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Centre de recherches pour le développement international

Governance for Equity in Health Systems

Final Prospectus Report

This report was prepared by the International Development Research Centre's Governance for Equity in Health Systems program (2011-2016) as part of its external evaluation.

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Note: some links in this report are not publicly accessible

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List of Acronyms

ADDRF	African Doctoral Dissertation Research Fellowship
AfHEA	African Health Economics and Policy Association
APHRC	African Population and Health Research Centre
CAS	Complex Adaptive Systems
CIHR	Canadian Institutes of Health Research
CHESAI	Collaboration for Health Systems Analysis and Innovation
DFATD	Department of Foreign Affairs, Trade and Development
ECSA-HC	East, Central, Southern African – Health Committees
EQUINET	Network in Equity in Health in Southern Africa
EQUITAP	Equity in Asia Pacific health systems
EVIPNET	Evidence Informed Policy Network
GEHS	Governance for Equity in Health Systems
GHRI	Global Health Research Initiative
GNHE	Global Network for Health Equity
HRCS	Health Research Capacity Strengthening
HSR	Health Systems Research
ICPD	International Conference on Population and Development
ICTs	Information and Communication Technologies
ICT4D	Information and Communications for Development
IDRC	International Development Research Centre
LMICs	low- and middle-income countries
LAC	Latin America and the Caribbean
MDGs	Millennium Development Goals
MNCH	Maternal, newborn and child health
MSP	Municipal Services Project
NEHSI	Nigeria Evidence-based Health System Initiative
RCC	Regional Consultative Committee
RCT	Randomized Controlled Trial
SDSN	Sustainable Development Solutions Network
SEARCH	Strengthening Equity through Applied Research Capacity building in eHealth
SHIELD	Strategies for Health Insurance for Equity in Less Developed Countries
SOCHARA	Society for Community Health Awareness Research and Action
SEP	Social and Economic Policy
TARSC	Training and Research Support Centre
UHC	universal health coverage
WAHO	West African Health Organisation
WHO	World Health Organization

Section 1 Introduction

The Governance for Equity in Health Systems (GEHS) program prospectus (2011–2016) was approved by the International Development Research Centre (IDRC) Board of Governors in June 2011. Building on a strong foundation of an initial exploratory phase (2002-2006) and a subsequent five-year programming cycle (2006-2011), the prospectus paved the way for a more focused program contributing to the ultimate outcome of strengthening equitable health systems and improved health outcomes. This report is a self-assessment by members of the GEHS team to explain and understand how the program theory of change did or did not unfold. The approach used to develop the report enabled critical self-reflection beginning soon after the prospectus was finalised in June 2011. A monitoring and evaluation plan was established with set points of inquiry, data collection, analysis and reporting. The final prospectus report has benefited from these inputs and represents a true team effort, with support from IDRC evaluation colleagues.

Why health systems research matters

The aspiration of the GEHS prospectus was ensuring equitable health systems with primary health care being the cornerstone. The "effective principles" of governance, equity and systems integration were set to be the defining lens by which research was supported. With such a focus the drivers of development and good health would be addressed for lasting impact. It was clear for GEHS that this approach of health systems research was both the program's niche and overall strategy to support people's ability to fulfill their potential and live a healthy life in low- and middle-income countries (LMICs).

During this period of the prospectus there was the rise on the global agenda of universal health coverage (UHC) and the reduced focus on the Millennium Development Goals (MDGs). To date the post-2015 goals have yet to be finalised. The debate continues. The MDGs clearly have been too vertical in their approach yet at the same time they have fulfilled the quest for clear and measurable goals and have had political appeal. While universal health coverage is clearly an undeniably important goal, the challenge lies in developing indicators that have political traction and are easily communicable. The Lancet (2014) now claims that we are in our third revolution in global health: the issue of quality. The first revolution was on the metrics – measurement of a country's progress. The second revolution was on accountability - with Canada stepping in front and centre in 2011 with the Commission on Information and Accountability explicitly linking metrics to politics. At the same time as the global heath revolution evolved into a broader agenda of quality, Canada with much applause internationally announced in May 2014 $3.5 billion for maternal and child health (2015–2020). This builds on Canada's existing $2.85 billion contribution, allocated as part of its 2010–15 Muskoka initiative (launched during Canada's leadership of the G7 Summit in 2010).

At the end of the day science and evidence tells us that if we really want to prevent the death of one of the 287,000 women that die every year from pregnancy or childbirth, it is not enough to simply count the deaths. It is not enough to provide the commodities such as oxytocin, antibiotics or magnesium sulfate (Lancet, 2014). What is needed is the stewardship, capacities and fiscal space to ensure the existence of a system which offers a continuum of care and support for the mother and her family. This system needs to be in the context of a social, political and cultural environment that demonstrates that women and children are valued. This is what health systems research delivers on. This is why health systems research matters. It is the silver bullet to prevent the deaths of women and children around the world.

Health systems research as a growing field

Health Systems Research is an emerging field that is multidisciplinary in form and focuses on both medical and socio-political aspects of health problems. Building on the 2008 Bamako Consensus which recognised the crucial role of health research in addressing health problems and accelerating development, the global health community has come together to strengthen the contribution of health systems research. Various meetings and high-level consultations identified the importance of building national capacity for health systems research and embedding it as a core function of health systems.[1] Researchers, policy stakeholders, practitioners and donors have joined efforts as part of the series of Symposia for Health Systems Research, and Health Systems Global, a new international society for health systems research.

GEHS has contributed to building this growing field through supporting rigorous implementation research that is led by low-and middle-income countries and is firmly anchored in their local policy environment. In terms of building national capacities, investments have focused both on strengthening individual and institutional capacities to conduct research. This has involved a variety of modalities from awards and fellowships to curriculum and organizational development. Larger projects have lent themselves more easily to strengthening institutional and systems-level capacities. For instance, the Nigeria Evidence-based Health Systems Initiative (NEHSI), a 19 million partnership project with Government of Nigeria and Canada's Department of Foreign Affairs, Trade and Development (DFATD), integrated learning-by-doing and training at multiples levels and for various actors in order to nurture a culture of evidence-based planning in Nigeria. Embedding health systems research as a core function of health systems has also been a key feature of GEHS programming. This has been done by supporting strong research partners who are well connected to their health system and policy environment, and making sure the research is integrated into national processes and existing systems.

A dashboard of GEHS programming during the current prospectus phase is available in Annex 1, including an explanation of the graphs and charts presented.

Building on the strong foundation of the previous phases

The current prospectus has built on the strong foundation laid out by a first exploratory phase (2002-2006), followed by a five-year programming cycle (2006-2011). During these first two phases, the Program demonstrated that a health systems approach with governance and equity as key analytical principles *can* and *does* strengthen health systems. External reviews conducted towards the end of both prospectus periods validated that the Program filled an important niche and had a critical role to play given the continued disease-specific focus of most global health interventions and funders. However, as the field of health system strengthening was receiving greater attention, external reviewers saw the need to better define the program's niche. This led to the recommendation in 2005 for greater clarity on the conceptual framework, and in 2011 for a sharper focus on the themes of governance, equity and health systems. Other notable recommendations from the 2005 external review included the need to identify funding modalities that maximize impact of investments; to develop novel ways to make

[1] For instance, the WHO Global Strategy on Health Systems Research, and the Beijing Consensus from the 2nd Global Symposium on health Systems Research.

research matter through strengthening knowledge-to-policy linkages; to support grantees in evaluating project results; and to avoid compromising objectives when leveraging funding.[2]

Carrying these recommendations forward, the Program focused during its second phase on facilitating Southern voice and impact in policy debates, strengthening capacities, and catalysing changes in practice and action.[3] The external review of the 2006-2011 cycle assessed the program accomplishments for each outcome to be from good to excellent.[4] It validated the point that supported projects deepened the understanding about the dynamics of governance and equity in strengthening health systems, with notable contributions to financing, health information systems, and service delivery. Moving forward, the review panel advised GEHS to: 1) further develop the health financing and maternal health themes; 2) deepen work in francophone Africa; and 3) ramp up the role of the program in influencing international public policy by bringing the messages of its research to the attention of major stakeholders.

GEHS theory of change, coherence, strategies and trajectories

The current prospectus was developed to build on its strong foundation, address the recommendations from the external review, and provide further leadership in the field of health systems. The theory of change that has guided the Program implementation calls for:

> *Strengthening LMIC research teams and institutions to collaborate, facilitate and catalyse rigorous and relevant research methodologies generating a body of knowledge and evidence-based research findings. This body of research will be used to inform and influence local, national, regional and global policies, practices, agendas and funding priorities to strengthen equitable health systems in LMICs, thereby contributing to improved health outcomes.* (GEHS prospectus, p.9)

With the ultimate outcome set as strengthened equitable health systems contributing to improved health, the program made funding and operational decisions explicitly based on the systematic application of the principles of governance, equity, and systems integration. These principles provided the *coherence* in programming, with the implementation of multiple strategies based on regional and local contexts to deliver on the Program outcomes. The theory of change is illustrated and further explained in Annex 2.

Coherence: application of governance, equity and systems integration as 'effective principles'

These three principles served as a mechanism to provide guidance that was to be interpreted, applied and adapted to contexts, as opposed to being prescriptive (Patton, 2011). Moreover, this sharper focus

[2] See the summary report of the 2005 external review, which was conducted by Norberto Dachs, Sarah Macfarlane, and Sally Stansfield.

[3] More specifically, the Program in its 2010 self-assessment report reported the following outcomes: 1) reflection of Southern voice and power in local, national, regional, and global health policy debates; 2) capacity development for generating, exchanging, and applying policy-relevant knowledge; and 3) changes in practice and action to improve health service delivery practices, inform policy at local and national levels, and modify donor practices. The self-evaluation report for 2006-2011 is available here.

[4] See the findings briefs of the 2010 external review, which was conducted by Suneeta Singh, Demissie Habte, and George Brown with support by Emily Taylor.

on governance for equity in health systems ensured that the core challenges to improving health, decision-making, resource allocation, and power distribution in health systems were addressed.

In practice, the projects sought to unpack the dynamics of power and deal with the structural issues of health and development. The projects supported the involvement and interaction of stakeholders at all levels, especially communities, in the decision-making related to the health system and their own health. By focusing on access to health services, the projects dealt with the inequities related to the barriers to access and how they affected those most in need; including examining gender considerations and the social determinants of health which drive marginalisation and exclusion.[5] Lastly, by addressing the demand and supply side with a particular attention to their integration**,** and examining the interconnections among the components of the health system, it not only broke down the siloed approach to health but also improved the upstream drivers to better health and prosperity.

Social and Gendered Analysis

As part of the equity focus, GEHS is committed to applying a social and gendered analysis in its programming. This stems from the understanding that gender must be understood in conjunction with the other social factors driving inequities and discrimination, including race, ethnicity, age, caste, religion, education and wealth.

Programming strategies

The strategies deployed to build a critical mass of actors aligned around shared approaches and priorities for action include actively supporting capacity development, and facilitating networking, coordination, and collaboration among LMIC institutions and researchers. It involved active engagement in global fora, using the body of knowledge generated to inform and influence policies, practices, agendas, and funding priorities. This also responded to the external review recommendation for a greater program voice in global health policy debates. Importantly, the program sought to enhance recognition and mainstreaming of the approaches and methods used to strengthen equitable health systems. In practice, this involved:

- getting the approach funded by others
- building leaders with influential power
- being more visible and catalyzing the potential of large global conferences
- ensuring the peer review knowledge base was led by LMIC researchers.

In terms of *funding strategies*, GEHS supported projects that linked long-term research partners with new researchers, and seized policy windows. For instance, building on investments in three regional networks on health financing, GEHS supported linkages to form a Global Network for Health Equity (GNHE, 106439) with increased visibility and impact to provide the knowledge base to strengthen the global drive for universal health coverage.[6] Any funding decision had to demonstrate demand and respond to locally driven need and context, which is critical to develop sustainable solutions with uptake.

Two specific areas of programming were developed through *competitive grants* making: the integration of ICTs into health systems, and strengthening of West African capacity and knowledge base in health systems research. A competition modality was implemented due to the content challenge of both areas of work, the desire to bring in new grantees, and the large budget allocations. It is important to mention

[5] An overview of social and gendered analysis in GEHS programming is available here.

[6] The three regional networks that have been supported through earlier grants are Lanet (103905) in Latin America; SHIELD in Sub-Saharan Africa (103547, 103905), and Equitap in the Asia-Pacific (105231). More information is available at gnhe.org.

that both competitions incorporated a proposal development workshop to work with shortlisted teams in order to strengthen their final project submissions and strengthen the application of effective principles in the research design.

