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INNOVATING FOR MATERNAL AND CHILD HEALTH IN AFRICA (IMCHA) SUMMATIVE EVALUATION

Main Report (Vol 1)

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EXECUTIVE SUMMARY (CORRECTED 06/05/2021)

The Innovating for Maternal and Child Health in Africa (IMCHA) initiative is jointly funded by the International Development Research Centre (IDRC), the Canadian Institutes of Health Research (CIHR) and Global Affairs Canada (GAC). It was launched in March 2014 with a funding volume of C$ 36 million over seven years and supports 28 research grants (19 original research grants and 9 synergy grants) in 11 African countries. All projects are led by a Principal Investigator (PI) affiliated with an African university, research institution or NGO. A decisionmaker working in local, regional or national government is embedded as Co-Principal Investigator (Co-PI) in each research team, as well as a Co-PI affiliated with a Canadian research institution. Two Health Policy and Research Organisations (HPROs) in West and East Africa are tasked with supporting knowledge translation and raising the profile of the research in order to facilitate the adoption of the results at scale in national and regional health policies, supporting capacity-building of research teams and facilitating mutual learning across IMCHA.

IMCHA is expected to contribute to improved maternal, newborn and child health outcomes in programme countries through …

1. enhanced production, analyses and syntheses of health systems implementation research prioritising gender and equity;
2. enhanced partnering and collaboration between decisionmakers and researchers on health systems strengthening; and
3. enhanced integration of health systems research findings into primary health care policies and practices.

The summative evaluation was tasked with assessing the overall performance of IMCHA and the value-added of its design and delivery. Evaluation questions were grouped under four headings:

1. What are the achievements of IMCHA with regard to the performance measurement framework (PMF) as well as to policy uptake and scale up of successful interventions?
2. How effective has the management of the initiative been and what difference has that made to IMCHA achievements?
3. How well has IMCHA been operationalised and how could it be improved on in future undertakings?
4. How is the work conducted under IMCHA documented for contributing to the legacy of the initiative?

Data for the evaluation were collected through document reviews, and on-line survey of current and former members of IMCHA research teams and key informant interviews with IMCHA stakeholder during visits to programme countries and to Canada and through remote interviews using a voice over internet protocol (VOIP).

KEY FINDINGS

IMCHA ACHIEVEMENTS OF ULTIMATE AND INTERMEDIATE OUTCOME TARGETS

EXPECTED RESULTS	INDICATORS AND TARGETS	ASSESSMENT
Ultimate Outcome Improved maternal, newborn and child health outcomes	Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services **Target:** 50% of the implementation research demonstrate improvement in any of the 11 accountability indicators	**The target was met:** Project contributions or potential contributions to improved maternal and child health outcomes could not be measured directly for many projects, but the projects provided sufficient information to infer such contributions.
Intermediate Outcomes 1. Enhanced production, analyses and syntheses of health systems implementation research prioritising gender and equity	Proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions **Target:** All research projects have >75 % (three of four processes) adequate gender and equity dimensions	**The target was not met:** 15/28 projects (54%) integrated adequate gender dimensions, and 7/28 (25%) adequate equity dimensions in at least three research processes.
	Proportion of health systems research outputs and syntheses that are gender and equity focused **Target:** 75% of outputs include gender and equity focused analyses/syntheses	**The target is not likely to be met:** Research outputs, including gender and equity analyses were still being generated at the time of the evaluation. Among 98 outputs from 22 projects that were available for analysis, 44 (46%) included a gender focus and 21 (22%) an equity focus.
2. Enhanced partnering and collaboration between decisionmakers and researchers on health systems strengthening	Number of total projects per country that demonstrate high level of collaboration with decisionmaker (documented by project, country and regional levels) **Target:** Minimum of one per country	**The indicator as defined was not assessed:** The decisionmaker is defined as the '*national focal point for MNCH*'. Most projects communicated their activities and preliminary results at this level, but for others this was not the main respondent at national government level.
3. Enhanced integration of health systems research findings into primary health care policies and practice	Number (type) of influence of IMCHA research projects on policy and programming per project **Target:** 20 references to research findings or recommendations in country-led technical decision-making platforms	**The target was likely met:** Although it was too early in the programme to assess this outcome, the target of 20 was already reached. All sampled projects had made presentations of research results in national fora and most had plans for further discussions once final research results were available.

MANAGEMENT EFFECTIVENESS

IMCHA management was described as responsive and flexible by interviewed researchers and online survey respondents. About two-thirds of survey respondents rated the support provided for the preparation of implementation plans, technical reports and financial reports as very helpful. The financial holdback policy for the last semester payment until project completion raised concerns among some African researchers who foresaw difficulties in pre-funding their final data collection, analysis, knowledge translation and documentation activities.

IMCHA DOCUMENTATION

The research teams, the HPROs and IMCHA management generated a large number of materials that document the IMCHA initiative, some of excellent quality. A considerable number of documents were still in preparation at the time of the evaluation. The IMCHA website, managed by the East Africa HPRO has strong branding, however it is not regularly updated and presents primarily East African content. IDRC maintains a webpage for IMCHA that is more complete and up to date, but it is primarily presented under the IDRC brand.

LESSONS LEARNT

IMCHA funded implementation research projects that included the embedding of decisionmakers in the research teams and that also included South-South technical support and networking through the funding of HPROs. Additional characteristics of IMCHA were (1) a PMF that, at the ultimate outcome level, asked for measuring implementation outcomes rather than research and knowledge translation outcomes, and (2) a South-North partnership between African and Canadian research institutions in each project. The lessons from IMCHA are that it is possible to combine these design elements in a single programme, but that it does generate conceptual tensions: (1) The balance between the focus on interventions to generate health outcomes versus the focus on research to generate answers to the questions of whether these interventions are appropriate, feasible, effective and affordable in the local context, and how they can be best delivered. And (2) the balance between supporting local partnerships between researchers and decisionmakers within a Southern network, and the definition of a meaningful role of Canadian researchers within such a partnership.

- In general, research teams of African and Canadian researchers who knew each other well and who had a record of past collaboration worked well within the IMCHA model. They did not necessarily change their established mode of cooperation, but they met their institutional objectives.
- In the early phases of IMCHA, the role of HPROs was unclear to the research teams. As the initiative evolved, the appreciation of the HPRO model increased among African researchers but not among Canadian researchers.
- Awarding synergy grants to allow selected research teams to expand scope and depth of their work was a positive experience. The launching of synergy grants also allowed a realignment of IMCHA with evolving Canadian policy priorities. Several researchers felt that the synergy grants were launched too early in the implementation of IMCHA.
- The partnership between CIHR, GAC and IDRC allowed the three institutions to go above and beyond what they would be able to achieve on their own, while bringing a unique asset to Canadian researchers and the international research community.

SUMMARISED RECOMMENDATIONS

IMCHA is ending in 2021 and there are therefore no recommendations for the implementation of the initiative. One recommendation, however, addresses concluding activities:

1. Global experience and knowledge about the approach of embedding decisionmakers in implementation research is limited. IMCHA can potentially make an important contribution to this knowledgebase. At a time when IMCHA projects have completed their knowledge translation activities and generated a sufficient volume of publications to document them, a meta-analysis of the approach should be commissioned and published.

For any future initiative

2. The PMF for a future initiative should be more clearly linked to the objectives of implementation research. Improved maternal and child health and increased utilisation of quality health services are high level outcomes and therefore appropriate ultimate outcomes for a logic model. However, as stated in the IMCHA logic model, many factors contribute to these outcomes and it is therefore not appropriate to include them in the PMF. The PMF of an implementation research initiative should instead be used to monitor the extent to which funded projects are able to document or reject the effectiveness and feasibility of researched interventions in the implementation context, and the extent to which they are able to translate these findings into improvements in MNCH programmes and policies.
3. The design of a future initiative should be clear about the scale at which it expects policy and programme changes to be generated by its grantees. If national MNCH policies are the primary targets, project grants should be of sufficient size to assure national visibility. As an alternative, multiple networked projects could be selected within countries to generate a critical volume of evidence. Scaling to national policy does not necessarily have to be the objective of all projects. Applicants should, however, be clear about the level of scaling they are targeting, and most importantly, this should also be reflected in the administrative position of the decisionmaker Co-PI embedded in the project.
4. Programme objectives in terms of promoting gender equality and health equity should be clearly spelled out in the call for proposals and in the monitoring frameworks of each project. Funded projects should include methodologies and plans on how they intend to address these objectives. Prior to finalising the implementation plans, all selected applicants should participate in workshops and webinars where their capacity and their approach to meeting the objectives are clarified and steps are taken to address any capacity gaps.
5. HPROs should be selected and contracted early in a new initiative and should participate in the selection of research grantees. If they have early knowledge about what will be funded in which country, they will be in a better situation to develop their own workplan for supporting projects in knowledge translation and networking.
6. In the grant selection process, care should be taken to avoid funding opportunistic partnerships between Canadian and African research institutions and between African research institutions and decisionmakers that are solely formed in response to the proposal call. While new partnerships should not be excluded *per se*, they should be subjected to additional scrutiny to assure that partners have common objectives and compatible ways of working.

7. The preparation phase of IMCHA prior to starting project activities was almost two years, considerably shortening the implementation time of projects. While this may be unavoidable, especially if capacity-building in gender and equity mainstreaming is included in the preparation phase of a new initiative, it should be factored into the overall duration of the initiative. Allocating additional time to the closing phase of projects for advocacy and knowledge translation activity may also be considered.
8. A future initiative should, from the start, create a strongly branded internet presence through a single web portal that is independent of the IDRC web site. Management of the site could be outsourced, even to an HPRO, but the source contract should assure that the initiative is presented comprehensively and that the site provides timely access to all communications.

RÉSUMÉ (VERSION CORRIGÉE 06/05/2021)

L'initiative 'Innovation pour la santé des mères et des enfants d'Afrique' (ISMEA) est financée conjointement par le Centre de recherches pour le développement international (CRDI), les Instituts de recherche en santé du Canada (IRSC) et Affaires mondiales Canada (AMC). Il a été lancé en mars 2014 avec un financement de 36 millions de dollars canadiens sur sept ans et soutient 28 subventions de recherche (19 subventions de recherche originales et 9 subventions de synergie) dans 11 pays africains. Tous les projets sont dirigés par un chercheur principal (CP) affilié à une université africaine, un établissement de recherche ou une ONG. Un décideur travaillant au sein du gouvernement local, régional ou national est intégré à titre de co-chercheur principal (Co-CP) dans chaque équipe de recherche, ainsi comme Co-CP affilié à un établissement de recherche canadien. Deux Organisations de politique et de recherche en matière de santé (OPRS) en Afrique de l'Ouest et de l'Est sont chargées de soutenir l'application des connaissances et de mieux faire connaître la recherche afin de faciliter l'adoption des résultats à grande échelle dans les politiques nationales et régionales de santé, de soutenir le renforcement des capacités des équipes de recherche et de faciliter l'apprentissage mutuel dans l'ensemble de l'ISMEA.

L'ISMEA devrait contribuer à l'amélioration des résultats en matière de santé des mères, des nouveau-nés et des enfants dans les pays du programme grâce à :

1. l'amélioration de la production, des analyses et des synthèses de la recherche sur la mise en œuvre des systèmes de santé en accordant la priorité au genre et à l'équité;
2. le renforcement des partenariats et de la collaboration entre les décideurs et les chercheurs sur le renforcement des systèmes de santé; et
3. l'intégration accrue des résultats de la recherche sur les systèmes de santé dans les politiques et les pratiques en matière de soins de santé primaires.

L'évaluation sommative a été chargée d'évaluer la performance globale de l'ISMEA et la valeur ajoutée de sa conception et de sa prestation. Les questions d'évaluation ont été regroupées sous quatre rubriques:

1. Quelles sont les réalisations de l'ISMEA en ce qui concerne le cadre de mesure du rendement (CMR) ainsi que l'adoption dans les politiques et la mise à échelle des interventions réussies?
2. Dans quelle mesure la gestion de l'initiative a-t-elle été efficace et comment ceci a influencé les réalisations de l'ISMEA?
3. Dans quelle mesure l'ISMEA a-t-elle été opérationnelle et comment ceci pourrait être amélioré dans les initiatives futures?
4. Comment les travaux menés dans le cadre de l'ISMEA sont-ils documentés pour contribuer à l'héritage de l'initiative?

Les données relatives à l'évaluation ont été recueillies par la revue de documents et d'un sondage en ligne auprès des membres actuels et anciens des équipes de recherche de l'ISMEA et des entrevues avec des intervenants de l'ISMEA lors de visites dans les pays du programme, au Canada, et par le biais d'entrevues à distance à l'aide d'un protocole VOIP.

PRINCIPALES CONSTATATIONS

RÉALISATIONS DE L'ISMEA EN MATIÈRE DE CIBLES DES RÉSULTATS FINAUX ET INTERMÉDIAIRES

RÉSULTATS ATTENDUS	INDICATEURS ET CIBLES	EVALUATION
Résultat final Amélioration des résultats en matière de santé maternelle, néonatale et infantile	Proportion de la recherche (financée) sur la mise en œuvre qui améliore les résultats en matière de santé maternelle et infantile et l'accès aux services de soins de santé primaires **Cible:** 50 % de la recherche sur la mise en œuvre démontre une amélioration de l'un des 11 indicateurs de responsabilisation	**La cible a été atteinte:** Les contributions des projets ou les contributions potentielles à l'amélioration des résultats en matière de santé maternelle et infantile n'ont pas pu être mesurées directement pour de nombreux projets, mais les projets ont fourni suffisamment d'information pour déduire ces contributions.
Résultat intermediaire 1. L'amélioration de la production, des analyses et des synthèses de la recherche sur la mise en œuvre des systèmes de santé en accordant la priorité au genre et à l'équité	Proportion de l'ensemble de projets qui ont au moins 75 % (trois des quatre processus) de dimensions adéquates en matière de genre et d'équité **Cible:** Tous les projets de recherche ont au moins 75% (trois des quatre processus) des dimensions adéquates en matière de genre et d'équité	**La cible n'a pas été atteinte:** 15/28 projets (54 %) ont intégré des dimensions adéquates en matière de genre, et 7/28 (25 %) en matière d'équité dans au moins trois processus de recherche.
	Proportion des résultats et des synthèses de recherche sur les systèmes de santé axés sur le genre et l'équité **Cible:** 75 % des extrants comprennent des analyses/synthèses axées sur le sexe et l'équité	**Il est peu probable que la cible soit atteinte:** les résultats de la recherche, y compris les analyses sur le sexe et l'équité, étaient encore en cours d'élaboration au moment de l'évaluation. Parmi les 98 extrants de 22 projets qui étaient disponibles pour analyse, 44 (46 %) ont inclus une orientation sexospécifique et 21 (22 %) une orientation vers l'équité.
2. Le renforcement des partenariats et de la collaboration entre les décideurs et les chercheurs sur le renforcement des systèmes de santé	Nombre de l'ensemble de projets par pays qui démontrent un niveau élevé de collaboration avec le décideur (documenté au niveau des projets, des pays et des régions) **Cible:** Minimum d'un par pays	**L'indicateur tel que défini n'a pas été vérifié ?:** le décideur est défini comme le '*point focal national pour la SMNI*'. La plupart des projets ont communiqué leurs activités et leurs résultats préliminaires à ce niveau, mais pour d'autres, ce n'était pas le principal répondant au niveau du gouvernement national.
3. L'intégration accrue des résultats de la recherche sur les systèmes de santé dans les politiques et les pratiques en matière de soins de santé primaires	Nombre (type) d'influence des projets de recherche de l'ISMEA sur les politiques et la programmation, par projet **Cible:** 20 références aux résultats de la recherche ou aux recommandations dans les plates-formes de prise de décisions techniques dirigées par le pays	**La cible a probablement été atteinte:** bien qu'il soit trop tôt dans le programme pour évaluer ce résultat, l'objectif de 20 a déjà été atteint. Tous les projets échantillonnés avaient présenté les résultats de la recherche au niveau national et la plupart avaient des plans pour d'autres discussions une fois que les résultats définitifs de la recherche étaient disponibles.

EFFICACITE DE LA GESTION

La gestion de l'ISMEA a été décrite comme réactive et flexible par les chercheurs interviewés et les répondants au sondage en ligne. Environ deux tiers des répondants au sondage ont jugé très utile le soutien fourni à l'élaboration des plans de mise en œuvre, des rapports techniques et des rapports financiers. La politique de retenue financière pour le paiement du dernier semestre jusqu'à l'achèvement du projet a soulevé des préoccupations chez certains chercheurs africains qui prévoyaient des difficultés à préfinancer leurs activités finales de collecte, d'analyse, d'application des connaissances et de documentation.

DOCUMENTATION DE L'ISMEA

Les équipes de recherche, les OPRS et la direction de l'ISMEA ont produit un grand nombre de documents qui documentent l'initiative ISMEA, dont certains sont d'excellente qualité. Un nombre considérable de documents étaient encore en préparation au moment de l'évaluation. Le site web de l'ISMEA, géré par l'OPRS d'Afrique de l'Est, a une forte image de marque, mais il n'est pas régulièrement mis à jour et présente principalement du contenu lié à l'Afrique de l'Est. Le CRDI tient à jour une page Web pour l'ISMEA qui est plus complète et à jour, mais elle est principalement présentée sous la marque du CRDI.

LEÇONS APPRISES

L'ISMEA a financé des projets de recherche de mise en œuvre qui comprenaient l'intégration de décideurs dans les équipes de recherche et qui comprenaient également le soutien technique sud-sud et le réseautage par le biais du financement des OPRS. D'autres caractéristiques de l'ISMEA étaient (1) un CMP qui, au niveau des résultats finaux, demandait de mesurer les résultats de la mise en œuvre plutôt que les résultats de la recherche et de l'application des connaissances, et (2) un partenariat Sud-Nord entre les institutions de recherche africaines et canadiennes dans chaque projet. Les leçons tirées de l'ISMEA sont qu'il est possible de combiner ces éléments de conception dans un seul programme, mais qu'il génère des tensions conceptuelles: (1) l'équilibre entre l'accent mis sur les interventions visant à générer des résultats en matière de santé et l'accent mis sur la recherche pour générer des réponses aux questions de savoir si ces interventions sont appropriées, réalisables, efficaces et abordables dans le contexte local , et comment ils peuvent être mieux livrés ; et (2) l'équilibre entre le soutien aux partenariats locaux des chercheurs et des décideurs au sein d'un réseau du Sud et la définition d'un rôle significatif des chercheurs canadiens dans un tel partenariat.

