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Research for Innovation and Equity

Innovating for Maternal and Child Health in Africa: A Mid-Term Formative Evaluation

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EXECUTIVE SUMMARY

Innovating for Maternal and Child Health in Africa (IMCHA), a joint initiative funded by the Canadian Institutes of Health Research (CIHR), Global Affairs Canada (GAC), and the International Development Research Centre (IDRC), was launched in March, 2014. A seven-year, $36 million initiative, it aims to improve maternal, newborn and child health (MNCH), with projects in 11 countries in East and West Africa.

The specific objectives of IMCHA are to:

- Address critical knowledge gaps and increase awareness among policy decision-makers about affordable, feasible, and scalable primary health care interventions to improve maternal and child health delivery and outcomes;
- Build individual and institutional capacity for gender-sensitive health systems and solution-oriented research, and enhance the uptake of relevant and timely research that informs policy and practice; and
- Strengthen collaborations between Canadian and African researchers, working in partnership with African decision-makers, to implement and scale up high-quality and effective services, and technologies that improve maternal and child health outcomes.

The initiative supports 19 research teams (13 in East Africa and 6 in West Africa). To encourage Africa-Canada collaboration in MNCH, each team has a Principal Investigator (PI) based in Africa, and a Canadian researcher co-PI based at a research institution in Canada. Each team also has a decision-maker co-PI from the local, district or national level in the same country as the PI's institution, who can help steer the research towards areas of interest to their government, and encourage and guide uptake of the research outcomes.

In addition to the original grants, referred to as Implementation Research Teams (IRTs), nine of the research teams have received Synergy Grants, with which they are carrying out supplementary research activities on a theme related to their IMCHA work. IMCHA has also established two Health Policy and Research Organizations (HPROs), whose main goal is to support the teams and help them liaise with decision-makers and raise the profile of their research interventions. One HPRO is based in East Africa (EA-HPRO) and the other in West Africa (WAHO).

In this mid-term formative evaluation, the objective is to learn from the early years of IMCHA and identify strategies that can inform and strengthen IMCHA's implementation until the end of the initiative, as well as speak to related future activities. The evaluation addresses a total of ten evaluation questions on four themes:

1. Integrity in the design of the IMCHA model: How has the IMCHA design been operationalized, relative to the purpose and objectives of the program?
2. Integration of gender/equity dimensions: How are the components of the IMCHA initiative addressing equity-sensitive and gender dimensions at the current state of implementation?
3. Innovation and scaling: How has the focus on innovation and scale been articulated in the research projects of IMCHA?
4. Program delivery: How is the implementation of IMCHA being facilitated by IDRC, relative to the purpose and objectives?

Methods

To conduct the evaluation, Small Globe, Inc. was contracted following a competitive process. We carried out a systematic data collection and analysis process involving:

- A thorough document review of a wide array of documents related to the initiative.
- In-depth, semi-structured interviews with 16 representatives from CIHR, GAC and IDRC.
- Online surveys sent to 44 African PIs and Canadian researcher co-PIs and 19 decision-maker co-PIs, probing their views and experiences of IMCHA. The response rate from the researchers was 82%, and from the decision-makers, 63%.
- Fieldwork in five African countries (Burkina Faso, Kenya, Nigeria, Tanzania and Uganda) and Canada. We interviewed 19 researchers (PIs, co-PIs and other members of the research teams), eight representatives of the HPROs, and 15 decision-makers and other external stakeholders. In addition, we conducted three focus group discussions with a total of 22 people, including additional PIs and members of research teams.
- We thematically analyzed and triangulated the data using different data sources to produce an evaluation presentation; this report; and two issue briefs.

Evaluation Results

Overall, IMCHA seems to be, despite a slow start, on track. The teams are working closely with their communities and are, to varying degrees, involving their decision-maker co-PIs. They are producing evidence about affordable, feasible, and scalable

primary health care interventions. There are some early wins in which the research has started to influence policies and practices, and there is enthusiasm that more changes are in the pipeline. To strengthen capacity in gender- and equity-sensitivity, and to maximize scale-up of the interventions, more training and further customized support is needed.

Theme 1: Structure and Operationalization. In this evaluation, we found that the vision and objectives of IMCHA had been operationalized to encourage knowledge flow between researchers and decision-makers, and between researchers in Africa and Canada. In general, the surveys, interviews, and focus group discussions we held found that the research teams saw their collaboration with the decision-maker co-PIs as successful, although Canadian researchers were less certain about the success of the collaboration than the PIs. Several of the teams experienced a high rate of turn-over in government positions, which led to frequent changes among decision-maker co-PIs. Changing priorities by their own governments have also been a challenge for some of the teams.

The collaboration between the African and Canadian researchers was also viewed as highly successful and important to meet the objectives of the projects, according to our survey and interviews. There was a wide range of types of collaboration, with some involving capacity-building efforts, and others involving complementary expertise and bi-directional knowledge flow. Over 80% of survey recipients said that the relationship between the African PIs and Canadian co-PIs was a collaboration of equals.

The HPROs lacked a clear role at the beginning of the initiative. Since then, with clearer communications and revised agendas, their interactions with research teams have proceeded more smoothly, and they have been able to provide useful training to the teams. Further, as the research teams begin to produce results, there are increasing demands for the HPROs to contribute by supporting policy uptake.

Our evaluation found that the priorities of GAC, CIHR, and IDRC are generally well aligned in IMCHA, and the partners share a strong emphasis on promoting MNCH in Africa. Even though there has been a change in the Canadian federal government, IMCHA continues to be a priority, while being slightly adjusted to align with Canada's Feminist International Assistance Policy. In general, the partnership among these organizations has been successful, and can now start to think about what they can learn from IMCHA for future endeavours.

Theme 2: Gender and Equity IMCHA emphasized gender and equity issues from the very beginning, and provided opportunities to build capacity among the research teams for gender analysis. The teams have taken various measures to integrate gender and equity

into their work. The majority of our survey respondents and interviewees expressed the opinion that gender issues are being well-addressed by IMCHA. Our fieldwork, however, showed that there was demand for more applied training in gender analysis in community settings. IMCHA in general did not pay as much attention to strengthening capacity in equity analysis, and according to our fieldwork, most research teams have not deliberately incorporated equity considerations to any significant degree.

Theme 3: Scale-Up of Innovations The main innovation in most IMCHA research is the replication and scale-up of interventions developed in other settings. The PIs and co-PIs have placed considerable emphasis on building mechanisms for knowledge translation. That some projects have already contributed to changes in policies and practices is an exciting achievement. The typical approach to promote scale-up in IMCHA is disseminating the research findings to local and national governments, and working together with them on scale-up activities. As more evidence has been collected, there is demand to help the teams develop effective approaches for further knowledge translation and scale-up.

Theme 4: Program Delivery and Management Mechanisms and strategies have been put into place to supervise and monitor the research teams and HPROs in IMCHA with substantial and demanding involvement of Program Officers at IDRC. IDRC is in the process of developing a risk mitigation strategy to monitor the research projects. Respondents to our survey were generally satisfied with IDRC's supervision of IMCHA, and felt that the strong support and flexibility from their Program Officers, as well as the mid-term meeting in Dakar, were helpful. One challenge was the perception of a relatively high turn-over among Program Officers at IDRC.

Recommendations

For the remainder of IMCHA:

- Hold country-level meetings among the research teams, including the decision-makers, in countries in which there is more than one research team. Also, consider holding a final meeting of all the research teams to share lessons learned.

- Integrate gender and equity considerations into the program, by supporting and building capacity among the teams to do more gender and equity analyses of their data sets. Request that the HPROs organize workshops to help research teams identify practical strategies to address gender and equity issues specific to their projects, and encourage the teams to seek expert advice. Finally, maintain clarity on the differences and overlaps between gender analysis and equity analysis.

- Encourage the HPROs to continue working with each team individually to develop a customized knowledge-translation plan promoting scale-up. As the initiative reaches its conclusion, provide support to the research teams in securing future funding that supports further scale-up activities.

- Encourage more cross-learning and knowledge-sharing mechanisms between the East and West African HPROs.

For future initiatives:

- Provide researchers with support to set up collaborations and provide training to potential applicants at the pre-proposal stage. This can be done through online arrangements to save resources.

- Offer grantees, particularly those inexperienced in managing Canadian grants, management training at the beginning of an initiative.

- Provide applied and separate gender and equity training at the onset of the project, to reach a common initiative-wide conceptualization of gender and equity issues.

- Define the roles and expectations clearly at the outset of the initiative of any HPRO-like component.

RÉSUMÉ

Le programme Innovation pour la santé des mères et des enfants d'Afrique (ISMEA), une initiative financée conjointement par les Instituts de recherche en santé du Canada (IRSC), Affaires mondiales Canada (AMC) et le Centre de recherches pour le développement international (CRDI), a été lancé en mars 2014. Cette initiative de 36 millions de dollars sur sept ans vise à améliorer la santé des mères, des nouveau-nés et des enfants (SMNE) grâce à des projets dans 11 pays de l'Afrique de l'Est et de l'Afrique de l'Ouest.

Les objectifs précis de l'ISMEA sont les suivants :
- combler des lacunes critiques au chapitre des connaissances et sensibiliser davantage les responsables des politiques aux interventions abordables, réalisables et susceptibles d'être portées à grande échelle en matière de soins de santé primaires, pour améliorer la santé des mères et des enfants et les soins qui leur sont prodigués;
- renforcer les capacités des particuliers et des établissements en matière de recherche sur les systèmes de santé tenant compte des sexospécificités et axée sur les solutions, et accroître l'adoption des résultats des recherches pertinentes et opportunes qui éclairent les politiques et les pratiques; et
- resserrer la collaboration entre les chercheurs canadiens et africains qui, de concert avec des décideurs africains, s'emploieront à la mise en œuvre et au passage à grande échelle d'interventions efficaces et de grande qualité qui améliorent la santé des mères et des enfants, qu'elles aient trait à des services ou à des technologies.

L'initiative soutient 19 équipes de recherche (13 en Afrique de l'Est et six en Afrique de l'Ouest). Afin d'encourager la collaboration entre l'Afrique et le Canada pour la SMNE, chaque équipe est composée d'un chercheur principal basé en Afrique et un cochercheur principal canadien basé dans une institution de recherche au Canada.

 Chaque équipe compte également un cochercheur principal décideur à l'échelle locale, départementale ou nationale dans le même pays que l'institution du chercheur principal, qui peut aider à orienter la recherche vers des domaines d'intérêt pour son gouvernement, et encourager et guider l'application des résultats de la recherche.

En plus des subventions initiales, désignées comme équipes de recherche sur la mise en œuvre (ERMO), neuf des équipes de recherche ont reçu des subventions de synergie avec lesquelles elles mènent des activités de recherche complémentaire sur un thème lié à leurs travaux d'ISMEA. L'ISMEA a également établi deux Organismes de politiques et

recherche en matière de santé (OPRS) dont le principal objectif est de soutenir les équipes et les aider à communiquer avec les décideurs et à mieux faire connaître leurs interventions en recherche. Un OPRS est basé en Afrique de l'Est (AOPRS-AE) et l'autre est basé en Afrique de l'Ouest (OOAS).

Dans cette évaluation formative de mi-parcours, l'objectif est de tirer les leçons des premières années de l'ISMEA et de déterminer des stratégies qui peuvent orienter et renforcer la mise en œuvre de l'ISMEA jusqu'à la fin de l'initiative, ainsi que d'aborder les futures activités connexes. L'évaluation traite au total dix questions d'évaluation sur quatre thèmes :

1. Intégrité de la conceptualisation du modèle de l'ISMEA : De quelle manière le concept de l'ISMEA a-t-il été mis en œuvre par rapport au but et aux objectifs du programme ?
2. Intégration des dimensions de genre et d'équité : Comment les composantes de l'ISMEA abordent-elles les dimensions sensibles de genre et d'équité dans l'état actuel de la mise en œuvre ?
3. Innovation et passage à grande échelle : Comment l'accent sur l'innovation et le passage à grande échelle a-t-il été mis dans les projets de recherche de l'ISMEA ?
4. Exécution du programme : Comment la mise en œuvre de l'ISMEA est-elle facilitée par le CRDI, par rapport au but et aux objectifs ?

Méthodologie

Afin d'effectuer l'évaluation, le marché a été attribué à l'entreprise Small Globe Inc. à la suite d'un processus concurrentiel. Nous avons procédé à une collecte de données et à un processus d'analyse systématiques comprenant les étapes suivants :

- Un examen minutieux d'un grand volume de documents liés à l'initiative.
- Des entrevues semi-structurées approfondies avec 16 représentants des IRSC, d'AMC et du CRDI.
- Des enquêtes en ligne envoyés à 44 chercheurs principaux africains et cochercheurs principaux canadiens, et à 19 cochercheurs principaux décideurs, sollicitant leurs avis et expériences par rapport à l'ISMEA. Le taux de réponse des chercheurs était de 82 % et celui des décideurs de 63 %.
- Un travail sur le terrain dans cinq pays africains (Burkina Faso, Kenya, Nigéria, Tanzanie et Ouganda) et au Canada. Nous avons eu des entretiens avec 19 chercheurs (chercheurs principaux, cochercheurs principaux et autres membres des équipes de recherche), huit représentants des OPRS et 15 décideurs et autres parties prenantes externes. En outre, nous avons mené

trois discussions de groupe avec un total de 22 personnes, y compris d'autres chercheurs principaux et membres des équipes de recherche.

- Nous avons analysé les données de façon thématique et les avons triangulées en utilisant différentes sources de données pour produire une présentation de l'évaluation, le présent rapport et deux « Issue Briefs ».

Résultats d'évaluation

Dans l'ensemble, l'ISMEA semble, malgré un départ lent, être sur la bonne voie. Les équipes travaillent en étroite collaboration avec leurs communautés et font participer, à divers degrés, leurs cochercheurs principaux décideurs. Elles produisent des données probantes sur les interventions en matière de soins de santé primaire abordables, réalisables et susceptibles d'être portées à échelle. Il y a quelques victoires précoces, où la recherche a commencé à influencer les politiques et les pratiques, et il y a de l'expectative que plus de changements à venir. Pour renforcer les capacités en matière de sensibilisation au genre et à l'équité, et maximiser la mise à l'échelle des interventions, plus de formations et un soutien encore plus personnalisé sont nécessaires.

Thème 1 : Structure et opérationnalisation. Dans cette évaluation, nous avons constaté que la vision et les objectifs de l'ISMEA avaient été mis en œuvre pour encourager le transfert de connaissances entre chercheurs et décideurs, et entre chercheurs en Afrique et au Canada. En général, les enquêtes, entretiens et discussions de groupe que nous avons menées ont révélé que les équipes de recherche considéraient leur collaboration avec les cochercheurs principaux décideurs comme étant réussie, même si les chercheurs canadiens étaient moins sûrs du succès de la collaboration que les chercheurs principaux. Plusieurs équipes ont subi un taux de roulement élevé dans les postes gouvernementaux, ce qui a entraîné des changements fréquents parmi les cochercheurs principaux décideurs. Les changements de priorités de leurs gouvernements ont aussi été un défi pour certaines équipes.

La collaboration entre les chercheurs africains et canadiens a également été considérée comme très réussie et importante pour atteindre les objectifs des projets, d'après notre enquête et nos entretiens. Il y a un vaste éventail de types de collaborations, avec certaines impliquant des efforts de renforcement de capacités, et d'autres une expertise complémentaire et un transfert bidirectionnel de connaissances. Plus de 80 % des participants à l'enquête ont indiqué que la relation entre les chercheurs principaux africains et les cochercheurs principaux canadiens était une collaboration entre pairs.

Les OPRS n'avaient pas un rôle bien défini au début de l'initiative. Depuis lors, grâce à des communications plus claires et à des plans révisés, leurs interactions avec les

équipes de recherche se sont mieux déroulées, et ils ont pu offrir des formations utiles aux équipes. De plus, au fur et à mesure que les équipes de recherche commencent à produire des résultats, les OPRS sont de plus en plus sollicités pour contribuer à l'adoption par les politiques.

Notre évaluation a trouvé que les priorités d'AMC, des IRSC et du CRDI sont généralement bien en phase dans l'ISMEA, et que les partenaires partage le fort accent sur la promotion de la SMNE en Afrique. Même s'il y a eu un changement de gouvernement fédéral, l'ISMEA reste une priorité, tout en étant légèrement ajustée pour être en ligne avec la Politique d'aide internationale féministe du Canada. Dans l'ensemble, le partenariat entre ces organisations a été fructueux et elles peuvent désormais commencer à réfléchir à ce qu'elles peuvent apprendre de l'ISMEA pour de futures entreprises.

Thème 2 : Genre et équité. L'ISMEA a mis l'accent sur le genre et l'équité dès le tout début et a donné des possibilités de renforcement des capacités aux équipes de recherche pour l'analyse basée sur le genre. Les équipes ont pris diverses mesures pour intégrer le genre et l'équité dans leurs travaux. La plupart des participants à notre enquête et des personnes interrogées ont estimé que les questions de genre sont bien prises en compte par l'ISMEA. Cependant, notre travail sur le terrain a montré qu'il y avait une demande pour plus de formation appliquée en analyse basée sur le genre en milieu communautaire. De façon générale, l'ISMEA n'a pas accordé autant d'attention au renforcement des capacités en matière d'analyse de l'équité, et selon notre travail sur le terrain, la plupart des équipes de recherche n'ont pas intentionnellement intégré les considérations d'équité de manière significative.

Thème 3 : Mise à l'échelle des innovations. La principale innovation dans la majorité des recherches de l'ISMEA est la réplication et mise à l'échelle d'interventions développées dans d'autres contextes. Les chercheurs principaux et les cochercheurs principaux ont fortement mis l'accent sur la mise en plave de mécanismes de transfert des connaissances. Le fait que certains projets aient déjà contribué à des changements de politiques et de pratiques est une réalisation formidable. L'approche typique de promotion de la mise à l'échelle dans le cadre de l'ISMEA est de disséminer les résultats de la recherche auprès des gouvernements locaux et nationaux, et de collaborer avec eux pour des activités de mise à l'échelle. Étant donné que plus de données probantes ont été recueillies, il y a une demande pour aider les équipes à élaborer des approches efficaces de transfert des connaissances et de mise à l'échelle.

Thème 4 : Exécution et gestion de programme. Des mécanismes et des stratégies ont été mis en place pour superviser et surveiller les équipes de recherche et les OPRS de l'ISMEA avec une implication substantielle et exigeante des administrateurs de

programme au CRDI. Le CRDI est en train d'élaborer une stratégie d'atténuation des risques pour superviser les projets de recherche. Les participants à notre enquête ont été généralement satisfaits de la supervision de l'ISMEA par le CRDI, et ont trouvé que le fort soutien et la flexibilité de leurs administrateurs de programme, ainsi que la réunion à mi-parcours de Dakar, ont été utiles. Un défi a été la perception d'un changement relativement fréquent parmi les administrateurs de programme au CRDI.

