GEHS' effective principles, and then addressed these challenges using innovative methodologies that address these root problems and inform national policy through evidence.	• A project in Guatemala (106815) involves building on a methodology that focused on implementing a participatory health rights-based approach to citizens' empowerment for the monitoring of public policies and healthcare services. This project integrates deep PAR and ethnographic approaches with impact evaluation methodologies. The discussions that have taken place between the Co-PIs has placed the health system challenge at the centre and worked through a feasible, ethical and rigorous way to use these different paradigms and approaches in a single project. • Researchers are taking an existing framework (the Three-Delays Model to reduce maternal mortality), evidence from verbal autopsies and an emerging database of obstetric risk, to develop more gendered frameworks for analyzing health systems, and apply it to ongoing field research on women`s health in Karnataka State. To inform policy and practice the project (106683) has in-built platform for knowledge-Implementation link between researchers and Karnataka state government officials to promote ongoing dialogue with state actors. • Publication of a special issue in a high-impact journal that addresses sexual and reproductive health rights that brought a feminist perspective that brought evidence that challenges power relations and structural level inequities and thus addressing the effective principles to strengthen health systems. The journal promoted evidence-based dialogue debate among country partners, donors and other actors (107248).

Outcome 3: Building a body of knowledge and evidence-base of research findings on governance for equity in health systems

Some of the major global initiatives and ongoing routine health reviews were examined more critically by applying a governance, equity and systems integration lens rather than relying on analytical frameworks that consider health programmes as neutral technical interventions and reforms.

Achievement	Example
GEHS supported research has enabled the evidence and the arguments to be grounded in and validated by the context and actors in LMICs.	• 107501 A fair path towards universal coverage: National case study for Ethiopia, Uganda and Zambia – IDRC-supported research produced context-specific case studies and enabled engagement by LMIC experts in the global discussions. This involvement was reflected in the development of the guidelines submitted by the Working Group on Making fair choices on the path to universal health coverage • 105675 EQUINET. Equity Watch Series. The national and regional Equity Watch reports resulted from analysing existing health data from a governance, equity and systems integration perspective. The products, developed with key officials and stakeholders, provide a much sharper and more critical understanding of equity gaps within countries and the Eastern and Southern Africa Region.

Achievement	Example
GEHS- supported research (that is applying the effective principles, social and gendered analysis and innovative use of ICTs) is generating usable evidence and knowledge on how to transform and strengthen equitable health systems at various entry points.	• 107129 Strengthening Primary Health Care and Social Protection: Universal Coverage in Pakistan through Heartfile Health Financing – This project has started to demonstrate how innovative uses of technology can be integrated into a health system to build the foundation for systematic registration and monitoring of patients across the continuum of care, thereby transforming the system from the previous focus on catastrophic episodes of illness. • 106751 Rajiv Health Insurance – This research into a state level health insurance scheme in Andrha Pradesh, India, provided needed evidence on the importance of risk pooling, primary health care, and the public health sector in addressing health inequities. • 107313 Preparing states in India for universal health coverage – This implementation research focused directly on how to equitably implement national-level health reforms. It was designed to link research directly into the political and policy-making process and thus moved from pilot to scale up focus. • 104613 – NEHSI – This project generated evidence through innovative use of handheld tablets that provided real-time data to state-level planners. Relevant evidence was then developed into various formats to position it for use. At the community level, the evidence around social and gendered factors affecting maternal and child health were 'socialised' back to the community in videos, TV programmes, popular theatre to support community and household behaviour change. Routine data was integrated into the state health information system to inform planning and resource allocation. The State governments were so convinced by the results that they are now institutionalising evidence-based decision-making, and have put funds to continuing the methodology of collecting community-based information for planning beyond the project. • 106920 Strengthening the Indonesia Health Policy Network to Promote Equity and Social Protection – This project created a critical mass of evidence around the challenges of achieving universal health coverage in Indonesia. 200 academic and policy analysts from 17 governmental and non-governmental institutions published 77 articles and engaged with more than 1,000 decision-makers through meetings and workshops across the country. The products, written in Bahasa Indonesia, are aimed for national and sub-national users and are well-positioned to have impact. • 106817 Uruguay and Child Health Care Quality - This project contributed some evidence to the body of knowledge in health systems research focusing on intersectoral policies, health governance and health reforms in the Latin American and Caribbean region. The study found that generous allocations of resources to an intersectoral policy that is targeting health inequities doesn't automatically or necessarily translate into equitable allocation of those resources. • 107022 – RSP on the Science and practice of people centered health systems supplement in Health Policy and Planning Journal. To keep the health systems research community engaged between symposia, GEHS supported the development and publication of 11 papers on people-centred health systems in the Health Policy and Planning Journal, of which 80% were led by LMIC authors (107022). This engagement of health systems researchers globally on specific topics is also a great way to build a community of practice. It was launched at the 3rd Health Systems Research Symposium.