Given the challenges of capacity strengthening and recognition that increasing supply of doctorates was not adequate to prevent the brain drain, GEHS entered into *cross programming* with another IDRC program, Fellowships and Awards. This leveraged additional funds and at the same time linked individual training – from front line practitioners to senior researchers - to ongoing research.[7]

Another explicit strategy, is *partnering with other funders* to leverage investment and influence agendas and priorities. This is not a new strategy as GEHS has always had a portfolio of externally funded initiatives. The newer aspects of this strategy were partnership for scaling up and intentional parallel funding. The former was not as successful as the latter approach. Parallel funding leverages IDRC investment and at the same time builds relationships enabling influence (see Annex 3).

Parallel Funding

Parallel funding leveraged additional funds for several projects. Donor institutions included new philanthropies like Sri Ratan Tata Trust in India, established foundations like the Rockefeller Foundation, and international agencies such as the WHO Alliance for Health Systems and Policy Research, among others.

Regional programming

Regional programming was clearly aligned around regional strengths and weaknesses. Programming in Africa became stronger as did in Asia. The Latin America and Caribbean (LAC) region lagged, primarily due to staffing issues; specifically in filling the LAC post and shortly after it was filled, it was frozen in May 2014. To fill this void, an existing GEHS program officer took over the portfolio.

As recommended by external reviewers, West Africa has been a priority region: due to the fragmentation of the research community and weak capacity for health systems research. A strategy was developed based on three pillars: 1) close collaboration with and support to the West African Health Organisation (WAHO) which is mandated by regional governments to work with decision makers to improve health outcomes; 2) support for a regional consultative committee of diverse leaders working broadly with WAHO to inform and catalyse this work and identify additional regional activities and strategies; and 3) support for a number of research projects on the generation and use of evidence to address concrete health systems problems.[8]

Continuing learning and adapting

Lastly, while the current prospectus is only in its fourth year there has been a strategy of continuous learning and adapting. The self-reflection process engaged team members to reflect on how their work was progressing in achieving the outcomes. It has served to provide and strengthen coherence and rigour in the program as well encourage an openness to innovation and change. In addition, through dialogue it allowed the team to gain a better understanding of the prospectus in practice as a majority of the team has not been part of its development. The focused discussions leant themselves to innovation in terms of brokering linkages or developing a new area of work. For example development

[7] In Africa, award projects include the African Doctoral Dissertation Research Fellowship (ADDRF, 106266, 107508); Building Capacity in Health Systems and Policy Analysis in sub-Saharan Africa (106129); and the Collaboration for Health Systems Analysis and Innovation (CHESAI, 106788). In Asia, this include the Community Health Learning Program for Health Equity in India (107304) and the Asia Health Systems Research Capacity Strengthening Initiative (107757).

[8] See programming strategy for West and Central Africa, available here.

of indicators in Indonesia, application of systems thinking to health systems research and child protection issues in Rwanda. Further details of this learning and adapting strategy can be found in Annex 4.

Changing context and new opportunities

Any program and institution operates within changing environments. GEHS has faced significant changes as well as new opportunities during the implementation of this prospectus. A timeline of GEHS programming is available in Annex 5.

Significant opportunities arose from the global community embracing universal health coverage in 2012, with the recognition at the Rio+20 conference that health care should be accessible to all and should go beyond being a health goal to being a development goal (Evans, Marten, Etienne, 2012). The GEHS Program was well on its way to capitalising on this window of opportunity given that it already had strong evidence to bring to the global tables.[9] At the national level, the Program supported projects to inform health reforms in China and India for the progressive realization of universal coverage. At the global level as part of the UN Sustainable Development Solutions Network (SDSN), this Program supported its research partners to be part of a Thematic Working Group on Health so they could provide local evidence of measurement and need for universal health coverage as a sustainable development goal.

At the same time, GEHS had to do a delicate balancing act in Canada where the country was clearly detaching from the universal health coverage agenda. GEHS' efforts in this area ran parallel to an all IDRC discussion about how to more closely align with the Government of Canada priorities, an approach which has now has been clearly established with the new corporate strategy that commenced in December 2014. While GEHS may have lost the space for showcasing its substantive work on UHC, the focus of maternal, newborn and child health has provided another window of opportunity. The Program was able to bring forward its long history of work on maternal and child health and continue to demonstrate how health systems research is a core function of ensuring high quality maternal and child health services.[10]

This focus was further amplified with the merger in December 2013 between GEHS and the Global Health Research Initiative (GHRI)[11] which had just signed off on a three-partner CA$36 million initiative focusing on maternal, newborn and child health. The merger was a win-win for both programs. GEHS was already preparing to program with Canadian partners in order to be more aligned with Government of Canada priorities, and needed to have this Canadian linkage and presence if it was to grow. For the GHRI, there was growing funding partner dissatisfaction with the functioning of the program leading to the heads of agencies, in January 2014, mandating an early closure of the GHRI Secretariat by the end of March 2015. In addition, the political and conceptual fit was clear – both programs had health systems as a focus and GEHS after all had given 'birth' to GHRI. Despite this and the fact that they were housed in the same program area, the two programs had grown in separate directions in how they functioned internally and how they operationalised health systems research. This made the merger more challenging than expected.

[9] See GEHS brief on universal health coverage.
[10] See GEHS brief on maternal health.
[11] GHRI is a partnership between the Canadian Institutes of Health Research (CIHR), Canada's Department of Foreign Affairs, Trade and Development (DFATD), and IDRC.

The prospectus period was also marked by several other organizational changes at IDRC. In 2011, the end of the Information and Communications for Development (ICT4D) program area offered the opportunity to integrate the ehealth portfolio[12] and further this area of funding with a stronger health systems strengthening approach. The SEARCH Program (106229)[13] was designed to deepen the understanding on how the integration of ehealth into health systems can strengthen health systems with attention to equity and governance considerations. Importantly, IDRC structural changes in 2012 which resulted in the closure of the Singapore and Dakar offices significantly affected regional programming. Ground field presence in West Africa was considerably reduced following the transfer of the program officer from Dakar to the Nairobi office. Programming in the region has also been disrupted since the summer of 2014 with the Ebola outbreak. In addition, the Program gradually saw a reduction in its budget - from $10million allocation in 2013-2014 to $4million in 2014-2015 – which clearly limited some of larger projects planned for funding.

The merger with GHRI also marked the end of the Global Health Policy program area, putting health back into the Social and Economic Policy (SEP) program area (July 2014) and placing the non-communicable disease program in the Agriculture and Environment program area. In addition the Development Innovation Fund which supports Grand Challenges Canada was integrated into the Science and Innovation program area; thus a clear dispersion of health programming across IDRC. Formal mechanisms of horizontal information sharing among the dispersed health programs is currently under discussion. Nonetheless, for GEHS the 'return' back[14] into the Social and Economic Policy program area is an opportunity for health to work with programs striving for economic opportunities and justice in order to leverage better health outcomes and investment for the most vulnerable. Some concrete areas are being developed as the Program moves into the period of a SEP Implementation Plan under the new IDRC Corporate Strategy (2015-2020).

Lastly, with the introduction of the new IDRC Corporate Strategy, the GEHS prospectus will not be able to be taken to its final conclusion in 2016. Although the results to date are strong, their level of achievement will be affected given that the aspirations of the prospectus will not have the needed time to fully come to life. Nonetheless, since 2011 the GEHS program globally achieved a number of successes as it was able to capitalise on policy windows while at the same time having to adapt due to internal changes. There has been much investment of human capital by the team to address these changes but the Program continues to be committed to improving access to high quality care for the most vulnerable.

[12] Note that the projects inherited are indicated as legacy projects in GEHS dashboard spreadsheet.
[13] SEARCH stands for Strengthening Equity through Applied Research Capacity building in eHealth. It includes 7 grants as well as cross-learning activities.
[14] The Program was part of IDRC Social and Economic Policy area during its first two phases until the creation of a Global Health Policy area.

Section 2 Program outcomes

The GEHS prospectus set out four interconnected outcomes intended to lead to the ultimate outcome of strengthened equitable health systems that contribute to improved health. These outcomes are:

- development of capacities for a critical mass of LMIC researchers and institutions
- development of a knowledge base of research methodologies
- generation of a body of knowledge and research findings
- influence of policies, practices, agendas and funding priorities.

The progress towards achieving the outcomes and strategies was conceptually mapped out using the S-curve of innovation.[15] GEHS planned to forge ahead with some early adopters and address any resistance along the pathway by supporting capacity strengthening and innovation in methods until a critical mass would be formed. This critical mass of researchers and institutions would in turn be ready to influence policies, practices, agendas and funding priorities contributing to the ultimate outcome.

This framework recognized that the progression across outcomes was not linear; nor was one outcome more important than another. There was synergy and interdependence – for example, ultimate influence could not result unless there was capacity. It was also recognized that there were spheres of engagement at various levels and it was important to understand the differing contexts.

The process of analysing and reflecting on the progress towards achieving the outcomes at the program level as a whole was done individually and as a team. While challenging at times, the GEHS team believes that this consolidated reflection of each outcome will make it easier to identify lessons that can inform scaling up strategies and bringing in new partnerships for future programming. As discussed elsewhere, this review reflects three and a half years of implementation and thus presents 'achievements to date'.

GEHS achievements to date

#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

[15] See Annex 2 on GEHS theory of change.

Development of capacities for a critical mass of LMIC researchers and institutions

Developing a critical mass of LMIC researchers and institutions is the foundational outcome and represents an important and conscious part of GEHS' contribution to building the field of health systems research (Hoffman *et al*, 2012). Capacity strengthening happens at multiple levels (e.g. individual, institutional, and network; local, national, regional and global) and through various approaches (e.g. training, mentorship, networking, and exchange). It is about enhancing abilities and skills, empowering, raising confidence, instilling habits such that individuals, organizations and institutions can themselves tackle any challenge effectively. Two significant achievements have been made to date. The first achievement is at the individual level (numbers) and the second builds on the numbers and to create a vibrant critical mass.

> *"Critical mass is not just about the numbers. It's about people with the necessary disciplines, perceptions, capacities, and consciousness to act."*
>
> Rene Loewenson, Training and Research Support Centre (TARSC), Zimbabwe, and EQUINET network

Achievement #1: Increasing number of skilled health system researchers and institutions across LMICs consider the effective principles in health system research

The GEHS program has significantly contributed to increased numbers of skilled health systems researchers in LMICs adopting the GEHS three effective principles of governance, equity and systems integration. The focus was on increasing numbers and improving skills of health systems researchers ranging from frontline health workers to national officials to academic researchers and thought leaders, and from civil society organizations to research institutions. Approaches were tailored according to the type and extent of the need for capacity strengthening. Along with assuring the financial and technical support, various mechanisms were used including: curriculum development, scholarships for short training, fellowships for post-graduate studies, mentorships and internships embedded in research projects, and leadership and research management skills development. The multiple mechanisms were intentionally introduced at various levels to ensure impact on number of stakeholders and to address the contextual challenges.

In order to develop and effectively implement appropriate health policies and programs, countries urgently need a significant number of *health providers and national officials* (including policy analysts) in various institutions with adequate analytical capacities. Consequently, it was critical to design curricula and mechanisms to provide short and effective training opportunities with a comprehensive plan to institutionalize the training by involving training institutions in developing and delivering the training. For example, GEHS supported the young African Health Economics and Policy Association (AfHEA) to collaborate with the training centre Centre Africain d'Etudes Supérieures en Gestion and the think tank African Population and Health Research Centre (APHRC) to deliver the training to governmental and non-governmental analysts as well as policy makers from various African countries (106977). For the front line workers, a similar approach of institutionalizing the training was done by the Society for Community Health Awareness Research and Action (SOCHARA) in Bangalore, India (107304). Supporting these institutions, in turn, strengthened the capacities of these organizations (AfHEA and SOCHARA) to accomplish their mandate and become strong international stakeholders attracting other funding and working to 'mainstream' their work. Similarly, working with the Indonesian Ministry of Health and

specifically the Indonesia Health Policy Network to undertake health policy research is increasing capacity to respond to the implementation of the health reform processes (106920). Through face-to-face training and learning-by-doing approaches, researchers and officials are addressing equity and social protection challenges in the country.

To significantly contribute to the sustainable health system research capacity in LMICs, investment in *post graduate* education is key. To begin this investment in Africa, GEHS in collaboration with Fellowship and Awards supported the African Doctoral Dissertation Research Fellowships (ADDRF) project. As the project progressed it became clearer the dearth of post graduate support in the field of health systems, and the lack of support for candidates to successfully complete their degrees through provision of strong supervision. Thus GEHS has continued to support the ADDRF in multiple phases (Phase III (106206), Phase IV (107508)) to raise interest in health systems research across sub-Saharan Africa and to allow young African PhD students to complete their studies in time and with appropriate skills. To retain new graduates, the project has expanded beyond PhD research fellowships to allow new graduates to collaborate and engage in research projects through small research grants. Research partners in Asia were inspired by the ADDRF achievements and developed the Asia Health Systems Research Capacity Strengthening Initiative (107757) to address similar challenges. Tailored to the needs and context of Asia, this initiative is setting out to establish a pool of doctoral-level trained health systems researchers working in institutions in low and middle income countries in Asia. It also aims to link the resulting research with policy institutions to inform change.