Recommandations

Pour le reste de l'ISMEA :
- Organiser des réunions à l'échelle nationale entre les équipes de recherche, y compris les décideurs, dans les pays où il y a plus d'une équipe de recherche. De plus, envisager d'organiser une réunion finale avec toutes les équipes de recherche pour partager les leçons apprises.
- Intégrer les considérations de genre et d'équité dans le programme en soutenant les équipes et en renforçant leurs capacités à faire plus d'analyses basées sur le genre et l'équité de leurs données. Demander que les OPRS organisent des ateliers pour aider les équipes de recherche à déterminer des stratégies pratiques pour traiter les questions de genre et d'équité propres à leurs projets, et encourager les équipes à solliciter l'avis d'experts. Enfin, maintenir la clarté sur les différences et les chevauchements entre l'analyse basée sur le genre et l'analyse de l'équité.
- Encourager les OPRS à continuer à travailler individuellement avec chaque équipe pour élaborer un plan personnalisé de transfert des connaissances qui promeut la mise à l'échelle. A mesure que l'initiative arrive à terme, apporter un soutien aux équipes de recherche pour l'obtention de futurs financements qui soutiendront encore plus d'activités de mise à l'échelle.
- Encourager plus d'apprentissage croisé et de mécanismes de partage des connaissances entre les OPRS de l'Afrique de l'Est et de l'Afrique de l'Ouest.

Pour les initiatives futures :
- Offrir un appui aux chercheurs pour établir des collaborations et fournir une formation à l'étape de proposition préliminaire aux soumissionnaires potentiels. Ceci peut être effectué à travers des arrangements en ligne pour économiser des ressources.
- Offrir aux bénéficiaires de subvention, en particulier ceux qui n'ont pas d'expérience en gestion de subventions canadiennes, une formation en gestion au début d'une initiative.

- Offrir une formation appliquée et distincte en genre et en équité au début du projet, afin de parvenir à une conception commune à travers l'initiative des questions de genre et d'équité.
- Définir clairement les rôles et attentes de toute composante similaire aux OPRS dès le début de l'initiative.

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LIST OF ACRONYMS

APHRC - African Population and Health Research Centre
CIDA - Canadian International Development Agency
CIHR - Canadian Institutes of Health Research
Co-PI - Co Principal Investigator
DFATD - Department of Foreign Affairs, Trade and Development
ECOWAS - Economic Community of West African States
ECSA - East, Central and Southern Africa Health Community
GAC - Global Affairs Canada
GHRI - Global Health Research Initiative
HPRO - Health Policy and Research Organization
IDRC - International Development Research Centre
IMCHA - Innovating for Maternal and Child Health in Africa
IRTs - Implementation Research Teams
MDGs - Millennium Development Goals
MNCH - Maternal, newborn and child health
PPD - Partners in Population and Development
PI - Principal Investigator
RQ+ - Research-Quality-Plus approach
WAHO - West African Health Organization

ACKNOWLEDGEMENT

1. INTRODUCTION

1.1 Background

Innovating for Maternal and Child Health in Africa (IMCHA), a joint initiative organized by the Canadian Institutes of Health Research (CIHR), Global Affairs Canada (GAC), and the International Development Research Centre (IDRC), was launched in March 2014. A seven-year, $36 million initiative, it is aimed at improving maternal, newborn and child health (MNCH) in select countries in Sub-Saharan Africa. It was established in response to a wish from the government at the time to promote MNCH in developing countries, expressed in the Muskoka Initiative on Maternal, Newborn and Child Health. In 2010, the leaders of the G8 countries endorsed the Muskoka Initiative and pledged to allocate US$ 5.0 billion in new funding for MNCH over five years.[1] In addition, the leaders encouraged other nations and organizations to top up their promise and contribute an additional US$ 2.3 billion to MNCH for the same period. To fulfill this pledge, Canada committed to $1.1 billion in new funding for MNCH from 2010 to 2015.[2]

The Muskoka Initiative represented a shift in Canadian international assistance towards a targeted focus on reducing morbidity and mortality rates in mothers, newborns and children. It also reflected a heightened emphasis on showing measurable impacts, as expressed in the Millennium Development Goals (MDGs), and on making greater use of performance indicators. At the same time, there was a growing tendency among Canadian funders to opt for larger initiatives that could only be accomplished through shared efforts by multiple organizations. This was fuelled by the view that solving global challenges typically needed considerable resources and entailed a relatively long time frame. By working together, Canadian organizations could support research on these larger-scale challenges.

Under these circumstances, it seemed appropriate for IDRC, CIHR and GAC[3] to work together to contribute to fulfill the government's commitment to promote MNCH. CIHR

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[1] G8 (2010). Muskoka Declaration: Recovery and New Beginnings.
http://www.g8.utoronto.ca/summit/2010muskoka/communique.html#2
[2] Government of Canada (2011). https://www.canada.ca/en/news/archive/2011/09/projects-under-muskoka-initiative-partnership-program.html
[3] Global Affairs Canada (GAC) was called the Department of Foreign Affairs, Trade and Development (DFATD) at the time. The Department of Foreign Affairs, Trade and Development (DFATD) was created when CIDA amalgamated in 2013 with the Department of Foreign Affairs.

and IDRC had already been working together, along with the Canadian International Development Agency (CIDA), Health Canada, and the Public Health Agency of Canada, under the Global Health Research Initiative (GHRI), the preceding multi-partner large-scale initiative aimed at tackling global health challenges. With the strong government emphasis on MNCH, The Department of Foreign Affairs, Trade and Development (DFATD) was a logical partner for IDRC and CIHR in this new initiative.

These organizations signed a grant agreement for IMCHA in March 2014. Its goal was "to improve maternal, newborn and child health outcomes by strengthening health systems, using primary health care as an entry point."[4] The references to health systems and primary health care reflect the spirit of the GHRI and the importance that CIHR and IDRC, in particular, put on the systemic dimensions of promoting global health. The group also decided that IDRC would be in charge of managing the initiative.

The specific objectives of IMCHA are to:

- Address critical knowledge gaps and increase awareness among policy decision-makers about affordable, feasible, and scalable primary health care interventions to improve maternal and child health delivery and outcomes;

- Build individual and institutional capacity for gender-sensitive health systems and solution-oriented research, and enhance the uptake of relevant and timely research that informs policy and practice; and

- Strengthen collaborations between Canadian and African researchers, working in partnership with African decision-makers, to implement and scale up high-quality and effective services, and technologies that improve maternal and child health outcomes.

The initiative focuses on four priority research themes:

- High impact, community-based interventions;
- Quality facility-based interventions;
- Enabling the policy environment to improve healthcare services and outcomes; and
- Human resources for health.[5]

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[4] IDRC https://www.idrc.ca/en/initiative/innovating-maternal-and-child-health-africa
[5] IDRC. Program Overview. https://www.idrc.ca/sites/default/files/sp/Documents%20EN/Maternal-Online-ENG.pdf

In order to manage IMCHA, three committees were established. The Governance Committee provides strategic direction to IMCHA. For the first years of the initiative, it included the Presidents of CIHR and IDRC, as well as an Assistant Deputy Minister at DFATD, reflecting the importance of IMCHA to these organizations. Later on, as IMCHA became established, the participation of the Presidents was no longer needed. Instead they decided that participation to the Governance Committee could be effectively delegated to senior-level representatives from the three organizations. The second committee created was the Technical Committee, which involved Canadian and African experts in MNCH and health systems. It provided technical guidance and conducted peer reviews of the proposals submitted in response to the call for proposals for the Implementation Research Teams (IRTs). As all the funding has now been allocated, this committee is no longer in operation. The third committee is the Management and Operations Committee, which looks after the implementation of IMCHA. It is made up of representatives from GAC, CIHR and IDRC, and meets bi-monthly.

In 2014, IMCHA launched two competitive calls. The first, in March 2014, was for the Health Policy and Research Organizations (HPROs), whose main goal was "to function as catalysts and enablers for moving research evidence to policy and practice at the national levels within the targeted countries, therefore enabling connections between research and decision making."[6] This was an experiment for IMCHA, as such a body had not been included in other Canadian international development programming. The rationale was that knowledge translation and making a connection to policy was challenging for individual researchers, and support from an entity that had expertise in influencing policy would strengthen these efforts.

A total of 16 proposals for the HPROs were submitted, and two were chosen. One focused on West Africa and was submitted by the West African Health Organization (WAHO), based in Bobo-Dioulasso in Burkina Faso. WAHO is an agency of the Economic Community of West African States (ECOWAS),[7] established to coordinate health agendas in the region. The other HPRO was focused on East Africa and was a consortium led by the African Population and Health Research Centre (APHRC), a policy research organization in Nairobi, Kenya. The other consortium members were the East, Central and Southern Africa Health Community (ECSA), based in Arusha, Tanzania, aimed at strengthening regional cooperation and capacity to address health needs; and the Partners in Population and Development (PPD) Africa Regional Office, based in Kampala, Uganda, and focused on expanding South-South cooperation for reproductive

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[6] GHRI (2014). Overview of Call for Proposals, Health Policy and Research Organizations, Innovating for Maternal and Child Health in Africa, Global Health Research Initiative.
[7] The Economic Community of West African States (ECOWAS) is a regional economic union made up of fifteen member countries that are located in the Western African region. These countries have both cultural and geopolitical ties and shared common economic interest.

health, population and development. Each of the HPROs received up to CAD $2.5 million for the duration of IMCHA. The EA-HPRO oversees 13 research teams, while WAHO oversees six.

The second call was made in August, 2014 and was for Implementation Research Teams (IRTs) that would "conduct implementation research to strength equitable health systems to improve maternal, newborn and child health outcomes in sub-Saharan Africa."[8] The research had to address one of IMCHA's four priority research themes.

The intention was to fund 20 Implementation Research Teams (IRT) that would receive up to CAD $1 million over 54 months. Eligible countries were identified on the basis of DFATD's list of priority countries in Africa at the time, namely Ghana, Mali, Nigeria, and Senegal in West Africa; and Ethiopia, Malawi, Mozambique, South Sudan and Tanzania in East Africa. The application process involved two stages: the first was a letter of intent. After reviewing 105 letters of intent, invitations were sent to 45 teams to submit a full proposal.[9] One of the teams declined the invitation, so the Technical Committee reviewed 44 full proposals. A total of 20 proposals were approved by the Governance Committee in February 2015. Of these, 19 projects are still active, as one of the teams was dissolved due to design and operational challenges. The primary thematic areas of the research teams show that there is a strong emphasis on research on community-based intervention, and a considerable focus on research on facility-based interventions (Figure 1.1).
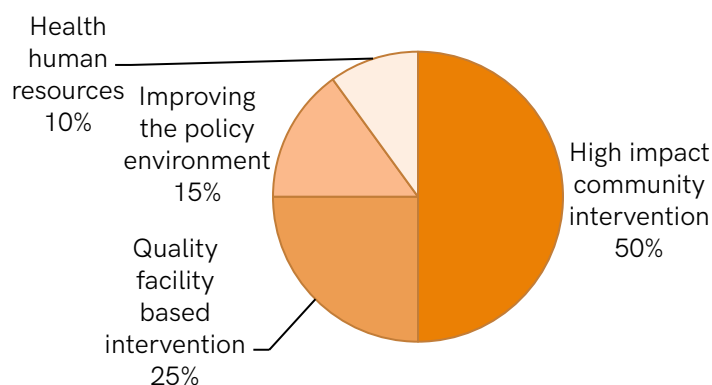
Figure 1.1 Thematic Areas of IRTs[10]

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[8] GHRI (2014). Overview of Call for Proposals, Implementation Research Teams, Innovating for Maternal and Child Health in Africa, Global Health Research Initiative.
[9] IDRC (2015). Informed Change for Maternal, Newborn, and Child Health through Innovation. Annual Narrative Report: April 1, 2014 - March 31, 2015.
[10] IDRC (2017). Innovating for Maternal and Child Health in Africa, Annual Narrative Report, April 1, 2016 – March 31, 2017.

Each research team had to have a Principal Investigator (PI) based at an African institution to ensure that the drive and ownership of the research was from the continent. In addition, each team had to have a Canadian researcher co-PI based at a Canadian research institution. One of the assumptions of the initiative's design was that both Canadian and African researchers would benefit from each other's experience and expertise. Another structural element was that each team had to have an African decision-maker co-PI from the local, district or national level in the same country as the PI's institution. The assumption was that the decision-makers could help ground the research, as they have an understanding of what is needed in their communities; and they could also play a key role to encourage uptake of the research findings. Including a decision-maker as a core team member has been used in previous Canadian global health programming, including the GHRI, and the Nigeria Evidence-based Health System Initiative.[11] Pairing decision-makers i.e. 'knowledge-users' with researchers within the same research grant is also a longstanding part of CIHR's programming to support knowledge translation.[12]

Within three to six months of starting the IMCHA-supported work, the research teams were expected to submit Implementation Plans. By doing so they would expand on their original proposals and potentially improve their research design by taking reviewers' comments into consideration. They were also asked to refine how they were integrating gender and equity dimensions in the research plan, and what mechanisms they would use to support scale-up.

A further design element of IMCHA was the Synergy Grants. In October 2016, IDRC announced that it would provide additional funds to high-performing research teams to give them an opportunity to carry out supplementary research activities on a theme related to their IMCHA work. The thematic focus of the Synergy Grants was research on the scale-up of promising interventions, or on complementary areas of focus such as on other interventions, research and knowledge translation activities that identified and examined how to address the root causes of high maternal and child mortality. These causes included early and forced marriage, unmet needs for family planning, and adolescent pregnancy, as well as the promotion of sexual and reproductive health services and information.[13] In addition to providing enhanced opportunities for additional IMCHA related research, the Synergy Grants allowed IMCHA to better align itself with the current government's priorities. IMCHA could place a larger emphasis on the empowerment of women and a feminist approach to development, without changing the

[11]Sridharan, S, Maplazi, J, Vijendran, M, Richardson, E et al (2015). Final report: Evaluation of Teasdale-Corti Initiative.
[12] CIHR (2015) A Guide to Researcher – Knowledge User Collaboration in Health Research. Available at: http://www.cihr-irsc.gc.ca/e/44954.html
[13] IDRC (2016) Call for Proposals for Synergy Grants, Innovating for Maternal and Child Health in Africa

previous projects' implementation plans. A total of 15 proposals for Synergy Grants were submitted, and IMCHA funded nine following a competitive process.

1.2 Objectives of the Evaluation

The objectives of this mid-term evaluation are to examine various dimensions of IMCHA research and implementation, and identify strategies that can inform and strengthen program implementation during the second half of the initiative and in new programming. Importantly, the focus of this evaluation is not to evaluate the performance of the IMCHA-supported researchers, but to use a systemic approach to evaluate the applicability of their research and to identify strategies that can strengthen the implementation of the IMCHA initiative as a whole.

Our guiding questions were on four themes and were the following:

Theme 1: Integrity in the design of the IMCHA model: How has the IMCHA design been operationalized, relative to the purpose and objectives of the program?

1. How well have the vision and objectives of IMCHA been operationalized, and what is the extent to which the operationalization will facilitate program success?

2. What elements are helping or hindering the collaboration between researchers and African decision-makers regarding policy uptake objective of IMCHA?

3. What is the quality of collaboration between the Principal Investigator, and the Canadian Co-Principal Investigator for the research teams and how has this collaboration affected progress toward the objectives of the projects?

4. How is IMCHA aligned with the priorities of the donor partners CIHR and GAC? How could the elements of the partnership between CIHR, GAC, and IDRC be strengthened for wider impact?

Theme 2: Integration of gender/equity dimensions: How are the components of the IMCHA initiative addressing equity-sensitive and gender dimensions at the current state of implementation?

5. How are the IMCHA Implementation Research Teams (IRTs) and synergy grants integrating gender and equity dimensions? What strategies are proving successful, and why? Which are not, and why?

6. How are Health Policy and Research Organizations (HPROs) contributing to strengthening the capacity of IRTs for integration of gender and equity dimensions, if at all? What strategies have they employed and what has been their effect?

Theme 3: Innovation and scaling: How has the focus on innovation and scale been articulated in the research projects of IMCHA?

7. How is the focus on testing and promoting innovation being articulated in the research projects? Are the processes in place in each of the projects to successfully translate the findings into policies and practices?

8. What have been the approaches for scaling up for each research intervention? What have been some of the hindering or supporting factors?

Theme 4: Program delivery: How is the implementation of IMCHA being facilitated by IDRC, relative to the purpose and objectives?

9. What mechanisms and strategies have been put in place for project-level and program-wide supervision and monitoring?

10. What mechanisms and strategies exist and/or have been used for sufficient learning to ensure that the operationalization of the design is rolling out in the most effective and efficient way possible?

1.3 Evaluation Approach

We used the Innovation Systems Framework as an underlying conceptual framework for this work. Innovation systems are open, evolving complex structures that include relationships and flows of knowledge within and between organizations, institutions and the socio-economic structures in which they are embedded. [14] These relationships determine the rate and direction of change, innovation, and competence-building that result from both formal and experience-based learning. This approach understands innovation as resulting from configurations of different factors and conditions, in contrast to a more linear cause-and-effect model, which typically only acknowledges the contribution of research to innovation. In our view, it was important to learn from the perspectives of an array of stakeholders about how the IMCHA-supported research and

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[14] See e.g. Lundvall, B. Å , Vang, J., Joseph, K.J. ,Chaminade, C. and Vang, J. (2009). Handbook of Innovation Systems and Developing Countries. Cheltenham, UK and Northampton MA, USA: Edward Elgar.

capacity-building can contribute to change, and how these contributions can be most effective (Figure 1.2).