- En général, les équipes de recherche de chercheurs africains et canadiens qui se connaissaient bien et qui avaient une histoire de collaboration passée ont bien fonctionné dans le cadre du modèle ISMEA. Ils n'ont pas nécessairement modifié leur mode de coopération établi, mais ils ont atteint leurs objectifs institutionnels
- Dans les premières phases de l'ISMEA, le rôle des OPRS n'était pas clair pour les équipes de recherche. Au fur et à mesure que l'initiative a évolué, l'appréciation du modèle OPRS a augmenté chez les chercheurs africains, mais pas chez les chercheurs canadiens.
- L'octroi de subventions de synergie pour permettre à certaines équipes de recherche d'élargir la portée et la profondeur de leur travail a été une expérience positive. Le lancement de

subventions de synergie a également permis un réalignement de l'ISMEA avec l'évolution des priorités politiques canadiennes. Plusieurs chercheurs ont estimé que les subventions de synergie avaient été lancées trop tôt dans la mise en œuvre de l'ISMEA.

- Le partenariat entre les IRSC, l'AMC et le CRDI a permis aux trois institutions d'aller au-delà de ce qu'elles seraient en mesure d'accomplir par elles-mêmes, tout en apportant un atout unique aux chercheurs canadiens et à la communauté internationale de la recherche.

RECOMMANDATIONS

L'ISMEA prend fin en 2021 et il n'y a donc pas de recommandation pour la mise en œuvre de l'initiative. Une recommandation, cependant, concerne les activités de clôture :

1. L'expérience et les connaissances mondiales sur l'approche consistant à intégrer les décideurs dans la recherche sur la mise en œuvre sont limitées. L'ISMEA peut potentiellement apporter une contribution importante à cette base de connaissances. Lorsque les projets ISMEA auront terminé leurs activités d'application des connaissances et généré un volume suffisant de publications pour les documenter, une méta-analyse de l'approche devrait être commandée et publiée.

Pour une initiative future

2. Le cadre de mesure du rendement (CMR) d'une future initiative devrait être plus clairement lié aux objectifs de la recherche sur la mise en œuvre. L'amélioration de la santé maternelle et infantile et l'utilisation accrue de services de santé de qualité sont des résultats de haut niveau et donc des résultats finaux appropriés pour un modèle logique. Cependant, comme indiqué dans le modèle logique de l'ISMEA, de nombreux facteurs contribuent à ces résultats et il n'est donc pas approprié de les inclure dans le CMR. Le CMR d'une initiative de recherche sur la mise en œuvre devrait plutôt être utilisé pour surveiller d'une part dans quelle mesure les projets financés sont capables de documenter ou de rejeter l'efficacité et la faisabilité des interventions recherchées dans le contexte de la mise en œuvre, et d'autre part dans quelle mesure ils sont capables de traduire ces résultats en améliorations des programmes et des politiques de la santé de la mère, du nouveau-né et de l'enfant (SMNE).
3. La conception d'une future initiative doit être clair et prendre en compte à quelle échelle les changements de politiques et de programmes seront générés par les bénéficiaires de subventions. Si les politiques nationales en matière de SMNE sont les cibles principales, les subventions des projets devraient être suffisamment importantes pour en assurer une visibilité nationale. Comme alternative, de multiples projets en réseau pourraient être sélectionnés dans un même pays afin de générer un volume critique de preuves. Le passage à l'échelle de la politique nationale ne doit pas nécessairement être l'objectif de tous les projets. Les candidats doivent cependant être clairs sur l'échelle qu'ils visent et, surtout, cela doit se refléter dans la position administrative du décideur ou du co-chercheur principal (co-CP) intégré au projet.
4. Les objectifs du programme en termes de promotion de l'égalité des sexes et de l'équité en matière de santé doivent être clairement énoncés dans l'appel à propositions et dans les cadres

de suivi de chaque projet. Les projets financés doivent inclure des méthodologies et des plans de mise en œuvre sur la manière dont ils comptent atteindre ces objectifs. Avant de finaliser les plans de mise en œuvre, tous les candidats sélectionnés doivent participer à des ateliers et des séminaires en ligne au cours desquels leurs capacités et leur approche pour atteindre les objectifs sont clarifiées et des mesures sont prises pour combler les éventuelles lacunes en matière de capacités.

5. Les organisations de recherche et de politique de santé (OPRS), devraient être sélectionnés et engagés dès le début d'une nouvelle initiative et devraient participer à la sélection des bénéficiaires de subventions de recherche. S'ils savent dès le début ce qui sera financé dans tel ou tel pays, ils seront plus à même de développer leur propre plan de travail pour soutenir les projets d'application des connaissances et de mise en réseau.
6. Dans le processus de sélection des subventions, il faut veiller à éviter de financer des partenariats opportunistes formés uniquement en réponse à l'appel de propositions entre des institutions de recherche canadiennes et africaines et entre des institutions de recherche africaines et des décideurs. Bien que les nouveaux partenariats ne doivent pas être exclus a priori, ils doivent faire l'objet d'un examen plus approfondi afin de s'assurer que les partenaires ont des objectifs communs et des méthodes de travail compatibles.
7. La phase de préparation de l'ISMEA avant le début des activités du projet a duré près de deux ans, ce qui a considérablement raccourci la durée de mise en œuvre des projets. Parce qu'inévitable, surtout si le renforcement des capacités en matière d'intégration du genre et de l'équité est inclus dans la phase de préparation d'une nouvelle initiative, il faut en tenir compte dans la durée globale de l'initiative. Il peut également être envisagé d'allouer du temps supplémentaire à la phase de clôture des projets pour les activités de plaidoyer et d'application des connaissances.
8. Une initiative future devrait, dès le départ, créer une présence Internet de marque forte par le biais d'un portail Web unique, indépendant du site Web du CRDI. La gestion du site pourrait être déléguée, voire même à une OPRS, mais le contrat source devrait garantir que l'initiative est présentée de façon exhaustive et que le site fournit l'accès à toutes les communications efficacement.

ABBREVIATIONS

AMC	Affaires mondiales Canada (GAC)
APHRC	African Population and Health Research Centre (HPRO)
CIHR	Canadian Institutes of Health Research (IRSC)
CMR	Cadre de mesure du rendement (PMF)
Co-CP	Co-chercheur principal (Co-PI)
Co-PI	Co-Principal Investigator
CP	Chercheur principal (PI)
CRDI	Centre de recherches pour le développement international (IDRC)
ECOWAS	Economic Community of West African States
ECSA	East, Central and Southern African Health Community (HPRO)
GAC	Global Affairs Canada (AMC)
GRAS	Gender Responsiveness Assessment Scale
HPRO	Health Policy and Research Organisations
IDRC	International Development Research Centre (CRDI)
IMCHA	Innovating for Maternal and Child Health in Africa (ISMEA)
IRSC	Instituts de recherche en santé du Canada (CIHR)
ISMEA	Innovation pour la santé des mères et des enfants d'Afrique (IMCHA)
M&O	Management and Operations (committee of IMCHA)
MNCH	Maternal, Neonatal and Child Health
OPRS	Organisation de politique et de recherche en matière de santé (HPRO)
PHC	Primary Health Care
PI	Principal Investigator
PMF	Performance Monitoring Framework
PPD	Partners in Population and Development (HPRO)
VOIP	Voice over Internet Protocol
WAHO	West African Health Organisation (HPRO)

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1 INTRODUCTION

1.1 THE IMCHA INITIATIVE

The Innovating for Maternal and Child Health in Africa (IMCHA) initiative was launched in March 2014 to issue grants for implementation research, a scientific discipline that '*seeks to understand factors that determine why an evidence-based intervention may or may not be adopted within specific healthcare or public health settings and uses this information to develop and test strategies to improve the speed, quantity and quality of uptake*'.[1] It is jointly funded by the International Development Research Centre (IDRC), the Canadian Institutes of Health Research (CIHR) and Global Affairs Canada (GAC) with a funding volume of C$ 36 million supporting 28 research grants (19 original research grants and 9 synergy grants) in 11 African countries. All 28 grant-funded projects are led by a Principal Investigator (PI) of an African university, research institution or NGO and have, in addition, a Co-Principal Investigator (Co-PI) affiliated with a Canadian research institution and a Co-PI in a decision-making position, generally in local, regional or national government. In addition, grants were awarded to two Health Policy and Research Organisations (HPROs) in West and East Africa that are tasked with supporting knowledge translation and raising the profile of the research in order to facilitate the adoption of the results at scale in national and regional health policies, supporting capacity-building of research teams and facilitating mutual learning across IMCHA. The West African Health Organisation (WAHO) in Burkina Faso was contracted for the HPRO role in West Africa. In East Africa, the role is shared among three institutions, the African Population and Health Research Centre (AHPRC) in Kenya, the East, Central and Southern African Health Community (ECSA) in Tanzania, and Partners in Population and Development (PPD) in Uganda. The IMCHA grants are listed in **Annex 2**.

1.2 MONITORING AND EVALUATION OF IMCHA

The IMCHA initiative has a logical framework (**Annex 3**) with a theory of change structure leading to the ultimate outcome of '*Improved maternal, newborn and child health outcomes in targeted countries*' via three intermediate outcomes:

1. *Enhanced production, analyses and syntheses of health systems implementation research prioritising gender and equity.*
2. *Enhanced partnering and collaboration between decision makers and researchers on health systems strengthening in the selected countries.*
3. *Enhanced integration of health systems research findings into primary health care policies and practice in selected countries.*

The logical framework acknowledges that the ultimate outcome to which IMCHA is expected to contribute is dependent on other factors and '*the IMCHA initiative is [therefore] not responsible for reporting on the ultimate outcome'*. [2] The performance measurement framework (PMF) nevertheless includes an indicator for reporting against this outcome, with a target that *'50% of the implementation research demonstrate improvement in any of the 11 accountability indicators'*: [3]

1. *Maternal mortality ratio*
2. *Under-five child mortality, with the proportion of newborn deaths*

3. *Children under five who are stunted*
4. *Proportion of women aged 15-49 years who are married or in union and who have met their need for family planning,*
5. *Antenatal care coverage*
6. *Antiretroviral prophylaxis among HIV-positive pregnant women to prevent vertical transmission of HIV, and antiretroviral therapy for women who are treatment-eligible*
7. *Percentage of live births attended by skilled health personnel*
8. *Percentage of mothers and babies who received postnatal care visit within two days of childbirth*
9. *Percentage of infants aged 0–5 months who are exclusively breastfed*
10. *Percentage of infants aged 12–23 months who received three doses of diphtheria/pertussis/tetanus vaccine*
11. *Percentage of children aged 0–59 months with suspected pneumonia receiving antibiotics*

Under the three intermediate outcomes and their associated immediate outcomes, the IMCHA PMF lists eight performance indicators and targets, and under the three output streams leading to the immediate outcomes a total of 14 output indicators. The indicators and targets are presented in **Annex 4**. According to the PMF, the summative evaluation is fully or partially responsible for reporting on all but one of the outcome-level indicators.[1] Annual performance reports to GAC provide data on two of the four immediate outcome and all 14 output indicators.

1.3 The midterm evaluation of IMCHA

A midterm formative evaluation of IMCHA was conducted in 2017/18. The evaluation report includes annotated status reports on all performance indicators presented in **Annex 15**. It issued 21 recommendations presented in **Annex 7**. In summary, the main recommendations are:

- For the remainder of IMCHA the evaluation recommended encouraging country-level meetings in countries with more than one research team; holding a final meeting to share lessons learnt; building more capacity among the teams in gender and equity analysis; providing access to a vetted roster of gender and equity experts; maintaining clarity on the differences and overlaps between gender analysis and equity analysis; assisting teams in developing knowledge-translation plans promoting scale-up and to secure future funding; and encouraging more knowledge sharing among East and West Africa HPROs.
- For future initiatives, the evaluation recommended support and training for researchers at the pre-proposal stage; management training for grantees at the beginning of the initiative; separate gender and equity training at the onset of the project; and a clear definition of roles and expectations of an HPRO-like component at the outset.

1.4 Terms of reference of the summative evaluation

The purpose of the evaluation was to assess the overall performance of the initiative and the value-added of its design and delivery. Specifically, the evaluation was expected to …

[1] All except Indicator 100.2: 'Proportion of recommendations from formative analysis of HPROs acted upon'

1. *examine IMCHA performance in relation to the PMF, in particular progress made towards achieving the immediate, intermediate and ultimate outcomes;*
2. *evaluate how the recommendations of the midterm evaluation were addressed and what difference they made in IMCHA achievements;*
3. *assess IMCHA management, and the value added by the initiative;*
4. *inform future partnerships and undertakings; and*
5. *evaluate how the work conducted under IMCHA is being documented for contributing to the legacy of the Initiative.*

The terms of reference list 82 evaluation questions and sub-questions under four main headings:

1. *What are the achievements of IMCHA with regard to the Performance Measurement Framework (in particular in terms of immediate, intermediate and ultimate outcomes) as well as policy uptake and scale up of successful interventions?*
2. *How effective has the management of the initiative been and what difference has that made to IMCHA achievements?*
3. *How well has IMCHA been operationalised and how could it be improved on in future undertakings?*
4. *How [is] the work conducted under IMCHA documented for contributing to the legacy of the initiative?*

The questions were reorganised by the evaluation team in an evaluation matrix into four areas of enquiry, ten main evaluation questions and 30 evaluation sub-questions. The terms of reference and the evaluation matrix are provided in **Annex 1** and **Annex 8**.

Findings responding to sub-questions on the effects of the midterm evaluation and on unpredicted outcomes were aggregated in **Section 3.2** and **Section 3.4** respectively. Responses to the evaluation questions of '*how well has IMCHA been operationalised and how could it be improved on in future undertakings'* were merged into the section on conclusions and lessons learnt. (**Section 4**)

2 APPROACH AND METHODOLOGY

The evaluation adopted a results-oriented approach, assessing the performance of IMCHA against the targets of the PMF, as well as a reflexive approach, drawing lessons from the processes of project and programme implementation. The approach and methodology are described in detail in **Annex 9**.

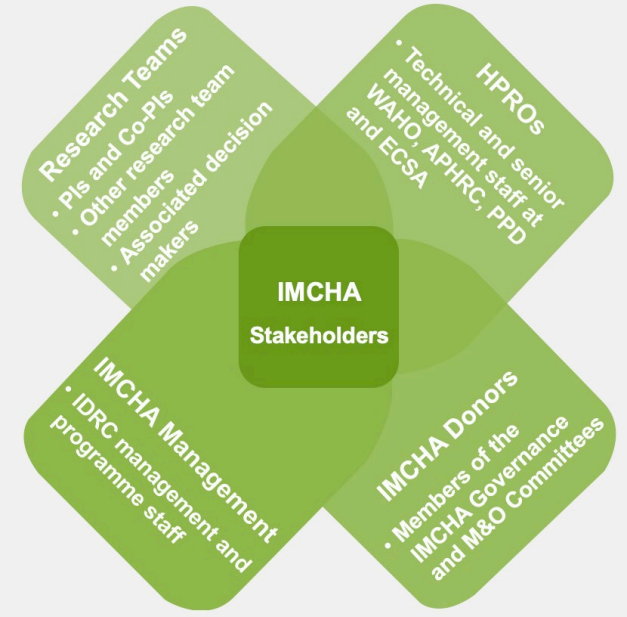
Data to answer the evaluation questions were collected between December 2019 and May 2020 through document reviews, an online survey of researchers and decisionmakers, and key informant interviews conducted during site visits or by remote voice over internet protocol (VOIP).

A library of technical and administrative documents was provided by IMCHA including annual programme reports, project approval documents (PADs), implementation plans, project progress reports, workshop reports and presentations, monitoring and financial databases, and reports of project monitoring visits. Additional documents were provided by interviewed key informants. In total, the evaluation collected 385 documents and entered them into the analysis.

An online survey of IMCHA grantees was launched in English and French on January 6th on the SurveyMonkey platform. Invitations were sent and received by 163 current and former researchers and decisionmakers identified by the PIs. Of these, 59 completed the survey for a valid response rate of 36 percent. HPRO staff was not included in the survey. **(Annex 10)**

The evaluation team interviewed 97 stakeholders in individual or group interviews in person or via VOIP. (**Annex 12**) The interviews were semi-structured on the basis of the evaluation questions, adapted to each of the four main stakeholder groups, and further adapted to each individual interview context and position of the informant.

Figure 1. Stakeholder groups



Key informants in each group were sampled by purposive sampling that aimed at reaching data saturation for each evaluation question. Researchers, decisionmakers and HPRO staff were interviewed during project visits or in VOIP interviews. All current IDRC staff involved in IMCHA management as well as all current members of the IMCHA M&O Committee were interviewed individually or in groups during a mission to Ottawa. Only one member of the Governance Committee was available for an interview.

Ten of the 19 research teams among whom six had obtained additional synergy grants were included in site visits or VOIP interviews, as well as all three East Africa HPRO partners and the West Africa HPRO. (**Table 1**) During site visits, additional interviews were conducted with three decisionmakers at

national level who were not Co-PIs. Three Co-PI decisionmakers, two PIs and one Canadian Co-PI did not respond to requests for interviews.

Table 1. Project interviews

Grant	Country	PI Institution	
108020 / 108546	Tanzania	Ifakara Health Institute	On-site
108022	Tanzania	Ifakara Health Institute	On-site
108023	Tanzania	University of Dar es Salaam	On-site
108024 / 108547	Tanzania	Catholic University of Health and Allied Sciences	On-site
108027 / 108548	Tanzania	Tanzanian Training Centre for International Health	On-site
108028	Ethiopia	Jimma University	VOIP
108033 / 108550	Uganda	BRAC Africa	On-site
108037 / 108553	Burkina Faso	Société d'Etudes et de Recherche en Santé Publique	VOIP
108040 / 108552	Nigeria	University of Ibadan	On-site
108041	Nigeria	Women's Health and Action Research Centre	On-site
107892 (HPRO)	Burkina Faso	West African Health Organisation	VOIP
107893 (HPRO)	Kenya	African Population and Health Research Centre	On-site
107893 (HPRO)	Uganda	Partners in Population and Development	On-site
107893 (HPRO)	Tanzania	ECSA Health Community	On-site

Fifteen Canadian Co-PIs and researchers participating in the ten original research and six synergy projects listed in **Table 1** were interviewed during the mission to Ottawa, in the context of the IMCHA learning workshop, or using VOIP.

The online survey responses included Likert and ranking scales as well as narrative responses. The data derived from scales were tabulated, proportions were calculated where appropriate and compared to proportions reported in the midterm survey. The narrative survey responses, the interview transcripts and the collected documents were analysed using the qualitative content analysis software MAXQDA.

2.1 Limitations

The response rate of decisionmakers to the online survey was low with only 5/29 invited decisionmakers responding. Requests for VOIP interviews with three decisionmaker Co-PIs in Ethiopia and Burkina Faso also remained unanswered. As a consequence, 5/5 decisionmakers who responded to the survey and 7/8 interviewed decisionmaker Co-PIs were from either Tanzania or Nigeria. A selection bias in this group can therefore not be excluded.