Strengthening leadership in health system research in LMICs is key to building a vibrant and sustainable community of health systems researchers. GEHS has supported projects that keep researchers engaged in addressing priority problems in their respective countries and strengthens peer-to-peer engagement, mentorship and internships. Through the Collaboration for Health Systems Analysis and Innovation (CHESAI, 106788) project, GEHS is actively supporting mid-level and senior health systems researchers to engage with their peers in debating new ideas, improving their skills and establishing or strengthening their leadership in the health systems research field. This involves improvements in analytical and writing skills and conceptual and methodological development through interdisciplinary and multi-sectoral engagement in complementary research projects.

GEHS has always supported junior researchers – through encouraging senior researchers to provide mentoring support and through creating the space and providing opportunities to become leaders in their domains. This is evident in projects such as SHIELD[16] (106334) and the improvement of the Rapid Response Mechanisms in Africa and Middle East (to be approved, building on project 107237) where emerging researchers fully lead or co-lead the design and implementation of the projects.

Internship programs have been integrated into several GEHS supported projects in order to increase leadership in health systems research. The Global Network for Health Equity (GNHE) which brings together research from different countries and regions runs a young leaders program. In Mexico, there is a multi-disciplinary and multi-stakeholder collaboration between research institutions and a civil

[16] This is actually the name of the regional network in health financing in Sub-Saharan Africa, titled: Strategies for Health Insurance for Equity in Less Developed Countries (SHIELD).

society organization[17] to strengthen their respective capacities in conducting research, understanding/interpreting results, advocacy and dissemination (106969). In fact it is the indigenous women who are the leaders in the study and presenting at an international conference.

Evidence of the achievement

If one is to focus on the numbers, some of the achievements include:

- Over 40 policy analysts have been trained in health financing analysis across sub-Saharan Africa to specifically understand and assess the various national initiatives being designed and implemented towards UHC (including performance-based financing and progressivity (or not) of health financing mechanisms). GEHS support has taken ground and AfHEA continues to receive request from countries and regional intergovernmental organizations to train their officials.
- More than 150 PhD graduates are expected and 20 new health systems research leaders will emerge from the African Doctoral Dissertation Research Fellowships (ADDRF, Phase III (106206), Phase IV (107508) and Asia Capacity Strengthening Initiative (107757). In addition, throughout the process, at least 10 institutions will have their health systems research capacity strengthened and could become centres of excellence across Africa and Asia.
- Through its training program, the Community Health Awareness Research and Action (SOCHARA) in Bangalore, India, strengthened to date the analytical capacity of 25 health providers to improve their clinical and service delivery practices at primary health care (107304).
- In Francophone Africa, 30 Master's awards have been granted with most of the graduates actively involved in health systems cross Francophone Africa (106129).
- In Nigeria, a total of 11,120 people were trained in data collection, analysis and use through the NEHSI project (104613). This includes community members, front line health workers, and local and state level health officials involved in formal training, workshops, executive and short courses, and action planning sessions.
- In Indonesia, 200 academic and policy analysts from governmental and non-governmental institutions involving 17 institutions have been trained (106920).
- In Peru, 15 members from different ministries were trained on using health information systems (106229-014) and in Lebanon, ministry of health members are active members being trained and working with the research team (106229-008).

Snapshot of GEHS capacity strengthening

27 projects integrating institutional strengthening

354 students supported at post-graduate level

334 researchers mentored or trained

739 professionals sharpening their research skills

230 workshops and training sessions funded

13 knowledge exchange platforms

These are just the numbers, which do not measure the depth and breadth of the capacities in terms of embracing the effective principles.

[17] The research institutions Instituto Nacional de Salud Publica and the Centro de Investigationes y Estudios Superiores en Antropologia Social (CIESAS) is collaborating with the civil society organisation Alternativas y Capacidades.

Achievement #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

The GEHS efforts to strengthen individual and institutional capacities were intended to establish a vibrant and diverse community of health systems researchers (e.g. academics, policy makers, health providers, civil society) with a clear understanding of the three effective principles and able to apply them in a systematic and coherent way. The strategy has focused on a) strengthening existing and new national/regional networks and institutions and b) brokering new partnerships and collaborations. This has resulted in the establishment of new committees, networks, conferences/symposia, and international/global societies bringing together researchers, policy makers and civil society organizations to engage them through policy dialogue, priority setting in health research, and conducting health systems research.

Strengthening existing/new networks and institutions

Through consultation a new approach was developed and supported to address the fragmentation amongst stakeholders in Francophone Africa: a multidisciplinary and multi-institutional group of thought leaders in West Africa called a regional consultative committee (RCC) was established. The committee is comprised of current and previous GEHS leading research partners and other key stakeholders in both Anglophone and Francophone West Africa. Working closely with the WAHO, this peer-to-peer group is tasked with identifying and strategically addressing gaps in building health systems research capacity, raising overall awareness and interest in health system research, and advising other researchers in the region. The RCC acts by example, and is playing a convening, dialoguing and planning role with the aim of bringing more resources for health systems research into the region.

As part of strengthening existing institutions, GEHS has recognised the need to support spaces for active dialogue and engagement. Researchers in Africa often feel isolated and need the space and time to interact with each other to produce academic and policy outputs. This is clearly working in the Collaboration for Health Systems Analysis and Innovation (CHESAI, 106788) project where regional divides are being broken with the exchange among West, East and Southern African researchers. The platform created by this project has been used by more than a thousand academics and practitioners through seminars, journal clubs, and seminars with visiting experts. In addition the research is informing the health decentralization process in South Africa resulting in more informed implementation of services. Similarly in Indonesia, the Health Policy Network has provided the space for research institutions across the country to interact and work through the challenge of achieving universal health coverage (106920). Together they have published 77 articles, engaging more than 1,000 decision-makers through meetings and workshops across Indonesia.

At the global level, GEHS has also built upon its investment in three regional (African, Asian and Latin American) networks by bringing them together through the establishment of the Global Network for Health Equity (GNHE, 106439). Through this network, researchers (senior and junior) are exchanging information, collaborating and developing research initiatives that are cross-regional and contributing to key issues in their respective countries, particularly by providing evidence to inform the implementation

of universal health coverage. GNHE has also provided a strong voice of southern researchers on global agendas such as the indicators of the post-2015 goals as explained letter in the influence outcome section.

Brokering new partnerships and collaborations

To build a critical mass of researchers, GEHS has partnered with like-minded funders to further leverage its capacity strengthening activities. This is the case for the project with AfHEA (106977) which involves the Rockefeller Foundation and the project with SOCHARA (107304) involving the Sir Ratan Tata Trust (see Annex 3). GEHS has also encouraged partnerships amongst research partners and encouraged cross-learning and potential collaboration in order to strengthen the health systems research community and contribute to developing a critical mass of health system researchers. For example, the collaboration of institutions implementing both the Masters and PhD programs in Africa has enabled the establishment of a platform to discuss how to address the research capacity gaps in health systems research in Francophone Africa. Another collaboration was brokered between the Network in Equity in Health in Southern Africa (EQUINET) (105675) and the Municipal Services Project (MSP, 105141) to strengthen each other and importantly to join efforts and collaborate in advancing equity and access to health.

At the global level GEHS has also collaborated with the World Health Organization and the Alliance for Health Policy and Systems to support all three Global Symposia for Health Systems Research that bring together the broad community of health systems researchers, with the intention of focusing health systems research using an effective principles approach and including a significant and active presence participation of GEHS research partners (107022). GEHS played a significant role in the establishment of the first international society for health systems research – Health Systems Global which brings together health systems researchers from across the world. On the first elected Board a significant number of members (including the Chair) were GEHS research partners. Currently, on the Board of 11 members, 7 have partnered with GEHS. Of the eight LMIC Board members, half are GEHS research partners.

Reflections on partnerships and institutional strengthening cannot be complete without mentioning the Health Research Capacity Strengthening (HRCS, 104959) Initiative. This was a partnership between the UK's Department for International Development, the Wellcome Trust and IDRC. Its overall goal was to strengthen institutional capacity to conduct and coordinate health research in Kenya and Malawi. Initiated in 2004, this £21 million initiative spanned a period of nearly seven years with IDRC playing a funding and implementing role (through incubation of the new institution in Kenya and facilitation of an overall learning component). During this period, differences in approaches emerged and ultimately IDRC withdrew from the incubation role in 2010 and the learning component was ended in 2011. Despite the discontent at the time about the institution that was established[18], the institution became and remains a functioning NGO in Kenya. Afterwards an external evaluation even validated such an approach.[19] In

[18] Namely the Consortium for National Health Research. For more information, see: http://cnhrkenya.org/

[19] See external evaluation on the National Health Research Consortium, Kenya, available here. Also see external evaluation of on HRCS, available here.

addition, IDRC commissioned an internal summative desk review (finished in 2011) which highlighted a number of lessons learned (see box on the right). These lessons while clear are not always easy to put into practice when work is undertaken in partnership because of competing agendas. Nonetheless, partnerships have worked to increase GEHS' investment in capacity strengthening initiatives.

Lessons learned from HRCS experience

- *the lack of consensus around how health research capacity should best be strengthened*
- *the importance of allowing for a foundation stage for institution building before undertaking programming activities*
- *the need to allow for the capturing of process indicators as opposed to only programming output ones*
- *the importance of taking the time to clarify governance arrangements before going ahead with activities and programming*

See report from HRCS desk review, available here.

Evidence of the achievement

GEHS has significantly contributed to the creation of a vibrant critical mass of health system researchers. This critical mass is at the tipping point of its sustainability given the growing interest and capacities in health systems research at the global and country levels. Some highlights of this critical mass include:

- The establishment of the RCC (106948) has been instrumental in developing regional approaches of capacity strengthening and of linking research with policy priorities through the West African Health Organization. This is still at its beginning and more investment is needed to enable it to make a significant impact through the involvement and contribution of training institutions in the region.
- The GNHE is now a community of about 50 researchers across Africa, Asia and Latin America. There is now a group of about 10 young researchers who are leaders for equity across the three regions. All networks are continuously growing in numbers of individuals, institutions and countries.
- As part of SEARCH (106229), a new network linking its seven projects is being forged and nurtured through a coordinated effort to support cross-grant learning and networking, innovative tools being explored such as an online platform.[20]
- At the last two symposia in health systems research, more than 110 participants from LMICs were financially supported by GEHS, the majority being current and recent GEHS grantees. However, the total number of GEHS current and past research partners participating in the two symposia is estimated at more than 400 as some of them funded their participation through existing research grants or other means. Those research partners who presented in plenary sessions highlighted the approach using the effective principles and this is shaping the priorities in health systems research.
- The LMIC membership of the Health Systems Global Board is an indicator of GEHS contribution to the leadership of the global mass of health systems researchers.
- 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.
- The SEARCH project is also generating a critical mass of dedicated professionals focusing on HSR as it relates to the integration of ICTs in health systems (106229).

[20] See report of the inception workshop, available here.

Clearly establishing sustainable capacities to generate and use evidence to strengthen health systems and improve health equity and health outcomes requires a long-term investment through a process of progressive realization. While the progress is significant, it is critical to continue these efforts, especially at country level where in some cases the capacities are still fragile and require adapted approaches given the specific needs and priorities of countries. The potential of going to scale exists by further developing existing and new partnerships.

Development of a knowledge base of research methodologies

As part of building the field of health systems research the development of research methods is critical. The Program role has been to support the research community to innovate, use and promote methods that deliver stronger governance, equity and systems integration analysis. This has required pushing the boundaries on traditional methods and ensuring researchers examine structural change and power differentials while addressing health problems. This approach increases the probability of long-term sustainable change.

Working with the early adopters, the Program has been able to gain ground and contribute to the field. Specifically two areas of achievement lies in the innovation and increasing scope to deliver impact.

Achievement #3: Deepened the foundation of health systems research methodologies including innovations in research design

Methodological innovation was supported through various strategies including: a) dialogue and exchange; b) requiring research questions to demonstrate demand and follow the problem to their root causes; c) use of trans-disciplinary research approaches; d) promoting workshops and other avenues for discussion and deliberation specifically related to methods; and e) encouraging projects to incorporate learning-based evaluations. These strategies stem from the focus around the effective principles and are part of the course of social science research. As seen in the mid-term self-evaluation report, based on an analysis of a sample of projects, 65% of the projects had multidisciplinary teams and a similar percentage aimed to push methodological boundaries.[21] Pushing boundaries was defined as crossing disciplines at a conceptual or methodological level and other areas of research management. Where there were weaker capacities, program officers provided technical support and also brokered in outside support.

Evidence of the achievement

Early in the prospectus, as part of the monitoring framework, three dimensions of innovations were articulated to facilitate measurement: a) *concepts* (way of thinking about research); b) *ways of doing research* (working with new participants or groups and how that reflects in the methods); and design and methods (collection, generation of data, analytical techniques, representation of data and/or findings). There are several projects that have achieved or in the process of achieving these dimensions of innovations.