In our analysis, we borrowed elements of the Research Quality Plus approach (RQ+), spearheaded by IDRC, particularly when we are analyzing the innovation and scale-up theme.[15] RQ+ likewise looks at research quality using a systemic perspective. It involves an ordered and transparent process that incorporates context and the potential use of the research into an assessment of quality. While the innovation systems framework provides us with a conceptual lens for the evaluation, the RQ+ approach provides us with a practical way forward. The RQ+ approach combines quantitative and qualitative methods, and typically solicits input from various key informants, including the researchers themselves, but also experts in the field and stakeholders. As many of the IMCHA research teams have not yet completed their main publications from their research, it is not realistic at this stage to solicit reviews from external examiners based on analysis of publications, as RQ+ suggests.
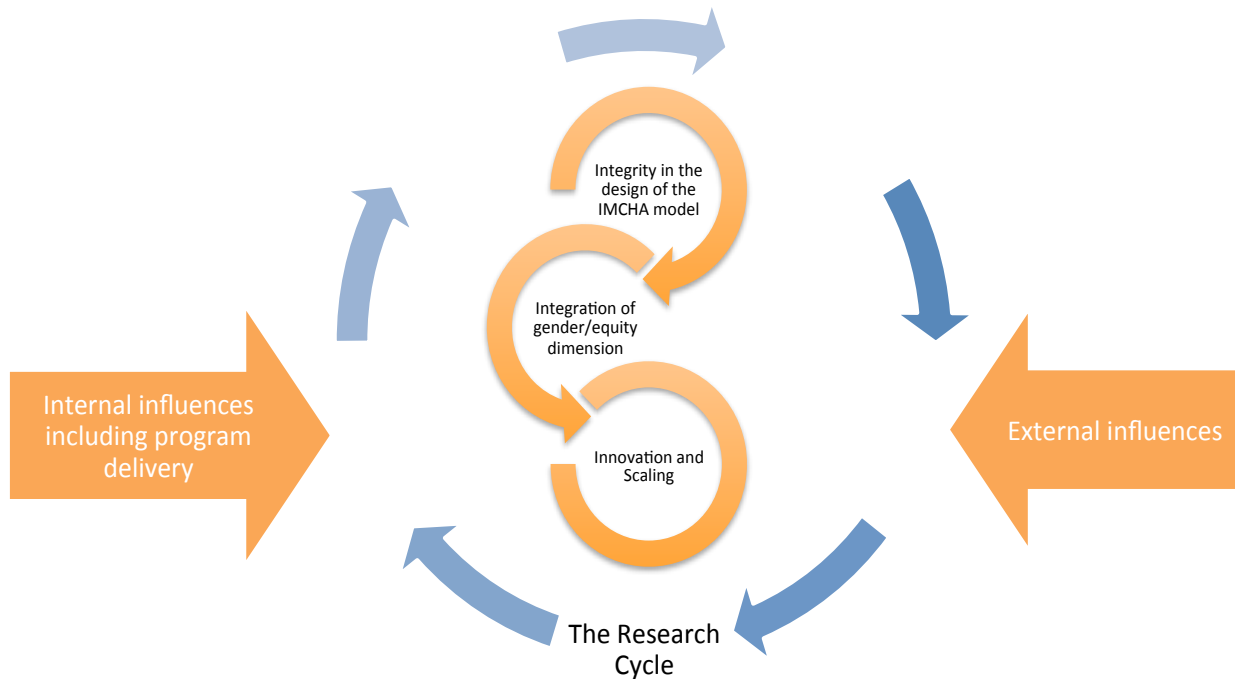

Figure 1.2. The Focus of the IMCHA Mid-term Evaluation

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[15] Ofir, Z,, Schwandt, T., Duggan, C., and McLean, R. (2016). Research Quality Plus: A Holistic Approach to Evaluating Research. International Development Research Centre, Ottawa.

2. METHODOLOGY

To address the evaluation questions with rigour and breadth, we used a mixed-methods, qualitative and quantitative approach, with five phases of data collection and analysis.

Phase 1: Document Review

The team conducting the evaluation began in December, 2017 by reviewing documents and all other available information about the IMCHA initiative, its context, and the projects IMCHA has supported. This review included annual reports on IMCHA, the performance measurement framework, requests for applications, technical reports submitted by IMCHA-supported projects to IDRC, documents from the HPROs and all other available documents generated by IDRC's monitoring activities of the initiative. Through this background review, we became familiar with the overall aims and operation of IMCHA, as well as the projects and collaborations supported by the initiative. Using knowledge gained from our background review helped us develop the draft interview guides for our interviews with donor representatives, PIs, co-PIs and external stakeholders and the surveys we administered to the PIs and co-PIs.

Phase 2: Interviews with Donor Representatives

To gain a detailed understanding of the expectations of the co-funders of the IMCHA initiative, the hopes for the initiative and for this evaluation, and the culture of the IMCHA initiative, we interviewed 16 key informants from IDRC, GAC, and CIHR who are, or were, involved in planning and managing the initiative. These interviews were semi-structured; lasted approximately 60 minutes; and were conducted in January—February 2018 either in person in Ottawa and in Toronto, by telephone, or by Skype (see interview guide in Appendix 1). Combined with the document review, this phase of interviews provided the evaluation team with an enhanced understanding of the evaluation questions and the initiative's goals and vision. This increased understanding was used as a basis for more focused questions in the evaluation's subsequent phases.

Phase 3: Surveys of PIs and Co-PIs

To collect data on the perceptions of the grantees of the initiative, we developed surveys for the PIs, the Canadian researcher co-PIs, and the decision-maker co-PIs. The goal of the surveys was to get as complete a sense as possible of the views of these individuals, since we were not able to interview all the research teams in person. The survey questions were designed to answer the evaluation questions and measure the incidence and distribution of key themes. We created two surveys, which were similar, but

adjusted to the different roles of the researchers and decision-makers (see surveys in Appendix 2). The questions focused on the respondents' motivations for taking part in the research, perspectives on their collaboration, the integration of gender and equity considerations in their projects, the roles of the HPROs and IDRC, and innovation and scaling-up of their interventions.

The surveys were kept as brief and clear as possible to minimize the respondent burden for the PIs and Co-PIs. The surveys were offered in the respondents' choice of English or French, and took, on average, approximately 20 minutes to complete, according to the survey provider. We administered the surveys using Survey Monkey in mid-March 2018. They were sent to 44 PIs and Canadian researcher co-PIs, and we obtained 36 responses (an 82% response rate). The decision-makers' survey was sent to 19 decision-makers and a total of 12 responded (a 63% response rate). The responses to the surveys were representative of the diversity of the population sampled, as shown in Table 2.1 below.

Table 2.1: Distribution of Respondents to Survey

Type of Respondent	East Africa Research Teams: 13	West Africa Research Teams: 6	Canada Research Teams: 19	Other Research Teams: 1[16]
Researchers	31%	19%	47%	3%
Decision-Makers	67%	33%	n/a	n/a

Phase 4: Fieldwork

To address the evaluation questions in greater detail, we conducted fieldwork in five African countries, where we interviewed a select group of PIs, their research teams, decision-maker co-PIs, and other stakeholders about their views on the IMCHA initiative (Table 2.2; see interview guides in Appendix 2). The fieldwork took place in April and May, 2018 in Tanzania, Kenya, Uganda, Nigeria, and Burkina Faso. We also interviewed Canadian co-PIs, either in person if they were in the African fieldwork countries, or by

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[16] One co-PI is based in the Unites States.

Skype or telephone. In addition, we interviewed representatives from Ministries of Health at the national, district and local levels in the fieldwork countries, as well as representatives of Canadian Embassies and High Commissions working on health issues. We also conducted three focus group discussions (in Tanzania, Kenya and Nigeria) with PIs and members of their research teams. By taking advantage of a training event in Nairobi, we were able to hold a focus group discussion with PIs and researchers from teams in the region whom we were unable to visit on site. In the interviews and focus group discussions, we explored themes and differences identified during the previous stages of the evaluation. We encouraged participants to support their answers with concrete examples to ensure that the answers were as evidence-based as possible.

Like the interviews with the donor representatives, the fieldwork interviews were semi-structured; lasted approximately 60 minutes. The interviews were conducted either in English or in French, according to interviewee preference. The three focus-group discussions were semi-structured, lasted approximately two hours, and were conducted in English, according to the preference of the participants. In total, we conducted 49 interviews and three focus-group discussions with 22 experts and thus included input from 71 individuals during fieldwork.

Table 2.2 Fieldwork Interviews for the IMCHA Mid-term Evaluation

	East Africa	West Africa	Total
African researchers	9	3	12
Canadian researchers	5	2	7
Decision-makers/stakeholders	11	4	15
Canadian High Commission	1	2	3
HPROs	5	3	8
Others*	2	2	4
Total	33	16	49

* Others include two nurses, a senior MNCH researcher and a consultant.

The focus group discussions and all the interviews were recorded, with one exception, and transcribed for further analysis. In the case of the interviewee who did not wish to be recorded, two team members took detailed notes. The selection of sites for visits was conducted in consultation with IDRC. Our goal was to choose a representative sample of projects from East and West Africa, Anglophone and Francophone countries, with and without synergy grants.

The site visits allowed us to collect first-hand data on the views of PIs, co-PIs, other members of the research teams, and external stakeholders on the IMCHA initiative, and to examine the context shaping the project outcomes and contributions to policies/practices. We were also able to investigate how the IMCHA initiative could have greater impact, and what lessons could be learned for the design of future grants.

Phase 5: Analysis and Reporting

In our analysis, we examined our findings from the background document review, the surveys, interviews, focus group discussion, and all other information, including quantitative data, that we collected. We triangulated our findings by comparing data from the variety of sources used in this evaluation.

We analyzed the survey results by examining the frequency and distribution of different answers, and looked for patterns among different groups (such as Africans / Canadians; recipients / non-recipients of Synergy Grants; researchers/decision-makers; West Africans / East Africans, etc.). We coded all the interviews according to themes, paying particular attention to systemic factors affecting the IMCHA-supported activities. This helped us understand how these interventions fit within the complex innovation systems in Sub-Saharan Africa. In Table 2.3 we list the main data sources we relied on to address each research question.

Based on our analysis, we drafted our findings on the outcomes of our work and our recommendations, and presented them to representatives from IDRC, GAC and CIHR. In addition, we created two issue briefs, one on the experience of having decision-maker co-PIs in IMCHA, and the other on how equity issues are understood and integrated in the initiative.

Table 2.3 Main Data Sources to Address Evaluation Questions

Evaluation Questions	Main Data Sources
Theme 1: Integrity in the design of the IMCHA model: How has the IMCHA design been operationalized, relative to the purpose and objectives of the program?	
1. How well have the vision and objectives of IMCHA been operationalized, and what is the extent to which the operationalization will facilitate program success?	Donor representatives interviews and document review

2. What elements are helping or hindering the collaboration between researchers and African decision-makers regarding policy uptake objective of IMCHA?	Surveys, and fieldwork,
3. What is the quality of collaboration between the Principal Investigator, and the Canadian Co-Principal Investigator for the research teams and how has this collaboration affected progress toward the objectives of the projects?	Surveys, and fieldwork,
4. How is IMCHA aligned with the priorities of the donor partners CIHR and GAC? How could the elements of the partnership between CIHR, GAC, and IDRC be strengthened for wider impact?	Donor representatives, and document review
Theme 2: Integration of gender/equity dimensions: How are the components of the IMCHA initiative addressing equity-sensitive and gender dimensions at the current state of implementation?	
7. How are the IMCHA Implementation Research Teams (IRTs) and synergy grants integrating gender and equity dimensions? What strategies are proving successful, and why? Which were are not, and why?	Surveys, fieldwork, and document review
8. How are Health Policy and Research Organizations (HPROs) contributing to strengthening the capacity of IRTs for integration of gender and equity dimensions, if at all? What strategies have they employed and what has been their effect?	Interviews with HPRO representatives, fieldwork, and document review
Theme 3: Innovation and scaling: How has the focus on innovation and scale been articulated in the research projects of IMCHA?	
9. How is the focus on testing and promoting innovation being articulated in the research projects? Are the processes in place in each of the projects to successfully translate the findings into policies and practices?	Surveys, and fieldwork
10. What have been the approaches for scaling up for each research intervention? What have been some of the hindering or supporting factors?	Surveys, and fieldwork
Theme 4: Program delivery: How is the implementation of IMCHA being facilitated by IDRC, relative to the purpose and objectives?	

11. What mechanisms and strategies have been put in place for project-level and program-wide supervision and monitoring?	Donor representatives interviews, fieldwork, and surveys
12. What mechanisms and strategies exist and/or have been used for sufficient learning to ensure that the operationalization of the design is rolling out in the most effective and efficient way possible?	Donor representatives interviews, and fieldwork

3. RESULTS

3.1 Structure and Operationalization of IMCHA

3.1.1 General discussion on operationalization

The first question we address in this mid-term evaluation is: How well have the vision and objectives of IMCHA been operationalized, and what is the extent to which the operationalization will facilitate program success? The vision of IMCHA is to improve MNCH outcomes in Africa, and to use primary health care as an entry point. As discussed above, IMCHA operationalizes its vision through three specific objectives:

1. Address critical knowledge gaps and increase awareness among policy decision-makers about affordable, feasible, and scalable primary health care interventions to improve maternal and child health delivery and outcomes.

To address this objective IMCHA has, firstly, supported implementation research on affordable and feasible health care interventions to improve MNCH. IMCHA supports 19 research teams working to improve MNCH in 11 countries in East and West Africa. Most of these teams focus on maternal, rather than child, health and there is a strong emphasis on the role of communities in promoting MNCH. As the research is still ongoing, it is premature to evaluate the extent to which IMCHA research has filled knowledge gaps.

Secondly, IMCHA is addressing the objective of increasing awareness among decision-makers about affordable, feasible, and scalable primary health care interventions to improve MNCH delivery and outcomes in different ways. One way is to include a representative from local or national governments as decision-maker co-PIs on each research teams.

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Thirdly, IMCHA is encouraging awareness among decision-makers about options to improve MNCH by establishing the HPROs. As discussed above, the HPROs are intended to help the teams liaise with decision-makers to let them know about interventions that are likely to work. This element was an innovation in the IMCHA design. Later in this section we will discuss how this experiment has contributed to the projects so far, and how the HPROs can be involved more for the remainder of IMCHA.

2. Build individual and institutional capacity for gender-sensitive health systems and solution-oriented research, and enhance the uptake of relevant and timely research that informs policy and practice.

The IMCHA initiative has put in place a focus on gender-sensitive health systems in different ways. One way has been to emphasize gender in its research and other activities. In its calls for proposals for the HPROs, IMCHA requested that the applicants embed gender equality and equality in health "into a comprehensive analysis of the differential effects of health policies and interventions as it relates to maternal, newborn and child health."[17] A strong understanding of gender equality and equity issues was one of the criteria for the evaluation of the proposals. Further, the HPROs were asked to commit to supporting the research teams in undertaking gender and equity analyses within and across countries. In the same vein, the call for the IRTs asked that health equity and gender equality be embedded throughout the proposed research. IMCHA's commitment to gender considerations was further reinforced in the implementation plans the research teams were asked to prepare. The focus on gender was reinforced again in the Synergy Grants.

IMCHA also organized specific activities to strengthen capacity in gender. These included presentations on gender at the inception meeting, and other events such as at WAHO's Regional Validation workshop and the IMCHA-wide mid-term workshop. IMCHA has also supported capacity in gender by encouraging the research teams to add gender experts to their teams who can provide more thorough input on the topic. Gender was a theme in some of the mapping exercises the HPROs have been carrying out, such as the context mapping of MNCH in Tanzania, Malawi, Ethiopia and Uganda carried out by the East Africa HPRO.

It is clear that IMCHA has tried in different ways to build capacity in gender-sensitive health systems and solutions-oriented research. Section 3.2, below, will describe how the operationalization of gender has contributed to the work and what can be done to strengthen the incorporation of gender perspectives in the remainder of IMCHA.

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[17] GHRI (2014). Overview of Call for Proposals, Health Policy and Research Organizations. Innovating for Maternal and Child Health in Africa, Global Health Research Initiative.

3. Strengthen collaborations between Canadian and African researchers, working in partnership with African decision-makers, to implement and scale up high-quality and effective services, and technologies that improve maternal and child health outcomes.

The structure of IMCHA itself attempts to strengthen collaboration both between Canadian and African researchers, and between the researchers and the decision-maker team members. We discuss below, how these arrangements have contributed to the program's success.

3.1.2 Collaboration

Collaboration between the PI and co-PI researchers and the decision-maker co-PIs

The collaboration with the decision-maker co-PIs was generally described as successful, with PIs evaluating the relationships more favourably than Canadian co-PIs (Figure 3.1). The PIs from East Africa seem to be particularly positive about their collaboration with their decision-maker co-PIs. None of the respondents from East Africa indicated that the collaboration was 'neither successful nor unsuccessful' or 'somewhat unsuccessful,' whereas one West African PI indicated it was 'neither successful nor unsuccessful' and another one indicated that it was 'somewhat unsuccessful'. From the perspective of the decision-maker co-PIs, the collaboration was also perceived as highly successful.
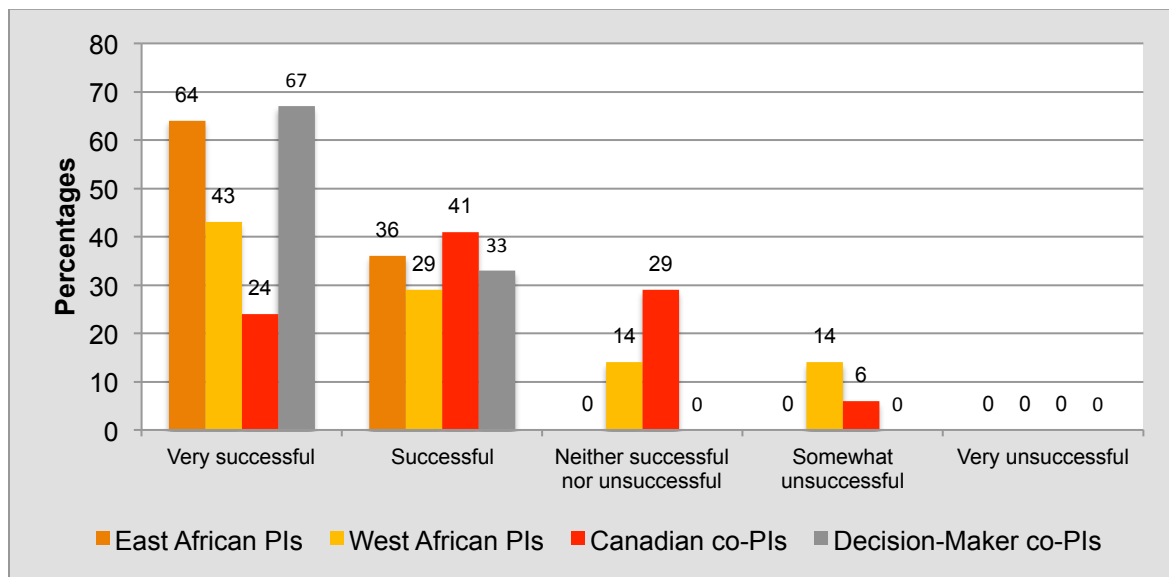

Figure 3.1. Respondents' perception of success of collaboration
with the Decision-Maker co-PIs

The interviews with the PIs supported the notion that including a decision-maker co-PI was important for the project. As one PI commented: "Engaging the decision-maker is a good check. They make sure you address what the community needs, and government priorities. However good your results are, it doesn't matter if they don't fit."

One issue that may have affected the perception of the collaboration with decision-makers is the frequent mobility between positions of the decision-makers. Among the survey respondents, over 58% of the decision-makers who responded had been involved with the IMCHA initiative since the beginning, 33% for one to two years, and 8% for less than one year. The usual arrangement was that decision-maker co-PI status on the IMCHA project remained with the position (not the individual). In at least one case, when the decision-maker co-PI was promoted to a national-level position, the team kept the decision-maker on in addition to the new person who occupied the original position. Describing this frequent turn-over of decision-maker co-PIs, one interviewee said "In two years there have been four, and now there is another one coming. Now we have a system of re-orientation."

A few of the interviewees remarked that there has not been much collaboration with the decision-makers, and they had not delivered much so far. Others felt that the time would come when the research had advanced and there was more evidence to share with the decision-maker co-PIs and their governments at different levels.