All teams of the sampled projects were engaged in final data collection and analysis at the time of the evaluation and could not share data on MNCH or service outcomes. The same applied to research publications, with all teams still working on planned or draft documents.

All projects undertook initiatives to generate policy influence, but most of these were still ongoing at the time of the evaluation or waiting for the analysis and documentation of research results. It was arguably too early in the programme to evaluate the success of knowledge translation and scaling initiatives.

The unit of analysis of stakeholder perceptions and experiences in the final evaluation comprised all individuals listed in the four stakeholder groups in **Figure 1**. During site visits, interviews were held

with all project staff. Current and former researchers and decisionmakers who were identified by the PIs were invited to participate in the online survey. While the survey respondents could not be disaggregated by project, a disaggregation by affiliation with African or Canadian research institutions and by project countries indicates a relatively equal representation of all projects. The survey responses are, however, not strictly comparable to those obtained in the midterm survey which only invited responses from PIs and Co-PIs. This is further discussed in **Annex 11**.

Further details on limitations are provided in **Annex 9**.

3 FINDINGS

3.1 IMCHA PERFORMANCE AND OUTCOMES

3.1.1 EVALUATION QUESTION 1

What is the outcome of IMCHA in terms of improved maternal, newborn and child health in targeted countries?

(a) What are the achievements of IMCHA in relation to the eleven indicators on MNCH?

(b) What have been the main strategies to obtain these achievements? And how appropriate are they for achieving the intended outcomes?

It is highly likely that the IMCHA PMF target that *'50% of the implementation research demonstrate improvement in any of the 11 accountability indicators'* was surpassed. However, only a small number of projects monitored performance on these indicators and none of them had yet completed their final analysis and could report results. Nevertheless, there is qualitative evidence that the majority of projects had potentially direct or indirect effects on improving MNCH indicators in their project areas.

A strategy applied by all IMCHA-funded projects to achieve outcomes was the embedding of decisionmakers in the research teams as Co-PIs. Beyond this common strategy, projects differed substantially in theme, focus and scope of the MNCH issues they addressed, each with its distinct strategic approach. On a conceptual level, the main lines of differentiation that distinguished projects was the weighting of research versus programme implementation activities. There was no common understanding of the concept of implementation research among stakeholders interviewed by the evaluation team.

IMCHA ACHIEVEMENTS IN RELATION TO THE ELEVEN MNCH INDICATORS

Interviews and survey responses by researchers and decisionmakers indicated that all research teams perceived that their projects contributed to improvements in MNCH, although not all of them directly and in the same manner. In the online survey, 43/54 researchers (80%) selected at least one indicator that according to their assessment was improved by the project, and three more stated that they had collected data on these indicators that were still being analysed.

A review of the monitoring and evaluation sections of the 16 implementation plans that were provided to the evaluation team for the 19 original research projects found that only four planned to monitor or evaluate any of the eleven indicators, all of them related to maternal health services. In interviews, all PIs stated that data were still being analysed, and results could not yet be communicated.

Among the projects, there were large differences in the populations covered by the researched interventions and by the potential level of contribution of the interventions to the IMCHA ultimate outcome indicators. This renders an aggregation of data for these indicators meaningless and in many cases impossible as illustrated by two examples:

- One project researching the impact of supply and demand-side interventions on access, utilisation and outcome of maternity services in primary health care (PHC) facilities covered a

population of about 10,000 served by three PHC centres. The project reported indicator changes of several hundred percent based on highly unstable fluctuations of single or double-digit indicator values. Another project researched changes in service availability, quality, access and utilisation due to the national introduction of a free maternity care policy. The research population was more than ten million and the changes may have affected thousands of women. They could, however, not be attributed to the project although the research results may well lead to a more effective and equitable application of the policy.

The perceptions by 85 percent of researchers who responded to the online survey and by all interviewed researchers that their project contributed to an improvement of at least one IMCHA ultimate outcome indicator is plausible. It is highly likely that the PMF target that '*50% of the implementation research demonstrate improvement in any of the 11 accountability indicators*' was met and largely surpassed. However, for many projects the effect on any of the indicators was indirect and not reflected in the projects' M&E plans. Data were therefore not collected and reported. A quantified result that is based on a measurement of the indicators in the 28 IMCHA projects can therefore not be reported.

MAIN STRATEGIES AND THEIR APPROPRIATENESS

The strategies implemented by the project teams to generate intended outcomes were outlined in the project implementation plans of the original research projects. These were generated on the basis of the research proposals after extensive feedback by technical reviewers, in many cases requiring major revisions of the proposed activities. For projects funded with synergy grants, implementation plans were not prepared because they were conceptualised as complementary to existing projects, although some of them addressed new research questions.

A strategic concept that characterised all IMCHA-funded projects was the approach to knowledge translation by embedding decisionmakers in the research teams as Co-PIs. This was pursued by all projects and is further discussed under evaluation questions three and four.

Beyond this common characteristic, projects differed substantially in theme, focus and scope of the MNCH issues they addressed, each requiring distinct strategic approaches that were only comparable among small clusters of similar projects. On a conceptual level, the main lines of differentiation that distinguished projects was the weighting of research versus programme implementation activities. There was no clear dividing line, but rather a continuous positioning on a scale with a range illustrated by the assessment of one PI who classified the original project he led as 20 percent research and the subsequent synergy project as 80 percent.

The conceptual tension between the research objectives and programme implementation objectives was well known at the time IMCHA was launched and, according to a senior IDRC executive, generated discussions at that time. Interviews with stakeholders including researchers, IMCHA programme managers and staff of funding agencies indicated that this tension is still not fully resolved and that there is no common understanding of the concept of implementation research among members of project teams and among staff of funding agencies and IMCHA programme staff.

While there was consensus among interviewed stakeholders on the strategy for generating uptake and scale-up of project results, the views on the strategies of how these results were to be generated differed widely. They ranged from implementing and monitoring interventions to research strategies that were built around policy-relevant research question such as *'what is the mechanism of impact of home visits on maternal outcomes?'* or *'how do activities of CHWs differ with alternative modes of income support?'*

3.1.2 Evaluation question 2

Has IMCHA enhanced the production, analysis and synthesis of health systems implementation research prioritising gender and equity?
(a) How were gender and equity dimensions integrated by the IMCHA research teams?
(b) How did HPROs contribute to the integration of gender and equity in research activities, capacity strengthening and knowledge translation?
(c) How did IMCHA management contribute to the integration of gender and equity?

The targets for the two PMF indicators for measuring the intermediate outcome of integrating gender and equity in IMCHA research were not met. Integrating adequate gender dimensions in at least three research processes was achieved by 54 percent and for adequate equity dimensions by 25 percent of projects against targets of 100 percent. However, several interviewed PIs stated that they planned to do additional equity analyses prior to closure of the project. Of a sample of 95 research outputs reviewed, 44 (46%) included a gender focus and 21 (22%) an equity focus against targets of 75 percent.

The HPROs supported the integration of gender dimensions through formative studies, training and encouraging the research teams to include a focus on gender in their outputs. They analysed the equity orientation of MNCH policies in programme countries but did not contribute to the integration of equity considerations in IMCHA projects. IMCHA management required researchers to integrate gender and equity dimensions in the implementation plans and the technical reports.

Integration of gender dimensions

The **first indicator** (Indicator 1.1) for measuring the outcome of '*implementation research prioritising gender and equity*' in the IMCHA PMF is the '*proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions*' with a target that this should be met by all funded projects. Research processes, according to the PMF, include the project design, data collection, data analysis, and dissemination. We assessed the extent to which gender was integrated in these processes by analysing research protocols, technical reports and research outputs. Overall, only 15/28 projects (54%) were assessed as having integrated adequate gender dimensions in three of four research processes.

Since 'adequate gender dimensions' were not defined in the PMF, we applied the WHO Gender Responsiveness Assessment Scale [4] to assess whether methods were used and information was presented in a way that was gender unequal, gender blind, gender sensitive, gender specific or gender transformative at each stage of the research process (see textbox). Although the scale was developed for assessing health programmes rather than research projects, it could be applied to the IMCHA

projects as they all included an implementation component. The research process was considered to 'adequately' integrate a gender dimension if it was gender-sensitive or gender-specific or gender-transformative.

WHO Gender Responsiveness Assessment Scale

1. GENDER UNEQUAL

- Reinforces unbalanced norms, roles, and relations
- Privileges men over women (or vice versa)
- Often leads to one sex enjoying more rights or opportunities than the other

2. GENDER BLIND

- Very often reinforces gender-based discrimination
- Ignores differences in opportunities and resource allocation for women and men
- Constructed based on the principle of being "fair" by treating everyone the same

3. GENDER-SENSITIVE

- Does not address inequality generated by unequal norms, roles or relations
- Indicates gender awareness, although often no remedial action is developed

4. GENDER-SPECIFIC

- Considers women's and men's specific needs
- Intentionally targets and benefits a specific group of women or men to achieve certain policy or programme goals or meet specific needs
- Makes it easier for women and men to fulfil duties that are ascribed to them based on their gender roles

5. GENDER TRANSFORMATIVE

- Addresses the causes of gender-based health inequities
- Includes ways to transform harmful gender norms, roles, and relations
- The objective is often to promote gender equality
- Includes strategies to foster progressive changes in power relationships between women and men

Project design

A review of the 28 accepted grant proposals found that gender was integrated by all research teams, although to varying degrees. All proposed projects aimed at ultimately benefitting women and girls, 21 proposals (75%) intentionally targeted a specific group of women, but only 12 (43%) included research questions explicitly referring to gender issues. Gender issues were mentioned in the objectives of the research by 20/28 proposals (71%), with 17 including gender differences in the context analysis. About half of the research proposals also proposed to address gender-based inequities created by norms, roles and/or relationships.

Table 2. Integration of gender in IMCHA research proposals

	YES	NO	% YES
Women/girls beneficiaries	28	0	100%
Intentionally targets specific group of women/men	21	7	75%
Gender in objectives	20	8	71%
Considers differences for men and women	17	11	61%
Women/girls consulted during design	15	13	54%
Addresses inequities created by norms, roles and relationships	14	14	50%
Gender research question	12	16	43%

This assessment is confirmed by the online survey in which respondents were asked about the extent to which six aspects or activities related to gender equality were included in their projects, for instance including gender in a research question or consulting women and girls during project implementation. **(Annex 11)** At midterm the same questions were asked. The responses to both surveys indicate an awareness of respondents about actions to strengthen the integration of gender in their research projects. At midterm, 64 percent of respondents declared that they had conducted gender sensitivity

training and 91 percent that women or girls were the beneficiaries of their projects. In the final evaluation survey, these two aspects also received the lowest and highest proportion of positive responses, but by a higher proportion of respondents of 75 and 95 percent respectively. Seventeen research teams also included specific gender expertise in their project team and several teams sought to achieve a gender balance among researchers in their project.

Applying the Gender Responsiveness Assessment Scale, 12/28 research proposals (43%) were designed to be gender transformative, four were gender specific (14%), eight were gender sensitive (29%) and four were gender blind (14%). Of the 12 gender transformative proposals, seven were for original research grants and five for proposals funded with synergy grants. All of these were submitted by teams that included a researcher with gender expertise. However, one of the four proposals rated as gender blind was also submitted by a team that reported gender expertise. Researchers may highlight gender expertise in their profile, however this does not automatically assure that gender is integrated in the proposals they submit

Project implementation

In the first year, the research teams (RTs) were asked to refine the implementation plans, for example by specifying how the intervention would address gendered power imbalances. Consequently, 14/19 original research projects (74%) addressed gender more comprehensively in the implementation plans. Most projects for which information was available on data collection, analysis and dissemination (21/28) included a focus on gender in these processes. For example, three out of four projects with a gender-blind design improved the integration of gender in subsequent research processes. The majority of processes used were gender aware (15/21 - 71%) and included conducting surveys of women, including sub-analyses on gender in the baseline survey, including a women's economic empowerment survey tool in the end-line survey, separating focus group discussions by sex, and including monitoring and evaluation indicators assessing the level of participation of women and men. Gender transformative processes (5/21 projects 24%) included assessing the level of gender norms and gender relations in baseline surveys, analysing key barriers for women and identifying strategies to overcome these, assessing the level of women's decision-making power in the household, and monitoring the impact of the intervention on behaviours among both men and women.

Implementation strategies

The research teams implemented a number of strategies to address gender issues:

- Targeting women as main beneficiaries. (either as health workers or as clients of health services)
- Strengthening women's participation and capacity in health either as service providers or community members. (women's support groups)
- Conducting gender sensitivity training for health workers to provide respectful maternity care.
- Implementing male involvement and male engagement strategies. (male champions to deliver health messages; joint analysis and assessment of barriers to health seeking behaviours; encouraging men to accompany women to antenatal care visits; involving the spouses of female community health workers)

As noted by the midterm evaluation, framing gender as a women's health issue, focusing primarily on women in the context of reproductive health and childbearing, does not in itself guarantee an improved status of women. Several projects analysed the barriers for women's health or health seeking behaviours and found that lack of autonomy and decision making were root causes.

Male involvement in women's health issues featured prominently in several projects. One project included an indicator for male involvement, monitoring the number of male partners who accompanied women to antenatal visits. While there is evidence that the involvement of men in their partners' reproductive health strengthens gender equality, policies that establish reward or punishment systems to promote this involvement may also decrease the autonomy of women in making decisions about their own health. A project in Tanzania, for instance, found that a policy that gave preferential treatment to women in antenatal clinics who were accompanied by their spouse discriminated against single women and against women whose partners were reluctant to accompany them. Some of them delayed first antenatal care attendance or enlisted other men to accompany them, defying the purpose of increased spousal engagement in the pregnancy.

Shared decision-making was encouraged by some projects, for example in home visits of pregnant women by community health workers (CHWs) during which pregnancy risks were discussed with both partners. Encouraging shared decision-making is acknowledged as a successful strategy when women are simultaneously empowered with more knowledge, confidence, and capacity to claim their rights. [e.g.5,6,7] The combination of empowering women and encouraging them to discuss their issues with men to find joint solutions was adopted by the four projects that were rated as gender transformative.

Research outputs

The **second indicator** (Indicator 1.2) for measuring the outcome of '*implementation research prioritising gender and equity*' in the IMCHA PMF is the '*proportion of health systems research outputs and syntheses that is gender and equity focused*'. In May 2020, the IMCHA monitoring database listed 151 IMCHA project outputs of which 86 were accessible to the evaluation team. An additional nine were collected during field visits for a total of 95 outputs from 22/28 projects. Among the 22 projects, 18 had produced at least one output that addressed gender issues, some quite superficially. Overall, 54 percent of outputs were assessed as gender blind. The majority of these were journal articles (15), policy briefs (15), other outputs (9), presentations (7), mentions in the media (4) and blogs (1). The remaining 46 percent had a gender focus, ranging from gender sensitive (17%), to gender specific (12%) and gender transformative (16%) in the categories of the WHO Gender Responsiveness Assessment Scale. The PMF target of 75 percent was therefore not met.

Barriers to gender integration

Researchers and decisionmakers who responded to the online survey expressed considerable insecurity and differences in understanding concepts such as gender analysis, gender integration or gender equality. One interviewed HPRO informant noted: '*The barriers to the incorporation of gender and equity analysis were primarily in the area of expertise and understanding. For most researchers gender just means an acknowledgment that there are males and females.*' Five online survey

respondents also noted that they lacked training or guidance on how to integrate gender considerations.

The lack of clarity about gender integration in the conceptualisation of the projects was mentioned by two survey respondents, one of them adding that '*the design was not clear on gender issues since the beginning. It was a big challenge to introduce gender issues along the way*'. A similar view was expressed by an interviewed PI: '*If gender equality and social equity had been missed at the early stages during the design phase and sampling strategy, how could you mainstream it at a later stage or add it to the analysis? It would require additional research*'.

INTEGRATION OF EQUITY DIMENSIONS

The IMCHA call for research proposals requested that the proposals integrate health equity dimensions, described as '*differences in health status [which] typically relate to inequalities and inequities across racial groups, rural/urban status, socio-economic status, gender, age, and geographical region'*. [8] The midterm evaluation highlighted that most of the projects had not incorporated equity considerations to any significant degree, that the integration of equity consideration was not well understood and that it was often conflated with the integration of gender considerations.

In the IMCHA PMF, the indicators and targets for measuring the outcome of equity integration are merged with those for integrating gender, i.e. Indicators 1.1 and 1.2 cited above. The indicators and targets for equity integration do not define an '*adequate equity dimension'*. For the evaluation of Indicator 1.1, we analysed project documents as well as survey and interview responses to determine the extent to which the projects (i) identified and focused on disadvantaged or vulnerable groups; (ii) collected data that were stratified according to factors of disadvantage and vulnerability; (iii) analysed these data to document health inequities; and (iv) addressed recognised inequities in their knowledge translation activities. While evaluation data were being collected, the research teams were introduced to equity analysis in the IMCHA learning workshop in January 2020. In interviews, several PIs stated that they planned to conduct equity-focused data analyses and knowledge translation activities after attending the workshop. A final assessment of the **performance on Indicator 1.1** (adequate equity dimension in three of four processes) could therefore not be made. A preliminary assessment, however, indicated that the 100% target will not be met, as only 7/28 projects (25%) were found to have integrated equity in at least three processes.

Project design

At least one equity dimension was addressed in 20/28 research proposals or implementation plans

Table 3. Primary equity dimension in 20 IMCHA research proposals

	NUMBER OF PROJECTS
Place of residence (focusing on rural populations or distance to a health facility)	13
Socio-economic position (focusing on the most vulnerable women and children)	4
Age (focusing on adolescents)	3

One proposal referred to using the GRADE tool [9] for random sampling and increasing participation rates of marginalised groups. Another proposal referred to the PROGRESS framework [10] for identifying social factors affecting health opportunities and outcomes. Several key informants stated that social equity was not a primary concern of their research. As one PI stated: '*Social equity has not been integrated or we have not yet thought about it. But we can probably do it in the final analysis, because the data is there*.'

Interviews conducted with researchers and decisionmakers in Africa and Canada found that they understood the integration of equity as a call to conduct their project among disadvantaged populations with the aim of improving their access and utilisation of MNCH services. They did not plan to analyse how interventions reach or affect groups or individuals with differential vulnerabilities within their project areas. This is reflected in statements such as '*equity aspects were taken into consideration when a decision was made about the project sites*.'

Project implementation

Evidence that data were collected that included social parameters such as wealth, ethnicity, religion, education, age, occupation, place of residence, or marital status was found for 8/28 projects (29%). For 7/28 (25%) there was evidence that these data were analysed to understand the needs and effects of the intervention on different groups or sub-groups. However, several interviewed PIs stated that they planned to do such an analysis in future. One project went a step further and found that traditional equity criteria based on levels of income were insufficient for identifying vulnerabilities that affect access to MNCH services. Additional factors of vulnerability in the project area were alcohol consumption by either partner, a history of home deliveries, having only given birth to girls, living in fishing sites, and being accused of practicing witchcraft.