- Alternative Public Service Delivery Models in Health, Water, and Electricity project (105141) contributed to innovation in concepts. It was the first coordinated effort to systematically articulate a set of research methods and frameworks on 'successful public services' in the health, water and

[21] The midterm evaluation report is available here.

electricity sectors, and to construct cross-sector narratives with a focus on health systems. Thus, the project delved into conceptually clarifying the idea of 'publicness' across sectors, which can be key in striving towards national public health systems. Drawing on experiences and debates from Sub-Saharan Africa, Latin America and Asia, the first stage of the research developed a methodological framework to evaluate service delivery alternatives and established 'success criteria' which have been adopted to evaluate basic services. During the second stage, case studies were then identified for in-depth research in key cross-sectoral and cross-regional focus areas. Support to this project reflects the Program's explicit focus on other sectors that have an impact on health as part of the systems integration principle.

- Reducing HIV risk in Botswana project (105053), used a national cluster randomized controlled trial (RCT) methodology to examine the structural level factors causing HIV (eg. poverty, poor education, and gender violence). The innovation was two-fold: a) conceptually as the research/intervention enabled individuals in vulnerable social groups ('choice-disabled') to gain the agency to choose ('choice-abled') and benefit from the traditional prevention programs; and b) in the design, where the traditional stepped-wedge RCT was used to measure and implement prevention intervention for the most vulnerable.
- 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. Innovative aspects of this methodology include the convergence of a) a strong bottom-up capacity building processes that work with rural citizens who are negatively affected by inequities; b) the development of a monitoring system using mobile phones that is easy to use; and c) a rigorous impact evaluation that is being conducted to measure the effects of the intervention on aspects of equity and governance.
- Other areas of innovation that gained traction was in health financing where Program support led to the standardization of methods used in health financing and equity assessment. In rural China as part of supporting health reform developed a new planning tool for human resources for health was developed (106816).
- In West Africa, there has been an integration of mixed methods to fully understand issues around national fee abolition and subsidization policies (105309). This work has been presented at a number of regional fora increasing the awareness of the important contribution of qualitative research to health systems research.
- Another innovation in methods, particularly analytical techniques in health systems research was through the development of a supplement on systems thinking (106975). While complex adaptive systems (CAS) is not new, it is relatively new in the field of health systems research. GEHS ventured into this initiative as CAS shares conceptually the similar approaches supported by GEHS, and there were limitations on how the subject was treated in the first systems thinking document by WHO.
- As a contribution to evidence for use at global levels, the Global Health Diplomacy project (106810) brought stakeholders from different backgrounds and disciplines together for a methods workshop to discuss research approaches from a range of disciplines and finalize the best fit for the research questions to be addressed. The innovation is in the way of doing research such that it contributes to global dialogue at the World Health Assembly.

Overall, the Program has supported innovative approaches to make a difference on access to care. The course was not always clear, and risks were taken on these early adopters, with strategies to bring in other innovators. Although there were promising results, the question remained if increasing the investment would yield the requisite impact. The risk paid off and led to the second achievement.

Achievement #4: Increasing recognition, impact and adoption at scale of health systems research methods applying the effective principles

Innovation at project level is not sufficient. The Program continuously strived to mainstream those innovations in research methods for increased impact. Part of this process involves recognition and adaptation of those methodological approaches. To accelerate these processes some of the strategies employed by GEHS include playing a bridging role between projects and global/regional dialogues; for longer running projects or those projects that have developed, refined, and used expertise in certain research approaches, encouraging them to develop guidelines/curriculum for other/newer groups so their rigorous research approaches could be adapted in other contexts.

Evidence of achievement

Several project examples indicate how the above programmatic strategies have achieved recognition of the results and their methodologies. They range from increasing visibility of the work done by GEHS research partners at global level processes related to policy and research and then inviting our research partners to such fora to highlight perspectives from the global South. Within national boundaries, it entailed supporting GEHS research partners to work on issues of national health and development priorities and also by embedding their research in policy processes. The following examples indicate these aspects. Challenges in this area relate to raising the profile of health systems research as a field globally. At the regional and national levels the research landscape continues to be dominated by discipline-specific research approaches and in particular those of clinical/biomedical in nature. GEHS as a funder has been highlighting health systems research at various global/regional fora and linking with like-minded organizations to promote the field so that receptivity of the work of GEHS research partners is enhanced.

- EQUINET's (105675) production of Equity Watch reports has been embedded in policy processes in the Eastern and Southern Africa and in some cases the Ministries of Health and Finance. The process has resulted in publications of Equity Watches in at least six countries in sub-Saharan Africa. Some countries have even done multiple Equity Watches report which has facilitated identifying trends and reporting on progress of health outcomes. The work has been widely cited and was even 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.
- An example of bridging project level work to global processes and deliberations was around UHC and the development of guidance on the ethics of UHC. GEHS actively brought in Southern voices and on the ground case studies to the development of international ethics guidance on UHC (107501, and travel grants under 107215).
- As an example of taking a project to scale is the Botswana project mentioned above. Supported and requested by the Government of Botswana, the current project (107531) expanded the methodology supported in an earlier project (105053) to scale as part of a roll out of a national poverty alleviation program.

- There are a number of projects that have built on years of expertise in a particular area of health systems research that GEHS has supported to document that experience in the form of guidelines or scientific readers. One example was an initiative on national resource allocation guidelines (105675). Another is the development of a Scientific Reader on Participatory Action Research in Health Systems Strengthening (107532) in addition to maintaining a pra4equity listserv since 2005. Lastly the above mentioned systems thinking initiative also supported the development of case study teaching materials.

Generation of a body of knowledge and research findings

GEHS intended to support the creation of a body of knowledge that would focus attention on and deepen understanding about critical health systems issues; that would contribute to strengthening leadership amongst researchers, decision-makers and front line workers to address these problems and that would inform efforts to roll out research as an intervention and good practice at scale.

In planning how to achieve this outcome, we developed an approach that was consistent with IDRC's *Research Quality Plus (RQ+) Assessment Framework (*Ofir, Schwandt, 2014). By applying our own guiding principles of *governance, equity* and *systems integration*, the Program proactively aimed to showcase the *Framework's* sub-dimensions as elements of robust, quality development research.The conceptual alignment between the effective principles and the *Framework* dimensions is summarized below:

GEHS Effective Principles	***Research Quality Plus Assessment Framework*** (Ofir, Schwandt, 2014)	***Alignment through GEHS research process requirements***
governance	***research legitimacy*** [22]	sensitivity to local traditions, local authorities, and relationships within a community or with powerful authorities
	research importance **(salience)**[23]	alignment with key development policies, strategies, and priorities of the user
	positioning the knowledge for use[24]	mapping of influential individuals and groups
equity	***scientific merit*** **(integrity of the research process)** [25]	inclusion and safeguarding of rights of vulnerable populations
	research legitimacy	although treated separately in the *Framework,* GEHS consciously combines social and gendered analysis given overlapping and cumulative impact of multiple exclusions such as race, gender, ethnicity, and economic status
systems integration	***research legitimacy***	engagement with local knowledge and embedding research in broader real contexts
	research importance	addresses problems relevant to stakeholders
	positions the research for use	requires understanding and engaging with user contexts

[22] Defined as taking into account the perspectives, needs and voices of all stakeholders, by addressing potentially negative consequences and outcomes, by being gender responsive, inclusive and by engaging with local knowledge, p. 17-19.
[23] Defined as being perceived as useful to key intended users through its originality and relevance, p. 19.
[24] Defined as accessibility of publications, user engagement and knowledge sharing, as well as timeliness and actionability, p. 20-21.
[25] Evaluated through the overall research design and execution, the integrity of the research process and the quality of publications, p. 16-17.

Three significant achievements have been made to date. The achievements examine the extent of the alignment between the effective principles and the Research Quality Framework as well as the extent to which the overall quality of the knowledge created have been demonstrated during the implementation of the prospectus.

Achievement #5: A growing body of knowledge with scientific merit that is applying the GEHS effective principles

The Program has used the following strategies to develop, support and ensure scientific merit:

- all proposals were systematically and rigorously reviewed through set criteria reviewing the research design and other Framework dimensions;
- calls for proposals and journal submissions were specifically designed to integrate the effective principles and to include authors from less well-represented regions;
- inclusion of proposal development, inception and methods workshops and/or provision for ongoing mentoring and accompaniment by programme staff and stronger research partners;[26]
- publications and dissemination activities were systematically included in project budgets resulting in peer-reviewed journal articles and other documents placed in the public domain;
- special supplements in well respected and highly ranked peer-reviewed journals were targeted. The supplements typically include at least one synthesis paper to provide cross-project comparative insights which contributes to increasing depth, breadth and innovation in the field and to deepening the analysis of the effective principles. The supplements are open-access thereby encouraging greater access and use;
- support for specific conferences and participating in the steering/executive committees has put important programme-level issues and evidence on the agenda.

Evidence of achievement

GEHS-funded research partners have used a number of approaches to put evidence into the public domain. An analysis of research outputs shows that there were **287 academic publications**[27], **377 professional publications**[28] and **329 event documents.**[29] In addition there were **86 media**[30] outputs. All research outputs are listed in the dashboard excel spreadsheet.

Annex 6 highlights some of the significant research outputs; particularly listing special issues of peer reviewed journals, high profile reports and training materials important for deepening the health systems research field. Primarily the scientific merit resides in the depth of the knowledge in terms of addressing governance, equity and systems integration issues and the influential nature of the publication.

[26] For example, the West Africa Initiative to Build Capacities through Health Systems Research (106948) has applied all of these strategies to accompany the research teams.
[27] Including journal articles, journals, scoping studies, theses
[28] Including policy briefs, project briefs, training materials, synthesis and analysis reports.
[29] Including workshop reports, presentations and proceedings.
[30] Including media articles, bulletin, newsletter, brochures.

Notable supplements or special issues published (or forthcoming) in recognized academic journals include:

- *Special issue of Health Policy and Planning on the Science and Practice of People-centred Sealth Systems* includes a highly accessed commentary – this supplement framed the discourse for the 3rd global symposium on health systems research and intentionally reflected southern voices rather than using the approach of the 2nd global symposium which depended on 'commissioned papers' from known researchers. The result is an influential publication, indexed in the formal literature.
- *Special issue of the Global Public Health Journal on Sexual and Reproductive Rights and Health beyond 2014*, which assesses progress 20 years after the 1994 International Conference on Population and Development (ICPD). The articles demonstrate that the challenges recognised by the ICPD still stand, and that lessons learned can inform the way forward and priority actions as the global community discusses a post-2015 global development agenda. Note that the call for articles consciously sought submissions from young researchers.
- *Special issue of Health Research Policy and Systems on Advancing the Application of Systems Thinking in Health*, which contributes to filling the knowledge gap between abstract concepts and practical use of systems thinking. The GEHS teams was closely involved in its development process to sensitize contributors to the importance of governance, equity and systems integration in making sense of complex health systems.
- Global health and diplomacy papers (awaiting publication in the Journal of Health Diplomacy in early 2015)
- A special issue on selective subsidies for health services (105309) is to be published shortly by BMC Health Services Research.
- The West Africa Initiative (106948) will publish a special supplement in 2016/2017.

Achievement #6: The growing body of knowledge applying the GEHS effective principles is both legitimate and important to key stakeholders

To encourage the ultimate application of the knowledge to address important development issues, GEHS has tried to ensure that the knowledge not only has scientific merit but is also legitimate and important.

To ensure research legitimacy, conscious efforts were made through our review and support process to ensure that projects were developed by and with a range of engaged and representative stakeholders. For example, multi-stakeholder advisory groups were convened for the research projects in the West African regional initiative (106948). Several funded projects consciously sought to strengthen community engagement and governance.[31] The vast majority of projects were awarded directly to Southern researchers and their institutions in order to increase responsiveness to key stakeholders. This process also strengthened the application of the equity and governance effective principles.

[31] This includes: Enhancing Participation of Indigenous People to Address Discrimination and Promote Equity in Health Systems (106815)[31], Governance Analytical Approach (103998) and Health Systems Governance: Community Participation as a key strategy for realising the Right to Health (106972), The Contribution of Civil Society Organizations for Achieving Health for All (107580).

To ensure research importance, GEHS has assumed risks by providing support over multiple phases and to groups of projects working on similar issues in order to deepen understanding, to build cumulative credible evidence bases and to strengthen important stakeholder relationships that could ultimately impact positively at scale. Should the impact be negative, our learning-based approach to programming (see Annex 4) would support the identification of lessons to inform future efforts.