An additional challenge for both the researchers and the decision-maker co-PIs was changing government priorities. In some countries, new governments were in power with new priorities. While, in these cases, the IMCHA project might still be grounded in the needs of the country, the new government might no longer be interested in the research. This posed a particular challenge for the decision-maker co-PIs, as they might be perceived as working on issues that were a priority of the former government. As one interviewee said: "It is a challenge. The government has a strategic plan for health and they emphasize what is in it. If you plan outside the plan, you are out! They ask us: what part of your work fits the plan?"

In some cases, the researchers felt that even though policies had changed and their research was no longer a national priority, it was still valuable at the district level, and more locally there would continue to be interest in uptake. This was one of the reasons that not everyone perceived national-level decision-makers to be the best co-PIs, and felt their ties with local actors were valuable.

Some of the Canadian co-PIs were more skeptical about the collaboration with the decision-maker co-PIs, and felt that they did not deserve the status of co-PI in the

project. As one said: "The decision-maker co-PIs come to the meetings, they are our partners, but they are not researchers."

Decision maker co-PIs activities

In the survey, we asked the PI and co-PI researchers how helpful the decision-maker co-PIs had been with select activities. The most helpful activity was 'grounding the research in the local context' (Figure 3.2). The decision-maker co-PIs agreed with the idea that they had been very helpful in grounding the research, with three quarters of them saying they had been very helpful in grounding the research. This indicates that the decision-maker co-PIs play an important role for the researchers as a source of knowledge of the local context. Integrating gender considerations, on the other hand, was rated particularly low, with only 17% of researchers indicating that the decision makers were 'very helpful' with this.

Notably, PIs from East Africa indicated that the decision-maker co-PIs had been the most helpful in grounding the research in the local context (81% said very useful) as well as in connecting the research team to other decision-makers (45% said very useful). In comparison, 43% of West African PIs described the decision-maker co-PIs as having been important in grounding the research in the local context and 33% said they had been very useful for connecting the research team to other decision-makers. Some other activities that the decision-maker co-PIs have helped with are assisting the research team to understand recent changes in the local health systems; promoting sustainability; and facilitating research uptake through international conferences.

Factors supporting and hindering collaboration with decision makers

We asked survey respondents to list the most important factors that aided the collaboration between researchers and decision-maker co-PIs. They listed commitment; regular communications; and having a previous working relationship. Other factors mentioned were having a representative from the decision-maker's office on the team, and whether the decision-maker co-PI was in a position of influence, reflecting that some decision-maker co-PIs are senior with larger potential to influence policies and practices.
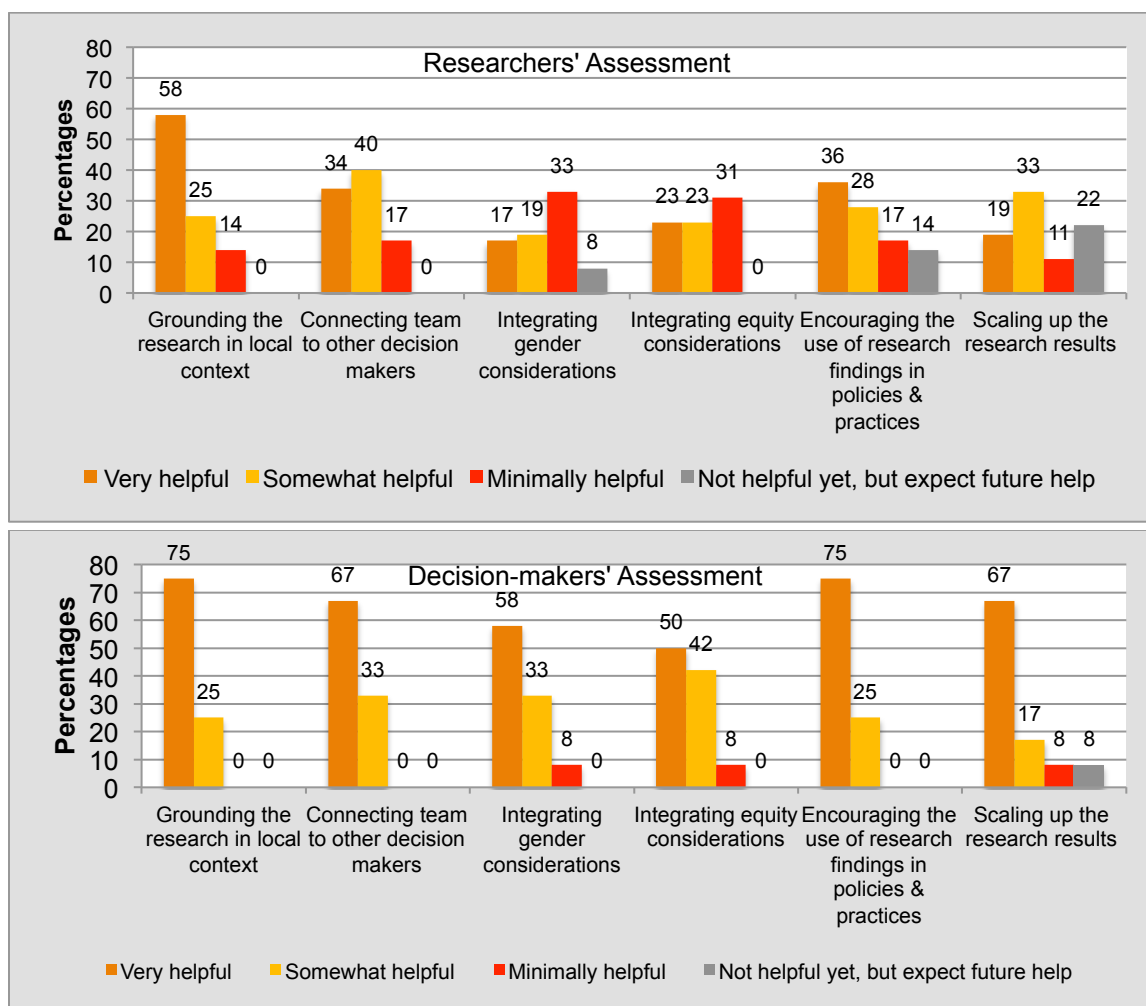
Figure 3.2. Respondents' assessment of how helpful the
Decision-Maker co-PIs were with select activities[18]

When asked if the decision-maker co-PIs unavailability or lack of interest in the research were barriers to collaboration on this project, most respondents indicated that these were not important barriers (Figure 3.3). This was confirmed in the interviews with the African researchers who said that time was a limiting factor for their collaboration with the decision-makers, but still not an important barrier. One interviewee said, for instance: "These are very busy people. They really have a lot on their desks. Despite

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[18] 'Researchers here means both the PIs and the Canadian co-PIs but not the decision-maker co-PIs. For ease of presentation, we omitted the 'Not helpful' and 'Don't know' answer options, which were selected rarely by the participants.

those hindrances, they are interested in the area of study itself. I see them trying to find time for this study. They have to find space, and they do."
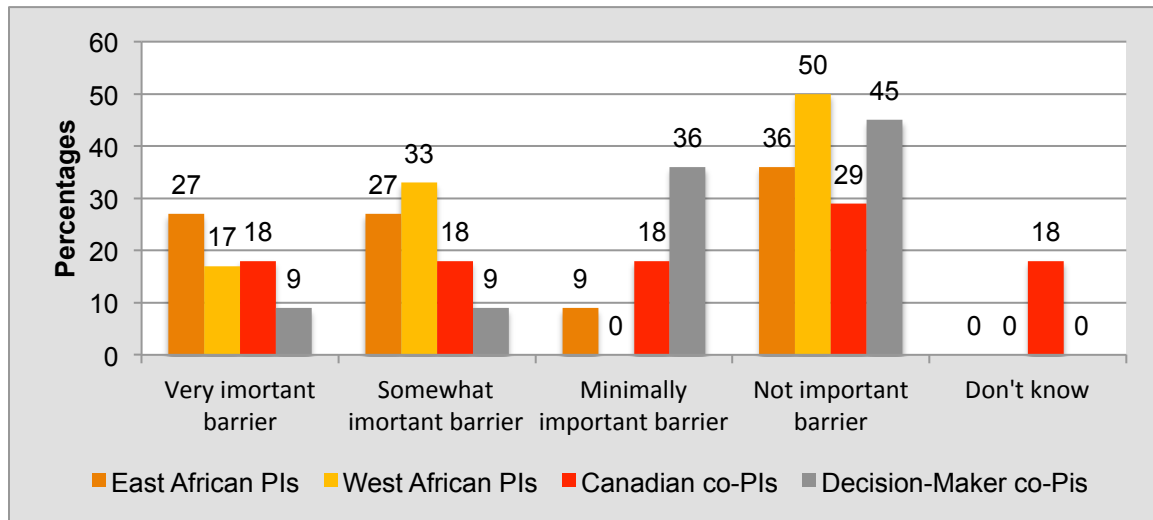

Figure 3.3 Respondents' perception of whether unavailability of Decision-Maker co-PIs was an important barrier to the collaboration

Lack of interest by the decision-maker was described as even less important as a barrier, with 6% saying it was a very important barrier and 60% indicating it was either not or was a minimally important barrier. The decision-maker co-PIs agreed that their lack of interest and unavailability were not barriers, and said that lack of financial resources was the greatest barrier.

This suggests that decision-makers are, on the whole, interested in the research, and their lack of availability could be, but is typically not, an impediment to the work. Some of the elements that strengthen the collaboration between researcher and decision-maker co-PIs are consistency in the decision-makers' employment and government priorities, successful grounding of the research, commitment, and frequent communications. As most of the projects are still at an early stage, it will become clearer with time how successfully these collaborations are able to address their challenges and how well the structure of IMCHA including a decision maker co-PI will contribute towards uptake. For the remainder of IMCHA it is clearly important to encourage the research teams to have frequent communications with the decision-maker co-PIs so they are effectively involved with the work.

Collaboration between the African PIs and the Canadian researcher co-PIs

In the survey, we asked the researchers to evaluate the collaboration between the PIs and the Canadian co-PIs (Figure 3.4). Almost all who responded felt the collaboration

had been highly successful. Only two respondents (one West African and one Canadian) indicated that it was 'somewhat unsuccessful'. Slightly more Canadians than Africans evaluated the collaboration to be successful. There was no difference between West and East African PIs in their evaluation of the collaboration with the Canadian co-PIs.
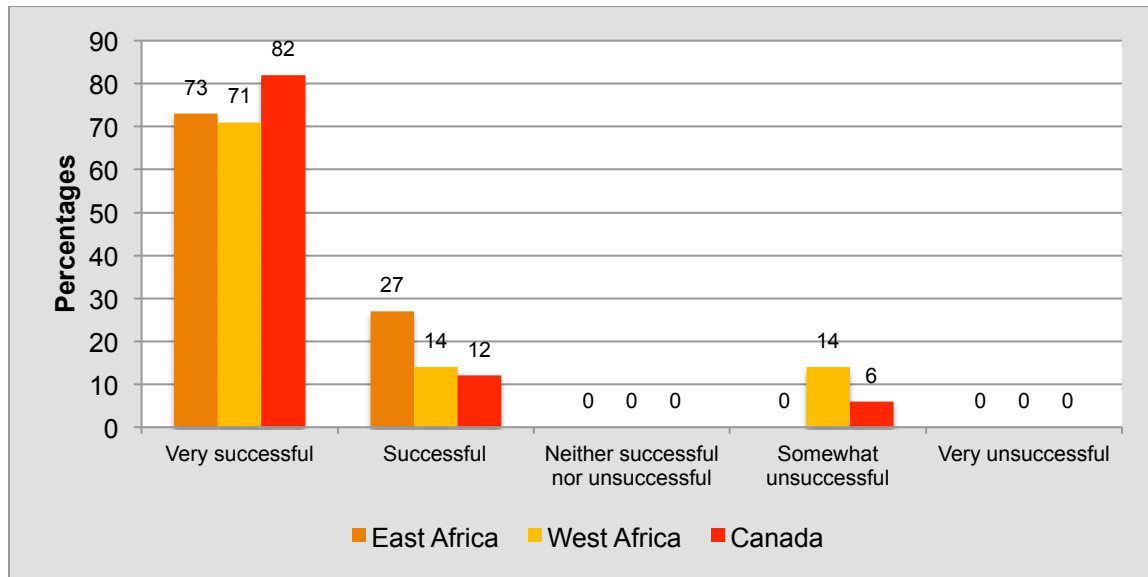

Figure 3.4. Researchers' perception of how successful the collaboration was between African PIs and Canadian researcher co-PIs

This was generally confirmed in our interviews with the African PIs and the Canadian co-PIs, which, in almost all cases, described very good working relationships between the collaborators. An African PI described their[19] collaboration with their Canadian co-PI in the following way:

> "Working with [the Canadian collaborator] has brought new insights, more exposure, and looking for ways to share and come up with solutions. [They are] very committed and down to earth. [They] come here and [they] look just like an African when they are here, open-hearted and involved."

Along the same lines a Canadian researcher said: "The collaboration is fantastic, [they are] a font of wisdom and experience…. It has been a pleasure to collaborate. I learned a lot from [them]".

A few of the interviewees relied heavily on training by Canadian researchers. In some cases, the African PIs were clinicians and collaborated with more seasoned Canadian researchers. One African researcher said, for instance: "I am not undermining our

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[19] To guard the confidentiality of our interviewees we use gender neutral pronouns in the third person and use 'they' instead of 'he' or 'she'.

capacity, but we have a lot to learn. I am not saying this because you are Canadian; we gain a lot from them." In other cases the collaboration was based on complementary expertise, and involved senior African researchers. The survey results also showed that the majority of respondents (83%) agreed with the statement that 'the African PIs and Canadian co-PIs collaborate as equals'. There was not total consensus on this opinion, though, and two PIs and two Canadian co-PIs disagreed with the statement.

All the interviewees agreed with the requirement by IMCHA that the projects should have an African PI, and felt that it encouraged African ownership. One member of a focus group discussion emphasized that IMCHA was special in stipulating that the African researchers be PIs and be in charge of the research agenda and the funds. However, one Canadian researcher expressed dissatisfaction with this arrangement, commenting in the survey that the proposals had been prepared by the Canadian co-PIs, and criticizing IDRC for defining the PI according to socio-demographic or citizenship characteristics rather than contribution and merit. In our fieldwork, we did not find any confirmation that the proposals were initiated and written by Canadian co-PIs only. Rather, we heard the opposite; the work of preparing the proposals had been shared by the African and Canadian researchers. One interviewee, however, remarked that it would be beneficial for IDRC to include the Canadian co-PI in their communications on the project to ensure more inclusive and effective collaboration.

Factors supporting and hindering collaboration between the researchers

In the survey we asked respondents to list the most important factors aiding the collaboration between researchers. The most common factors listed were: shared research interest and commitment; frequent communications; having worked previously together, and transparency and respect.

During fieldwork, the interviewees also mentioned these factors. They stressed the importance of frequent communication for the collaboration. Some interviewees said they spoke with their collaborators more than once a week. They also mentioned that being transparent strengthened the collaboration. One PI said, for example: "My approach is to be more transparent. This has been a big problem in Africa. If there is a problem, be open".

Building trust was also singled out as being important for the collaboration. Typically, frequent communication and at minimum yearly in-person meetings were considered important for trust-building. More options for the African researchers to come to Canada was also mentioned as something that would help the collaboration. It would make it easier for the research team to plan if they could travel both ways, and it was

felt to be unbalanced that the Canadians could travel easily to the collaborator's country, but not the other way around.

Many of the interviewees we talked to had collaborated with each other prior to IMCHA, and felt that previous history had facilitated the current collaboration. Of those researchers who responded to the survey, over 36% had worked together on research before the IMCHA project, 31% knew each other beforehand but had not collaborated, and 33% did not know each other before the IMCHA project. When we looked at those who had received synergy grants, a slightly higher proportion (47%) had previously worked together on research, suggesting a marginally higher chance of getting a synergy grant for teams that had worked together before IMCHA.

There were some cases where the collaboration was new, set up specifically for IMCHA. One interviewee described contacting several Canadians after seeing the call for proposals, and not receiving any responses. The requirement to have a Canadian collaborator was, therefore, sometimes a challenge for African researchers who wished to participate in IMCHA.

During one of the focus group discussions some participants suggested that IDRC could do more to bring together African and Canadian researchers. Its convening power could help bring different researchers together and set up the collaboration. IDRC could, they suggested, explore whether the organization could set up an app (like a dating app) that matched researchers interested in research collaboration. Canadian researchers who had declared an interest in collaborating with African researchers would be more likely to respond to invitations to collaborate from African researchers. A potential challenge, however, is that IDRC may not wish to seem to be endorsing particular researchers. To overcome this, the interface would be transparent and make it clear that IDRC has not vetted the candidates and any Canadian researcher would be able to put their name on the list.

In the survey, we inquired further whether Canadian co-PIs' unavailability was a barrier to the collaboration in the project. Only one respondent (3%) said it was a very important barrier, and 73% said it was either a minimally important barrier or not an important barrier at all. This shows that the unavailability of Canadian co-PIs did not seem to be a problem for the research, and most of the interviewees emphasized their commitment to the collaboration.

At the end of the survey the respondents were asked about their agreement with the statement: 'The collaboration between the African PI and the Canadian co-PI has been important to meet the objectives of the project.' In total, 94% either strongly agreed (61%) or agreed (33%). This was generally supported in our interviews. Based on these

findings, we believe that the collaboration between the African and Canadian researchers has positively affected progress toward the objectives of the IMCHA initiative, and one of the ingredients for further success is frequent and transparent communications.

3.1.3 The roles of the HPROs

The HPROs were designed to address the view that "generating implementation research evidence alone is not sufficient to improve MNCH outcomes," and "essential knowledge-brokering mechanisms and processes need to be in place to ensure that the research is available and can be readily used."[20] Put simply, the idea was that the HPROs would function as a connection between researchers and their outputs on the one hand, and policymakers and the policy environment on the other.

In our interviews with IMCHA donor representatives, we asked why they designed the HPROs as part of the structure of IMCHA. One interviewee explained that "the thinking was that a specialized HPRO, who really excelled in research communication, and was connected to the right actors, would help to draw the research from the researchers and to share and make it more widely known. It would act as a force multiplier on the knowledge translation."

In the survey administered to PIs and co-PIs, we asked respondents to indicate their agreement with the statement: 'The HPRO has been important to meet the objective of the project' (Figure 3.5). In general there was strong agreement with the statement, particularly by decision maker co-PIs and East African researchers. The Canadian researchers were most non-committal in their agreement, with 41% of them neither agreeing nor disagreeing with the statement. Only a few PI and none of the decision-maker co-PIs disagreed with the statement, compared to almost a quarter of the Canadian researchers. Survey respondents in East Africa were more positive about their HPRO than respondents in West Africa. This was somewhat surprising, as interviews with the donor representatives suggested that the East Africa HPRO had many more challenges, particularly at the beginning, than WAHO. There are, however, fewer projects in West Africa, so these findings are based on fewer respondents.