Implementation strategies

When asked about what strategies were used for addressing inequities in access to health, the responses in the online survey varied widely but could be grouped into two categories:

- **Ensuring equal coverage of the intervention** through universal coverage, promoting messages of equal care for all, ensuring all pregnant women were covered by home visits using GPS location and tracking, and providing knowledge to all beneficiaries.
- **Addressing health inequities of specific groups** by establishing a fund to ensure that pregnant women at the time of delivery could afford to get a pregnancy kit a and pay for transport to the health facility, encouraging male involvement in women's health seeking behaviour, or strengthening women's participation.

These strategies again highlight how equity dimensions were understood and integrated in different ways across the projects. In the online survey, only 42 percent of respondents agreed with the statement that there were differences among beneficiaries and efforts were made to focus on the most vulnerable. The remaining either considered equity not as an issue (10%) or that it was addressed automatically because all beneficiaries were vulnerable (47%).

Equity expertise and training were reported by few respondents and the information was difficult to corroborate with available documentation. One survey respondent commented that '*we worked with a consultant and conducted formative research with vulnerable women to identify the important issues to look at in the study*'. One project included a junior equity expert in the team which reportedly helped mainstreaming equity analysis throughout the research processes.

Project outputs

For **Indicator 1.2**, the '*proportion of health systems research outputs and syntheses that is gender and equity focused*', only 21/95 reviewed research outputs (22%) included a focus on equity, for example by presenting how different equity parameters (e.g. education, occupation, household wealth) affect women's health seeking behaviours, documenting how age and public participation are correlated with maternal deaths, assessing how institutional deliveries are correlated with socio-demographic factors, focusing on what factors influence health seeking behaviour of nomad women, assessing how performance-based financing of health services would affect services to vulnerable populations and analysing how the social capital of community health workers can be improved.

Barriers to integrating equity

In response to the online survey question about barriers to the integration of equity considerations, most researchers and decisionmakers mentioned financial and logistical barriers for reaching vulnerable groups. This reflected the findings reported in the equity issue brief of the midterm review. Some teams understood inequity as a matter of geography and stated that more time and funding would have allowed the project to reach remote and vulnerable populations. A lack of interest in exploring social equity issues in MNCH services by some project partners was also mentioned by three respondents. The main barrier, however, was that capacity and knowledge on how to integrate equity considerations in the implementation of the project and the analysis of research data was low. One HPRO respondent noted, *'[equity analysis] was new to many people. This type of analysis needs more technical input and qualified people to do it.*'

CONTRIBUTION OF HPROS TO GENDER AND EQUITY INTEGRATION

As per the call for proposals, the HPROs were expected to (i) conduct a comprehensive analysis of the differential effects of health policies and interventions and make sure that discussions on gender equality and equity are integrated in these analyses, (ii) offer capacity strengthening support to the RTs, including on gender and equity analysis and (iii) ensure a strong gender and equity focus in dissemination products. [11]

Formative research

The two HPROs conducted formative research that focused on policy uptake and context mappings. The East Africa HPRO (EA-HPRO) commissioned a rapid review of the MNCH resolutions passed by the East, Central and Southern Africa Health Community which found that gender and health equity issues were not effectively addressed in the countries covered by the IMCHA initiative. Additionally, the EA-HPRO conducted a situation analysis for Uganda, Ethiopia, Malawi, Mozambique, South Sudan and

Tanzania highlighting equity and gender issues in relation to health policies, health services, health system gaps, other barriers to access and national policies related to MNCH.

In West Africa, WAHO commissioned a study on the role of gender and equity in MNCH programs in West Africa in 2016 focusing on six countries (Benin, Burkina Faso, Ghana, Mali, Nigeria and Senegal). The report assessed how programmes in the region aim to reduce gender inequalities and inequities in terms of education, socio-economic status, distance to health facilities, etc. It found that very few programmes address gender norms, roles and relations and that there is a lack of diversity in the equity focus, with the majority of initiatives focusing on removing geographic, knowledge related, and economic barriers. In February 2016, WAHO organised a regional workshop to discuss the findings.

Capacity strengthening

The EA-HPRO organised a four-day gender equity course in November 2018 that focused on gender frameworks and intervention processes. It addressed gender issues that affect health system components and proposed solutions to address them and strengthen health systems in general. The EA-HPRO also supported a one-day gender training for researchers and decisionmakers in Uganda. WAHO organised a regional five-day training on gender integration and analysis in May 2019 and assisted one research team in identifying a consultant to conduct a three-day raining on the UNICEF EQUIST model. Neither HPRO organised or supported capacity-building activities on equity integration of analysis.

In the online survey, 15/28 (54%) African and 7/24 (29%) Canadian researchers stated that they had participated in a training workshop on gender. Training on equity was reported by 10/24 (42%) African and 4/24 (17%) Canadian researchers. These included workshops organised by HPROs as well as those organised by IMCHA management.

Knowledge translation

HPROs were also expected to support the RTs in integrating gender and equity dimensions in the dissemination and translation of the evidence. Three researchers confirmed, either in the online survey or in interviews that they received HPRO support in including gender considerations in their knowledge translation outputs. Three other researchers, however, were less positive about HPRO support.

CONTRIBUTION OF IMCHA MANAGEMENT TO GENDER AND EQUITY INTEGRATION

The first call for proposals required the HPROs and the research teams to address gender equality and equity in the grant application. While this approach was helpful for ensuring that none of the projects were gender neutral, informants voiced concerns that the focus on gender and equity in the proposals was mainly a '*box-checking exercise*'. Technical reviewers requested several applicants to refine their approach in the implementation plan but only six teams made significant changes. As one HPRO informant stated: '*The way [gender equality and equity] were integrated into IMCHA [by IMCHA management] was not well articulated and almost came in as a retrofit because it was not at the basis of the way the country teams were developing their research methodologies or doing their political economy analyses.*' This was confirmed in an interview with IMCHA management staff: '*What I see as a really big barrier is that when we issued the calls for proposals, there were sections on gender and*

equity considerations with some wonderful words around them. But when a project does not really have concrete questions that touch on these issues and if they just mention that gender aspects will be considered, it does not happen.'

This was, however, different for the synergy projects in which gender was more explicitly addressed during the research design. The call encouraged proposals with a gender focus on research topics that addressed root causes of high maternal and child mortality (e.g. early and forced marriage, unmet need for family planning, adolescent pregnancy) and promotion of sexual and reproductive health (SRH) services and information. In terms of the research design, the projects funded with synergy grants were more likely to integrate gender considerations than those funded with the original research grants.

Orientation sessions on gender were included in the IMCHA inception meeting in 2015 and the midterm workshop in 2017, and a session on equity in the learning workshop in 2020. While the sessions were much appreciated and were reported to have improved the understanding of gender and equity, the timing of the health equity session came too late for the evaluation to assess changes in the approach to equity integration by the research teams.

3.1.3 Evaluation question 3

To what extent has there been enhanced partnering and collaboration between researchers and decisionmakers on health systems strengthening?
(a) How have the research teams and/or HPROs demonstrated collaboration with decisionmakers?
(b) How has IMCHA management contributed to this work?

The IMCHA model of embedding decisionmakers as Co-PIs in the research team was rated as successful or very successful by 90 percent of researchers. The contribution of the decisionmaker Co-PIs was particularly appreciated for grounding the research in the local context and for encouraging the use of research in policy and practice. The HPROs provided an important contribution to linking the projects to national high-level health authorities and to introducing the project results in national and regional discussions of MNCH policy. Constraints mentioned in interviews and survey responses included: (i) Continued engagement of the decisionmaker Co-PI was not always achieved; (ii) the high mobility of decisionmakers resulted in frequent changes of Co-PIs; and (iii) not all projects included a decisionmaker Co-PI who occupied a position of influence in the policy or programme area where the project sought to affect change.

Collaboration of researchers and decisionmakers

The inclusion of a Co-PI decisionmaker in the research teams was a key design feature of the IMCHA initiative. It was an innovative approach that is sometimes referred to as 'embedded implementation research' and that was recently analysed in a multi-country study in Latin America and the Caribbean. The study concluded that '*embedding research into real world policy and practice bears the potential to improve implementation and scale-up of effective health interventions, thus contributing to the relevance of research to support universal health coverage schemes globally*'. [12]

The research teams collaborated with decisionmakers at various levels in the health system. In addition to the identified Co-PI who was part of the research proposal, several projects established

collaborations with decisionmakers at community, district and regional levels in order to obtain buy-in and ownership of the research findings and with policymakers at national level to share research results, to advocate for policy change or to scale up research findings.

In the online survey, all decisionmakers and 90 percent of researchers rated the collaboration as very successful or somewhat successful. There was a difference between the Canadian and African respondents. Four of 19 Canadian researchers were ambivalent about the success of the collaboration, and one even rated it as unsuccessful. Since the midterm survey, however, the proportion of researchers who rated the collaboration as very or somewhat successful increased from 75 to 90 percent, primarily due to increased ratings by Canadian researchers.

Some survey respondents and interviewed informants highlighted the need to involve decisionmakers at the appropriate level. One HPRO informant noted that the choices of the Co-PI were often opportunistic, and many projects did not choose policymakers at the appropriate level. '*Before you start a project, you need a strategic objective of what change you want to affect, and this objective informs who your policymakers are'*. The initial situation and stakeholder analyses conducted by the HPROs could have informed the choice of Co-PI by clarifying the processes and the levels at which policy and programmatic decisions are made. However, as noted by the informant: '*By the time we were able to engage with the research teams, the policymakers were already there. Many did not have the right profile and seniority*.' This was also reflected in an interview with a project PI: '*We partnered with provincial health but in the end, it would have been better to involve a national health decisionmaker'.*

Policy processes differ greatly among the IMCHA programme countries. In some countries all health policy decisions are made at national level, while others are highly decentralised and policy change, even at the national level, can only be achieved in alliance with decentralised health authorities. This is illustrated in the textbox on strategic choices.

Strategic Choices

The free maternity care policy in Burkina Faso was introduced by the national Ministry of Health. In order to monitor the impact of this decision on equity, quality, cost, etc. the ministry needed information and analyses that were provided by an IMCHA project. Embedding a national decisionmaker in the research team was an obvious choice for assuring that research findings were translated into policy decisions.

In Nigeria, the institutions responsible for delivering primary care health services are the State Primary Health Care Development Agencies (PHCDA). The highest policy-making body for health in Nigeria is the National Council on Health in which the States and the Federal Ministry of Health are represented as equal partners. The IMCHA project that aimed at introducing services for the diagnosis and treatment of perinatal depression at the primary health care level, therefore appropriately engaged with the PHCDA decisionmaker who was the link of the project to the State health authorities which, in turn, prepared a submission to the National Council on Health and will defend it in order to translate the research findings into national health policy.

The mobility of decisionmakers was a challenge experienced by several projects. One PI in Tanzania reported that the Co-PI changed four times over the lifetime of the project. When there were transitions, it took time to rebuild the relationship, trust and buy-in. One positive effect of the mobility was reported from Tanzania where a decisionmaker Co-PI moved from a decentralised to a central position in the ministry of health, and the project was therefore provided with a direct link to influence national policy.

Some decisionmakers were too busy to engage closely with the project activities. The expectations of some Co-PIs, especially in terms of available funds to implement programmes and training opportunities were not always met as indicated by the constraint of '*insufficient funds*' selected most frequently by decisionmakers in response to questions about implementation barriers in the online survey. Building partnerships of trust across the research/policy divide takes time and effort, something that was achieved by many IMCHA projects but that was not always evident from the start. The researchers who reported successful cooperation with their Co-PIs noted that an existing relationship and early involvement were key contributing factors:

In the online survey, the research teams were asked to rate the contribution of decisionmakers to different areas of cooperation.

Table 4. Researchers ratings of decisionmakers' contributions

AREAS OF COOPERATION	SOMEWHAT HELPFUL	VERY HELPFUL
Grounding research in local context	22%	75%
Encouraging the use of research findings in policies and practices	31%	60%
Connecting to other decisionmakers	32%	52%
Scaling up of research results	42%	44%
Integrating equity considerations	40%	40%
Integrating gender considerations	33%	35%

Overall, the researchers rated the contributions of the decisionmaker Co-PIs highly, especially for grounding the research in local context and for encouraging the use of research findings in policies and practices. The rating for all areas of cooperation was considerably higher than at midterm. Across all six areas, an average of 84 percent of researchers rated the contribution as very or somewhat helpful, compared to only 69 percent at midterm. This suggests that despite constraints and challenges, the teams did grow together across the research/policy divide.

Collaboration between HPROs and decisionmakers

HPROs were tasked to '*catalyse mechanisms to support the uptake and integration of research and research evidence into practice and policies*.' [11] They did so by strengthening the capacity of research teams in knowledge translation through training workshops, by facilitating meetings between individual research teams and policymakers and by organising national conferences.

As regional institutions, the HPROs were directly linked to regional political institutions. WAHO is a Specialised Agency of the Economic Community of West African States (ECOWAS) and ECSA is governed by the Ministers of Health of the East, Central and Southern African member states. In this role, HPROs were able to implement initiatives in regional policy development.

CONTRIBUTIONS OF IMCHA MANAGEMENT

The contributions of IMCHA management to the achievements of the IMCHA initiative is discussed in Section 3.2.1 responding to Evaluation Question 8. Management provided support for the uptake of research findings in programmes and policies in the IMCHA inception, midterm and learning workshops in which the Co-PI decisionmakers participated and during which various aspects of knowledge

translations were discussed. IMCHA management also supported the research teams and HPROs by promoting, publishing and presenting research, and by providing contacts for networking with other institutions and actors in the region. More than 80 percent of respondents to the online survey noted that they had received support in these areas. Beyond this, the task of promoting and supporting knowledge translation at national and regional level was largely devolved to the HPROs without direct involvement by IMCHA management.

3.1.4 Evaluation question 4

To what extent has there been enhanced integration of health systems research findings into primary health care policies and practice in the selected countries, and scale up?
(a) How have research teams and HPROs demonstrated influence on policy and programming?
(b) How successful have research teams and HPROs been in scaling the research results?
(c) How has IMCHA management contributed to this work?

Integrating research findings into policies and programmes was the third high level outcome objective of IMCHA pursued by all funded projects. Success in terms of documented instances of influence on policy decisions were reported by some projects, but for the majority it was too early to ask for such documentation because policy processes have their own timelines which are generally quite long. However, by the way the projects were designed within the IMCHA conceptual framework, all succeeded in engaging the research teams in health policy and programme decision processes that are likely to directly or indirectly affect primary health care policies in the longer term.

IMCHA influence on policy and programming

'*Enhanced integration of health systems research findings into primary health care policies and practice in selected countries*' is the heading of the third arm of the IMCHA logic model at the intermediate outcome level. Among the respondents to the online survey, 27/53 researchers (51%) stated that their research findings were already translated into policies or practices and 26/53 (49%) that there were prospects for translation in the future. Among the 27 who already reported knowledge translation, 11 mentioned the regional level, ten mentioned the national level and six a sub-national level. Among the five decisionmakers who responded, four stated that they had used information provided by the research in their work. However, in all cases this was limited to dissemination of research findings.

Twenty-four researchers provided details on how their research findings were translated into policies or practice. While many of them noted that policy changes were still under discussion or in preparation, several mentioned early results that included:

- The State adopted the practice of home visits by community extension workers and developed a micro-plan for state-wide roll-out. (Nigeria)
- The Ministry of Health adopted the curriculum for training of care providers in comprehensive emergency maternal and neonatal care. (Tanzania)
- The district health management teams are supervising the training of community distributors for malaria chemo-prevention delivered by head nurses. (Burkina Faso)
- The district adopted the distribution of birth kits. (Tanzania)
- The State integrated mental health into PHC services. (Nigeria)

Interviews with researchers and decisionmakers confirmed that they were active in knowledge translation from research evidence to policy and practice. In most cases, however, decisionmakers were still waiting for the final analysis and documentation of the evidence, and several informants noted that processes of policy change have their own timeline and dynamic and are not instant reactions to new evidence.

The IMCHA PMF includes two outcome and three output indicators to measure progress on integration of project findings in policies and programmes. The data reported in the monitoring ('trackify') database by February 2020 raised some questions:

- The intermediate outcome indicator 3.1 '*Number (type) of influence of IMCHA research projects on policy and programming per project*' has a target of 20. The number is not monitored. It has certainly been reached as almost all 29 projects can document an influence on policies and programmes, although the number that can actually document an attributable change in policies is likely smaller, at least within the timeframe covered by the evaluation.
- The immediate outcome indicator 300.1 *'Proportion of [decisionmaker Co-PIs] who follow up on recommendations from research into health systems planning forums'* has a target of 100 percent. This target is likely not met since not all decisionmaker Co-PIs remained engaged with the projects throughout. It is also not clear what is understood under a '*health systems planning forum*'. The IMCHA trackify database lists 22 events of follow-up reported by 12 projects, five of them by one project. While they may be considered 'follow-ups on recommendations', the relevance in terms of 'health systems planning' is questionable for some.
- Reports on output indicators for 'number of policies promoted' and 'frequency of knowledge translation activities' are highly inflated. For instance, one project is listed as having promoted 81 evidence-based policies and practices based on the number of recommendations that were included in policy briefs prepared by the project. The policy briefs themselves are counted as individual knowledge translation activities to the effect that the project reported 40 knowledge translation activities. Another project is listed as having generated 50 knowledge translation activities, most of them presentations and posters at conferences, many of them delivered by students in Canada.

Success in scaling research results

In the online survey, 35 respondents reported success in scaling of research findings in 55 instances whereby multiple answers were allowed in terms of scaling to district, provincial, national or regional level. Only 15 respondents stated that scaling was not an objective of their project or that they did not succeed in scaling their project. However, when asked about their approaches to scaling, almost all who reported success mentioned presentations of their findings to decisionmakers or including decisionmakers in their research activities. Respondents apparently made no distinction between approaches to knowledge translation and approaches to scaling.

Contribution of IMCHA management

IMCHA management strengthened the participation of decisionmakers as Co-PIs in research teams by inviting them to the three IMCHA workshops at inception, midterm and the final learning event. This

validated their position and exposed them to the concepts of embedded implementation research. To questions in the online survey about the helpfulness of IMCHA management, workshops were mentioned by several respondents, but none mentioned support for knowledge translation. This task was, after all, delegated to the HPROs.

3.1.5 Evaluation question 5

To what extent was the capacity of researchers and research organisations strengthened to conduct gender and equity informed implementation research?

How have the HPROs acted on the recommendations from the formative/situation analyses they conducted?