Evidence of achievement

- Projects that are legitimate and important to key stakeholders can have significant impact. In the field of HIV/AIDS, CIET a long-time partner, worked closely with national stakeholders to research the drivers of and relevant interventions to reduce HIV incidence amongst vulnerable populations in Southern Africa.
- EQUINET systematically worked with national stakeholders in Eastern and Southern Africa to develop and undertake assessments of national health system performance in terms of delivering equitable services. The support for *Equity Watch* analyses and follow up work with regional bodies has resulted in the East Central and Southern Africa Health Community (ECSA-HC) adopting the framework and integrating equity indicators into its annual reporting cycle for member states.
- Repeated investment in a series of health financing projects has created a recognised body of evidence on the detrimental effect on health outcomes from catastrophic out-of-pocket health expenditures. The results also provide needed evidence on the importance of risk pooling, primary health care, and public health sector in addressing health inequities. This evidence has fed into national efforts to reduce health costs.[32]
- In the Nigeria Evidence-based Health System Initiative (NEHSI, 104613), the Ministries of Health in two states drove the process to produce quality coherent evidence that deepened the understanding about the impact of inequities, poor governance and lack of systems integration on achieving good health outcomes. 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. Further information about this initiative is provided under Outcome 4.

Achievement #7: A recognised body of quality GEHS knowledge is well positioned for use and has had impact, particularly at the community level

Lives are ultimately changed at the community level – where users and primary health care services meet. Thus it is critically important that rigorous, legitimate and quality knowledge is accessible to and used at the community level. Given the scope of impacting on primary health care, the Program has done well at ensuring that evidence is positioned for use at the community level and beyond to actual use.

[32] Related project include: Equitap (105231), LANet-EHS (103905), SHIELD (106334), GNHE (106439), Maternal mortality in Colombia (104373), Evaluation of Aarogyasri Health Insurance Scheme (106751).

Evidence of achievement

Early discussions with research partners in 2012 underlined the need for reflective spaces and pointed out that 'cutting edge requires application….it is not just the 'what'…. But it's the 'how' that is where cutting edge resides.[33] We have consciously applied a number of strategies to position research for use at community levels. Examples include:

- Regular dialogues with local practitioners have led to a better understanding of local health problems and has enabled the research to inform change in front line practices (106788).
- The production and publication of the *Participatory Action Research for Health Systems Research Reader* (107532) combined with the planned translation into French and Spanish puts into the public domain an important resource for advancing health systems research grounded in community level realities and leadership.
- Building on an earlier IDRC grant, a project in Guatemala (106815) initially implemented in 6 municipalities is now being scaled to 22 municipalities. It is creating deep engagement with community members and empowering them to reclaim better health services for indigenous populations.
- Substantial investment has accelerated the link to resources for community level decision making. Building on earlier knowledge translation initiatives[34], support has been provided through extending the Evidence Informed Policy Network (EVIPNET, 105666), supporting the implementation of a rapid response service to enable researchers to respond to direct user requests in Uganda, and consolidating the African Centre for Systematic Reviews based at Makerere University (107237).
- Other research partners have developed popular booklets, films and used other media to share findings and catalyze action (see the list of media outputs).

At the same time, it is clear that not all health challenges can be handled exclusively by community members; there is often a chain of responsibility extending to district, national and global levels. Thus often many actors are required to solve complex health problems. It is therefore important to strengthen linkages across these spheres to influence policy, practice and agendas at these broader levels.

Influence of policies, practices, agendas and funding priorities

Building on the achievements, strategies and challenges from the other three outcomes, this particular outcome on influence captures the main driver of the program to have research make a difference. The fourth outcome deals with achieving measurable influence on policies, practices, agendas and funding priorities related to improving the lives of individuals and communities through responsive and fair health systems. The other three program-level outcomes contribute to the achievement of this outcome.

Influence is defined both as a product and a process – arguably more the latter than the former in the realm of research for development (Carden, 2009). According to a study commissioned to examine this aspect of GEHS' programming, nearly half of the projects sampled demonstrated more than one type of influence at multiple levels.[35] The strategies require a nuanced understanding of supply-side and demand-side factors related to achieving influence. Acknowledging and responding to context is of

[33] This was mentioned as part of key information interviews conducted during the Global Forum for Health Research in Cape Town in 2012. See team analysis of interviews, available here.

[34] This includes grants from previous phases for the Research Matters project and the Regional East African Community Health (REACH) Policy Initiative.

[35] See report done by Universalia on the influence outcome in 2014.

paramount importance. The process is often cumulative over a long period of engagement with key stakeholders. GEHS intentionally avoided adopting generic or prescriptive strategies when funding projects to achieve influence. Nevertheless, a systematic approach of learning and reflection throughout the prospectus period defined the deliberate and considered plan to customize projects that leverage proven strategies and integrate others that respond to both supply- and demand-side contextual realities.

Achievement #8: Progressive influence in key policy areas and primary health care delivery by 'being there and staying there'

Driven by the aspiration of ensuring equitable health systems with primary health care as the cornerstone, the Program's firm understanding of the drivers of development and its strong networks at multiple levels enhanced its ability to respond to windows of influence[36]. This amplified existing bodies of knowledge and leaders in health systems research, while seizing new opportunities for partnerships.

These results have been possible because of GEHS' sustained and responsive engagement and support of key health systems research issues. GEHS-supported activities achieve influence outcomes through a combination of 'bottom-up' (responding to PHC demands at the local level) and top-down (national and global commitments to address health inequities). In other words, research is the intervention and it is embedded in change processes. The research has collectively strengthened primary health care through improving health practices, financing mechanisms and strengthening of leadership at all levels to influence policy and practice that supports primary health care.

Evidence of achievement

Influencing policy and practice to improve primary health care: GEHS directed its support to strengthen the primary health care level of service – the level that plays a critical role in prevention of illness, promotion of wellbeing and provision of needed health services at the community level. Primary health care (PHC) services in many countries are weak with numerous challenges around management, human resource levels, supply of drugs and devices and quality of care. GEHS has supported research and activities to influence policy and practice to strengthen PHC based on evidence.

- In West Africa a series of projects has examined the impact of partial subsidies on access to specific health services in Burkina Faso (103858, 105309), Niger and Mali (105309). The methodologies put the voice and experience of communities at the centre of the debate, exposed challenges faced by dysfunctional clinics and put the issues on the national agendas. Follow up research in Niger (106949) is studying 'neglected problems of health systems research' that negatively impact on care at the community level. Despite initial hostility by the government in Niger to the research, there is now a growing recognition of the value of qualitative research at community and institutional levels. The organisation was subsequently asked to undertake an in-depth review of the civil service to inform a national strategy to modernise the state.
- For six years, the state governments of Bauchi and Cross-Rivers in Nigeria were supported to strengthen evidence-based planning and decision making through the development of comprehensive health information systems and accompanying socialization and engagement processes to ensure that the data was used (104613). This initiative had an important impact on primary health care services, specifically *improving health practices*. For children, it improved the

[36] Influence windows can be defined as a certain threshold of appetite to change policy, practice, agendas and/or funding priorities.

use of bed nets, improved the management of diarrhea using simple, life-saving practices like providing extra fluids, and increased immunization uptake. For mothers it increased the likelihood of the recommended four antenatal checkups, increased the likelihood of post-natal check-ups, increased men and women's knowledge of danger signs such as bleeding during child birth; and increased breast feeding practices. The project also *influenced policy* agendas where it has been mentioned in high level forums. For example, the Nigerian Minister of Health (June 2014) noted that NEHSI was the right type of research needed to address Maternal Newborn and Child Health in his remarks at the High level Summit on Maternal Newborn and Child Health hosted by Canadian Prime Minister Stephen Harper in Toronto.

- In Southern Africa where the epidemic of HIV persists, working at a primary health care level to address the structural causes of HIV/AIDS, interventions were developed and tested through a randomized controlled trial demonstrating reduction in HIV incidence rates in Botswana (107531). This research convinced the Government of Botswana in the roll out of its national poverty programme at scale to partner with the researchers and use this approach in its roll out. [37]
- In Karnataka State, India, primary health care services were improved by introduction of tools to help providers at PHC centres to address health problems presented to them by women (106683). Issues of harmful obstetric practices and discriminatory care were also addressed through involvement of the state government that subsequently set out to establish better nursing practices.
- In Ayacucho region, Peru a project resulted in improving nutrition for indigenous mothers and children through recovering traditional practices and better understanding local attitudes and perceptions (107433).
- In Guatemala through a participatory research approach, municipalities have been able to improve the governance of their primary health services ensuring availability of medicines, ambulance services and improved health workers' attitudes (106815).

Influencing financing policy and practice for equitable access to health: A critical aspect of primary health care is to ensure access to people when they need services. Paying for fees for health services has been a major barrier to access over the years and GEHS has provided consistent support to health financing research for over a decade.

- Specific support was provided to build credible methodologies that explicitly dealt with the equity issue and how to create the fiscal space for covering the costs of a relevant package of services. This was accompanied by support for three regional networks in Africa (SHIELD), Asia (EQUITAP) and Latin America (FUNSALUD). Their research influenced national level policies; for example, SHIELD influenced Ghana to extend insurance coverage beyond government employees. This foundation was well placed to influence the more recent window of opportunity that emerged to put universal health coverage on the global agenda. When these networks came together under one Global Network for Health Equity, they scaled up their research and engagement with key stakeholders globally. Their work has contributed to defining the indicators and measurements to promote UHC as a post-2015 goal. They have launched UHC assessments of countries to help inform the progressive realisation of universal coverage for countries[38].
- At the UHC agenda advanced, the ethics of what to invest was explored through a WHO ethics Guidance where GEHS intervened to ensure Southern voices were at the table and the evidence (107501).
- In collaboration with Rockefeller and the WHO Alliance for Health Policy and Systems Research, GEHS shaped a research call to explore the role of non-state actors in health services (107449).

[37] In the Botswana pilot sites the HIV incidence rates of young women was 10.6% compared with 22.3% HIV-positive in control communities. Peer-reviewed articles about the Botswana roll-out will be produced as the project results are obtained.
[38] See gnhe.org.

Influencing agendas through supporting leaders: To facilitate influence, the GEHS strategies have recognised the importance of providing a space for leaders to meet, to set their own agenda and to develop relevant strategies to strengthen primary health care provision.

- In West Africa the regional consultative committee (RCC) working with the West African Health Organisation (106948) is paving the road by developing a regional capacity plan and proposal with institutional stakeholders across the language divide to strengthen health systems research capacity within country health systems. These efforts over time are contributing to building a critical mass of researchers and research organisations, practitioners and other stakeholders able to increasingly influence polices and to prioritize health systems research.
- At the global level, GEHS has used the opportunities of global commissions and committees to support the participation of leaders from LMICs. For example GEHS supported the participation of five Southern leaders on the UN Commission on Life-Saving Commodities for Women's and Children's Health and in a working group (106970). The LMIC representation catalysed good discussions on ownership; for example, how LMICs can be part of the innovation on the production of the commodities. GEHS participation in the working group raised the importance of thinking about access within a health systems framework.[39]
- Similarly, to bring forward the agenda of access to care for all in the post-2015 agenda, GEHS had the opportunity to support a thematic working group on health (107339). This group was led by a prominent Indian researcher 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.

Achievement #9: Measurable change in the health of individuals and communities

GEHS' ultimate aim is to contribute to improving people's lives through improved health outcomes. Such change does not occur overnight and is embedded in complex processes of transformation from family / community to global levels. The sustained efforts by GEHS over the past 13 years demonstrate that consistent, comprehensive support to committed leaders, researchers, research institutions and other stakeholders can impact positively on people's lives. At the same time it is difficult for a program to roll up the number of lives saved and measure definite attribution. However, the program sought such an opportunity through a partnership with the Government of Nigeria and Foreign Affairs, Trade and Development Canada. It is one initiative, but large in size of the budget, and it operationalises GEHS' approach to strengthening equitable health systems. The NEHSI experience is described below.[40]

Evidence of achievement

The ultimate outcome set out in the prospectus was to contribute to improved health outcomes. The Nigeria Evidence-Based health System Initiative (NEHSI, 104613) provides an important example of how a comprehensive intervention driven by local stakeholders over time can impact positively on people's lives. The size of the budget, CA$19 million, enabled the initiative to have an impact that addressed systemic problems in the primary health care system in two states in Nigeria: Bauchi and Cross River.

- Through this implementation research initiative, maternal mortality rates were reduced in the focus local government area[41]; and state and local level ownership of the project was achieved with both

[39] See reflections in the project completion report.

[40] See products aimed at communicating the NEHSI approach: Building a culture of Evidence-based planning in Nigeria, and Lasting change – strengthening capacity to improve health systems.

[41] In the focus local government area maternal mortality ratios (511 per 100, 000 live births) and infant mortality ratios (34 per 1,000 live births) were lower than in other LGAs (MMR: 597 per 100, 000 live births; IMR 42 per 1,000 live births).

states investing financial, human and infrastructure resources into the project. Cross River State institutionalised the social audit and used the data in their key planning documents (Local Economic Empowerment Development Strategies) for all 18 Local Government Areas. In Bauchi State there has been initiative to institutionalise the community surveillance system. The impact of the NEHSI project reverberated at the Federal level. Senior officials noted the system changes at the state level and sought to reinforce the approach used and expand it to other states by integrating aspects of the social audit into the new federal health information systems policy.[42]

This example shows what health systems research delivers on and why health systems research matters. With investment and focus on issues of governance, equity and systems integration, it can and does improve women's and children's lives.