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[20] The Global Health Research Initiative. Call for Proposals: Innovating for Maternal and Child Health in Africa. Health Policy and Research Organizations. Ottawa, March 17, 2014.
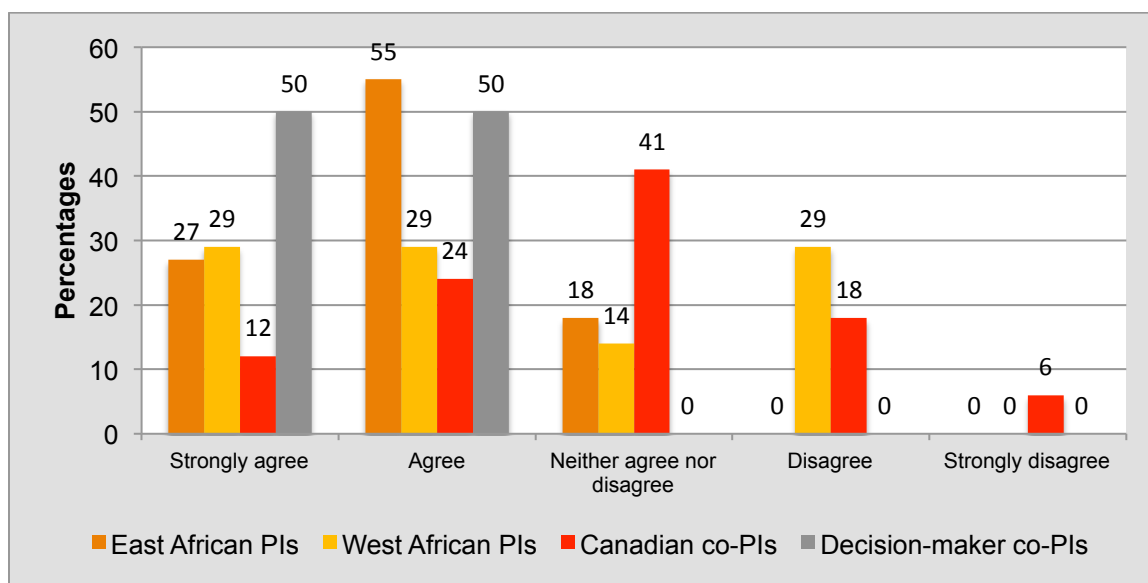
3.5 Respondents' agreement with the statement
'The HPRO has been important to meet the objectives of the project.'

We asked the survey respondents if they would recommend that IDRC include an HPRO-type component in future grant designs. All the decision-makers answered this question in the affirmative. The answers amongst researchers were split, with 53% saying yes, 31% saying no, and 17% saying they don't know. Not surprisingly, relatively fewer Canadian researchers recommended including an HPRO-like organization, with 35% of Canadians saying yes and 35% saying no, versus 72% of African researchers saying yes, and 22% saying no. There was no difference between researchers in East and West Africa in terms of their recommendations on this point.

HPROs supporting activities

We also asked the respondents to rate a number of activities in terms of how effective their HPROs were at doing them. The results (Figure 3.6) show that the PIs found the HPROs to be most effective at 'connecting the teams to decision makers' and 'research methods training'. They were also described as effective in 'grounding the research in the local context' and 'supporting your team to network and share with other teams'. They considered the HPROs to be least effective in equity and gender sensitivity training and supporting the teams to network and share with other teams. However, the Canadian co-PIs felt the HPROs had been effective in supporting networking as well as in research methods training, but many respondents indicated that they did not know how effective the HPROs had been in supporting these activities. Respondents also

commented that the HPROs had been effective in arranging invitations for international workshops and supporting the design and implementation of intervention activities.
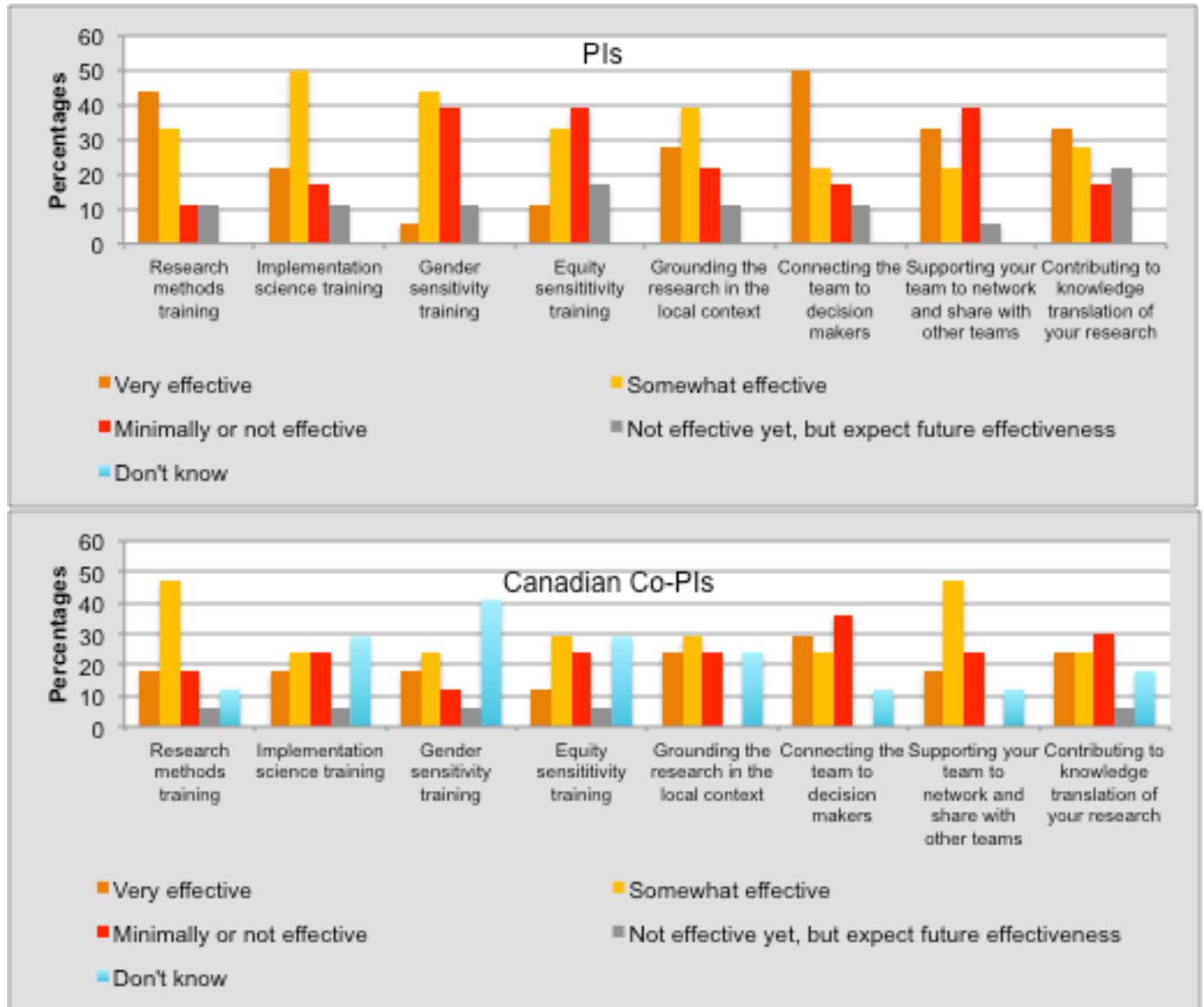
Figure 3.6. Researchers' perceptions on how effective
the HPROs are at different activities[21]

When we asked which other activities the HPROs could support, there were requests for training and direct help with developing policy briefs and packaging the results for dissemination to policy makers. Some also wanted more training in research methods

[21] As decision-maker co-PIs are typically not involved in the daily research activities of the projects, we omitted their input from this graph.

and in incorporating a gender perspective. There were further suggestions that the HPROs could assist in soliciting more funding opportunities as well as facilitating team presentations at African conferences. Some of the Canadian researchers commented that the Canadian teams should have access to the trainings and other services offered by the HPROs.

The interview evidence showed that the most positive reaction to the HPROs came from teams, and team members, who had benefited from the capacity-building work done by the HPROs in both East and West. One African team member put it succinctly: "Personally I have loved the training, the capacity building; it has always been great. I did one on mixed methods, systematic reviews, policy engagement…Those were really helpful to me as a young researcher." Another said "our team … has very limited capacity in terms of research methods. We presented this to the HPRO. They were very quick to help us."

Challenges

A common theme in the interviews, both with the researchers and the HPRO representatives, was that at the onset of the initiative there was a lack of clear definition of the intended role and scope of the HPROs within IMCHA. This lack of clarity was detrimental not only to the HPROs themselves, but also to the relationship between the research teams and the HPROs. In our interviews with the researchers, we heard that in both East and West Africa, the expectations for the HPROs were high. As one PI put it:

> "…the HPRO was a good idea. Most researchers are good at research, but not at translating it. So the idea was good. However, the expectations we had, to be frank, have not been met. We had high expectations that these guys are really going to help us. But they need to do a little more."

Another interviewee remarked: "how it was communicated, set up—most of the teams and researchers didn't really understand how it was supposed to work."

In our interviews with the HPROs, it was clear that they were well aware of the criticisms and unmet expectations about their work in the early years of the initiative, particularly in the East African HPRO. One interviewee put it plainly: "for us, I would say, we could have done better; but we need to coordinate better." The acknowledgement that they had not lived up to expectations was tempered by considerable frustration with the lack of a clear mandate for the HPROs.

One interviewee said that the timing of conducting the call for proposals for the HPROs before the call for the IRTs was a challenge, as the HPROs made their work plans with no idea of what kind of teams they were expected to support. "The only problem is that

they [the HPROs] were selected before the IRTs were selected, and we made a lot of assumptions about that. So the IRTs should have been identified first. Knowing what the teams are, what their focus is, would have helped." Indeed, they were surprised that many of the research teams that were chosen lacked research skills. Rather than focusing on supporting knowledge translation activities, they needed to support capacity-building in basic research methods.

Both the HPROs in East Africa and West Africa also remarked that it was a particular challenge not to have access to any technical reporting or the implementation plans from the research teams. Sharing these would have made it much easier for them to understand the challenges the teams were facing, and come up with a plan to add value to their work. One HPRO interviewee stated, for example: "As the HPRO, we didn't have the benefit of knowing what the IRTs were planning to do. It was very difficult to know even what their research questions were....there were so many attempts by us to get involved."

To clarify the roles of the HPROs, in 2016 IDRC conducted a survey of representatives of the research teams (PIs and both groups of co-PIs) on the performance, quality, timeliness, and relevance of the HPROs' work. The results of this survey are described in detail in a report, which draws three key conclusions. First, the HPROs "are in [a] good position to advance the IMCHA goals."[22] Second, there is a gap between the original objectives set out for the HPROs, and the needs of the research teams, and efforts need to be made to tailor activities to the specific and varying needs of the teams. Third, there needs to be more collaboration between the HPROs and the research teams: "for the IMCHA partnership to be successful, [the] HPRO-IRT collaboration needs to be a two-way process based on common understanding of the goals and greater collaboration."[23]

IDRC disseminated the results of the survey. This led to a useful dialogue on the roles of the HPROs in IMCHA that contributed to aligning the expectations for the HPROs within the initiative. It is clear that the HPROs should continue their training efforts, but as the research teams advance in their projects and gather more evidence, the HPROs should increase efforts to provide them with tailored dissemination support.

Timeliness, and a lack of respect for researchers' time, were other challenges that came up in interviews about both the East and West African HPROs. As one researcher in East Africa told us:

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[22] IDRC. Findings from the Survey on the Role of the Health Policy and Research Organizations—Innovating for Maternal and Child Health in Africa. White Paper. Ottawa, August 2016.
[23] IDRC. Findings from the Survey on the Role of the Health Policy and Research Organizations—Innovating for Maternal and Child Health in Africa. White Paper. Ottawa, August 2016.

"some of their notifications have been last-minute. They don't plan ahead. We fail to attend their meetings because we are not notified in time; we are busy. So they talk about a workshop, and you discuss with your team that maybe we should go…then you get an e-mail saying it is already over."

We heard a similar point in West Africa: "they are very disorganized. They call a meeting and tell us about it 24 hours in advance! What are they thinking?"

Future expectations

We heard optimism, however, from most teams about the possibility for a positive contribution of the HPROs in the remaining years of the initiative, particularly in the areas of knowledge translation and scale-up. One of the Canadian co-PIs explained that soon "we will be starting to talk a lot more about sustainability and scale-up. … That is where the HPRO would be really helpful." As another PI remarked: "I'm sure 2019 will be busy for them."

Interviewees also expressed the expectation that the HPROs would make a positive contribution in capacity-building in gender and equity analysis, remarking that "they don't even have to provide direct technical expertise themselves, but identify some experts who could actually help."

It was clear to us, then, that the HPROs got off to a rocky start. In structuring IMCHA, it seems there were assumptions that the research teams and the HPROs would naturally work together to achieve common goals, and that consideration was not given to the need to build trust and clearly define roles for successful collaboration. Neither the research teams nor the HPROs themselves seemed initially to have a strong grasp of the role and functions the HPROs were expected to play, much less how this would be accomplished. Without a structured mechanism for the research teams to share their proposals, work plans, and reports with the HPROs, the latter were unable to access even basic information about the projects, and thus felt unable to contribute effectively. Our interviews showed a shift towards greater responsiveness and communication. By conducting a survey in 2016 on the roles of the HPROs and stimulating dialogue, the IMCHA team encouraged more communications between the HPROs and the research teams, and expectations became better aligned.

During the remaining years of the IMCHA initiative, as the research teams begin to have data and results, there is a clearer role for the HPROs. Activities that have proven successful, such as capacity-building, can be directed to specific needs for the teams as they work to scale up their research and translate their findings into policy and practice.

In many ways, this second half of the initiative is when the HPROs' expertise should prove most valuable.

3.1.4 Alignment with the priorities of donor agencies

With its focus on MNCH, the IMCHA initiative was strongly aligned to the priorities of all three partners. IMCHA was born inspired by GHRI, which was an earlier partnership, with similar elements of research and capacity-building to solve pressing health problems in low-and-middle income countries. One aspect the partners emphasized is that IMCHA would retain a strong focus on primary health care and on strengthening health systems, which had been a shared priority of IDRC and CIHR in GHRI.

The importance of IMCHA, and its close alignment with the priorities of the government at the time, was reflected in a number of features. Prime Minister Harper announced the selection of the research teams during a visit by Bill Gates to Canada.[24] Also, the presidents of CIHR and IDRC were members of IMCHA's Governance Committee, and visited six research teams and the East Africa HPRO early on in the initiative,[25] demonstrating its importance to the Canadian government.

IMCHA continues to fit the priorities of the current government. Health is one of the key tenets of the new Feminist International Assistance Policy that focuses on gender equality and the empowerment of women and girls.[26] The current government's emphasis is wider and includes a focus on the root causes of gender inequities, and topics such as sexual and reproductive health and rights and adolescent health. IMCHA has shown flexibility in its ability to adjust to the broader focus. As one interviewee stated, "At the time it [IMCHA] was quite particular as it was connecting to a particular policy environment. But even though this policy environment has broadened, it is still, I would say, absolutely essential."

One way IMCHA has adjusted to the widened emphasis is through the Synergy Grants. As one interviewee said, "I would say the Synergy Grants were probably the most critical thing to keep within the margins of priorities." Another interviewee expanded on this: "I've noted that, for instance, the Synergy Grants were able to bring in new areas of work. I was impressed by that. They were already doing stuff on adolescent health,

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[24] IDRC (2015). Informed Change for Maternal, Newborn, and Child Health through Innovation. Annual Narrative Report: April 1, 2014 - March 31, 2015.

[25] IDRC (2016), Innovating for Maternal and Child Health in Africa. Annual Narrative Report: April 1, 2015 – March 31, 2016.

[26] GAC (2017). Canada's Feminist International Assistance Policy, #her voice, her choice. http://international.gc.ca/world-monde/assets/pdfs/iap2-eng.pdf

while we were saying it was important: they were already doing it. They have the flexibility to readjust."

IMCHA has, thus, been able to align with the priorities of its three donors and different Canadian governments. Another aspect of IMCHA that aligns with the priorities of its donors is its emphasis on gender issues. Promoting gender equity is a long-term focus of the participating organizations. IDRC has, for example, emphasized it for over 30 years in its programming[27] and CIHR has a specific institute that focuses on Gender and Health.[28] In the current government, gender remains at the forefront for GAC:

> "...for them [GAC] this gender/feminist lens will be ever more important. There will be an expectation for them that they [GAC] have to really demonstrate how everything is contributing to gender. It is a possible win, but there may also be grounds to ask how can we do more, how can we do better? We are really walking the talk with this program, which is good."

Suggestions for strengthening the partnership

In our interviews, we asked for suggestions on how to strengthen the partnership between CIHR, GAC, and IDRC to ensure wider impact. In general, interviewees expressed their satisfaction with the collaboration, and did not have many recommendations. One suggestion was to increase the visibility in Canada of the research supported by IMCHA. It would not only lead to increased attention being paid to the findings of IMCHA, but also lead to increased recognition of the partnership between the donors in general, and by the current senior leadership of the organizations. One way to do this would be to invite IMCHA researchers to present their research at GAC or CIHR headquarters.

Another way to strengthen the partnerships and maximize the impact of IMCHA is to establish more communication and interaction with the High Commissions/Embassies in the countries where IMCHA-supported research takes place. As mentioned in the methodology section, we had the opportunity during our fieldwork to interview High Commission / Embassy staff working on health in three of the IMCHA countries. Of the three, only one was aware of IMCHA and the presence of IMCHA-supported research in the country in which they worked. In our discussions, all three were happy to learn about the initiative, and indeed, expressed interest in becoming more involved. Considering in-country staff rotation, regular communication with these GAC representatives could play

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[27] IDRC (2011). IDRC at 40: A Brief History,
https://www.idrc.ca/sites/default/files/sp/Documents%20EN/idrc-at-forty.pdf
[28] CIHR (2018). Institute of Gender and Health, http://www.cihr-irsc.gc.ca/e/8673.html

an important role in strengthening the impact of IMCHA and amplifying the policy impact of the research.

Most interviewees representing the donor agencies felt the frequency of the partners' meetings was about right, and thought more frequent meetings would be tedious. Still, some interviewees felt that now, at the midpoint of the program, was an opportune time to meet and engage in a dialogue about the next steps in the partnership. One said: "It's just good to have a touchdown at some point, and this is the right time in the life cycle. So, more like an informal communication, have a coffee together." Another interviewee echoed this:

> "We used to get together regularly to talk about issues of monitoring, stewardship, direction, and alignment. So maybe it is because we have kind of spent the money, and it is now in the hands of the IDRC and the researchers, so as long as we've got evaluators we are fine. As opposed to how are we going to build on this and what is going to come next? That question is not too far away. … But then the question remains: what are you going to learn from your current investments? Are you just going to ignore them? What is going to be the utility of this evaluation in informing future decision-makers?"

With the mid-term evaluation in hand, it is an opportune moment to chart future collaboration between the partners in promoting global health, learn from what has gone well, and see what aspects can be strengthened to have greater impact.