To address the gaps and needs in terms of knowledge translation the two HPROs commissioned situation analyses for each of the IMCHA countries and for the West-Africa region. The quality of the analyses varied. Most of the analyses presented recommendations, although not always directed to specific actors. The recommendations that were relevant for the HPROs touch upon (1) capacity strengthening of researchers and decisionmakers in systematic reviews, gender and equity integration, knowledge translation and evidence-based decision making, (2) national research uptake by developing frameworks and guidelines for systematic use of evidence, and by supporting platforms for knowledge transfer and to facilitate discussions between researchers and decision makers and (3) the dissemination of results. The two HPROs acted on these recommendations using slightly different approaches. The online survey confirmed that more than two-thirds of the researchers and decision makers believed that the HPRO support was effective, in particular for supporting national research uptake and capacity strengthening.

HPRO response to the formative/situation analyses

The two HPROs conducted situation analyses or context mappings for each of the countries in their region.

WAHO commissioned three types of formative analyses: (1) a regional analysis of the state of knowledge transfer and use of evidence in the field of MNCH in ECOWAS and the institutional capacity of WAHO to act as HPRO; [17] (2) a regional gender and equity analysis (discussed in section 3.1.2) and (3) six country-specific analyses in Benin, Burkina Faso, Ghana, Mali, Nigeria and Senegal focusing on contextual and health system factors, gender and equity, and knowledge transfer processes. [15,16] The results of the situation analyses were discussed in a regional workshop in 2016. [13,14]

The EA-HPRO conducted context mapping studies in Ethiopia, Malawi, Tanzania, Uganda, Mozambique, and South Sudan. The reports describe the health system gaps, equity concerns and other barriers to service access and national policies related to MNCH. They also describe the processes by which policies are formulated and the opportunities for knowledge translation in each country. The reports were shared with the respective research teams and initial findings were presented at the IMCHA midterm workshop in 2017. Following the workshop, the EA-HPRO developed country strategies to encourage country teams to work more collaboratively and strategically in order to maximise engagements with national-level policymakers.

Recommendations of the situation analyses are presented in **Annex 6**. Those that are relevant to the work of the HPROs and the actions taken by them are summarised in the Table 5.

Table 5. Actions taken by HPROs in response to situation analyses

Recommendation	Actions taken by WAHO	Actions taken by EA-HPRO
Capacity-building		
Improve the capacity of researchers to prepare data syntheses, systematic reviews and strategic or policy briefs	• Regional training on implementation research (all teams)	• Sessions on knowledge translation at IMCHA midterm workshop • Training in developing key messages in Tanzania • Regional training in systematic reviews • Regional training in qualitative analysis • Regional training in scientific writing • South Sudan research methods training • Regional training in qualitative systematic review • Regional knowledge translation training
Improve the capacity of researchers on gender analysis and equity integration, focusing on the most disadvantaged populations	• Training of WAHO and Senegal research staff in gender issues. • Training of project M&E officers in gender • Training in gender analysis and integration for 4 research teams	• Regional gender training
Improve the capacity of decision makers to request, access, evaluate, adapt and use evidence	• Training of the Bauchi research team in knowledge transfer • Training of the Benin City research team in EQUIST and knowledge transfer • Training sessions on MoH in Burkina Faso on evidence-based decision making • Training on evidence-based decision making for MoH in Mali	• Gender training for 6 policy makers from Uganda and South Sudan (with BRAC Uganda)
National research uptake		
Establish framework regulations and guidelines for systematic use of evidence	• Development of guide for use of evidence in MNCH for decisionmakers in West Africa sub-region and technical validation	• Development and adoption of an accountability framework for monitoring commitments on MNCH in East Africa
Support existing platforms for transfer and exchange of knowledge and/or facilitate discussions between researchers and decision makers	• 2 Nigeria Research Days to sensitise policy makers on use of evidence and provide exchange between researchers and users • MNCH Research Day in Burkina Faso	• Presentation of preliminary findings from 3 projects at a meeting of the African Parliamentary Committees on Health • Meeting with Ethiopia PIs and policy makers • Stakeholder meeting with all Tanzanian teams on 'how to steer innovation and evidence use to improve maternal and child health in Tanzania' • Meeting with Uganda MNCH technical working group. • Meeting with decisionmakers in Tanzania (Morogoro project) • Meeting with decision makers in Uganda (BRAC project) • Forum to share lessons from the IMCHA Nampula project with MoH

RECOMMENDATION	ACTIONS TAKEN BY WAHO	ACTIONS TAKEN BY EA-HPRO
Dissemination of results		
Advocate for better use of evidence	• Documentary film on project in Senegal • Television spot on Nigeria Research Days • Publication of 10 journal articles, 12 presentations at events, 6 policy briefs, 3 posters, 2 infographics, newsletter	• Launch of the IMCHA website. To date it includes 7 news articles, 16 publications/reports, 9 videos, 4 toolkits, 5 infographics and presentations of the inception and midterm workshops • Bi-monthly newsletter • Presentation on context mapping and political economy at the 'Towards a Pan-African Transformation' conference

The two HPROs acted on the main recommendations identified by the formative analyses. According to the IMCHA PMF indicator 100.2, HPROs should have acted on more than 75 percent of recommendations. The evaluation finds it difficult to quantify the proportion of recommendations that were acted on because the analyses did not address specific recommendations to the HPROs. However, the table documents that the six main recommendations were acted on.

The HPROs used slightly different approaches in responding to the recommendations. WAHO placed a stronger focus on strengthening the capacity of decisionmakers, while the EA-HPRO organised more training opportunities for the research teams. To promote national uptake of the research, WAHO organised national research days (twice in Nigeria and once in Burkina Faso) which were formal and highly publicised events where policy makers were sensitised on evidence-based decision making and researchers were able to present their findings. The EA-HPRO facilitated meetings between researchers and policymakers in several countries. Both HPROs supported the dissemination and communication of the IMCHA research projects and findings through newsletters, presentations at events, development of videos and infographics. WAHO published ten papers in peer-reviewed journals, whereas EA-HPRO produced several online blog posts and news items.

In the online survey, researchers and decisionmakers were asked about the effectiveness of HPRO support. Overall, a greater proportion of researchers rated HPRO support as very effective or somewhat effective in the final evaluation survey compared to the midterm survey (71% versus 64%). However, nine percent of respondents at midterm anticipated that effectiveness of HPRO support would improve over time. At the final evaluation, HPRO support for 'connecting the team to decision-makers' and 'contribution to knowledge translation' was ranked highest, closely followed by 'research methods training'. Support for 'equity sensitivity training' received the lowest scores. Decisionmakers responding to the final and midterm survey found the support of the HPROs generally effective. The effectiveness of gender sensitivity training was scored lowest, but the number of decisionmakers responding to the survey was too small to allow any inferences.

Researchers and decisionmakers in East Africa generally perceived the HPRO support to be more effective than in West Africa. However, there were nuances. For instance, the gender training provided in West Africa was perceived as more effective. The largest differences were reported for research methods and implementation science training which was perceived as more effective in East Africa where more training of this nature was provided than in West Africa.

3.1.6 Evaluation question 6

To what extent were partnerships and alliances between African researchers, decision makers and Canadian researchers strengthened?

How has the collaboration between African and Canadian researchers evolved since the midterm evaluation?

IMCHA provided opportunities for strengthening partnerships between African and Canadian researchers as already documented by the midterm evaluation. Interactions between Canadian researchers and decisionmakers were more limited as these partnerships were primarily active at the project implementation level. Pre-existing collaborations, clear definitions of roles and responsibilities and effective communication structures contributed to strong partnerships. Limited opportunities for face-to-face meetings and working sessions constituted challenges for some teams but were overcome by effective use of internet conferencing platforms by others. The opportunities to engage and build the capacity of emerging researchers were highlighted by interviewed PIs and Co-PIs.

Collaboration of African and Canadian researchers

In the online survey Canadian and African researchers were asked '*How successful is/was your collaboration with your Canadian or African research partner?*'. Fifty-three researchers in African and Canadian research institutions rated the collaboration equally with 74 percent of African researchers rating it as very successful and 26 percent as somewhat successful compared to 73 and 27 percent of Canadian researchers. No respondent selected a lower rating.

Table 6. Survey respondents' rating of African/Canadian collaboration

Collaboration between African and Canadian research institutions	African respondents	Canadian respondents	Total
Very successful	23 (74%)	16 (73%)	39 (74%)
Somewhat successful	8 (26%)	6 (27%)	14 (26%)
Total	**31**	**22**	**53**

Thirty-eight respondents provided additional comments in answer to this question, mostly confirming the ratings of successful cooperation. There were only two negative comments on the collaboration, both from African researchers who had rated the collaboration as 'somewhat successful'.

In interviews, PIs and Co-PIs echoed the positive statements about their collaboration. Some, however, also expressed that the collaboration did not fully meet their expectations.

- *It has been mostly an administrative relationship and not real collaboration. (African PI)*
- *I am appreciative of the idea of collaborating, but a real collaboration has not been possible. There were no funds for planning together at the stage of proposal development and at the stage of elaboration of other plans. The implementation has been full responsibility of the local partner. This was not a real partnership. We were contracted partners rather than intellectual partners. The project did not have an optimal start. (Canadian Co-PI)*

The patterns of collaboration were already well established at midterm and further clarified and strengthened during the midterm workshop in 2017. The survey responses to questions related to this collaboration did not change significantly from those of the midterm evaluation survey in 2018. In this

survey, 27/36 respondents (75%) rated the collaboration as very successful and 7/36 (19%) as somewhat successful. However, two respondents rated it as somewhat unsuccessful.

Three main factors for successful cooperation were mentioned by key informants and survey respondents:

1. An existing working relationship

Previous experience of working together on research projects was mentioned as a facilitating factor for successful collaboration. Trust had already been built, there was a common culture for collaboration, and partners knew their respective capabilities. *'Because we had been working together for a few years, we already had an established way of working together and knew where we wanted to go with the project. I would say "I think we need to work on this", and he would say, "yes, and plus this" sort of thing.' (African PI)*

New partnerships, on the other hand, faced more difficulties, in part also because there were no opportunities to work face-to-face in jointly developing the research proposal and the implementation plan. '*This is the first time we collaborate. There has been a reasonable exchange with the PI. Ideally what should have happened was that the two researchers sat together, elaborate the proposal and have a clear sense of their capacities. This did not happen in this project. We developed everything long-distance, which is a bit of a handicap. They had already made up their mind on what they wanted to do. I could have predicted the problems we faced.' (Canadian Co-PI)*

2. A clear understanding of roles and responsibilities

The African PIs had the overall responsibility for project implementation. Start-up delays experienced by most projects compressed the timeframe available for research activities and made it even more important that the partners agreed on their roles. The roles of the Canadian Co-PIs varied from project to project, with some taking on specific tasks such as the statistical data analysis or leading the writing teams for research publications, while others worked according to a traditional North-South technical assistance model. An equitable and mutually beneficial collaboration as specified in the call for proposals was, however, achieved by most projects, if not from the start, then at least during implementation: '*I was concerned that this was going to be top-down collaboration. However, this concern disappeared when good communication and collaboration developed over time and both sides showed true commitment to the project, were eager to share and learn from each other. In addition to good communication between researchers, time-lines were clear to all and deadlines were respected by both parties.' (African PI)*

3. Effective communication and face-to-face interaction

Several teams reported communication challenges because of time differences, difficult internet connections and delayed email responses due to travel or busy schedules. The importance of face-to-face meetings and working sessions was mentioned by several interviewed PIs and Co-PIs. Budgets to finance travel of Canadian researchers to the implementation sites were limited, and two Canadian Co-PIs noted that funds from their own institutions were used to fill this gap. Missions of African researchers to conferences or other meetings in Canada were also used to conduct working meetings

with one African team mentioning Canadian visa policies as another challenge. Some of the teams, however, mentioned that they were able to conduct regular virtual team meetings using an internet conferencing platform.

Collaboration of Canadian researchers and decisionmaker Co-PIs

Responses to questions about the cooperation between Canadian researchers and decisionmaker Co-PIs differed between the interviews and the on-line survey. In the on-line survey, Canadian researchers rated the collaboration with decisionmakers as very successful (16/22 – 73%), somewhat successful (5/22 – 23%), and unsuccessful (1/22 – 5%). The interviewed Canadian Co-PIs strongly endorsed the association of decisionmakers with the projects, but only two claimed frequent contacts and a direct working relationship. Others recounted that they met the decisionmakers only during field visits and IMCHA workshops. This was confirmed by seven of the eight interviewed decisionmaker Co-PIs who stated that their main collaboration was with the local project teams, and that they only had occasional contacts with Canadian researchers. The eighth had been newly appointed and did not yet know the Canadian partner in the project. The mobility of decisionmakers was the most frequently cited constraint by interviewed Canadian Co-PIs.

3.1.7 Evaluation question 7

To what extent are decisionmakers better aware and able to use research evidence?

How were the findings of IMCHA research communicated to the project Co-PI decisionmaker?

The evaluation confirmed the findings at midterm that the integration of decisionmakers as Co-PIs in research teams were generally seen as a successful element of the IMCHA model. The mobility of decisionmakers within their administrative structures was noted as the most important constraint.

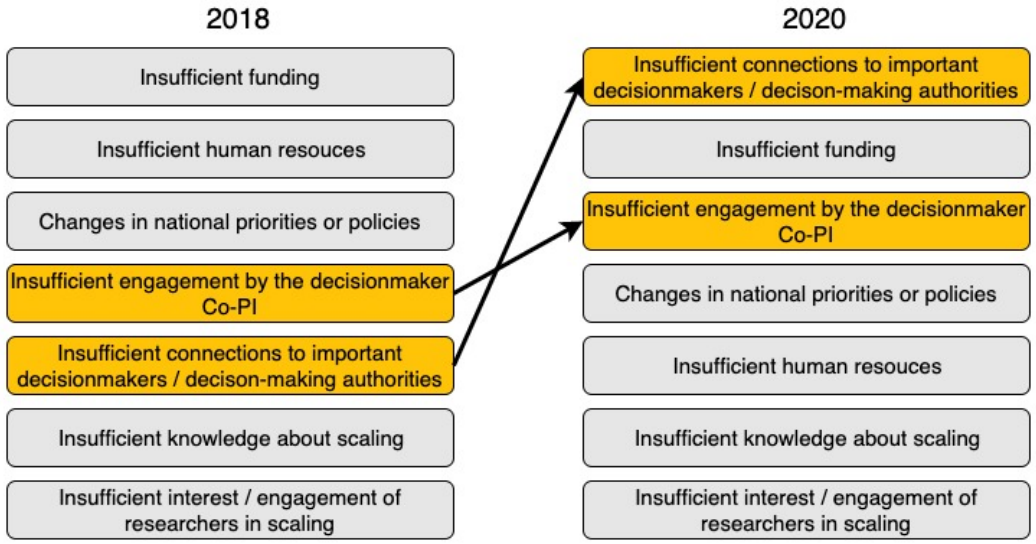
Working with decisionmakers in the research teams

Communication of research results to decisionmaker Co-PIs, as stated in the evaluation question, should not be an issue in the IMCHA model: They are Co-PIs and therefore members of the research teams. In reality, the application of the model was not uniform. Many Co-PIs assumed a more traditional role in the teams, as recipients of information rather than contributors to its generation. The five decisionmakers who responded to the online survey stated that they were either informed about progress every month, or whenever they required this information.

Survey responses and interviews confirmed findings reported by the midterm evaluation. Those decisionmakers who responded to the survey, and those who made themselves available for interviews during site visits were positive about the success of the collaboration and stated that they provided an important contribution to the projects. However, only 5/29 decisionmakers (current and former Co-PIs) responded to the survey invitation, and interviews could only be scheduled and conducted with eight of the 11 Co-PIs of sampled projects. Four of them had been involved with the project since inception. This supports the findings of both the midterm and the final evaluation that the mobility of decisionmakers within their government structures was a constraint to the IMCHA approach of embedded research. Those decisionmakers who were involved in the projects from the start, and potentially also in the conception and development of the intervention, were also most likely to be the most engaged.

All African researchers and decisionmakers who responded to the online survey rated the collaboration with the decisionmaker Co-PIs as either very or somewhat successful. However, in a ranking exercise of the importance of barriers to scaling of the project results, they ranked insufficient connection to decision-making authorities in first, and insufficient engagement of the decisionmaker Co-PI in third place among seven potential barriers. This represents a change from midterm where these barriers were ranked in fifth and fourth place respectively.

Figure 2. Rankings of barriers to scaling 2018 and 2020



3.1.8 Unpredicted outcomes of IMCHA

Sub-evaluation questions on unpredicted outcomes of IMCHA, especially gender-related outcomes, were included in the terms of reference of the evaluation under several of the main evaluation questions. Findings are aggregated in this section.

Respondents to the online survey and interviewed key informants were asked about unpredicted outcomes with specific prompting for outcomes affecting gender equality. Many of the outcomes mentioned were, in fact, not unpredicted but based on the research question and on outcomes listed in the IMCHA logic model. Truly unpredicted outcomes included:

- Quality improvements of services including improvements in data collection, management and use was mentioned four times.
- Three researchers working in projects that focused on CHWs in two projects reported findings that point to the importance of the role of male partners in programmes that are mostly implemented by female CHWs. They can be enablers providing support, encouraging autonomy and agency of the women, or they can be a hinderance. The role of partners has been a blind spot in the development of CHW programmes.
- Male involvement in pregnancy and maternity care was mentioned by three informants. Two of them reported the findings of their project that policies requiring men to accompany their partners attending ANC services can lead to discrimination of single women or women who do

not have a supportive partner and who are therefore pushed to the back of the line. Policy changes were initiated on the basis of this evidence.

- Three informants mentioned that support to women's groups provided by their project resulted in women becoming more active and effective in decision-making at the community level and in increasing women's autonomy.
- Other positive outcomes reported by single informants included increased networking among research institutions, NGOs and health departments; effects of individual capacity-building including the promotion of decisionmakers, researchers or health workers involved in the project to higher positions in their institution or organisation; and effects of institutional capacity-building reported by one HPRO that used its role in IMCHA as a model for the development of initiatives funded by other donor organisations. Several research teams also reported that work in IMCHA contributed to successful applications for grants from other sources.

No negative outcomes were reported. Some interviewed PIs and Co-PIs mentioned that their projects failed to achieve expected positive outcomes. For instance a project that focused on training and quality improvement in maternity care was not able to demonstrate an improvement in perinatal mortality. Another informant reported that the modalities of organising and paying for the transport of pregnant women for maternity services piloted by the project did not work well and needed to be reviewed. The same informant also reported less than satisfactory outcomes of a mobile phone network for CHWs.

3.2 IMCHA MANAGEMENT

3.2.1 EVALUATION QUESTION 8

How has support from the IMCHA management team and the M&O Committee contributed to the efforts of the research teams, the HPROs, and the initiative overall?
(a) How has IMCHA management implemented the recommendations of the midterm evaluation?
(b) What difference has this made in IMCHA achievements?
(c) How has the M&O Committee influenced IMCHA management and achievements?