Section 3 Lessons and conclusion

Since the approval of the prospectus in June 2011, the GEHS team has had the privilege of working with researchers, institutions and decision makers in LMICs to strengthen health systems – a key element of survival and hope. The field has grown with increasing number of funders and a recognition that no vertical program will work without considering health system strengthening. To achieve their intended impact, individual interventions need to be embedded in robust delivery systems that are adequately resourced and accessible to the most vulnerable The GEHS Program has embraced policy agendas of universal health coverage; maternal, newborn and child health; accountability; and information and communication technologies. These agendas have been used to continue to address challenges of decision-making, resource allocation, and power distribution in the system.

Achieving the outcomes

To date there is evidence that the Program has made strong progress on the outcomes that we set. Even at this early stage. The Program has achieved a critical mass of LMIC researchers and institutions, setting a solid foundation for evidence-based decision making that can build stronger health systems for the future. The progress has gone beyond the numbers to fostering a vibrant community that addresses health issues by explicitly applying the effective principles. By deciding to have a sharper focus on the principles of governance, equity and systems integration, GEHS knew it was critical to support the development of rigorous and innovative methodologies. Working with the early adopters, the foundation of health systems research methods was deepened with increasing innovation in key concepts, ways of doing research and the design and methods. For impact the Program strived to mainstream the methodology – having successes with outputs and processes such as Equity Watch, increasing the fiscal space for enabling universal health coverage, and getting a government to understand that structural factors of HIV/AIDS could be used as a strategy in a roll out of its national poverty alleviation program. In any research program a key question is whether the knowledge that is generated holds scientific merit, legitimacy and importance. The evidence shows a high number of quality outputs in influential journals and at the same time savvy outputs that inspire and transform decision makers and households. The legitimacy and importance of the research is demonstrated through the impact projects have achieved. A unique feature of the body of knowledge that has been supported by the Program, is its use by communities. This focus is key in changing behaviours and practices for better health. Lastly the Program with the formation of a critical mass of researchers, institutions, and knowledge has influenced policies, practices, agendas and funding priorities. By our focus on the development drivers that change and improve distribution, resource allocation and systems integration and at the same time by seizing policy windows the Program has been able to have an

[42] See reflections in the Project Completion report.

impact on primary health care. Working from a bottom-up approach, to supporting innovation in the organs of finance and health information systems to increase access to care, and by enabling leaders to lead nationally and globally to forge the agenda for equitable health systems. Partnership funding enabled the Program to leverage impact on a number of projects. Working in one of the more challenging countries, partnership funding allowed GEHS to operationalize the Program's values and methods to deliver on the ultimate outcome of improved health.

Addressing the cross-cutting issues

During the prospectus period, IDRC's Board had identified gender, ICTs and global governance as cross cutting issues. While gender is inherent in the equity principle the Program has consciously strengthened and integrated a better understanding and analysis of social and gender issues within Program processes, team's working culture, and with research partners. To ensure effectiveness the starting point has always been with team members – internalising the meaning and implication of gender through a series of workshops (See Annex 4). Evidence of this successful application ranges from a simplistic indicator of the number of women leaders GEHS supports to the reach and scope of the projects in underserved areas and for the underserved.

The integration of the ICT4D Program into GEHS provided the opportunity to harness a growing field and provide the needed evidence on how to better use technology as a means to enable better health outcomes. The prospectus period started with the development of the SEARCH project (106229) which through a competitive process has a suite of seven projects that are grappling with the integration issue of ICTs into health systems strengthening. This suite of projects rather than one single project is currently giving fruit to both challenges and solutions of integration and drawing increasing attention at global levels. The lesson learned from NEHSI, where ICTs were used in a number of ways, was to focus on the problem and identify where technology can play a role without getting side-tracked by the tool. This approach to integration is more likely to be successful.

The third cross-cutter, global governance was addressed only through one project (106810) where case study methods were used to build the evidence base for African Ministers to use to leverage informed decisions at the World Health Assembly. Lessons are still pending however, it is not a cross-cutter that was mined by the Program.

The continued challenge of programming in West Africa

GEHS has made and continues to make a concerted effort to address the challenges posed in Francophone West Africa, as recommended by the last evaluation of the Program. Reflections of the progress have been written up in the mid-term evaluation report[43]. The strategies of forming a regional consultative committee working with the West African Health Organisation, mentoring, cross regional linking, providing space for dialogue yet at the same time nudging action, and enabling leadership is gaining traction and catalysing change. The evidence lies more in conversations with stakeholders in the region and the slow but steady activity of curriculum building and implementation research on issues of providing effective decentralised primary health care. Despite the continuing challenges of communication logistics, the Ebola crisis, lack of on-the-ground presence, the Program is driven to continue its focus in this region. The support from the new Innovating for Maternal and Child Health in Africa program[44], which is working with WAHO and four Francophone research teams representing a CA$6.5 million investment, will serve to bolster GEHS' effort. There is also growing interest from funding

[43] See page 26-27 of the mid-term report, available here.

[44] This is a CA$36million program funded by CIHR, DFATD and IDRC.

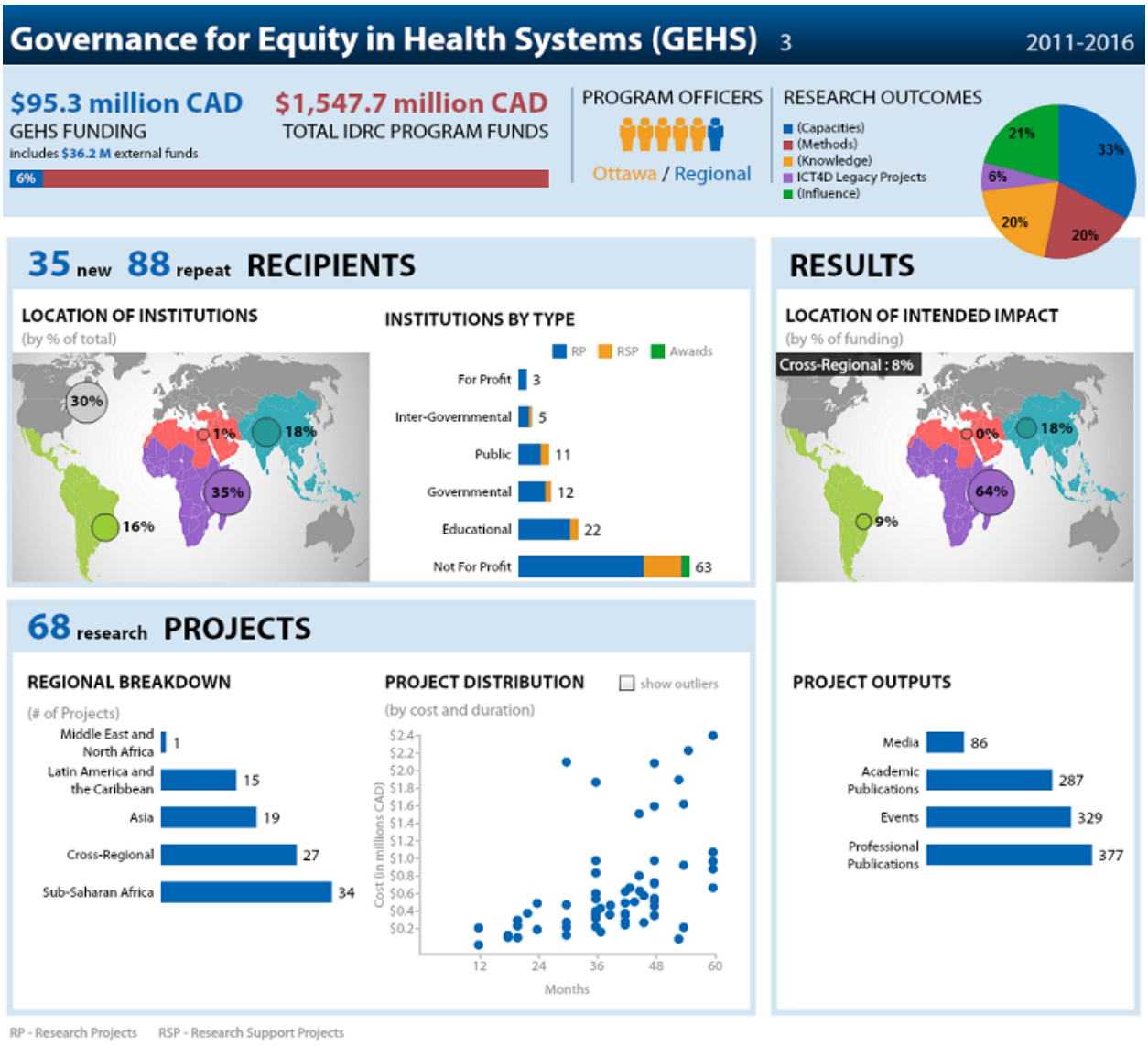
partners looking to GEHS' expertise in this region to invest together. The key will be to capitalise on the products delivered from existing projects, link them together, and amplify their impact.

Going forward

Since 2011, the Program has followed its way up the S-curve as conceptualised in the prospectus, constantly adapting and weathering the institutional externalities with sound progression of all four outcomes. The key lesson has been that by working on root causes with those whose lives are affected a program can deliver on improved health outcomes, reducing disparities, and leave a lasting impact embedded in people and institutions. If a health program is to invest in knowledge and innovations to improve the lives of people, it must embrace the opportunities of national and global agendas (e.g. MNCH, quality of care, adolescent health), integrate the lessons of health systems strengthening and be able to communicate its impact.

List of Annexes

Annex 1: Program dashboard and explanation



This dashboard is also available on IDRC Intranet at:
http://intranet.idrc.ca/dash/IDRC_Dashboard.html#program=GEHS&lang=EN

As of February 2015, the overall value of GEHS portfolio for the current prospectus phase was of $CA 95,250,659 for a total of 96 projects. This includes two large donor partnerships projects receiving a total of $CA 36,185,646 of external funds.

On average, since the beginning of the GEHS prospectus, six program officers including the program leader have managed funded projects.

The relatively high percentage of recipient institutions based in the North (30%) can be explained by a number of factors. Some projects funded by GEHS include more than one recipient institution, with at least one being based in a Northern country (e.g. 105141). Also, funding was provided to some Northern

recipients as a way of giving more prominence to LMIC researchers by , for example, developing supplements to improve knowledge of health system strengthening through the WHO Alliance for Health Policy and Systems Research (e.g. 106975) and providing direct funding to strategic conferences to support LMIC researcher participation (e.g. 107022). To ensure presence of LMIC decision-makers one project supported a global commission (106970). About one quarter of the institutions in this category were for those institutions, for ease of administration, where funding went to the institutions based in the North who then administered funds to the collaborating regional office (e.g. 105666, 105675, 106810, 106973, and 104222). Lastly, another quarter of the projects in this category are legacy projects inherited from ICT4D program area.

A total of 123 recipients directly received GEHS funding, including 88 repeat institutions and 35 new institutions; thereby indicating that the Program tends to repeatedly fund existing recipient institutions. However, it is important to note that repeat institutions include those that received IDRC funding in the past 10 years (moving back from the project start date). In addition, large institutional organizations and universities have been counted as a single entity, which overstates GEHS funding to repeat institutions. For instance, GEHS grants to various units of the World Health Organization (WHO) have all been computed as delivered to the WHO as a single entity; which for each grant has been computed as a repeat institution. Similarly, GEHS grants to research teams based in various departments and faculties of the University of Cape Town University (UCT) have all been computed as delivered to a single recipient, or repeat institution. Lastly, the main types of institutions funded are educational and non-for profit organizations.