3.2 Integration of Gender and Equity Dimensions

3.2.1 Conceptualization of gender and equity

To fulfil the expected outcomes of IMCHA, to promote gender- and equity-sensitive health systems, there has been a strong emphasis in the initiative on gender and equity from the outset. As mentioned earlier, gender and equity considerations were evaluation criteria in the calls for proposals for the HPROs and IRTs. IMCHA also started early to focus on capacity-building in gender issues, organising a presentation by an external gender expert on 'Gender, Equity, Rights in MNCH Implementation Research' at the inception meeting in Nairobi in April 2015; a presentation on 'Inclusion of Gender and Equity in Maternal, Newborn and Child Health Services in West Africa' at the West Africa regional validation workshop in Dakar in February 2016; and a panel discussion on Gender and Equity in IMCHA Research Efforts at the Mid-term Workshop in Dakar in April 2017.

IMCHA's approach to gender and equity is predicated on the belief that men and women experience differences in access to, and use of, health systems based on their sex,

ethnicity, socio-economic class, geographic location, and other aspects of their identity[29]. The understanding of gender and equity informing the mid-term evaluation is aligned to IMCHA's approach. Gender relations are relations of power and not necessarily, nor obviously, harmonious or co-operative and are unlikely to be so as long as they remain unequal. The intersectionality of identities and powers makes some women more or less vulnerable or powerless than others, giving them inequitable access to and control over services, resources, entitlements and rights[30].

3.2.2 Operationalizing and integrating gender

The majority of the survey respondents and interviewees expressed the opinion that gender issues are being well-addressed by IMCHA. In our survey, we asked recipients to indicate their agreement with the statement: 'Gender considerations are well-integrated into the project'. Nearly all agreed with the statement (Figure 3.7), There was no real difference between the way the African and Canadian respondents answered this question.
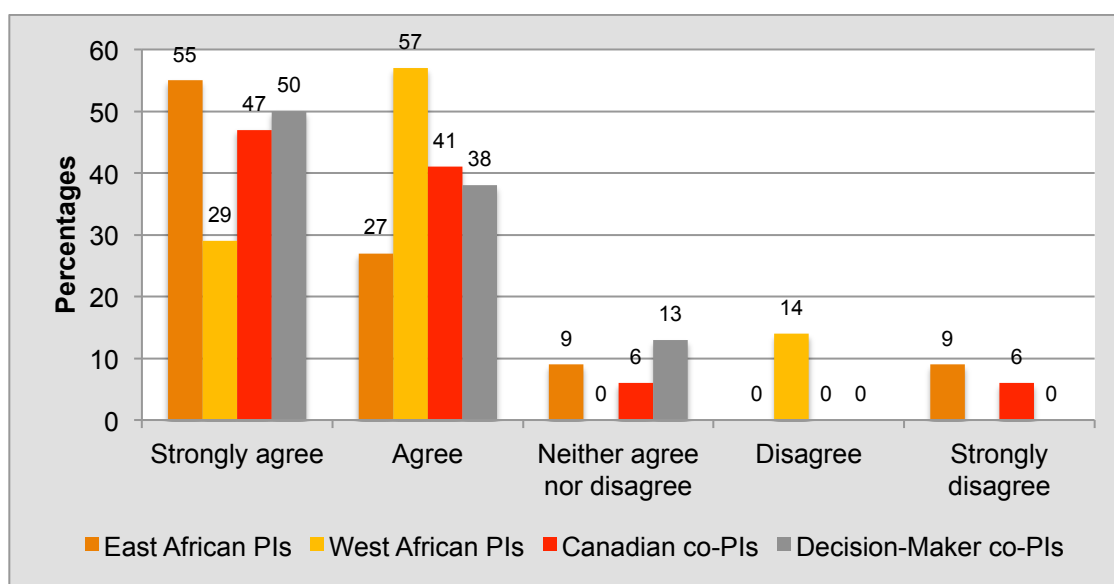

Figure 3.7 Respondents' agreement with the statement
'Gender considerations are well integrated into the project.'[31]

[29] IDRC 24 May 2018. Analysis of gender approach: Innovating for Maternal and Child Health in Africa, IMCHA, draft paper
[30] Whitehead, A. (1979/ 2006) 'Some preliminary notes on the subordination of women', IDS Bulletin, Vol. 10/3, pp. 10-13 & IDS Bulletin Volume 37 Number 4, September 2006. Kabeer, N. (1994) 'The Emergence of Women as a Constituency in Development' in Reversed Realities: Gender Hierarchies in Development Thought, Pg. 1- 10 Verso London/New York.
[31] As decision-maker co-PIs are typically not involved in the daily research activities of the projects, we omitted their input from this graph.

When we asked respondents what measures they had taken to integrate gender into their projects (Figure 3.8), the most common measures selected were 'Ensure that women and girls are beneficiaries of the project', 'Ensure that women on the team take part in decision-making within the project' and 'Included a reference to gender considerations in a research question'. Over 60% of the respondents said they had incorporated gender sensitivity training and brought specific gender expertise into the project, the lowest-rated gender inclusion activities listed in the surveys. These results represent widespread interest in capacity-building on incorporating gender measures into research on maternal and child health. Survey recipients also listed some other activities to incorporate gender considerations, such as engaging men; developing a gender strategy; ensuring that gender inclusion was envisaged in the research; and working on education to remove gender barriers. One respondent commented: "The project has multiple facets. In the community, we would see it as gender transformative. But in the big picture we see it as gender focused."

Design of the projects

The survey respondents emphasized that gender was integrated right from the start of IMCHA, as it was required to be a core part of the research design. One respondent said they considered empowerment of women in the community to be the main purpose of their research. Yet another said that before beginning the project, they aimed to understand social and cultural (gender) norms that hinder or enable better MNCH outcomes. Another said they built in on-going discussions on gender at each stage of the implementation of their project, which included discussions with the community about gender. Yet another respondent mentioned they had recommended gender-sensitive implementation strategies. There were, thus, a variety of ways gender was incorporated in the design of the projects.
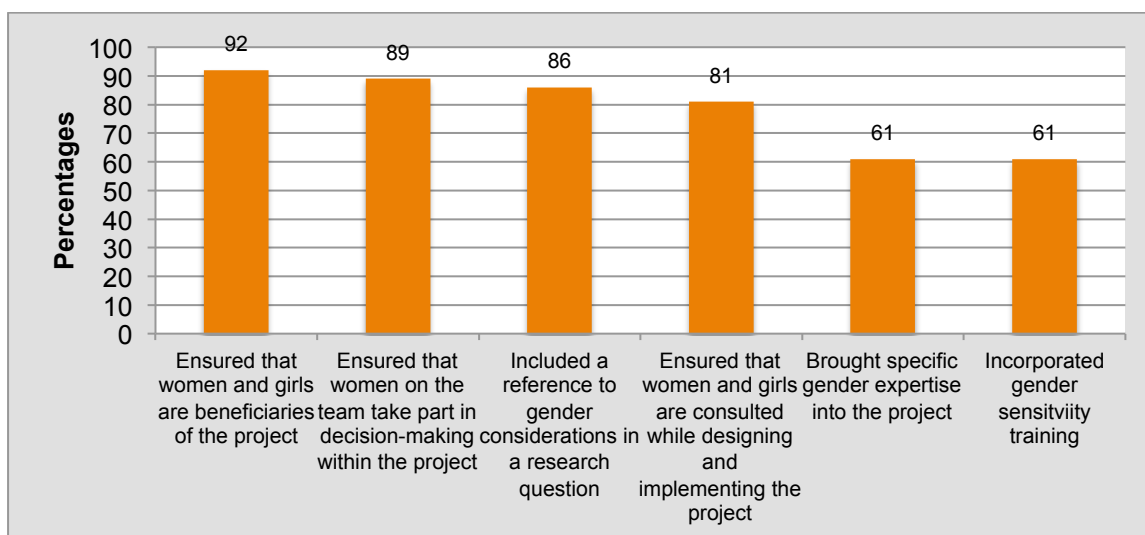
Figure 3.8. Activities indicated by researchers to integrate gender considerations[32]

Team capacities

Referring to team capacity, one respondent pointed out that team members' commitment to gender considerations was a valuable measure. Others talked about recruiting strong female researchers in the team. One respondent said that while recruiting team members, they were cognizant of the need for adequate representation of women in the team so that data could be collected in a gender-sensitive way. Another respondent mentioned augmenting the team's capacity to address gender issues through training and orientation workshops and on-going discussions, including discussions around publications. Efforts to enhance team capacities, therefore, involved enhancing capacity to address gender issues both through team composition, training and analysis.

Research, analysis and evaluation

Many respondents said they had fashioned their research tools, and data analysis approaches, to incorporate gender considerations. One described carrying out studies on female leadership. Others gave examples of measures such as adapting search tools to be gender sensitive; taking gender inequality into consideration during data collection; saturating qualitative inquiries with issues pertaining to women and girls; ensuring that gender issues were explicitly raised in focus group discussions during field work; conducting interviews with a gender lens, that is, including women in discussions; using gender analysis strategies for data analysis, especially when looking at access to services; and doing gender-disaggregated data analysis. Some respondents mentioned

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[32] As decision-maker co-PIs are typically not involved in the daily research activities of the projects, we omitted their input from this graph.

that they ensured that gender continued to be integrated into their projects by having process indicators for mainstreaming gender and equity considerations; by analyzing gender issue during the regular monitoring and evaluation process; and by monitoring operationalization of gender sensitive strategies that had been introduced at the beginning of the project.

Apart from the measures described above, one respondent specifically mentioned that the project helped women in the community overcome gender barriers in decision-making about accessing care. Another described IMCHA as having a sophisticated analysis of gender issues, constraints and opportunities, and mentioned how IMCHA provided expert gender training and helped develop a comprehensive gender strategy.

One survey recipient stated that as a gender expert, they felt that the research assistants in the team had not been adequately trained to analyze how gender structures, norms and values operate. They felt strongly that the researchers collecting data in the field should have had comprehensive training and in-field support to develop a 'feminist lens', which would have enabled them to pick up the complexities and fine nuances of gender inequities. According to this respondent: "From this perspective, our project failed to develop a gendered lens because our research assistants simply did not have the capacity to understand such complexities".

In the survey we asked the respondents to indicate what they thought were the most important measures to integrate gender considerations in their projects (Table 3.1). The suggestions reflected a larger role of female researchers as well as female research subjects.

Table 3.1 Suggestions by survey respondents of measures to increase representation of women

Areas	Suggestions
In the project teams	1. Have a woman as a key team member.
	2. Have women researchers in the team.
	3. Have interventions being carried out by women.
	4. Give more opportunities to women during selection of community health workers to work with their research team.
	5. During training of community health workers, make special considerations for pregnant and lactating women, so that they are not under-represented.

Among research subjects	6. Give more opportunities for women and girls during focus group discussions.
	7. Involve women and girls fully during interventions.
	8. Enroll the subjects using a gender perspective.
In decision making	9. Include women in design and decision making processes in the research
	10. Provide leadership opportunities to women in the teams.
	11. Advocate for including a repository of women in the decision-making bodies set up by the project.

3.2.3 Operationalizing and integrating equity

The agreement of the surveyed researchers with the statement: 'Equity considerations are well-integrated into the project' was a little more measured than their agreement on gender integration. Still, in general the respondents agreed with the statement (Figure 3.9). There was not much difference from the way African and Canadian researchers answered this question but a quarter of decision-maker co-PIs neither agreed nor disagreed with the statement.
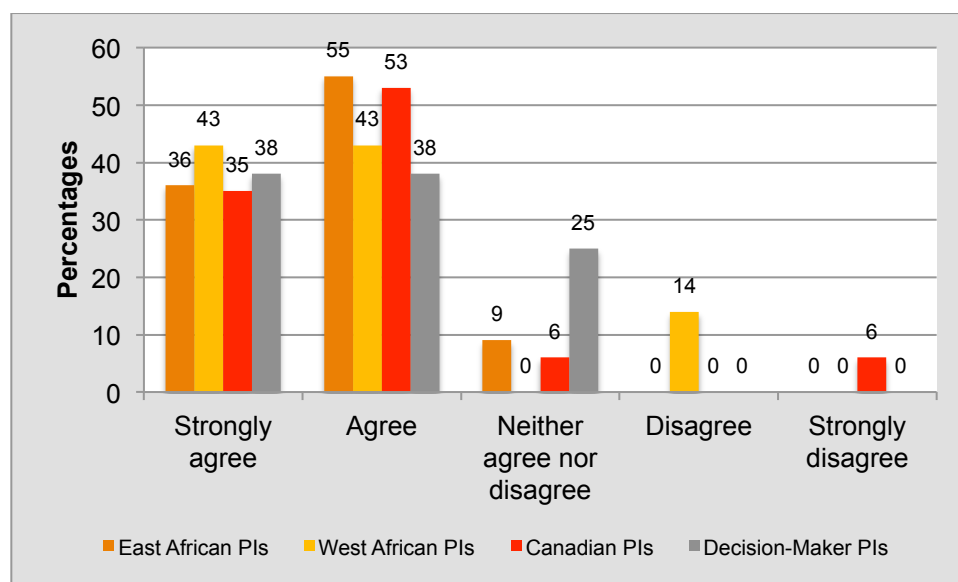

Figure 3.9 Respondents' Agreement with the statement
'Equity considerations are well integrated into the project.'

When we asked what kind of equity considerations were integrated into the projects, (Figure 3.10) the most common answer was: 'Ensured that the project reaches the

vulnerable populations in our context'. The respondents listed a few other equity considerations that they incorporated in their projects, including: addressing power relations within the health system; fairness and consideration during the selection of community health workers; incorporating equity considerations in their process evaluations; serving post-conflict settings and areas that are far away from health facilities; avoiding any segregation of subjects, stakeholders and other participants; including a study on the equity aspects of scale-up; and including cost considerations and efforts to alleviate costs as a barrier to services. Some responses to the question above reflected confusion between equity and gender equity. One respondent answered the equity question with: "We need to be trained in gender analysis so we can know how to integrate equity considerations." This respondent clearly saw no difference between paying attention to equity, and paying attention to gender.

It was noticeable how much less emphasis IDRC and the HPROs have placed on equity training in the IMCHA initiative than on gender training. As a result, only about half the respondents said the projects had contributed to capacity building in integrating equity considerations. Still a high number of respondents said they had ensured that the projects contribute to equity in the sense that it reaches vulnerable populations.

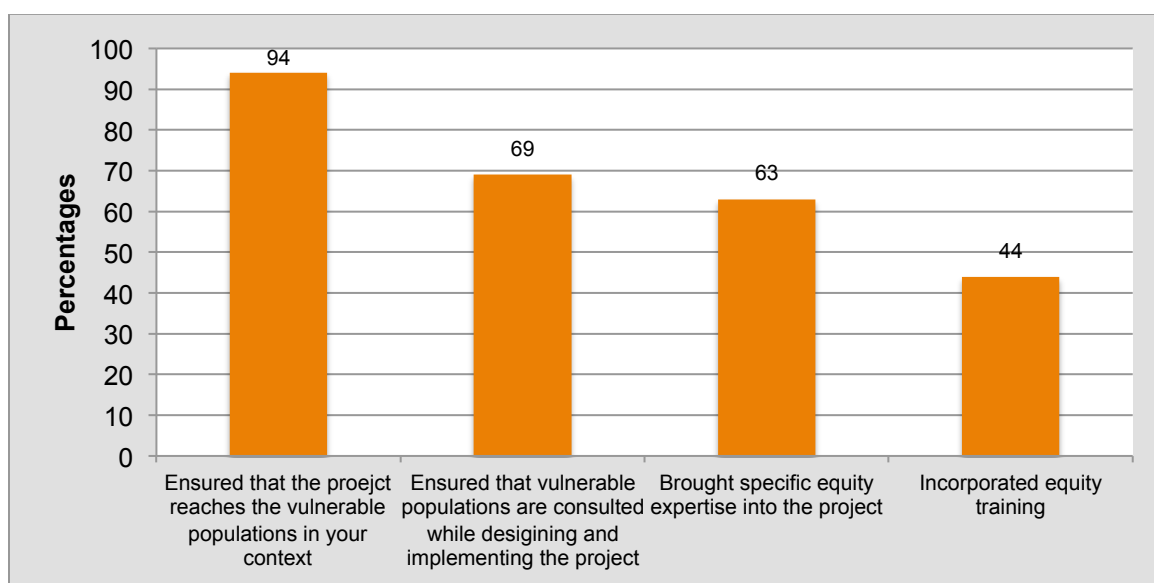Figure 3.10. Activities indicated by researchers to integrate equity considerations[33]

We also asked the survey respondents to suggest what they see as the most important measures to incorporate equity considerations in their projects (Table 3.2). There was a

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[33] As decision-maker co-PIs are typically not involved in the daily research activities of the projects, we omitted their input from this graph.

strong emphasis on providing equal access to all and to incorporate equity issues in research and project designs.

Table 3.2. Suggestions by survey respondents on measures to integrate equity considerations

Areas	Suggestions
	1. Reach the poorest among the vulnerable populations who do not have access to care.
	2. Monitor how socio-economic factors affect access to care, compliance with treatment, and outcomes for both mothers and infants.
	3. Remove financial barriers to women's access to services.
Providing equal access to all	4. Equalize opportunities of access to care for all women.
	5. Give all women equal and fair chances during selection and training of Community Health Workers.
	6. Increase access to health information for all women and men.
Incorporating equity issues in project and research design	7. Include research and analytic approaches that address equity issues in different dimensions.
	8. Identify specific groups of disadvantaged people and poll their opinion regularly.
	9. Have discussions with researchers and decision-makers to ensure that research meets the needs of the less fortunate and does not increase health inequalities.
	10. Analyze data concerning the health of women and children among the most vulnerable and those concerning the social protection policy.
	11. Analyzing equity issues when doing monitoring and evaluation.
	12. Use flexible monitoring and evaluation design to improve impact of implementation on marginalized populations.
	13. Consult with representatives from vulnerable communities at the project conception stage.
	14. Facilitate ongoing discussions on equity issues at each level of implementation.

	15. Analyze equity gaps during planning and implementation.
Strengthening commitment and capacity of project team	16. Ensure commitment from all of the team members to equity issues from the outset.
	17. Foster mutual mobilization and learning about equity issues.
	18. Be convinced at all levels that equity is a crucial area to be considered.
Addressing specific vulnerabilities	19. Reach out specifically to pregnant women who cannot access services due to distance to health facilities, or those who have pregnancy with complications.

3.2.4 Voices from the field

By conducting fieldwork involving interviews and focus group discussions we had an opportunity to examine in greater depth the gender and equity strategies followed by select research teams. These voices from the field echoed the majority view expressed in the survey. Almost all the African and Canadian researchers interviewed expressed the opinion that gender considerations were important to their research. They uniformly agreed that gender inequalities among men and women constrained women's ability to decide by and for herself about if and when to access MNCH care. They also agreed that men played a strong role in influencing these decisions. Even when women were motivated to seek care at health facilities, they did not always have the authority to spend family resources on transport or user fees. As one interviewee put it, "We here in Africa have male decision-makers. It is very bad that a mother dies because he won't take her to the hospital. Who decides how money is spent? On alcohol, or taking a child for treatment?" Poverty played a role in terms of accessing transport, but some interviewees expressed the opinion that lack of permission from husbands was a more insurmountable barrier for women to access to services.