Support by IMCHA management was rated positively by the research teams with 71 percent of online survey respondents rating the IMCHA meetings as 'very helpful'. Positive ratings in the final evaluation survey were considerably higher than at midterm.

The midterm evaluation issued seven recommendations for a follow-up initiative and 14 for IMCHA, most of them within the scope of the HPRO role. Most of the recommendations validated steps that had already been initiated in 2017. Additional recommendations were acted on in the agenda of the 2020 IMCHA learning workshop in Kigali.

The M&O Committee provided inputs into programmatic issues at key decision points such as the launching of the synergy grants or the commissioning of programme evaluations. It did not get involved in grant management issues. It provided a functional and appreciated cooperation platform for the three funding organisations.

SUPPORT BY THE IMCHA MANAGEMENT TEAM

The IMCHA grants were managed by programme staff engaged by IDRC for the IMCHA initiative. The team was strengthened by three members of the core IDRC programme staff who managed six grants. Leadership of the team was provided by the IDRC Programme Leader for Maternal and Child Health, and financial management by the IDRC Grant Administration Officer.

Most respondents to the online survey reported that they received support from IMCHA management for a number of tasks, most frequently for promoting, publishing and presenting the research (88%), for networking with other institutions (85%), for financial reporting (81%), for refining the research protocol and implementation plan (79%), and for addressing gender equality issues (77%).

Less support was reported for addressing equity issues (61%), solving technical or ethical issues (55%), and for seeking additional research funding (55%). The IMCHA inception workshop in 2015 and the midterm workshop in 2017 were rated a very helpful by 71 percent of respondents, while about two-thirds of respondents rated the support provided for the preparation of implementation plans, technical reports and financial reports as very helpful. Monitoring visits by IMCHA Programme Officers received the lowest approval scores with only half of the respondents (53%) rating them as very helpful. However not all projects were visited because of Canadian Government travel restrictions.

Overall, the proportion of survey respondents who reported that they received support from IMCHA management as well as the proportion who rated this support as very helpful increased substantially between the midterm and the final evaluation surveys. There were, however, outlier responses that rated the support as minimally or not helpful, ranging from three for IMCHA workshops to seven for the preparation of implementation plans, technical support and monitoring visits.

Interviews with grantees generally confirmed the positive assessment of the support provided by the IMCHA management team. Responsiveness and flexibility were mentioned most often. Several of the researchers stated that their relationship with IMCHA management was initially quite strained but improved after the midterm. The main source of initial tensions mentioned by two interviewed Canadian Co-PIs was due to differences in expectations: *'There was a disconnect between the objectives of the programme and what the researchers were trying to do. A lot of the negotiation was around the outcomes to be achieved, we couldn't agree to put improvements in maternal health in the contract, so it was about the framing and what we could realistically achieve within the time and budget.'*

More immediate concerns were raised by one PI about the policy of scheduling fund transfers for the final semester of project activities until project completion.

IMPLEMENTATION OF THE MIDTERM EVALUATION RECOMMENDATIONS

The midterm evaluation issued 21 recommendations (**Annex 7**) of which seven addressed plans for initiatives that may follow IMCHA. Most of the remaining 14 recommendations were directed at the HPROs or were within the scope of the HPRO mandate. The evaluation report was widely distributed among HPROs and RTs as well as discussed in a conference and a webinar, however most interviewed PIs and Co-PIs did not remember the recommendations, nor any action taken in response.

In the management response to the evaluation report, IMCHA management accepted the recommendations and aggregated them into four groups:

- Recommendations on knowledge-sharing among research teams
- Recommendations on the integration of gender and equity consideration in the programme.
- Recommendations on knowledge translation and scale-up
- Recommendation of knowledge sharing between East and West Africa HPROs

Knowledge-sharing among research teams

The recommended country-level meetings of researchers and decisionmakers, especially in countries with several IMCHA projects, were organised by HPROs since 2017. In interviews, HPROs reported meetings in Tanzania, Nigeria, Uganda, Burkina Faso and Senegal. Especially the regular meetings in Tanzania were reported as highly effective in contributing to recognition and knowledge translation. The annual 'Nigeria Maternal Newborn and Child Health Research Days' hosted by the Federal Ministry of Health, WAHO and IMCHA also provided an opportunity for the three Nigerian IMCHA teams to present their findings to an audience of national stakeholders. The recommended learning meeting of the IMCHA initiative was organised by IMCHA management in January 2020 in Kigali.

Integration of gender and equity considerations

Training workshops on gender analysis were organised by the HPROs. Both HPROs acknowledged that they did not address the recommendation for capacity-building in equity analysis. Methods and approaches to equity analysis were introduced in the IMCHA learning workshop in 2020. Some projects, for instance those examining how access and utilisation of services were affected by the introduction of performance-based financing or free maternity care policies had already included equity analyses by design. Interviews conducted for the final evaluation suggested that the understanding of the distinction between integrating gender and equity had improved since midterm.

Knowledge translation and scale-up

Workshops to develop knowledge translation plans were conducted by the two HPROs in 2018 as well as country-level training workshops for researchers and decisionmakers. The concept of scaling science in research for development was developed by IDRC concurrently with the implementation of the IMCHA initiative. A handbook on 'Scaling Impact' was published by IDRC in 2019 [18] and a 'Playbook' with practical guides for researchers in 2020. [19] One IMCHA project in Nigeria is cited as an example in the guide. The concept of scaling science and the tools for integrating it into research were presented at the IMCHA learning workshop in 2020. In interviews with research teams, HPROs and IMCHA programme officers, there was unanimous agreement that these were new concepts that had not been integrated in IMCHA, and that would only be relevant for a follow-up initiative.

In the IMCHA initiative, 'scale-up' was less formally understood as increasing the range of project impact. In the online survey, 20 researchers responded that they had successfully scaled their research findings to district, national or regional levels. However, the narrative responses to the survey question indicate that 'successful scaling' by most respondents meant successful communication of findings to health authorities. It may, in fact, be too early to assess the policy impact of most projects at scale.

Knowledge sharing between East and West Africa HPROs

IMCHA management responded to recommendations about increased sharing of knowledge between East and West Africa by stating that (i) it would continue encouraging the HPROs to conduct more knowledge sharing activities, (ii) continue supporting the IMCHA website, (iii) share information in quarterly newsletters and update its communication strategy. In interviews, HPRO staff mentioned that the two HPROs cooperated in identifying experts, for instance for capacity-building workshops in gender mainstreaming. One interviewed HPRO staff, however, noted that there was much room for increasing the collaboration between East and West Africa HPROs. A bilingual (English/French) IMCHA website continues to be maintained by APHRC in Nairobi. West African content is, however, limited. The IMCHA communications strategy was developed in 2015 and an update was prepared in 2017. [20] Further updates were not available to the evaluation team. Neither the original strategy nor the update addressed knowledge sharing between the East and West Africa HPROs.

What difference has the midterm evaluation made to IMCHA achievements?

Most of the recommendations were in line with directions that were already established and implemented by the HPROs and the IMCHA management team. Although they confirmed these directions, they may or may not have reinforced them which would be difficult to assess post hoc. At the time the evaluation report was submitted, project implementation plans and research protocols were already being implemented and the margins for adjustments were limited. Key recommendations on scaling and equity analysis were acted on at the IMCHA learning workshop in 2020. Their impact on the current initiative could therefore not be assessed by the evaluation but will presumably be limited.

M&O Committee role and influence

Information about the M&O Committee was collected in interviews of current committee members and the review of the minutes of ten M&O Committee meetings between May 2015 and March 2020 as well as the minutes of two Governance Committee (GC) meetings. The interviewed M&O Committee members representing GAC and CIHR had joined the committee within 12 months preceding the evaluation.

The M&O Committee met every six to eight weeks to discuss programme-wide issues while the management of grants was the responsibility of IDRC. Review of the minutes confirm that there were periods of intensive deliberation such as at the start of IMCHA, at the time of launching the synergy grants, in relation to the midterm and final IMCHA evaluations and, most recently, for the discussion of new cooperation initiatives. At other times, the committee meetings served primarily to update the funding partners on programme-wide activities such as IMCHA field visits and learning workshops. The CIHR and GAC representatives also interacted with IMCHA grantees during visits to Canada and in workshops organised by IMCHA management.

Committee members described their participation as a great opportunity for three organisations with shared goals but different mandates to work together. They acknowledged that the differing mandates of the three funding partners had at times been difficult to negotiate, but that the regular contacts in the M&O Committee provided a good platform to resolve differences. The Governance Committee,

which had been quite active at the launch of IMCHA, had since assumed a more ceremonial role while programme oversight by the funding partners was primarily provided by the M&O Committee.

3.3 Documentation of IMCHA

3.3.1 Evaluation question 10[2]

How have the research teams, HPROs, the IMCHA management team and the donor partners documented their work to contribute to the IMCHA legacy?
(a) How have the research teams, HPROs, the IMCHA management team and the donor partners documented their work (beyond publications and regular reporting) to contribute to the IMCHA legacy?
(b) How could this be improved in a future initiative?

IDRC, the HPROs and some grantees generated a considerable number of quality communications outputs and built an audience for IMCHA. There are two main online portals for external audiences to access information about IMCHA. The IMCHA site launched by APHRC in Nairobi has a strong brand, but it is primarily focused on the programme in East Africa and presents a very incomplete picture of the programme in West Africa. The IMCHA pages on the IDRC site provide a balanced and comprehensive view and they are updated more regularly, but they are somewhat hidden under the IDRC brand. Not having a single comprehensive access site with a clear brand, may have limited the ability of IMCHA communications reaching an even wider external audience.

Documentation to contribute to the IMCHA legacy

The 2015 IMCHA communications strategy set out five objectives .*'(1) create awareness and visibility for IMCHA with prioritised audiences, (2) clearly communicate the programme's value, uniqueness and positioning, (3) highlight the results achieved with IMCHA funding, (4) highlight the achievements of Canadian researchers and Canadian institutions in the context of IMCHA and (5) work with the media and other opinion influencers to disseminate IMCHA-supported breakthroughs and stories of success.*' [21] The strategy identifies key audiences and messages as well as communication products to be produced, such as a one pager, project profiles, stories of impact, newsletter, monthly email, media releases, photo and video library, website, blog posts and twitter account. The strategy was updated in 2017 to outline the approach of a quarterly newsletter. [20]

There are two main online portals presenting the IMCHA initiative, its successes, and results. IDRC has a dedicated project website for IMCHA which presents all research projects, including the duration, total funding, project leader, leading institution and published outputs. In addition, it has uploaded different types of communication materials such as journal articles, news items, perspectives, research in action articles, reports, stories and videos, training materials. The projects and stories that are featured on the opening page are easily accessible and include links to published articles, videos, or external websites, such as the websites of the research institutions. When expanding the search by clicking the 'view all' or 'view more' links, descriptions, stories and materials from all projects can be accessed, however through a standard IDRC digital library menu that may not appeal to all audiences

[2] Evaluation question 9 is primarily about lessons learnt in the implementation of the IMCHA model. It was integrated into Section 4 (Lessons Learnt)

and that, through its search links, easily takes the viewer out of the IMCHA environment into a more general IDRC web environment. The website was regularly updated between February 2016 and May 2020.

The top hit in a Google search of the term 'IMCHA', however, is the website that was launched by the AHPRC as a '*culmination of a close collaborative process with the West-Africa HPRO as well as IDRC*'. [22] The aim of the website is to become a reference point for IMCHA research work, and to serve as a bilingual resource for anyone interested in MNCH in sub-Saharan Africa and how research evidence can help save lives. The website presents the IMCHA initiative, the HPRO model and the work of the 19 RTs. The West African content on this site is, however, limited and the predominant language is English, even in the French version of the site. Some of the project information posted on the site does not correspond with information listed on the IDRC website. Updates had been irregular, and the site has sometimes been static. For instance between August 2018 and May 2019 there was a time-lag of eight months between two blog posts.

Searching for 'IMCHA' on the Global Affairs Canada page of the Government of Canada website yielded no results, although a profile for IMCHA can be found on GAC's Project Browser website. On the CIHR webpage, IMCHA is listed under 'recent CIHR global health initiatives' with a link to the IDRC IMCHA page.

Some of the research teams have also featured their participation in IMCHA and their outputs on their institutional websites. Three examples are Miseli (miselimali.org), Health Bridge Canada (healthbridge.ca) or the Women's Health and Action Research Centre (wharc-online.org).

Eight E-newsletters were published by IMCHA between October 2017 and January 2020. The number of times they were opened fluctuated between 20 and 50. Subscribers to the newsletter increased by 64 percent between 2017 and 2020. The newsletters start with a personal introduction from the IMCHA management team, followed by news items detailing what conferences IMCHA participated in, presenting details about ongoing research as well as featured publications. There is no link to the newsletter on the IDRC IMCHA site. Only one issue of the newsletter (of April 2018) features on the APHRC IMCHA site which also does not include a link to register requests for subscription.

AHPRC and WAHO also published quarterly newsletters with reference to IMCHA. According to the technical reports, AHPRC issued at least six quarterly newsletters between January 2018 and January 2020 but the evaluation team could not find copies of these newsletters. WAHO issued project specific newsletters on IMCHA, called MEP news. The evaluation team was able to access five newsletters issued between 2015 and 2018 (three of which were available on the WAHO website and two which were shared as part of the 2018 technical report).

The evaluation team was able to access a total of ten short videos covering the initiative or projects funded by IMCHA. Not all of these videos are, however, available on either the IDRC or the IMCHA website.

In terms of creating visibility of the work, IMCHA management facilitated the presence of IMCHA research teams at events such as the Canadian Conferences on Global Health, the Women Deliver events and the Global Symposia on Health Systems Research. Similarly, the HPROs encouraged

research teams to present their findings on different occasions. Besides these events, the evaluation team was able to find several references to IMCHA success stories on other online platforms. The work of the Mozambican and one of the Nigerian research teams was reported on the Canadian Geographic Charting Change website. The work of the Nigerian team was also referenced in the 'Charting Changes' issue of November/December 2018. The research on social enterprise models to improve women's livelihoods and health was reported in the Huffington Post (huffingtonpost.ca), while the work of two Tanzanian teams was featured on the website of the Canadian Partnership for Women and Children's Health (canwach.ca), although only one made a reference to IMCHA. An article on how research addresses key obstacles to maternal health in rural Africa was published by a Canadian Co-PI on the Conversation Africa website, without however referencing IMCHA. Finally, some of the research projects were featured in news outlets in their country of implementation.

The @IMCHA_ISMEA twitter account issued 203 tweets between October 2017 and May 2020, an average of eight tweets per month with repeated peaks associated with international conferences, meetings or campaigns. By May 2020, the account had 681 followers, mostly individuals but also including research institutions and NGOs working in MNCH, global health or health research.

IMPROVEMENT FOR A FUTURE INITIATIVE

IMCHA management, the HPROs and some grantees have conducted communications work within their networks and audiences and have generated outputs of considerable quality. These are, however, somewhat dispersed which may have limited their visibility to a wider audience. Stronger branding and stronger control of the brand would assure, for instance, that the top result for an internet search would be an entry portal to all programme communications outputs with links to journal publications and conference presentations.

4 LESSONS LEARNT

The lessons of the IMCHA initiative presented in this section respond to the sub-questions under Evaluation Question 9 of the terms of reference: '*How did the IMCHA model contribute to the performance of the initiative?*'

- *What new lessons can be learnt regarding the design and implementation of the model of the research teams?*
- *What new lessons can be learnt regarding the design and implementation of the model of HPROs?*
- *What worked well in the Synergy Grants? What were the challenges?*
- *What new lessons can be learnt regarding the design and implementation of the partnership between CIHR, GAC and IDRC?*
- *How relevant would an initiative such as IMCHA continue to be to address the needs of the donor partners and their alignment with Government of Canada priorities?*

IMCHA tested an approach to implementation research that included the embedding of decisionmakers in the research teams and that also included South-South technical support and networking through the funding of HPROs. While neither of these two characteristics of the model is unique, there is little existing analysis and documented experience about their joint application. The IMCHA model had two additional characteristics. (1) A PMF that, at the ultimate outcome level, measured implementation outcomes rather than research and knowledge translation outcomes; and (2) a South-North partnership between African and Canadian research institutions in each project. The reasons for including these two components were institutional rather than conceptual.

- While all implementation research projects have to document the effect of interventions on service delivery or health outcomes as the evidence base for programme and policy improvement, these outcomes are the subject of research and not their objective. They are, however, the strategic objectives of GAC and, according to interviewed GAC staff, their inclusion as ultimate outcomes in the IMCHA PMF was a requirement to make IMCHA fundable by GAC.
- There is a lot of experience in funding North-South research collaboration, and IMCHA also contributed examples of highly successful collaborations between African and Canadian researchers. The evaluation did not find evidence that North-South research collaboration fits well in a model based on embedded decisionmakers and HPROs. Supporting the Canadian research community is, however, a mandate of CIHR.

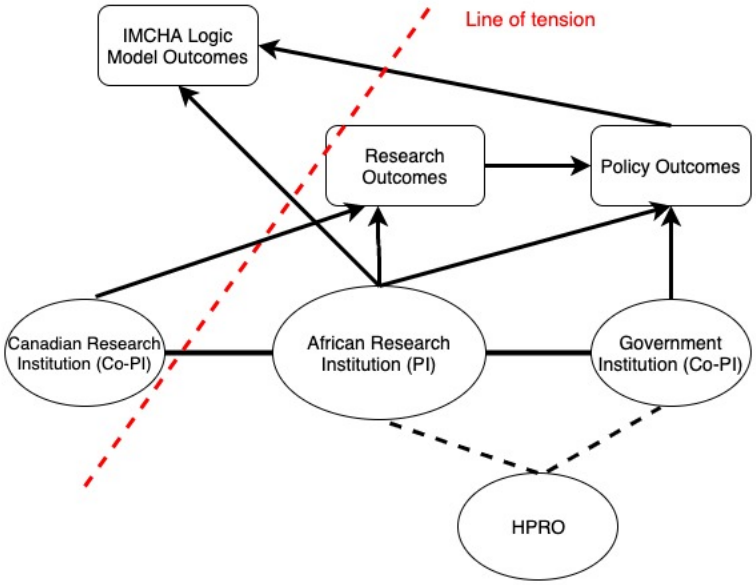
The lessons from IMCHA are that it is possible to combine these characteristics in a single programme, but that this invariably generates lines of tension. The word 'tension' in this context is used as a descriptive term not implying a conflict. It is used to communicate the findings of the evaluation confirming the *'long-recognised organisational wisdom that the pursuit of multiple and competing values, ends, and benefits inevitably gives rise to challenges about how to achieve balance.*' [23]

- The balance between the focus on interventions to generate health outcomes versus the focus on research to generate answers to the questions of whether these interventions are

appropriate, feasible, effective and affordable in the local context, and how they can be best delivered.