Achievement	Example
Some research networks have coalesced into influential groups that have produced a coherent knowledge base that is influencing agenda, policies and practices.	• 106439 – Equity in Health Financing. This group includes well-known economists playing key national roles in the development of national health insurance systems (e.g. Prof D. McIntyre in South Africa). The body of knowledge generated evidence about progress towards universal health care in Peru, South Africa, Taiwan, Tanzania, Uganda, Indonesia and Bangladesh. • 105675 EQUINET. Equity Watch Series. The national and regional Equity Watch reports resulted from analysing existing health data from a governance, equity and systems integration perspective. The products, developed with key officials and stakeholders, provide a much sharper and more critical understanding of equity gaps within countries and the Eastern and Southern Africa Region.

Outcome 4: Influence of policies, practices, agendas and funding priorities

Achievement	Example
Governments and other decision-makers at local and national levels changed their discourse, behaviours and/or took action in response to evidence revealing certain deficiencies in health systems functions or measurement practices.	• NEHSI (104613): The state governments of Bauchi and Cross-Rivers in Nigeria used evidence derived from the research supported in NEHSI along with accompanying socialization and engagement processes to improve primary health care services at the local government level. Specifically these actions focused on: i) the health of children: improved the use of bed nets, enhanced management of diarrhoea, and increased immunization uptake; and ii) the health of mothers by taking action to increase the likelihood of the recommended four antenatal check-ups and of post-natal check-ups, to deepen knowledge among men and women of danger signs such as bleeding during child birth; and improve exclusive breast feeding practices. Moreover, the data gathered through NEHSI was integrated in the state-level health management information system, and subsequently fed into the national health management information system through requests from federal level as part of their state monitoring activities. • CHESAI (106788): Vision 2030 of South Africa's Western Cape Department of Health has acknowledged being inspired and influences by a systems view that was cultivated by CHESAI's Journal Club. This club offers space to senior practitioners to explore implementation challenges and to work on integrated and systems-levels approaches to address these problems – both conceptually and practically. CHESAI's ability to convene decision-makers, practitioners and academics, among others, created the space for such deliberation and enriched the discourse as a result. • Guatemala (106815): Based on various types of evidence derived from community-based monitoring of various primary health services (availability of medicines and ambulance services, as well as health worker availability and attitudes), local members of the community have influenced members of municipal governments to gradually change their practices, including resource allocation, to ensure the health system is accountable to its citizenry • Gender & Equity in India (106683): Practices of nurses working in primary health care centres in the Indian state of Karnataka were improved based on findings from this project that demonstrated the prevalence of harmful obstetric practices and discriminatory care. This influence was achieved at the state government level.

Achievement	Example
	• EQUINET (105675): The production of Equity Watch (EW) Reports is embedded in policy processes in the Eastern and Southern Africa, and in some cases the Ministries of Health and Finance. These reports facilitated the identification of trends and reporting on progress of health outcomes. The work has been widely cited and was taken up by the regional body East, Central, Southern African – Health Committees (ECSA-HC) in its Monitoring and Evaluation framework for country reporting to include equity indicators.
Changes in discourse, knowledge and action related to the universal health coverage (UHC) agenda is observed at a sub-national (106502: India), national (106439: South Africa) and global level (107501: WHO guidance) based on different processes and types of evidence supported by GEHS.	• Maharashtra (106501): Focusing on the second objective of this project (to concretise models and shape public opinion and policy towards a regulated system for UHC as a key strategy for reduction of health inequities and reduction of irrational health care expenditures), the project managed to convene influential actors at their consultations (state level officials from the National Health Mission – State Health Dept of Maharashtra), produce a wide range of influential outputs (see FTR), and also in January 2011 to co-organize with the High Level Expert Group (HLEG) a consultation to discuss UHC in India. The discussion focused on the need for regulation of Private Health Sector in context of UHC. • GNHE (106439): In South Africa the project findings have informed national level debates for establishing the National Health Insurance. The PI for the project, Dr. Di McIntyre, is the co-chair of this body. • Fair Path to UHC (107501): GEHS support paved the way for LMIC representatives to participate in, and LMIC-based case studies to inform, a global guidance produced by WHO on ethics in UHC. This product had wide reach and has contributed to a change in discourse on UHC that more explicitly integrates lenses of equity, ethics and justice. • Influencing the SDG and providing needed metrics for UHC and other elements of the SDG#3 (RSP: 107399): this RSP presents evidence on how the program influenced agendas through supporting leaders. GEHS had the opportunity to support a thematic working group on health (107339) as part of the Sustainable Development Solutions Network (SDSN). The thematic working group was led by a prominent Indian researcher, Prof Srinath Reddy, who was appointed as a member of the United Nations Leadership Council of the Sustainable Development Solutions Network. The work of the thematic working group provided the needed evidence-base for the inclusion of health and well-being as a post-2015 goal. The goal that they suggested is now Goal 3. Ensure healthy lives and promote well-being for all at all ages in the SDGs.