Several interviewees said that the presentation on gender at the inception meeting opened their eyes to the ways in which gender subordination of women has differential impacts on their access to health services and health outcomes. One said, "Coming back from the meeting some of the team members thought that the gender impact described in the presentation was somewhat exaggerated. But after going to the field they came back to say, the situation was even more dire." There were also some comments that the feedback from the review process was helpful for them in order to focus more on gender issues:

"To be honest, like so many people, we thought we're working on MNCH, with women CHWs, isn't that good enough? But the feedback from the reviewer was 'you need to think more about gender.' That was good feedback. We built in a gender specialist, to do gender training, do a gender analysis: focus groups, interviews … I knew we could do more, and I wanted to know how to operationalize it".

When we asked our interviewees about equity issues, some interviewees stated that they incorporate an equity focus: "We introduce it at all levels as we go along. For example, we talk to the community around vulnerable populations, like people with disabilities, single mothers – how do we make sure these people are cared for?" More generally the interviewees were able to provide fewer details about their equity focus, and saw women as a unified category. As one interviewee announced: "Our study is generally applicable to all the women."

The main equity issue that was emphasized was the need of women and children in more remote areas to have better access to health services. As one commented:Yes, definitely the physical access lead to inequity, the further away from a health facility the less likely women will go." Another expanded on this point and said: "No health worker, no services, no roads, no telephone services unless you climb a tall tree. So we are trying to make an attempt to reach these communities. If we are able to make an impact, it will be with them."

Strategies to promote gender- and equity-sensitive health systems

Thus, among those interviewed, there was a robust and widespread acknowledgement of gender inequalities and women's lack of authority to decide that restrict women's access to MNCH care, and a readiness to address these issues. This is a strong starting point. However, the challenge lies in identifying promising strategies to deal with these issues.

The research teams' analysis of the dynamics of unequal power within gender relations was at times shallow. This in turn made some of their implementation strategies have unintentional consequences of adding to women's subordination. For example, some research teams consulted with men and influential members in community to persuade husbands to accompany their pregnant wives to MNCH facilities, in order to ensure women got to utilize the services on time and also that their husbands provided the money for transport. They also counseled nurses in the health facilities to give priority to women who came with their husbands, as the men may be dissuaded from coming again if they had to wait too long. In practice, this sometimes translated into nurses turning away women who were not accompanied by their husbands, thereby defeating the very

purpose of increasing all pregnant women's access to MNCH services. We heard that some women found an innovative way to overcome this new barrier. They paid the men who had transported them to the clinic, to pose as their husbands so that they could get services. This strategy also did not question why women would need their husbands' permission in the first place to use a service that is important to them, thereby accepting women's socially accepted status as dependents, rather than challenging the existing gender inequalities.

While it is important to work with men to make them take more responsibility in the family aspects of the household, there needs to be more emphasis on shared responsibility rather than reinforcing the notion of male guardianship of women. Moreover, this strategy also seemed to assume that all pregnant women are married and living with their husbands in traditional family arrangements, thus homogenizing the target group, excluding widows, unmarried pregnant women, or women who may have children with men other than their husbands.

The other preferred strategy to address gender considerations was to ensure representation of women, both in the target group and also on the research team. As the focus of IMCHA is MNCH, it is obvious that their target group comprises women and adolescent girls. It is also obvious that this in itself does not address gender inequalities, unless the lived realities of these women and adolescent girls are understood and addressed. Similarly, while ensuring representation of women on the research team is definitely a necessary step for ensuring gender parity, it is also essential to make sure the women as well as the men in the team have clarity about and commitment to address gender inequalities. Some research teams have recruited gender experts in their teams, but not all of these experts have the technical capacity to hone the gender strategies or strengthen the gender competence of their research team members. Some of them in particular appear to lack practical expertise of integrating gender at the community level much needed for IMCHA projects.

Although considerable attention is placed on gender issues (and to some extent equity issues) in IMCHA there are clearly opportunities to enhance the integration of these considerations in the IMCHA research in order for it to be successful in promoting gender- and equity-sensitive health systems. For the remainder of IMCHA it is important to strengthen capacity in gender and equity analyses to maximize the value of the data collected by the research teams.

3.2.5 Role of the HPROs in promoting gender and equity

Several interviewees, both researchers and representatives from the HPROs, mentioned that the emphasis on gender and equity in IMCHA should have been articulated more

clearly. Gender and equity considerations were among the assessment criteria in the IMCHA call for proposals for the IRTs,[34] but what we heard in interviews was that that it wasn't well-articulated by IMCHA at the beginning, and "there were a lot of delays getting started…they were ready to go and then they felt we were saying okay, now you need to integrate gender, and that would take another five months." It was difficult for both the HPROs and the research teams to understand what it really meant to incorporate gender and equity considerations into their work. "It was very difficult to break that down into something practical, that these teams could actually use, and embed it into projects that had already been defined."

However, gradual progress was being made in raising the level of understanding about gender considerations. As discussed above, there were, for example, sessions on gender and equity at the inception and the midterm meetings. One interviewee enthusiastically described a gender session at the mid-term workshop: "The light turned on! She asked people what they were doing on gender…at the end, all the people said okay! We're not really doing much, let us work on it more! It was to open the mind of people."

One of the early inputs into increasing the understanding within the initiative about how gender influences MNCH issues was made by the East Africa HPRO in their mapping exercises. In 2017, they conducted context mapping of MNCH in Tanzania, Malawi, Ethiopia and Uganda, to highlight health system gaps, equity concerns and other barriers to service access and national policies related to MNCH, and found gender and equity issues to be inadequately addressed in the health care system.

The HPROs, have not placed much emphasis on organizing meetings and consultations on equity issues . One HPRO representative described equity as "a very new concept," and described a slow process of awareness: "…awareness may happen. But will people appreciate equity by the end of IMCHA? No."

It is evident, then, that the HPROs have made efforts to build capacity among the research teams on the topics of gender and equity. But they recognize that more can be done for the remainder of IMCHA as there are still considerable unmet needs for training in incorporating gender and equity issues in community settings.

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[34] The Global Health Research Initiative. Call for Proposals: Innovating for Maternal and Child Health in Africa. Ottawa, August 2014.

3.3 Innovation and Scaling

3.3.1 The focus on innovation

The most common strategies for promoting innovation cited in our survey, involved replication or scaling up interventions that have been developed elsewhere, either in the respondents' countries or in other countries (Figure 3.11). The respondents could choose more than one option. Half of the respondents listed 'Replicating/scaling up of something tested in other countries' and an additional 35% said that their strategy involves 'Replicating/scaling up something tested elsewhere in your country'. 'Revising an existing approach' was also a common strategy cited. Using a technology new to the country was the least common strategy.
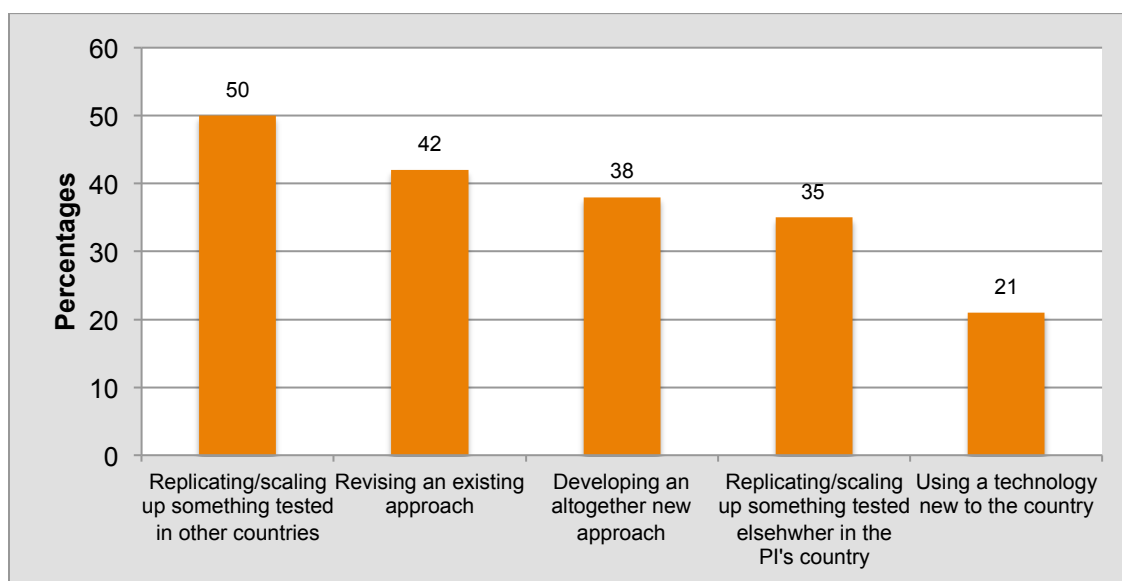
Figure 3.11. Strategies selected by respondents to promote innovation

Note that focusing on replicating or scaling up already-developed interventions in no way undermines the contribution of the projects to innovation. The literature on innovation emphasizes a broad definition of the concept. Ernst et al (1998) defined innovation as "the process by which firms [or other actors] master and implement the design and production of goods and services that are new to them, irrespective of whether or not they are new to their competitors [or other organizations] domestic or

foreign.[35] In the same vein, Everett Rogers, a pioneer thinker on the diffusion of innovation, defines innovation to be "an idea, practice, or object that is perceived as new by an individual or other unit of adoption. It matters little, so far as human behavior is concerned, whether or not an idea is 'objectively' new as measured by the lapse of time since its first use or discovery."[36] Thus, if an individual, organization, or country replicates an already-existing intervention, it constitutes an innovation to them, even though the intervention was already developed elsewhere.

As discussed in the introduction, many of the projects are focused on community interventions. What is clear from the fieldwork is that, while the interventions often involve replication and scale-up of existing innovation, they are not simple copy-and-paste procedures, as the innovation needs to be adjusted to the diverse needs and features of the communities that are adopting the innovations.

3.3.2 Influencing policies and practices

In the survey of researchers, we asked respondents if they had plans to translate their findings into policies and practices; all but one answered in the affirmative. We also asked the decision-maker co-PIs how they were involved in promoting the use of the findings for policies and practices. The most frequent answer was that they were members of particular teams, boards or other fora that work on promoting new policies or practices, and they planned to incorporate IMCHA results into their regular work. For example, one decision-maker commented "I am part of the team that goes to inform the Secretary of Health and other ministry senior officials on the progress of the study and identify areas that can be scaled up immediately without waiting for the end of the project." Another decision-maker emphasized how processes have been put in place to finance the intervention developed under IMCHA: "Already created a budget line for universal home visits in the state based on preliminary results from the research findings."

In our fieldwork, we also found that processes were being put in place by the teams to implement the IMCHA interventions. One decision-maker co-PI described how the IMCHA intervention was being tested at primary care facilities at the state level, and the decision-maker co-PI had already enthusiastically tabled this intervention at the highest policy making body in the country to facilitate wider use of the intervention at the national level.

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[35] D. Ernst, L. Mytelka and T. Ganiatsos, "Technological capabilities in the context of export-led growth: A conceptual framework," Technologial Capabilities and Export Success in Asia, D. Ernst (Editor), Routledge, London, 1998, pp. 4-45.
[36] E. Rogers, M., Diffusion of Innovation: Fifth edition, Free Press, New York, 2003.

> "… you see, one thing that I see here that is major, is the fact that we are thinking of tomorrow right from today. The issue of sustainability, and pushing it forward and making it a national thing, right from the beginning, is incorporated into the concept, and I think it's a good thing."

We also observed cases where IMCHA was already having an influence on practices and policies. Several projects described how the research teams had trained health care workers and community health care workers to treat their patients with respect, and not show prejudice towards women who were poor, or who had mental health issues. They reported that there had been measurable improvements. In Tanzania, one program influenced distribution of birth kits by district health authorities and policies on what medication to use to prevent post-partum hemorrhage. In Nigeria, IMCHA research has had an impact on training on how women in perinatal care are screened for mental health problems. Another Nigerian project has led to a home-visit scheme at the state level being rolled out which is now being planned for the national level. Considering that the research projects only started three years ago, and not all implementations may turn out to be successful, it is promising that the initiative is already having impact.

3.3.3 Approaches to scale-up

Scale-up in the context of IMCHA

On the question of what scale-up means in the context of IMCHA, the interviews and focus group discussions revealed two different pathways. One is vertical scaling, which involves making the intervention sustainable beyond the IMCHA funding. It seeks to reduce dependency on donors, to ground the intervention in the community, and to advocate to governments or communities themselves to foot the bill. One interviewee pointed out that IMCHA had built-in sustainability:

> "Because IMCHA has taken the health systems approach of involving big players in the projects, starting with community level people, policy makers – with the system, they have this inbuilt sustainability. Already embedding in the health system: that in itself promotes sustainability."

Not everyone agreed that sustainability was almost automatically promoted by IMCHA, and some were concerned about what would happen to their projects after IMCHA had run its course. While the idea with IMCHA was that the innovation implemented by the projects would be sustainable, if successful, not all the interviewees felt that this could be achieved during the timeframe of the initiative.

The second pathway for scale-up in IMCHA is horizontal scaling, in which an intervention is replicated in a different geographical area. Most of the IMCHA projects aim for horizontal scale-up. Many of the interventions are based in a few villages or districts, and the PIs want to expand the projects to neighboring areas. Other projects were looking at the possibility of national scale-up if they are successful, and have already engaged national policy-makers in dialogue about this:

> "The policy question, if our research works, is how do we implement this in routine practice? Does the scale-up in this case mean something from the national level, or does it mean 'here is a package of things you can do at a local level' and you replicate it at different local levels?"

A couple of projects mentioned that for their projects, scale-up could even extend beyond national boundaries. Even though no firm plans had been made to do so, the team members felt the intervention could easily be applied in different countries. This is not far-fetched, as IMCHA's activities have involved replicating interventions developed elsewhere. There are a lot of opportunities for learning across countries on how to improve MNCH.

Strategies for scale-up

In order to understand better how scale-up takes place, we asked survey recipients to specify the approaches (if any), they had taken, or planned to take, to scale up their interventions. The most typical responses were that they had started or had plans to start dissemination of research evidence to their Ministry of Health or to other national or sub-national policy-makers. In some cases, this involved preparing policy briefs with their findings, or organizing regular dissemination meetings. Some (both researchers and decision-makers) mentioned that they were members of technical working groups and were using these groups as fora for promoting the scale-up of their interventions. Several recipients mentioned that their discussions with policy-makers involved identifying other geographical areas that could benefit from scale-up of their interventions, i.e. horizontal scale-up.

1. Government
Connection to government was described as an important scale-up strategy in the fieldwork, and it was emphasized that the research need to be closely aligned with government priorities in order to achieve scale-up. "Nothing will be done without support from the government…. So if you are not following the government, you will be stopped."

One way around strict control of priorities by the government that was mentioned in the fieldwork was to work at multiple levels. "My approach was to involve the district, regional and also national governments. The regional authority was very supportive but there were some problems at the district level." There was some degree of decentralization in health services in the countries in which we did fieldwork, and sometimes representatives from the local level seemed to be more straightforward to work with, as they were more grounded in the community.

Government representatives, including decision-maker co-PIs, also emphasized the importance of researchers and governments engaging in dialogue. "Once the results are out, it is not difficult to scale up, as long as they are working at the local level. Not working alone. If you are working in isolation, it is difficult to scale up. But if you are working within the framework, the policy framework, it is easy to scale up."

They also emphasized the importance of starting dialogue with the government early on, in order to align the research to areas of importance to the government and start relationship building. As one government representative said:

> "You start from the beginning, involve those who are supposed to be involved, try to understand in terms of implementation, in terms of the research results, then it will be easy for scale-up, easy for sustainability. But if you come just at project end, no sustainability, no knowledge; it will not be easy."

Some governments have structures in place to review evidence for policies/practices. The Ugandan government has, for example, a structure of committees and working groups that review evidence quality and relevance. At the top, there is a committee with senior representatives from the government, donors, civil society and private sector organizations, who together review evidence and plan implementation. The interviewees also discussed that the Ministry of Health in Burkina Faso has established a specific department to provide direction and strengthen implementation based on scientific evidence.

2. Communities

For scale-up, it is not only important to have close ties to government, but also to communities. Some survey recipients emphasized that engagements and consultations with communities was an important strategy for their scale-up activities. This was also expressed in the fieldwork interviews: "The community engagement is very, very important. We have strengthened the community health workers, these are the ones who go and talk to the community." And "We want to do something that can be sustained in the community. We work to make sure they own the project, are engaged."

In our fieldwork, we asked the teams about the role the community had played in defining the topic and design of the research. In most of the projects we examined, the research had started with community-based focus group discussions or other consultations. The communities had, thus, participated in decisions on what to research and how to do it. Even though many of the IMCHA interventions were replications or scale-ups of interventions used elsewhere, the cultural features of different populations are diverse, as mentioned above, which underlines the importance of community-based involvement on implementation options.

3. Donors
Ties with donors were also considered important for scale-up. Donor involvement is, for instance, built into the decision-making structure for health interventions in Uganda, as mentioned above, where the most senior committee considering evidence of health interventions involves donor participation. One interviewee described the path of research as follows: "Research identifies the gaps, then donors bridge the gaps. Not just publish. Not just put it in the cupboard." We also heard a reference to the importance of providing good quality evidence because of donors' requests: "For scale-up, sure! We have organizations like UNICEF, the World Bank, DFID, SIDA…they don't want to waste their money. They want to put their money where the evidence is. "

Several interviewees also expressed the wish that Canada would continue to support the teams under a follow-up program. "I am satisfied with what [IMCHA] has done for me. But I am not sure about sustainability…. I don't know what their plan is in the future. More support would be best." While this can be viewed as a request for sustainable source of research funding, in implementation research the lines are not clear. If the researchers have not been able to set up sustainable funding for scale up during the IMCHA project, the scale-up could fail and the communities would forego the benefits of the intervention: "Once you say it is implementation research, you cannot run away." Instead the researchers need to ensure that the interventions continue with additional funding. There was also a moral value assigned to scale-up: "Scaling up for me is…indispensible. It is key to equity."

The IMCHA researchers seemed to differ in terms of how they saw their own involvement with scaling. Some felt they should be closely involved in raising funds and carrying out the scaling activities. Others were more unwilling to be involved after they had proven the implementation to be effective. "Yes, we will look for opportunities, but our bigger interest is to scale up packages that can be scaled up by others. Universities don't scale up per se.

> " A hand-over to government was also mentioned: "Scaling-up, those are the policy things…we hope we are able to get the policy makers to be sufficiently

interested so that can happen. So that's always out of the control of researchers. How to get this? – for us to demonstrate the feasibility of it, that's all that we can do."