- The balance between generating strong local alliances between researchers and decisionmakers supported by a Southern network, and the requirement of defining a meaningful role of Canadian researchers within such a partnership.

Figure 3. Line of tension in the IMCHA model



The IMCHA experience documented that some projects negotiated these tensions better than others. Characteristics of these projects included a longstanding relationship of trust between the African and Canadian research institutions; a good understanding and a solid commitment to the research objective by both partners; and a willingness of the Canadian Co-PI to engage and maintain contact with the HPRO and with the decisionmaker Co-PI in the project. Only three original research projects had unified single funding agreements managed by the PI institutions. One of them was sampled by the evaluation. In this project, the Canadian researchers were well integrated in all project activities and a strong collaboration was established. This is, however, a lesson founded on a small sample and it is uncertain that such an arrangement would have been feasible and acceptable in all cases.

At the origin of these tensions is the funding partnership between the three Canadian government agencies that have congruent goals but differing mandates. IMCHA effectively managed the balance between these mandates in the M&O Committee. The tensions were, however, not restricted to this level. They were also reflected in the design of the initiative and ultimately experienced by the projects.

The research teams

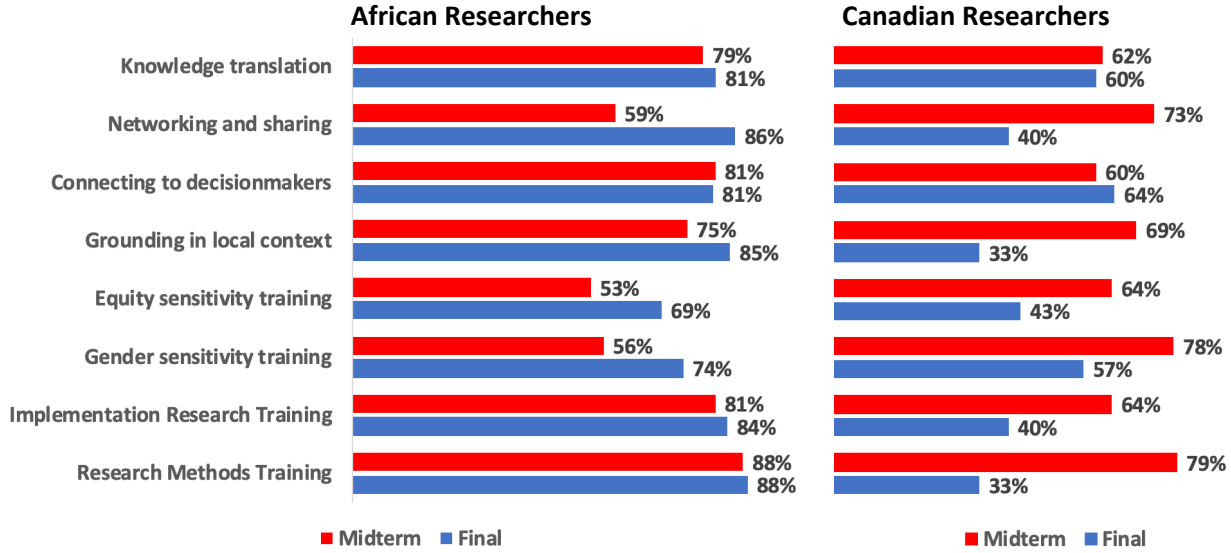
In general, research teams of African and Canadian researchers knew each other well and who had a record of past collaboration worked well within the IMCHA model. They did not necessarily change their established mode of cooperation, but they met their institutional objectives. For Canadian partners, these tended to be more academic in terms of opportunities for junior researchers to work on their theses and degrees, and for senior researchers on their record of publications. Most African

partners had the same objectives, but in addition a much stronger focus on generating evidence to influence policies and systems in their countries.

The HPROs

In the early phases of IMCHA, the role of HPROs was unclear to the research teams. As the initiative evolved, the appreciation of the HPRO model increased among African researchers but not among Canadian researchers as illustrated in the ratings of HPROs by respondents to midterm and final evaluation surveys.

Figure 4. Researchers rating HPRO support as somewhat or very effective



Note: The responses to the two surveys are not strictly comparable because at midterm only PIs and Co-PIs were invited to respond while responses were solicited from all researchers for the final evaluation survey

The question whether to include an HPRO component in a future initiative yielded an affirmative response by 76 percent of African researchers at midterm growing to 100 percent in the final survey. It did not change among Canadian researchers among whom 54 percent answered affirmative at midterm and 53 percent in the final evaluation survey.

The Synergy Grants

African and Canadian researchers reflected positively on the ability to use the synergy grants to fill gaps identified during implementation of their main research project. Others mentioned that it allowed the research teams to work more specifically on gender and equity issues or leadership and management issues that were missing in the original projects. In terms of challenges, a minority of researchers felt that the timing of the synergy grant call for proposals could have been improved. Several respondents stated that they were unable to apply because they were too busy with implementation activities to develop a strong proposal. While nearly everyone agreed that synergy grants were a good idea, some felt that they should have been informed about them from the outset to allow for adequate preparation and planning.

HPRO respondents felt that they could have added value to developing and allocating synergy grants if they had been kept appraised of developments.

THE PARTNERSHIP BETWEEN CIHR, GAC AND IDRC

Although not a universal opinion, most interviewees reflected positively on the partnership between CIHR, GAC and IDRC. Key informants mentioned that the three institutions are working collaboratively on other global health issues. The partnership allowed the three institutions to go above and beyond what they would be able to achieve on their own, while bringing a unique asset to Canadian researchers and the international research community. '*It is complementary. CIHR has more experience in working with Canadian researchers, GAC provides connections with the Canada´s development policies and global agendas. IDRC brings experience in research for development*.'

The issue of measuring the ultimate outcomes in the IMCHA PMF in terms of health status and service improvements elicited comments by funding partners and grantees. Funding partners acknowledged that this was a GAC requirement, and, as acknowledged by interviewed GAC staff, served primarily to make the initiative fundable under the GAC strategy. Several researchers expressed frustration and confusion about the focus on these outcomes, one of them stating that the label 'research' was misused for what was primarily an agenda to fund implementation projects and that research quality was lost to the demand for generating service outputs. One Canadian Co-PI commented that '*IMCHA is a hybrid programme which is not sure what it is… IDRC has a fundamental challenge, some sort of identity crisis. Is it a developmental organisation like GAC, or is it a research organisation?*' Others were more comfortable with the merged objectives: '*I think we need to not forget the research agenda when looking for outputs, but also not forget the outputs, because I think we also want to have an impact'.* Such statements illustrate the conceptual tension in IMCHA due to the differing mandates of partners, but they also illustrate that these tensions can be overcome when they are acknowledged and addressed.

THE ALIGNMENT WITH GOVERNMENT OF CANADA PRIORITIES

The IMCHA initiative was developed during the first phase of the Canadian Muskoka Initiative. The IMCHA call for research proposals was addressed to the seven African priority countries of this initiative plus Ghana and Senegal. The high-level outcomes of the IMCHA logic model were closely aligned with the logic model of the Muskoka Initiative.

At the time the proposal call for synergy grants was launched, the Government of Canada had made a second commitment under the Muskoka Initiative and was about to launch its new 'Feminist International Assistance Policy'. [24] The call reflected the new priorities of the commitment and the policy by requesting proposals that included '*interventions, research and knowledge translation activities that seek to address some of the root causes of high maternal and child mortality such as, early and forced marriage, unmet need for family planning and adolescent pregnancy and the promotion of sexual and reproductive health services and information*'. [25] This was reflected in the themes of 3/9 projects funded with synergy grants and strengthened the focus on gender-transformative approaches which were applied in more than half of the synergy projects (5/9) compared to only a third (7/19) original research projects.

5 CONCLUSIONS

The conclusions are structured according to the objectives of the evaluation as per the TORs: (**Annex 1**)

1. *To examine IMCHA performance in relation to the PMF, in particular progress made towards achieving the immediate, intermediate and ultimate outcomes.*
2. *To evaluate how the recommendations of the midterm evaluation were addressed and what difference they made in IMCHA achievements.*
3. *To assess IMCHA management, and the value added by the initiative.*
4. *To inform future partnerships and undertakings.*
5. *To evaluate how the work conducted under IMCHA is being documented for contributing to the legacy of the Initiative.*

5.1 IMCHA PERFORMANCE

IMCHA performance as assessed on the basis of outcome indicators is summarised in **Annex 14**.

Ultimate outcome - Improved maternal, newborn and child health outcomes in targeted countries:

All projects could document an effect or a potential effect on improved MNCH indicators, although with differences in terms of the size and attributability of effect. Projects that implemented and researched interventions at the community and primary health care service level were able to document a direct effect in their project areas. Final data were, however, not yet available at the time of the evaluation. Projects that researched issues at a more upstream health systems level could potentially generate larger effects, although the attribution of the project cannot be measured.

Intermediate outcome 1 - Enhanced production, analyses and syntheses of health systems implementation research prioritising gender and equity:

The outcome is measured by two indicators: '*The proportion of projects that have at least three of four processes with adequate gender and equity dimensions*', and '*the proportion of health systems research outputs and syntheses that are gender- and equity-focused*.'

15/28 projects (54%) integrated adequate gender dimensions, and 7/28 (25%) adequate equity dimensions in at least three research processes. Performance on gender integration improved over time and was considerably higher among projects funded with synergy grants than among those funded with the original research grants. Among 98 outputs from 22 projects that were available for analysis, 44 (46%) included a gender focus and 21 (22%) an equity focus. Approaches to equity analysis were introduced to the research teams at the IMCHA learning workshop in January 2020. At the time of data collection several PIs stated that they intended to use collected data to conduct equity analyses. The proportion of equity-focused outputs are therefore likely to increase.

Intermediate outcome 2 - Enhanced partnering and collaboration between decisionmakers and researchers on health systems strengthening in the selected countries/regions:

The indicator for this outcome defines the decisionmaker as the '*national focal point for MNCH*'. Although national MNCH focal points were generally not the decisionmakers associated as Co-PIs with

the projects, most projects communicated their activities and preliminary results at this level, either systematically by participating in national technical working groups on MNCH, through direct contacts with the ministry of health or during HPRO-facilitated national consultations. For some projects, the national MNCH coordinator was not the main government respondent and the projects worked more directly with departments for universal health coverage, health financing or health information. The evaluation team therefore considers that the framing of the indicator definition was too narrow to capture the entire IMCHA initiative and did not assess the performance against this indicator.

The embedding of decisionmakers as Co-PIs in research projects was an effective contribution to knowledge translation in IMCHA. Low levels of engagement by decisionmakers in some projects were mostly attributed to high mobility within their government structures. Those decisionmakers who had an existing professional relationship with the PIs, who were involved in the projects from the start, and potentially also in the conception and development of the project, were also most likely to be the most engaged.

Intermediate outcome 3 - Enhanced integration of health systems research findings into primary health care policies and practice in selected countries:

The outcome is monitored by the '*reference to research findings or recommendations in country-led technical decision-making platforms'*. Although the evaluation team considers that it is too early to assess the outcome against this indicator, the target of 20 was likely already reached. All interviewed PIs mentioned presentations and discussions of research results in national fora and most had plans for further discussions once final research results were available. The evaluation was, however, not able to identify any formal document from a national decision-making forum that specifically referred to research conducted by an IMCHA project.

Immediate outcome 100 - Strengthened capacity of researchers and research organisations to conduct gender and equity informed health systems implementation research:

The first indicator to measure this outcome is the '*proportion of total research projects that have adequately detailed gender and equity dimensions*'. Sufficient information on research design and research tools to address gender and equity was available for 20/28 projects. Among these 19 (95%) included data collection plans or tools for gender analysis and seven (35%) for equity analysis, albeit with varying depths. Outputs from 22/28 projects were available for analysis. Among these 18/22 (82%) had produced at least one output that included a gender dimension and 5/22 (23%) an equity dimension. However, in interviews several PIs stated that they were conducting or planning gender analyses, and some noted that they could use available data to perform a secondary equity analysis. A final assessment of performance against this indicator was therefore not possible.

The second indicator is the '*proportion of recommendations from formative analysis of HPROs acted upon*'. The 46 recommendations and sub-recommendations of the formative research reports commissioned by the HPROs include recommendations that are either not relevant or not actionable. For instance, a recommendation that the ministry of health increase its budget allocation to MNCH or its dialogue with donors. All recommendations that were actionable by HPROs were grouped by the evaluation team in six groups, under the headings of capacity strengthening, national research uptake

and dissemination of results. They were all acted on by the HPROs except for the recommendation on equity training.

Immediate outcome 200 - Strengthened partnerships and alliances between African researchers, decisionmakers and Canadian researchers:

The PMF indicator for monitoring this outcome '*proportion of implementation research projects that demonstrate effective collaboration and management*' is a compound indicator because the outcome focuses on cooperation among three partners. The indicator, in addition, refers to project management while the target only refers to project governance. Project governance was provided by IMCHA management and is addressed under a different heading. Management issues among some projects were primarily identified in the initial phases of IMCHA and were addressed effectively with support of IMCHA management. Among the reviewed projects, management issues related to the cooperation between Canadian and African researchers were raised in relation to the splitting of project grants between the two institutions and the lack of sharing financial information among them.

The collaboration between African and Canadian researchers was rated as successful by 74 percent of African and 73 percent of Canadian researchers. Partnerships between African and Canadian researchers was rated as strong where a working relationship had existed prior to the IMCHA project. Engagement between PIs and Canadian Co-PIs in all sampled projects (16/28 projects; 9/20 Canadian Co-PIs; 10/21 PIs) ranged from strong to acceptable. In all sampled projects there was at least regular information exchange between PIs and decisionmaker Co-PIs. None of the eight interviewed decisionmaker Co-PIs stated that they had a direct engagement with Canadian Co-PIs and only 2/9 interviewed Canadian Co-PIs mentioned a strong engagement with decisionmaker Co-PIs other than meetings during field visits and IMCHA workshops.

Immediate outcome 300 - Increased awareness and understanding of research evidence by decisionmakers at the primary healthcare level

The PMF indicator for monitoring this outcome is the '*proportion of Co-PI decision-makers' follow up on recommendations from research into health systems planning fora*'. Among the 29 current and former decisionmakers Co-PIs who were invited to the online survey only five responded (17%), and only 8/11 decisionmaker Co-PIs of sampled projects (73%) were available for interviews. All except one who was recently appointed stated that they followed up on evidence generated by their project, mostly by presenting it in policy fora and discussions. Some also stated that they were still waiting for final documentation of the evidence prior to following up. It is plausible that those who responded were more closely engaged in their project than the non-responders, and whether the target of 100 percent was reached could therefore not be confirmed.

5.2 Follow-up on the midterm recommendations

The midterm evaluation was implemented after the IMCHA midterm workshop in 2017 where many issues that affected the partnerships between HPROs and research teams as well as between researchers and decisionmakers in the teams were addressed. Following the workshop, HPROs and research teams engaged in activities that largely anticipated the recommendations of the midterm report which were then accepted as '*a confirmation that we were on track*'.

Most of the 14 recommendations on the current IMCHA initiative were directed at the HPROs or addressed issues that were within the HPRO mandate. All were implemented with the exception of the recommendation on equity training which was addressed later in the IMCHA learning workshop in 2020, arguably too late to be integrated in project implementation but with possibly some effect on the way project data are analysed.

5.3 IMCHA MANAGEMENT

IMCHA management was described as responsive and flexible by interviewed researchers and online survey respondents. The proportion of survey respondents who reported that they received support from IDRC as well as the proportion who rated this support as very helpful increased between the midterm and the final evaluation surveys. About two-thirds of respondents rated the support provided for the preparation of implementation plans, technical reports and financial reports as very helpful. The financial holdback policy for the last semester payment until project completion raised concerns among some African researchers who foresaw difficulties in pre-funding their final data collection, analysis, knowledge translation and documentation activities.

The M&O Committee was assessed by committee members as a successful mechanism for the three funding organisations to work together. They acknowledged that the differing mandates of the three partners had at times been difficult to negotiate, but that the regular contacts in the M&O Committee provided a good platform to resolve them. Frequent changes of delegates to this committee were mentioned as a constraint.

5.4 IMCHA DOCUMENTATION

The research teams, the HPROs and IMCHA management generated a large number of materials that document the IMCHA initiative, with a considerable volume of documents still in preparation. They range from research papers in peer-reviewed journals, to policy briefs, conference presentations, news stories, newsletters, blogs, and short films, some of excellent quality. The main access portals are the IMCHA website launched by APHRC and the IMCHA pages on the IDRC website. The IMCHA website has the stronger branding, however it is incomplete by presenting primarily East African content, and it is also not updated with sufficient regularity. The IDRC website is more up to date and more complete although it also misses some content, for example the IMCHA newsletters.

6 RECOMMENDATIONS

6.1 FOR IMCHA

IMCHA is ending in 2021 and there are therefore no recommendations for the implementation of the initiative. One recommendation, however, addresses concluding activities:

1. Global experience and knowledge about the approach of embedding decisionmakers in implementation research is limited. IMCHA can potentially make an important contribution to this knowledgebase. At a time when IMCHA projects have completed their knowledge translation activities and generated a sufficient volume of publications to document them, a meta-analysis of the approach should be commissioned and published.

6.2 FOR ANY FUTURE INITIATIVE

2. The PMF for a future initiative should be more clearly linked to the objectives of implementation research. Improved maternal and child health and increased utilisation of quality health services are high level outcomes and therefore appropriate ultimate outcomes for a logic model. However, as stated in the IMCHA logic model, many factors contribute to these outcomes and it is therefore not appropriate to include them in the PMF. The PMF of an implementation research initiative should instead be used to monitor the extent to which funded projects are able to document or reject the effectiveness and feasibility of researched interventions in the implementation context, and the extent to which they are able to translate these findings into improvements in MNCH programmes and policies.
3. The design of a future initiative should be clear about the scale at which it expects policy and programme changes to be generated by its grantees. If national MNCH policies are the primary targets, project grants should be of sufficient size to assure national visibility. As an alternative, multiple networked projects could be selected within countries to generate a critical volume of evidence. Scaling to national policy does not necessarily have to be the objective of all projects. Applicants should, however, be clear about the level of scaling they are targeting, and most importantly, this should also be reflected in the administrative position of the decisionmaker Co-PI embedded in the project.
4. Programme objectives in terms of promoting gender equality and health equity should be clearly spelled out in the call for proposals and in the monitoring frameworks of each project. Funded projects should include methodologies and plans on how they intend to address these objectives. Prior to finalising the implementation plans, all selected applicants should participate in workshops and webinars where their capacity and their approach to meeting the objectives are clarified and steps are taken to address any capacity gaps.
5. HPROs should be selected and contracted early in a new initiative and should participate in the selection of research grantees. If they have early knowledge about what will be funded in which country, they will be in a better situation to develop their own workplan for supporting projects in knowledge translation and networking.