Lastly, the percentage of projects focused on prospectus outcomes indicates that a relatively even distribution of projects in terms of their intended area of impact:

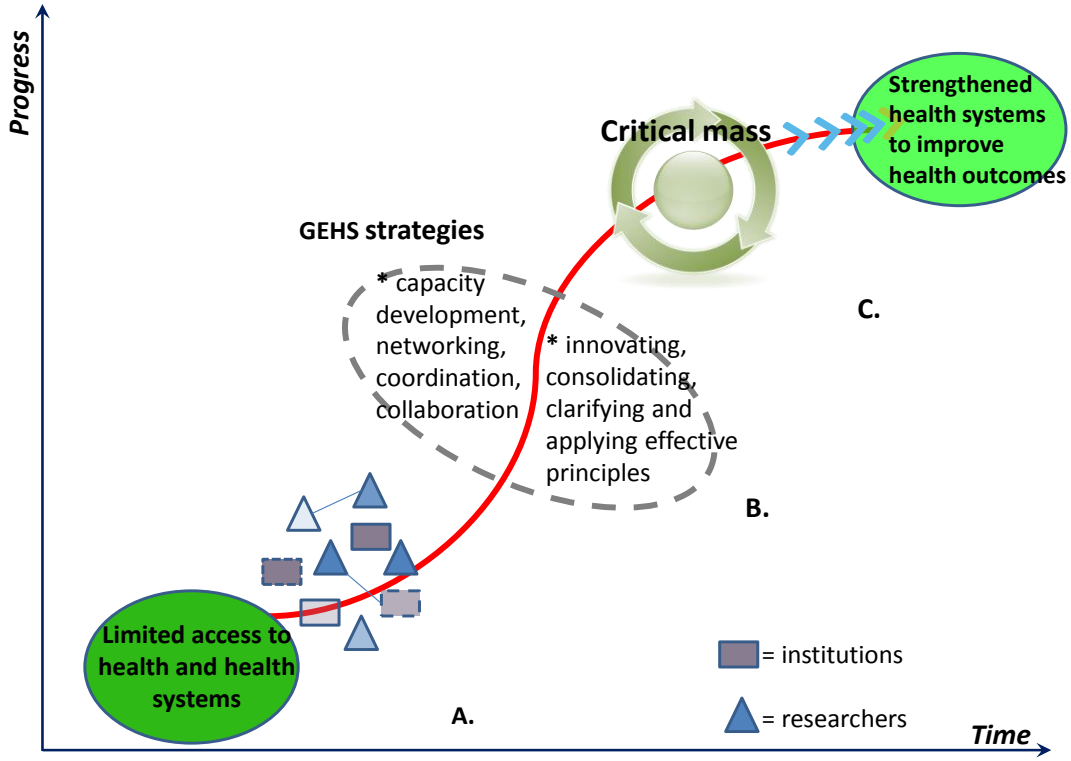
- 33% intend to building a critical mass and strengthening capacities of researchers and institutions;
- 20% intend to developing a knowledge base of research methodologies;
- 20% intend to generating a body of knowledge and research findings
- 21% intend to influencing policies, practices, agendas and funding priorities;
- 6% are legacy projects from the ICT4D program area.

This distribution in terms of outcomes is not surprising as most projects in their development try to address a number of outcomes and there are also strong linkages among the outcomes.

Annex 2: GEHS theory of change

As shown below, GEHS theory of change was conceptualized as on an S-shaped curve of innovation (Slater & Mohr, 2006, in GEHS Prospectus).[45] The graph illustrates how GEHS strategies intend to mark progress towards the building of a critical mass of LMIC researchers and institutions and the ultimate outcome of strengthened health systems and better health.

Illustrated GEHS theory of change



Explanation of the theory of change

In a systems context, progression to the ultimate outcome is not linear rather it is a process of constant feedback and adaptation of strategies. GEHS sought to work with early adopters (point A), who already have the vision and are conducting credible research. Supporting this group and involving other innovators, strategies were introduced (point B) to overcome the expected resistance (top part of the S-curve). Over time this was intended to result in the formation of a critical mass of researchers, institutions, and knowledge (point C) to influence needed change for better health.

[45] The S-curve theory was developed within the technology management field to explain the evolution of radical innovations which through adoption of various strategies overcome resistance to become the mainstream market.

Unpacking the assumptions behind the theory of change

As part of identifying its theory of change, the Program clearly stated its assumptions for each outcome area.

Developing a critical mass of LMIC researchers and institutions: There are 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.

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.

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

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.

Annex 3: Partnerships and parallel funding leveraged

Donor partnership projects

Project #	Timeframe	Title	Budget
104959	02/2008- 08/2013	Health Research Capacity Strengthening Initiative for Kenya	19,655,238
		IDRC	1,253,376
		The Wellcome Trust	9,200,931
		Great Britain Dept for International Development	9,200,931
104613	07/2008-12/2014	Nigeria Evidence based Health System Initiative (NEHSI)	17,397,789
		IDRC	1,034,153
		Canadian International Development Agency	18,000,000
105309	11/2008-11/2012	L'abolition du paiement des services de santé en Afrique de l'Ouest	826,660
		IDRC	517,500
		Agence Française de Developpement	309,160

Parallel Funding

Project #	Timeframe	Title	IDRC budget	Donor institution	Amount of parallel funding
105231	06/2008-07/2011	Health inequity in Asia: Strengthening research capacity to deepen the analysis	461,000	Rockefeller Foundation	18,000
				Australia Agency for International Development	82,000
106439	02/2011-11/2015	Research, capacity building and policy response for equity in health	1,627,640	European Union	66,700
				Research centre on social protection and health economics	157,000
				Carlos Slim Health Institute	8,500

Project #	Timeframe	Title	IDRC budget	Donor institution	Amount of parallel funding
106452	11/2010-06/2015	Health enterprise architecture laboratory	250,000	Rockefeller Foundation	613,620
106460	02/2011-03/2012	Meeting of three regional networks in health financing for equity and dissemination		World Health Organization	60,000
106498	02/2010-02/2015	Strengthening research for health system development in West Africa	750,000	Council on Health Research for Development	420,000
106683	07/2011-07/2015	Strengthening the evidence base for integrating gender and equity in health research and policy in India	575,000	World Bank	135,000
106751	09/2011-05/2013	Evaluation of Rajiv Aarogyasri health insurance scheme: towards improved health	327,700	Great Britain: Dept for International Development India: Andhra Pradesh Medical, Health and Family Welfare Department Rockefeller Foundation The Welcome Trust	233,325 32,345 117,244 276,576
106972	02/2012-02/2015	Health Systems Governance: community participation as a key strategy for realising	390,200	South African National Research Foundation	69,900
106973	02/2012-08/2013	Health trends in post conflict North Uganda	137,690	Fondazione Piero e Lucille Corti	9,332
106977	05/2012-07/2015	African Health Economics and Policy Research Capacity Building and Dissemination	429,200	Rockefeller Foundation	400,000

Project #	Timeframe	Title	IDRC budget	Donor institution	Amount of parallel funding
106815	02/2012-04/2015	Enhancing participation of indigenous people to address discrimination	995,500	Pan American Health Organization Universidad San Francisco de Quilto Friedrich Ebert Stiftung	10,088 20,176 30,265
106970	02/2012-12/2013	United Nations Commission on Commodities for Women's and Children's Health	265,500	Norway Ministry of Foreign Affairs Bill and Melinda Gates Foundation	450,000 450,000
107304	02/2013-05/2016	Community health learning program for health equity in India	352,000	Sri Ratan Tata Trust Ford Foundation Katholische Sentraistelle fur Entwicklungshilfe	291,000 6,600 24,300
107449	02/2014-03/2019	The role of non-state actors in strengthening health systems	1,090,000	Rockefeller Foundation	500,000
107487	08/2014-04/2018	Towards more equitable primary health care in Argentina and Latin America	316,000	Directorio del Consejo Nacional de Investigaciones cientificas y tecnicas	46,990
107499	09/2013-01/2018	Understanding violence against children in Rwanda	749,300	Centres for Disease Control and Prevention United Nations Children's Fund	88,445 107,760
107531	11/2013-01/2019	Reducing HIV risk in Botswana: a national cluster randomised controlled trial	2,397,500	Botswana Ministry of Health	3,125,000

Annex 4: Continuing learning

Common understanding of GEHS strategy and implementation (November 2011)

- Immediately following approval of the prospectus, the GEHS team sought to reinforce common understanding of the four outcome areas and how to operationalise them. Given that not all team members were involved in developing the prospectus, this exercise served to enhance team ownership of the strategy. It also refined the team thinking on the interconnectedness of the four outcomes areas and the non-linear process of strengthening health systems.

Real time learning and evaluation plan (continued)

- The Program integrated learning, monitoring and evaluation activities from the onset of programming to enable regular reflection which could improve implementation of the strategy.
- To assess and reflect on progress towards the prospectus outcomes, GEHS team members collectively developed a real-time learning and evaluation plan, with support from IDRC evaluation colleagues.
- A mid-term report was prepared on progress to date towards the outcomes.
- In addition, given the complexity around understanding the *influence outcome* an external evaluation was commissioned to deepen the understanding of the issues.

Key informant interviews with grantees and partners (April 2012)

- The Global Forum for Health Research in April 2012 provided an opportunity to engage with key grantees and researchers on specific areas of the prospectus. 13 key informant interviews were conducted to obtain research partner perspectives into specific areas of GEHS strategy and outcomes and further root the program in the reality on the ground.

Social and gendered analysis

- As part of deepening the team understanding of social and gendered analysis in its programming, a gender workshop was held with Ineke Busken in April 2012.
- Various activities were also initiated to reflect and further a social and gender analysis in GEHS programing; see overview.

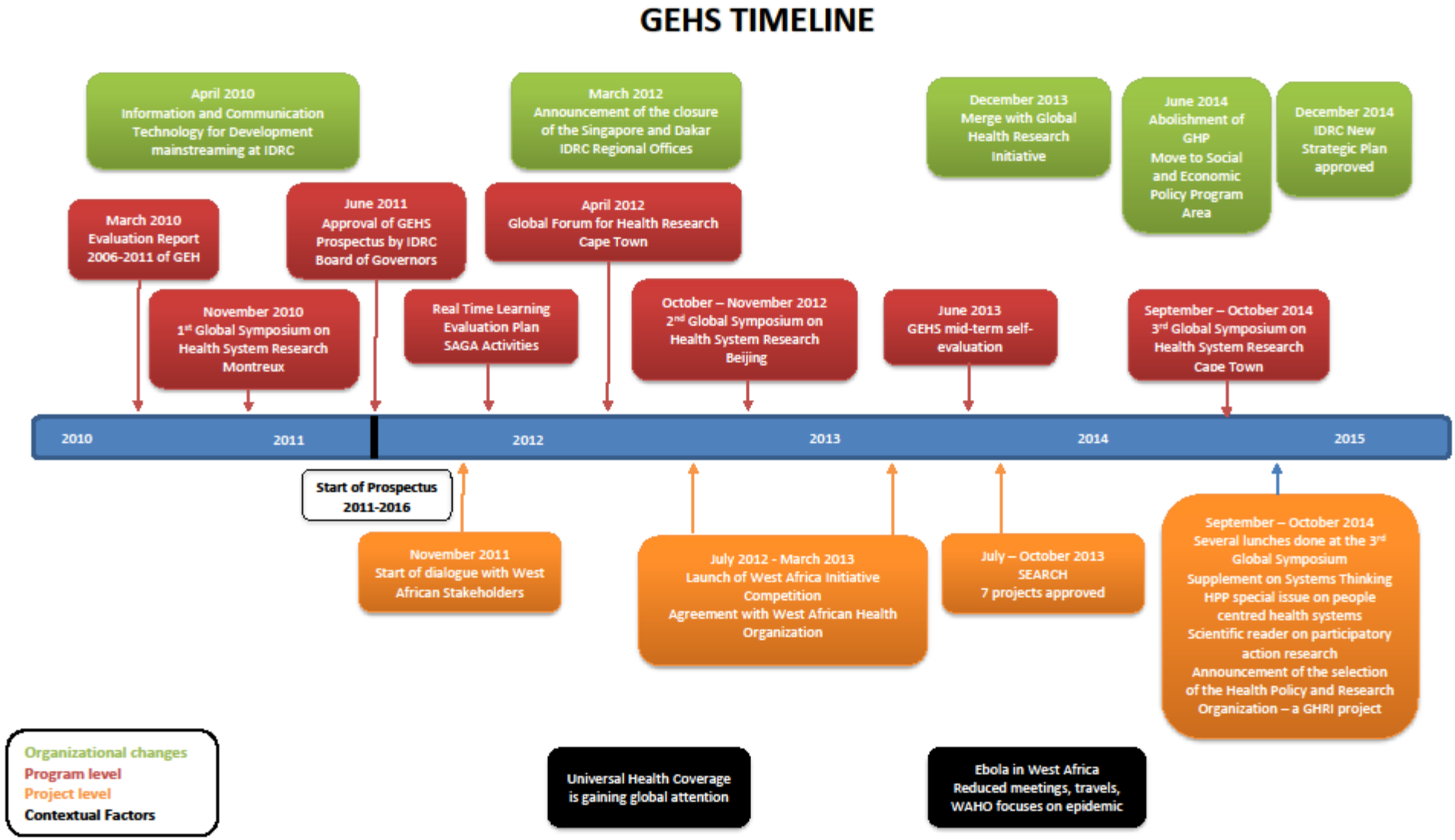
ICT cross cuts

- The process of developing the SEARCH provided an opportunity for the GEHS team to engage in discussions on ehealth integration and the effective principles as the focus of the project was refined through dialogue with key global stakeholders.
- A developmental evaluation is currently underway to foster mutual learning on how the projects unfold; see report from inception workshop.

Program meetings

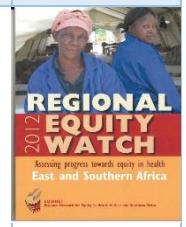
- Regular proposal review meetings provided an opportunity to rigorously examine submissions through applying the effective principles and discussing the implication for our programming.
- Annual planning meetings were also used to reflect on the strategy and prospectus implementation and to adjust subsequent plan.