In general our interviewees did not feel that scaling up bore risks. In comparison, not to scale up the intervention was seen to be worse: "As for risks, doing nothing is more risky." Still one interviewee warned against disseminating interventions that have not yet been proven to be successful. "The last thing you want is to have bad results having massive impacts." The middle ground between doing nothing and scaling up prematurely needs to be found. Another interviewee felt that the main risk in scale up was frequent turn-over among government officials. They can differ in how receptive they are to interventions, and a new and unsympathetic official could be an impediment to scale-up plans.

Hindering factors for scale-up

We asked survey recipients to rank what factors may hinder their ability to scale up (Figure 3.12). Lack of funding, human resources, and connections to other decision makers were considered the main impediments to scale-up. The researchers also ranked changes in national priorities and policies highly as a hindrance.

Our fieldwork interviewees echoed the view that lack of resources was one of the key barriers to scale-up, with almost all mentioning lack of funds as a limiting factor. They also said that availability of resources affected the scope of the scale-up: more resources, not surprisingly, allow for greater scale-up. Just as in the surveys, shifting policies were listed as detrimental to scale-up. Changes in government can be a challenge for scale-up activities, particularly when accompanied by shifting priorities. Lack of understanding by the government of the role of research can down-play the importance of evidence for policy initiatives. "Health research is a key component. But the implementation is poor. For me it is a lack of political commitment and under-standing of the role of research." Lack of communications was also considered an impediment to scaling up. "The research teams should be in constant communication with the policy makers."
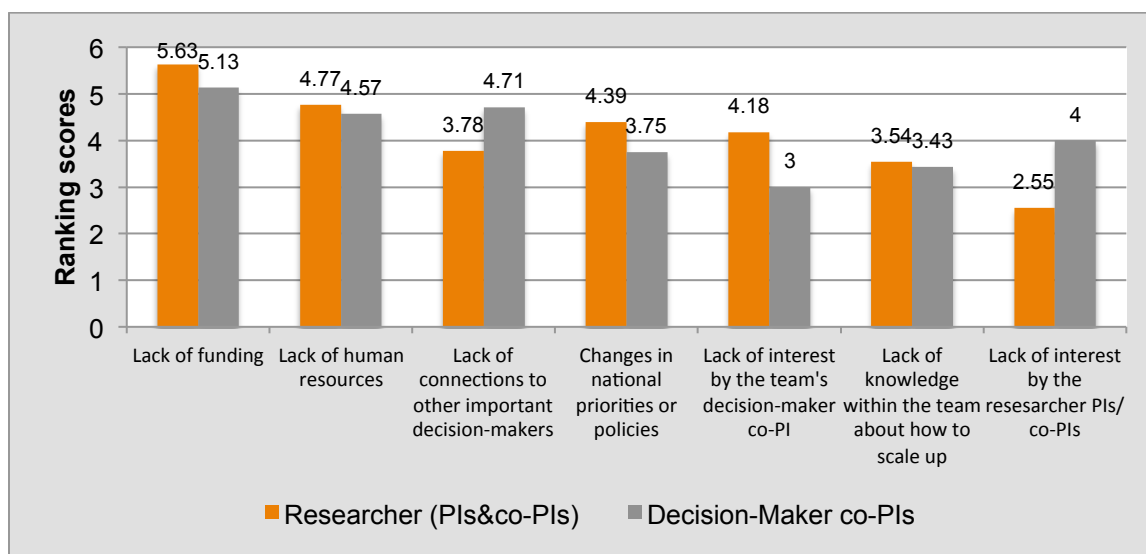
Figure 3.12. Respondents' ranking scores of factors that may hinder scale-up

Some features of the intervention itself can also make scale-up challenging. Overly complex interventions are less likely to be easily scaled up. "So, whatever intervention it is, it should be simple to use." The interventions also need to be affordable. "There are lots of initiatives, projects put in place with large cost structure. They are costly and when rolled out in more remote areas not so effective." Another point that was stressed is that interventions that have heavy community involvement may not be so easy to scale up as they can be time-consuming and costly to implement.

Supporting factors for scale-up

Our interviewees mentioned the quality of the evidence as one of the main factors that supports scale-up. "Data. Once we have it, it is encouraging." The teams we interviewed were still working on collecting evidence, so they were unsure how strong a case they could make for scale-up. "We hope that our results will strongly contribute to their taking it to scale: that's what we are really looking for. We are optimistic. They needed evidence, and we have provided it. It should work. It takes time, you have to push."

How well the interventions are aligned with the policies of the government also influences scale-up. "Using existing government structures is critical." With better alignment, there is greater likelihood of political commitment to the scale-up, which certainly is a supporting factor. "Political commitment is the key. There is structure in place, we have health policy in place."

The availability of human resources, the affordability of the intervention itself and the ability to package it so it would be easier for others to use were also emphasized as

supportive factors. In addition, one interviewee mentioned that the HPROs could make an important contribution to knowledge translation and scaling up: "If you have a good HPRO, they understand how the government decision-making process works … We could try to do it, but it's not what we're trained to do. We're trained to write things that no one understands." IMCHA at this point can support the research teams in showing they have quality evidence that can be put in practice. Systematic communications with governments, communities, and donors about the value of the IMCHA supported interventions can support scale-up.

Key influences

One phase of the RQ+ approach examines and rates the key influences on research. As these influences are likely to shape scaling-up activity, we looked systematically at how these factors are likely to influence the research supported by IMCHA. We present the findings in an aggregate form, looking at the IMCHA research in each fieldwork countries as a whole. Our analysis is only based on the projects we examined, and is not based on input from other projects in our fieldwork countries. We also focused on examining these factors from the perspective of scale-up potential rather than from the perspective of research quality per se. In Table 3.3 we present the findings of our analysis.

The first factor we examined is the 'maturity of the research field'. As the interventions in IMCHA projects were typically replicated or scaled up from elsewhere, we generally judged the maturity of the research field to be high in all the countries. A mature research field tends to pose less risk for the scale-up activities.

The next factor we examined was research capacity-strengthening. All the IMCHA projects greatly emphasized research capacity-strengthening and listed several trainees in their research teams. In addition, some of the PIs were new to implementation research and emphasized in the interviews the capacity-building strengthening of IMCHA on their own careers. This was less the case in Nigeria and Burkina Faso, where the PIs had long experience in their respective research fields. We therefore chose yellow for research capacity-strengthening in Burkina Faso and Nigeria because the research teams examined already had extensive research capacity before IMCHA. In Tanzania two of the PIs we interviewed stressed that they were new to implementation science, but one of the Tanzanian PIs we interviewed was a highly experienced researcher, which explains why we chose a slightly lighter colour green for Tanzania's research capacity-strengthening. As mentioned, one of the challenges for scale-up is lack of human resources, but IMCHA is trying to address this challenge through its focus on capacity-building in implementations research.

Table 3.3 Rating of key influences on IMCHA fieldwork projects

	Projects in Tanzania	Projects in Uganda	Projects in South Sudan	Projects in Nigeria	Projects in Burkina Faso
Maturity of the research field	🟩	🟩	🟩	🟩	🟩
Research capacity strengthening	🟨(light green)	🟩	🟩	🟨	🟨
Risk in the data environment	🟩	🟨	🟥	🟩	🟩
Risk in the research environment	(light green)	🟨	🟥	🟩	🟩
Risk in the political environment	🟨	🟩	🟥	🟩	🟩

(Dark green represents a very high value of maturity, a very high emphasis on research capacity-strengthening, or very low value of risk; light green represents a high level of research capacity-strengthening or low value of risk; yellow represents a moderate level of research capacity-strengthening or moderate value of risk; and red represents a high level of risk).

Risk in the data environment was the third factor we examined. It is the extent to which instrumentation and measures for data collection and analyses are widely agreed upon and available, and the extent to which the data environment is well developed, stable and data rich. Most of the teams used established data collection methods such as focus group discussions, interviews and questionnaires. The reason we assessed projects in South Sudan and Uganda as having higher risks is because of the challenges they have had in data collection environment. We learned in our interviews that it was particularly challenging to conduct randomized controlled trials in settings where there is a high level of political unrest and populations move to refugee and displaced persons camps.

Risk in the research environment is the next influence we considered. It represents the extent to which institutional priorities are supportive of research, and incentives and facilities are available for research. In some cases the research environment in Tanzania

was still being established, so we used lighter green for Tanzania, to reflect a growing research environment. In Uganda the research environment was also being built up in both the projects we examined. There was also some development of the research environment in South Sudan, but it seems to be fairly rudimentary and internet access was, for instance, a great challenge. A weaker research environment signals extra challenges for projects in these countries, and highlights settings where IMCHA needs to provide extra flexibility and support in dealing with unforeseeable conditions to enhance the potential for scale-up.

The last key influencer is risk in the political environment. It represents how stable the political environment is, how established governance practices are, and whether there is heavy political conflicts. A yellow for Tanzania reflects the change in government priorities since IMCHA started and the mixed messages from government representatives about how receptive they are to community-based research. Instead they seem to want to steer both researchers and donors towards building health infrastructure such as clinics. A green for Uganda, Burkina Faso and Nigeria reflects how receptive their governments are to the IMCHA research projects. One Ugandan stakeholder said for example: "We want to see their results—what are the pros and cons of each model. It's a lot like the model we're considering. So I'm anxious to see the findings!" While the political environment in South Sudan is dire, with considerable uncertainty, interviewees from that country emphasized that there was an interest in their research by the national government and that they were easily approachable: "In South Sudan, if we want to talk to some one [in government] it is easy." This openness to research suggests the elements exist for a supportive research and scale-up environment if and when the conflicts subside.

Using the RQ+ approach to examine factors that can influence scale-up, shows the wide range of influencer that can shape the potentials of scale-up activities. Considering the extent of the green colour in Table 3.3 the scale-up potentials of these projects are promising. The yellow and red spaces highlight specific areas that IMCHA personnel need to be aware of and come up with measures to support the teams to strengthen capacity and overcome risks.

3.4 Program Delivery

3.4.1 Effectiveness of IDRC supervision

Each research team in IMCHA has a responsible Program Officer at IDRC, who is their liaison and to whom they report as well as an assigned grant administrator. The projects also each have an alternate or co-Program Officer. The Program Officers, some of whom are based in Ottawa and some at an IDRC regional office in Africa, act as coaches,

mentors, and connectors to other teams, as well as ensuring that the research teams meet deadlines for deliverables and produce reports and financial statements. The research teams are required to file annual and semi-annual technical and financial reports.[37] Failure to file on time can lead to delay in disbursement of funds. Similarly, any other significant issues that arise with the research teams can lead to a revised schedule of funding in order to mitigate the risk to the project and to IMCHA. In addition, there are financial grants management visits by IDRC staff and extensive review of the financial systems at the organizational level.

Similarly, HPROs are considered projects from an administrative point of view. Therefore, each of them has a responsible Program Officer, and is required to file regular reports on their activities, outcomes and finances. As mentioned above, IDRC conducted a survey of PIs and co-PIs to investigate the role and performance of the HPROs. As a result of the survey and of discussions with the HPROs, the HPROs' roles were altered to better conform to the realities of their abilities and the needs of the research teams.

IDRC's approach to project monitoring, formerly known as Grants+, is especially hands-on compared to the other IMCHA funders' usual approaches. This involved approach allows IMCHA to invest in researchers and institutions in challenging contexts or situations that carry some risk. As one Project Officer commented, "We are able to guide them, advise them…The team knows that they can ask a question, and we will help them. We all have research backgrounds."

A question that came up in our interviews with donor representatives was whether this approach was perceived by the research teams as burdensome, or helpful. As one donor representative remarked, the idea is "to strike a balance not to create burden but at the same time…to provide support." For some Canadian co-PIs, "the level of reporting is much more intense then they are used to if they typically get their money from CIHR." However, most PIs and Canadian co-PIs expressed admiration for the generous support offered by IDRC and their assigned Program Officers: "I feel that there is a really good program level supervision with IMCHA by IDRC."

One challenge with this high level of support is, however, that it is extremely labour-intensive. In our Ottawa interviews with donor representatives, several mentioned that adding together the hands-on, collegial mentoring approach favoured by IDRC and the more quantitative, indicators-driven model used by other funders created an ever-increasing burden of work for IDRC. One Program Officer commented "We've been

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[37] The level of reporting depends on the risk associated with the institution of the PIs and researchers Co-PIs. Most African institutions are required to report semi-annually or annually, while the Canadian institutions report annually.

trained to be hands-on. We're not here just to sign cheques…". But with a broad array of projects spread across a wide geographical area, "if you don't have enough hands, and [in] such difficult terrain…it feeds into the risk piece, [because] everyone is so overworked all the time."

At the time this evaluation is being conducted, IDRC was also working on a strategy to formalize the risk mitigation strategy. As we understand it, this document is still ongoing. The basic idea is that as problems arise, first the Program Officer tries to work with the team to resolve it. If that is unsuccessful, consultants can be sent in to help the team directly on the ground. If the problems persist, the issue can be escalated within IDRC and increasingly higher levels of management can be involved. If all efforts fail, the project can be terminated for non-performing.

Our survey asked respondents to rate the extent to which they agreed with the statement "'IDRC has done a good job in monitoring and supervising the project." The results showed a high level of satisfaction with IDRC's involvement, with nearly half (47%) of all respondents indicating that they strongly agreed, and another 31% indicating that they agreed with the statement. Researchers in East Africa were particularly enthusiastic, with 73% indicating they strongly agreed with the statement.

Our survey asked respondents to rate the helpfulness of various activities undertaken by IDRC. The most helpful activity was 'communications with Program Officers', with 57% rating this very helpful and 29% rating it 'somewhat helpful'. Over half (51%) of respondents rated the mid-term meeting in Dakar to be very helpful.

Finally, the survey asked whether respondents had received support from IMCHA/IDRC with selected activities. The most commonly selected activities respondents received support with were 'help with networking' and 'help with financial reporting'.

We also asked the PIs we interviewed how they felt the management by IDRC of IMCHA had gone. Some interviewees, perceived that there had been a relatively high turn-over among Program Officers at IDRC. Several Canadian co-PIs observed that IDRC staff were stretched thin and not always able to be fully engaged: Most, however, were broadly satisfied with their relationship with IDRC and their program officers, and several mentioned the flexibility and openness with which they were treated. One PI declared that "this is an incredible project. I am so proud and honoured to be in this project."

3.4.2 Mechanism and strategies for learning

The clearest example of the strategies in place to learn and adjust the design of IMCHA relates to the survey on the role of the HPROs and the subsequent clarification efforts. This process, as one interviewee told us, "was a turning point; the HPROs were no longer just hearing from us, they had to take corrective actions, and they did."

In our interviews with donor representatives, we also heard that there is a culture of learning and reflection at IDRC that is expected to pervade all aspects of the work. IDRC staff are, for example, asked to produce project completion reports in which learning and reflection are strongly encouraged.

This formative evaluation has also aimed at identifying a number of lessons that can strengthen the reminder of IMCHA. Below we will present several recommendations that can put this learning into practice.

4. RECOMMENDATIONS

Overall, IMCHA seems, despite a slow start, to be on track. The teams are working closely with their constituencies and are, to various degrees, involving their decision-maker co-PIs. They are producing evidence about affordable, feasible, and scalable primary health care interventions. There are some early wins in which the research has started to influence policies and practices; and enthusiasm that more changes are in the pipeline. To strengthen capacity in gender- and equity-sensitivity, and to bring about effective scale-up activities, more training and further customized support is needed. Below are our recommendations based on the results of this evaluation that are aimed at the remainder of IMCHA, as well as recommendations aimed at the early phases of related future initiatives.

4.1 Remainder of IMCHA

General Recommendations

1. Hold country-level meetings among the research teams, including the decision-makers, in countries in which there is more than one research team. This would provide an opportunity for the research teams to form networks, to tap into the expertise of other teams' decision-makers, and to energize their contributions.

2. Hold a final meeting of all the research teams to share lessons learned. The meeting could synthesize learning from the different research teams, explore future implementation research and explore further scale-up opportunities and collaborations.

3. Ensure that the summative evaluation of IMCHA includes a wider focus on stakeholders views on the IMCHA supported projects to be able to better examines the factors and conditions that are shaping scale-up of IMCHA interventions. Paying particular attention to South-South collaboration in IMCHA would also be valuable.

Gender & Equity

4. Support the teams to do more gender and equity analyses of their existing and evolving data sets to maximize the impact of their research on gender and equity issues.

5. Organize a hands-on set of regional workshops for all the research teams and work with them as a group to look at their individual implementation plans to assess how far their strategies substantively address underlying causes of gender inequalities and inequities based on different axes of power, and to identify what they can do differently for the remainder of the initiative.

6. Organize capacity-building efforts on equity analysis through a dedicated workshop on how to carry out equity analyses. This would help ground the concept, differentiate it from gender considerations, and enhance understanding on how it applies in each research project.

7. Provide the research teams with a vetted roster of gender and equity experts who can support the teams in their gender and equity analyses. Place a particular emphasis on experts who have prior experience in promoting gender and equity issues in communities.

Innovation and Scaling

8. Enlist help from the HPROs in supporting the teams with writing policy briefs and setting up stakeholder meetings; consider requesting that the HPROs work with each team individually to develop a customized knowledge-translation plan for the results of their research.

9. Require the research teams to submit a plan as a part of their technical reporting, on how they are working with the decision-maker co-PIs to influence policies and practices and plan scale-up for the rest of IMCHA.

10. Provide support to the research teams in identifying funders that support further scaling up activities after IMCHA has run its course.

11. Provide grant-writing training to help the research teams seek further funding.
12. Investigate whether IDRC and GAC are able to act as a liaison on behalf of the research teams with potential future donors.

HPROs

13. Continue to provide tailored capacity-building for the research teams, particularly on knowledge translation, policymaker outreach, and seeking donor support for further research and scale-up.
14. Create formal mechanisms to ensure knowledge-sharing between the East and West African HPROs on a regular basis, perhaps through shared initiatives such as working together to update and enhance the IMCHA website to showcase the results of the research teams and to promote cross-cutting lessons, or collaborating on dissemination materials to be shared across the region, including to potential future donors.

4.2. Future Initiatives

General

15. Learn from IMCHA to include more structure at the beginning of the initiative, including offering management training. IMCHA grantees included a number of people who were inexperienced in managing Canadian grants who would have benefitted from early capacity-building in this area.
16. Create a template to develop stronger workplans from the outset. This would aid in better budgeting.

Collaboration between African and Canadian researchers

17. Support team-building and the preparation of applications by holding pre-proposal workshops or webinars on developing research proposals.
18. Explore innovative ways to facilitate 'matchmaking' between African and Canadian researchers who are interested in collaborating.

Gender & Equity

19. Provide applied gender and equity training ideally at the onset of the project to reach a common, Initiative-wide understanding of how inequalities play out in reality in communities, and present examples on how some of

these have been addressed effectively elsewhere, to bring about equity and gender-transformative changes.

HPROs

20. Define the role of an HPRO-like component in any future initiative that includes such a feature, clearly and specifically to all participants from the outset. It is crucial that the expectations for collaboration between the HPROs and research teams are explicit and concrete.
21. Shift the mandate of the HPROs towards offering tailored support to individual research teams, and require the HPROs to visit each team and work with them to understand their needs and to develop an outreach plan. Under this model, HPROs would be compensated based on the number of research teams they support.