Annex 5: Program timeline



Annex 6: Key publications

Type of publication	Year /Publisher	Title/*Authors*	Description	Related Project	Pictures
Special issue of academic journal	September 2014 Health Policy and Planning	Science and practice of people centered health systems *Editors: Kabir Sheikh, Michael Kent Ranson and Lucy Gilson*	This is a collection of 11 articles that discusses "people-centered" health systems which is relatively new and encompasses many factors affecting health beyond biomedical solutions, including health service delivery, social justice and human rights.	107022	
Special issue of academic journal	April 2015 Global Public Health: An International Journal for Research, policy and Practice	Sexual and reproductive health for all: The challenge still stands	This special assesses progress 20 years after the 1994 International Conference on Population and Development (ICPD), which established the sexual and reproductive health and rights framework for population and health policy (United Nations [UN], 1995). Contributors from different regions demonstrate that the challenges recognised by the ICPD still stand, and that lessons learned provide a clear way forward for the world's governments as they convene at the United Nations (UN) to agree on priority actions, and a post-2015 global development agenda.	107248	
Special issue of academic journal	June 2014 Health Research Policy and Systems	Advancing the application of systems thinking in health *Editor: Taghreed Adam*	This is a special 14 parts series that contributes to filling the knowledge gap between abstract concepts and practical use of systems thinking, which can help make sense of the inherent complexity of health systems.	106975	

Type of publication	Year /Publisher	Title/*Authors*	Description	Related Project	Pictures
Reports	December 2014 Global Network for Health Equity	Universal health coverage assessment	These seven assessments developed by GNHE features progress towards universal health care in Peru, South Africa, Taiwan, Tanzania, Uganda, Indonesia and Bangladesh.	106439	
Reader manual – Training material	October 2014	Participatory action research in health systems: a method reader *Rene Loewenson, Asa C Laurell, Christer Hogstedt, Lucia D'Ambruoso and Zubin Shroff*	This publication highlights the key features of participatory action research and its history. It outlines the processes and methods used in implementing this research approach, and the reality of applying it in health systems. The reader is used for training purposes and takes stock of how PAR has been used in public health and health systems research.	107532	
Report	September 2012	Regional Equity Watch: Assessing progress towards equity in health	An Equity Watch is a means of monitoring progress on health equity by gathering, organizing, analyzing, reporting and reviewing evidence on equity in health. The Regional Equity Watch report updates the 2007 regional analysis of equity in health drawing on the Equity Watch Framework developed by EQUINET in cooperation with East, Central, and Southern African Health Community and in consultation with WHO and UNICEF.	105675	
Special issue of academic journal	March 2012 Health Policy and Planning	Research to support universal coverage reforms in Africa: the SHIELD project *Editors: Di McIntyre and Anne Mills*	This is a collection of 10 articles that discusses health care costs, access to health care, health care financing and challenges to attain universal health coverage.	106439	

Type of publication	Year /Publisher	Title/*Authors*	Description	Related Project	Pictures
Special issue of academic journal	2015 Journal of Health Diplomacy	Africa, health and diplomacy *Note: forthcoming*	This special issue will cover concerns with theory and practice of health diplomacy of African states and organizations.	106810	
Special issue of academic journal	BMC Health Services Research	Lessons from abolition of health services fees *Note: forthcoming*	This special issue will cover the experiences and lessons emerging about partial abolition of fees for selected health services in Burkina Faso, Mali and Niger	105309	

Annex 7: Event highlights

Type of event	Year & Place	Name of event	Description/Links	Related projects	Pictures
Symposium	October 2014 Cape Town, South Africa	Third Global Symposium on Health Systems Research	Around 2,000 healthcare experts from 125 countries gathered to focus on cutting-edge research into people-centered health systems to address the question: How to make the patient the foremost consideration of health systems? IDRC event item IDRC event highlight	107022	
Workshop	October 2014 Cape Town, South Africa	International workshop on Participatory Action Research in people-centered health systems research	The one day workshop was open to delegates from all regions globally to foster cross regional exchange and to include people from the pra4equity network in east and southern Africa. It aimed primarily to bring together people involved in PAR, using it in various health system processes, but included also some delegates involved in other forms of participatory research. The meeting gathered 48 delegates from all regions and involved a mix of presentation and participatory processes.	107532	
Conference	April 2014 Cape Town, South Africa	Putting Public in Public Services: Research, Action and Equity in the Global South- Municipal Services Project	The conference featured 59 speakers from 22 countries, three plenary events and 15 panels; an additional 75 people, mostly from Africa, participated as observers. This generated an additional 28 conference papers from researchers outside the formal MSP network, most of which will be published as part of edited volumes to be released in 2015 (Zed Books in English and Icaria Editorial in Spanish) as well as a special journal issue focusing on South Africa.	105141	

Type of event	Year & Place	Name of event	Description/Links	Related projects	Pictures
Symposium	November 2013 Dhaka, Bangladesh	Urban Health Symposium: Taking Action for Healthy Cities in Bangladesh	The Symposium brought together a large and diverse audience (500 people on Day 1 and 300 on Day 2) which included policy makers, government officials, corporate representatives, NGO workers, donor agencies, academics, students and interested individuals. Over 75 national and international leaders were speakers and contributed as panel members to the program, many whom are individual leaders in fields impacting urban health from health systems, to migration, climate change, water and sanitation, housing and the environment.	106974	
Conference	March 2014 Nairobi, Kenya	Third Conference of African Health Economics and Policy Association (AfHEA)	The conference brought together 260 attendees including high-level policy makers such as ministerial staffs and Minister of Public Health of Burundi. Overall theme of this conference was “The post-2015 African Health Agenda and UHC: Opportunities and Challenges”	106977	
Inter-Ministerial Policy Dialogue	February 2014 Geneva, Switzerland	Joint Inter-Ministerial Policy Dialogue on eHealth Standardization and 2nd WHO Forum on Health Data Standardization and Interoperability	The objective was to facilitate a dialogue on the need for policy and governance mechanisms for adoption of health data standards in countries and to draft a policy and governance framework for full adoption of standards at national and sub-national levels.	106229; 106948	
Conference	July 2013 Sydney, Australia	iHEA 9th World Congress on Health Economics: "Celebrating Health Economics"	Organized by iHEA, this Congress brought together health economists and stakeholders of health systems throughout the world. Around 1,400 delegates attended the event, with about 40 of them being IDRC research partners.	107535	

Type of event	Year & Place	Name of event	Description/Links	Related projects	Pictures
Conference	March 2013 Sally, Senegal	Second Conference of AfHEA	Theme of this conference was "Toward universal health coverage in Africa".	106113	
Launch of results	February 2013, Abuja, Nigeria	Launch of results from the Nigeria Evidence-based Health System Initiative	The NEHSI release of results in Nigeria was hosted by the Federal Ministry of Health in Abuja, a decision that reflects the strong ownership of the project. The venue was filled by approximately 150 participants from the community level to senior officials of the Nigerian government and local media.	104613	
Symposium	November 2012 Beijing, China	Second Global symposium on health systems research. Inclusion and innovation towards universal health coverage	Around 1,700 experts (researchers, policy-makers, funders, implementers, civil society, media representatives and other stakeholders) gathered in Beijing, China to share new evidence, identify opportunities and gaps, build understanding across disciplinary boundaries, and discuss the way forward to support HSR and the use of evidence in decision-making in low- and middle-income countries.	107022	
Forum	April 2012 Cape Town, South Africa	Global Forum for Health Research	This forum focused on potential solutions in low and middle income countries and emerging economies for moving 'beyond aid' within the context of research and innovation for health equity and development. IDRC staff consulted key global health actors during the conference for their feedback into GEHS strategy and implementation.	Not funded by IDRC, but attended by many grantees.	

Type of event	Year & Place	Name of event	Description/Links	Related projects	Pictures
Conference	July 2011 Toronto, Canada	iHEA 8th World Congress on Health Economics: Transforming Health & Economics	Organized by the international Health Economics Association (iHEA), this Congress is a pre-eminent global event fostering application of economics to health and health systems. It brought together health economists and stakeholders of health systems throughout the world. On a total of more than 1,000 delegates from all continents, 50 of them were IDRC research partners. The Global Network for Health Equity (106439) was launched during an evening event	106237	
Regional Dialogue	November-December 2011 Dakar, Senegal	Dialogue with West African Health Systems stakeholders	This event was organized by GEHS to meet with stakeholders (government, research organization and regional bodies) to identify priority strategies to strengthen health systems research across the region.	106948	

Annex 8: Snapshot of GEHS communications

Title	Date	Material	Description an use
IDRC news: Sub-Saharan Africa	December 2014	Newsletter	The newsletter features IDRC's work supporting health systems research with an emphasis on Sub-Saharan Africa. It includes highlights from the 3rd Global Symposium on health systems research.
No magic pill- Pursuing universal health coverage through equitable health systems	2012	Overview of GEHS programming on UHC	The 4-pager provides core messages on GEHS programming and how it is contributing to paving the way for UHC. It covers several projects and is written as a think piece.
Health financing- Who pays for equitable health systems?	2012	Thematic brief	The 4-pager communicates GEHS approach to programming for a specific theme. It was designed for a general audience, prospective applicants for IDRC funding, or funders.
Maternal health-Making health systems work for mother and child	2012	Thematic brief	Idem as above.
Health information systems- From evidence to action	2012	Thematic brief	Idem as above.
GEHS Posters: What does it take to strengthen health systems	2012	Posters	15 Posters displaying quotes and ideas from GEHS grantees. The posters were displayed during a reception held at the Second Global Symposium on Health Systems Research in Beijing, as well as during the final plenary. Individual quotes were also used to communicate GEHS approach to health systems strengthening (e.g. see social media campaigns below).
Ending violence against women and IDRC communications	2014	Social media campaigns	To convey IDRC's story 16 Days of Activism Against Gender Violence (#16Days) campaign was launched. As the world observes the International Day for the Elimination of Violence against Women on November 25th and the National Day of Remembrance and Action on Violence Against Women in Canada on December 6th, IDRC asked researchers and staff: How do we put an end to violence against women?

Annex 9: Evaluation reports

Title	Date	Evaluation commissioned by	Description/Links	Related projects
African Doctoral Dissertation Research Fellowship (ADDRF) Program: Evaluation Report *Evaluator: David Abbott*	2013	IDRC	The report presents the background and rationale for the ADDRF Program. The report gives a broad look at the issues of completing a doctorate in sub-Saharan Africa and notes from the outset that PhDs are in short supply in the region. The report also provides an overview of the challenges and problems students in sub-Saharan Africa face in completing their doctoral studies.	107508 106206
Proof of Influence Evaluation of the Nigeria Evidence-based Health System Initiative (NEHSI) *Muhammed M Lecky, Sarah BJ Macfarlane, Ricardo Wilson-Grau*	July 15 2014	Evaluation Sub-Committee of the Project Advisory Committee and the IDRC/GEHS	The report examines project's outcomes to answer two questions: 1: To what extent and how has NEHSI influenced the evidence-based planning and decision-making (through changes in knowledge use, capacity, habit, and governance processes) in the primary health care system in particular and in the health system in general at the individual, community, and institutional level? 2: Sustainability: To what extent do the NEHSI outcomes achieved to date a) reinforce each other, and b) embody the principles of evidence-based planning and decision-making in the Nigerian primary health care system?	104613
Evaluating Influence Outcomes and Strategies for the Governance for Equity in Health Systems	October 2014	GEHS	The report aims to document the achievements of the GEHS under its fourth outcome which is "Influencing policies, practices, agendas and funding priorities". The primary user of this evaluation is the GEHS team and the primary purpose of the evaluation is to: "inform programming to ensure IDRC and its grantees influence practices, agendas, policies and funding priorities to strengthening equitable health systems	107082
Inception Report for the Learning Evaluation of Strengthening Equity	December 2014	IDRC	The learning evaluation of the SEARCH program was launched at the first program workshop in October 2014 in Cape Town and will accompany the implementation of the program until December 2016. The evaluation is use-focused and developmental (or real-time learning) in approach. The primary	106229

Title	Date	Evaluation commissioned by	Description/Links	Related projects
through Applied Research Capacity building in eHealth (SEARCH) *Evaluator: Right to health and development (Hera)*			users of the evaluation is the GEHS team. Secondary users include the SEARCH project teams. The evaluation will require the participation of all program stakeholders: the research teams, the GEHS staff, the team of evaluators, and to the extent that is feasible, project beneficiaries and other key stakeholders.	
Evaluation of West Africa Initiative *(in progress)* *Evaluator: Alain Dona Sayi*	October 2014	West African Health Organization	The evaluation was commissioned by WAHO as part of its preparation for the development of 2016-2020 strategic plan. It was conducted in the four countries in implementation of the West Africa Initiative (Guinea- Bissau, Liberia, Mali and Sierra Leone).	106948

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