6. In the grant selection process, care should be taken to avoid funding opportunistic partnerships between Canadian and African research institutions and between African research institutions and decisionmakers that are solely formed in response to the proposal call. While new partnerships should not be excluded *per se*, they should be subjected to additional scrutiny to assure that partners have common objectives and compatible ways of working.
7. The preparation phase of IMCHA prior to starting project activities was almost two years, considerably shortening the implementation time of projects. While this may be unavoidable, especially if capacity-building in gender and equity mainstreaming is included in the preparation phase of a new initiative, it should be factored into the overall duration of the initiative. Allocating additional time to the closing phase of projects for advocacy and knowledge translation activity may also be considered.
8. A future initiative should, from the start, create a strongly branded internet presence through a single web portal that is independent of the IDRC web site. Management of the site could be outsourced, even to an HPRO, but the source contract should assure that the initiative is presented comprehensively and that the site provides timely access to all communications.

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INNOVATING FOR MATERNAL AND CHILD HEALTH IN AFRICA (IMCHA) SUMMATIVE EVALUATION

Report Vol 2 (Annexes)

25.09.2020

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ANNEX 1. TERMS OF REFERENCE

INTRODUCTION AND PROJECT OVERVIEW

The Innovating for Maternal and Child Health in Africa (IMCHA) Initiative seeks to improve maternal, newborn and child health (MNCH) outcomes by strengthening health systems, using primary health care as an entry point. It is a seven-year partnership between the Canadian Institutes of Health Research (CIHR), Global Affairs Canada (GAC), and Canada's International Development Research Centre (IDRC). IMCHA was launched in 2014 with a budget of CA$36 million. It will end on December 31, 2020.

The IMCHA model is comprised of 19 Research Teams (RTs) and two African regional health policy and research organizations (HPROs). The research teams, composed of leading African researchers as Principal Investigators (PI), along with Canadian researchers and African Decision-makers as co-PIs have tested practical solutions to health system challenges, generating new knowledge to ensure that mothers and their children have better access to quality care they need. The RTs have also explored how successes can be scaled up to improve health equity for women and children across priority research themes including i) high impact, community-based interventions; ii) quality facility- based interventions; iii) enabling the policy environment to improve healthcare services and outcomes; and iv) human resources for health. The HPROs lead capacity building and knowledge translation efforts in collaboration with the research teams. They foster uptake of research findings by high-level policymakers to ensure that evidence informs decision-making and strengthens health systems. All 19 RTs received an original grant. In addition, nine RTs were awarded a Synergy Grant on a competitive basis, for a total of 28 research projects conducted by the 19 RTs.

The IMCHA management team is composed of a dedicated core team and several Program Officers within the Maternal and Child Health (MCH) Program at IDRC. The governance structure of the partnership consists of a Governance Committee and a Management and Operations (M&O) Committee. With representation from the three partner organizations, the role of the Governance Committee is to focus on strategic decision-making. The role of the M&O Committee is to conduct ongoing oversight of the progress of IMCHA and explore synergies to promote the communication and use of the findings from IMCHA.

DESCRIPTION AND SCOPE OF WORK

Project Scope

The purpose of the evaluation is to assess the overall performance of the Initiative and the value-added of its design and delivery. The evaluation will complement other monitoring activities conducted by the IMCHA management team to report on the Performance Measurement Framework (PMF).

Specific Objectives

The specific objectives are as follows:

1. To examine IMCHA performance in relation to the PMF, in particular progress made towards achieving the immediate, intermediate and ultimate outcomes.

2. To evaluate how the recommendations of the midterm evaluation were addressed and what difference they made in IMCHA achievements.
3. To assess IMCHA management, and the value added by the initiative.
4. To inform future partnerships and undertakings.
5. To evaluate how the work conducted under IMCHA is being documented for contributing to the legacy of the Initiative.

Intended Users of the Evaluation

Primary Users:

- IMCHA management team
- IMCHA governance structure (Governance Committee and M&O committee – including all funding partners IDRC, GAC and CIHR)

Secondary users:

- IMCHA grantees: (RTs and HPROs)
- Other external stakeholders, such as research organizations and donors, interested in the IMCHA model to improve MCH and/or working in similar settings
- Policy makers and program managers in Canada and all participating countries

Evaluation Questions

1. Performance of the Initiative: What are the achievements of IMCHA with regard to the Performance Measurement Framework (in particular in terms of immediate, intermediate and ultimate outcomes) as well as policy uptake and scale up of successful interventions (triangulation of evidence from IMCHA databases based on technical reports received and on field visits)**?**

A. Improved maternal newborn and child health outcomes in targeted countries.

- What are the achievements of IMCHA in relation to the eleven indicators on MNCH? (Provide data in relation to the baseline and target identified in the PMF for the indicator "Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services").
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]?
- What have been the main strategies to obtain these achievements? And how appropriate are they for achieving the intended outcomes?

B. Enhanced production, analyses and syntheses of health systems implementation research prioritizing gender and equity.

Expressed in data, assess progress on indicators 1.1 "Proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions" and 1.2 "Proportion of health systems research outputs and syntheses that is gender and equity focused" in relation to the baseline/targets identified in PMF.

Integration of gender dimension?

- How have the IMCHA RTs integrated gender dimensions? What strategies have been used? Which ones have proven successful, and why? Which ones have not, and why? What have been helping or hindering factors?
- How have the HPROs contributed to the integration of gender in the research projects' activities, capacity building, and knowledge translation? What strategies have been used? Which ones have proven successful, and why? Which ones have not, and why? What have been helping or hindering factors?
- How has the IMCHA management team contributed to this integration?
- How have the recommendations from the midterm evaluation influenced this integration?

Integration of equity dimension?

- How did the IMCHA RTs integrate equity dimensions? What strategies were used? Which ones have been proven successful, and why? Which ones have not, and why?
- How did the HPROs contribute to the integration of equity in the research projects' activities, capacity building, and knowledge translation? What strategies have been used? Which ones have proven successful, and why? Which ones have not, and why? What have been helping or hindering factors?
- How has the IMCHA management team contributed to this integration?
- How have the recommendations from the midterm evaluation influenced this integration?

The midterm evaluation highlighted some confusions between the concepts of "gender" and "equity". Has there been any change in the understanding of these concepts since then? If yes, what has changed, and what has contributed to this change?

What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model?

C. Enhanced partnering and collaboration between decision makers and researchers on health systems strengthening in the selected countries/regions

Expressed in data, assess progress on indicator 2.1 "Number of total projects per country that demonstrate high level of collaboration with decision maker (documented by project, country and regional levels)" in relation to the baseline/target identified in PMF.

- How have RTs and/or HPROs demonstrated collaboration with decision makers, and at what level of decision making (overall, by project, and at country and regional levels)? What have been helping or hindering factors?
- How has the IMCHA management team contributed to this work?
- How did the recommendations from the midterm evaluation influence this work?
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]?

D. Enhanced integration of health systems research findings into primary health care policies and practice in the selected countries & scale up

Expressed in data, assess progress on indicator 3.1 "Number (type) of influence of IMCHA research projects on policy and programming per project" in relation to the baseline/target identified in PMF.

- How have RTs and/or HPROs demonstrated influence on policy and programming (overall, by project, and at country and regional levels)? What have been helping or hindering factors?
- How have RTs and HPROs been scaling? What have been helping or hindering factors?
- How has the IMCHA management team contributed to this work?
- How did the recommendations from the midterm evaluation influence this work?
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model? [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]

E. Strengthened capacity of researchers and research organizations to conduct gender and equity informed implementation research

Expressed in data, assess progress on indicator 100.2 "Proportion of recommendations from formative analysis of HPROs acted upon" in relation to the baseline/target identified in PMF.

- How have the HPROs acted upon the recommendations from the formative/situation analyses they conducted?
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model? [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]

F. Strengthened partnerships and alliances between African researchers, decision-makers and Canadian researchers

- Since the midterm evaluation, how has the collaboration between African and Canadian researchers evolved? What factors are helping this collaboration? Why is that? What factors are hindering the collaboration? Why is that? How have these factors been addressed?
- How has the collaboration between researchers and African decision-makers evolved? What factors are helping this collaboration? Why is that? What factors are hindering the collaboration? Why is that? How have these factors been addressed?
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]?

G. Increased awareness and undertaking of research evidence by decision makers at the primary healthcare level

- How have recommendations from IMCHA research been communicated to the project co-PI decision maker? How has the co-PI decision maker used this information?
- What, if any, outcomes have been achieved that were not predicted in the PMF or IMCHA Logic Model [PROMPT FOR GENDER-RELATED OUTCOMES IN PARTICULAR]?

2. Assessment of the IMCHA management: how effective has the management of the Initiative been and what difference has that made to IMCHA achievements?

- How has the support from the management team contributed to the efforts of the RTs, the HPROs, and the Initiative overall?
- How has the IMCHA management team implemented the recommendations of the midterm? What difference has this made in IMCHA achievements?
- [Only for IMCHA donor partners] How has the Management and Operations Committee influenced IMCHA management and achievements?

3. Assessment of the value-added of the IMCHA Initiative (building up on findings from the midterm evaluation, and focusing on findings for the period thereafter: How well has IMCHA been operationalized and how could it be improved on in future undertakings)? How can the evaluation inform the design of the IMCHA model for future undertakings?

- How did the IMCHA model contribute to the performance of the initiative? What new lessons can be learned regarding the design and implementation of the model of the RTs (African PIs and Canadian researcher co-PIs and African Decision-maker co-PI)? What new lessons can be learned regarding the design and implementation of the model of HPROs? What new lessons can be learned regarding the collaboration between research teams and HPROs? How could the IMCHA model be improved on when designing future initiatives?
- The Synergy Grants are also an opportunity for RTs to expand on their original grant, explore new (but related) issues and/or engage in scale-up: What worked well in the Synergy Grants? What were the challenges? How could this be improved on in a future Initiative?
- What are other recommendations for designing any such future initiative?
- [Only for IMCHA donor partners] What new lessons can be learned regarding the design and implementation of the partnership between CIHR, GAC and IDRC? How relevant would an initiative such as IMCHA continue to be to address your need and alignment with the Government of Canada and your own organizational priorities? How could a similar donor partnership be strengthened in designing such future initiative?

4. To evaluate how the work conducted under IMCHA is being documented for contributing to the legacy of the Initiative

- How have the RTs and HPROs documented their work, beyond publications, indicators performance and impacts, to contribute to IMCHA legacy? How could this be improved on in a future Initiative?
- How has the IMCHA management team documented the work of IMCHA, beyond publications, indicators performance and impacts, to contribute to the legacy of the Initiative? How could this be improved on in a future Initiative?
- [Only for IMCHA donor partners] How have the 3 donor partners documented the work of IMCHA, beyond publications, indicators performance and impacts, to contribute to the legacy of the Initiative? How could this be improved on in a future Initiative?

Methodology

The proposed evaluation methodology will be judged on its suitability for addressing the evaluation questions. It should employ mixed data collection methods and multiples data sources. One source to be considered will be data already collected by IMCHA as a part of other monitoring activities.

IMCHA expects that the methodology will include the following components, although we invite proponents to propose other valid approaches that, in their view, would yield informative findings:

- **Document Review**: to include but not be limited to: IMCHA core documents (calls for proposals, workplan, logic model, documents analysing performance against the PMF, midterm evaluation report and other outputs, etc.); IMCHA grantees documents (abstracts, technical reports, impact statements, and IDRC projects monitoring visit reports and relevant trip reports); IMCHA annual reports to donor partner GAC; and any other available capacity building, knowledge translation and research uptake products.
- **Quantitative data collection/analysis**: The consultants will conduct an online survey to solicit input from all Principal Investigators (PIs) and co-PIs. The consultants will also have access to IMCHA databases compiling information gathered from the Technical Reports.
- **Qualitative data collection/analysis**: The consultants will conduct in-depth interviews to solicit perspectives from IMCHA grantees, IMCHA management team and other relevant IDRC staff, CIHR and GAC focal points (and others as specified), and other key external stakeholders. If possible, the consultants will also solicit perspectives from beneficiaries of the projects (communities, human resources for health, decision makers and other stakeholders) through interviews and/or focus group discussions.
- **Scope:** Proponents are expected to cover the entire IMCHA Initiative, including the 2 HPROs and 28 research projects (composed of the 19 original Implementation research grants and 9 Synergy grants).

Proponents will provide an overview of the limitations of their proposed approach and articulate mitigation strategies.

Tasks and Responsibilities

- Proponents will produce an evaluation design report. This report will include: the evaluation questions to be addressed, the methodology to be implemented, a work plan including a schedule of expected dates, and a framework (cross-listing questions, methods and data sources) which will be shared with and approved by IDRC. The proponents should also submit a plan of proposed travels for fieldwork.
- Proponents will engage in data collection and analysis as outlined in the evaluation design.
- Proponents will produce an outline of the key sections of the evaluation report, for feedback and approval by IDRC. The report should respond to the questions outlined above and include a summary table displaying progress data on each PMF indicator for the immediate (with the exception of 200.1 and 300.1), intermediate, and ultimate outcomes.
- Proponents will produce a presentation of preliminary findings and present to IMCHA donor partners for review, sense-making and discussion.

- Proponents will produce a draft evaluation report for review by the IMCHA donor partners. The report should take into account observations from the presentation of the preliminary findings.
- Proponents will integrate feedback received and produce a revised report. After review by the IMCHA partners, and possible additional revisions, the final report will be submitted to IDRC. The report should be a maximum of 25 pages (excluding annexes and executive summary). It should include an executive summary in English and French. The final evaluation report will be a publicly accessible document.
- Proponents will also produce two Issue Briefs on specific areas of interest (each maximum of four pages). The Briefs will synthesize IMCHA-wide lessons learned from the Evaluation Questions. The areas of interest will be decided upon discussions during the presentation of preliminary findings to IDRC and donor partners.

IMCHA will: provide relevant documentation, including core documents, projects documentation and other products to the consultant as needed; facilitate contact with grantees, staff at IDRC and donor partners, and other relevant stakeholders; and will interact closely with the consultants and provide input and feedback as needed.

ANNEX 2. IMCHA GRANTS

Implementation Research Grants

Grant	Country	PI Institution	Canadian Co-PI Institution	Start	End[1]	Grant Amount
108020: Quality Improvement for Maternal and Newborn Health At District-level Scale in Mtwara Region	Tanzania	Ifakara Health Institute	SickKids Centre, Toronto	10/15	03/20	980,834
108022: An mHealth Strategy to Reduce Preeclampsia-Eclampsia and Maternal and Infant Deaths in Tanzania	Tanzania	Ifakara Health Institute	Queen's University	03/16	04/20	999,350
108023: Integrating Demand and Supply Sides of Health Systems Governance to Improving Maternal, Newborn and Child Health in Tanzania	Tanzania	University of Dar es Salaam	HealthBridge	03/16	03/20	995,940
108024: Replicating MamaToto In Rural Tanzania	Tanzania	Catholic Univ. of Health and Allied Sciences	University of Calgary	03/16	05/20	987,800
108026: Building an Enhanced Cadre of Community Health Workers to Improve Maternal and Newborn Health in Rural Tanzania	Tanzania	Shirati District Hospital	Bruyere Research Institute, Ottawa	03/16	09/20	944,450
108027: Accessing Safe Deliveries in Tanzania	Tanzania	Tanzanian Training Centre for International Health	Dalhousie University	10/15	04/20	991,920
108028: Promoting Safe Motherhood in Jimma Zone, Ethiopia	Ethiopia	Jimma University	University of Ottawa	09/15	09/20	999,560
108029: Community-Based Cause of Death Study Linked to Maternal and Child Health Programmes and Vital Statistics in Ethiopia	Ethiopia	Addis Ababa University	Centre for Global Health Research, Toronto	01/16	09/20	986,896
108030: Integrating a Neonatal Healthcare Package in Malawi	Malawi	University of Malawi	University of British Columbia	02/16	08/20	981,153
108031: Improving the Standards-Based Management Recognition Initiative to Provide High Quality, Equitable Maternal Health Services in Malawi	Malawi	University of Malawi	University of Alberta	01/16	07/20	999,632
108032: Mother Child Health Lacor-South Sudan	Uganda / South Sudan	Lacor Hospital, Uganda & Torit Hospital, South Sudan	Université de Montréal	10/15	04/20	999,660
108033: Incentives and Social Enterprise models for Community Health Workers	Uganda / South Sudan	BRAC Africa	Cape Breton University	10/15	04/20	997,962

[1] Status in February 2020. End-dates for most projects have since been extended because of the impact of COVID-19

Implementation Research Grants

Grant	Country	PI Institution	Canadian Co-PI Institution	Start	End[1]	Grant Amount
108034 / 108508: Alert Community to Prepared Hospital Care Continuum (Phase 1 & 2)	Mozambique	Universidade Lurio	University of Saskatchewan	04/16 03/17	11/16 07/20	126,980 843,040
108035: Bajenu Gox: une porte d'entrée pour soutenir une approche communautaire intégrée visant la santé de la mère et de l'enfant	Sénégal	Université Cheikh Anta Diop de Dakar	Institut national de santé publique du Québec	08/15	06/20	852,400
108037: Des interventions innovantes et réalistes pour améliorer la santé des mères, des nouveau-nés et des enfants en Afrique de l'Ouest	Burkina Faso / Mali	Société d'Études et de Recherches en Santé Publique, Burkina Faso	Université Laval	06/15	09/19	999,859
108038: Financement basé sur les résultats en santé maternelle et infantile et l'équité au Mali et Burkina Faso	Burkina Faso / Mali	MISELI, Mali	Université de Montréal	10/15	10/20	989,190
108039: Video Edutainment at the Doorstep: Impact on Maternal and Infant Outcomes in Toro Local Authority in Bauchi State, Nigeria	Nigeria	Federation of Muslim Women's Associations in Nigeria	McGill University	08/15	05/20	943,520
108040: Scaling Up Care for Perinatal Depression for Improved Maternal and Infant Health in Nigeria	Nigeria	University of Ibadan	Jewish General Hospital, Montreal	08/15	02/20	999,400
108041: Increasing Women's Access to Skilled Pregnancy Care in Nigeria	Nigeria	Women's Health and Action Research Centre	University of Ottawa	11/15	05/20	999,880

Synergy Grants

Grant	Country	PI Institution	Canadian Co-PI Institution	Start	End	Grant Amount
108545: Enhancing Community Health Workers support for Maternal, Adolescent and Newborn Health Project plus Contraception in Rural Tanzania	Tanzania	Shirati District Hospital	Bruyere Research Institute, Ottawa	07/17	05/20	491,200
108546: Bridging the know-do gap among healthcare workers and decision-makers through improved routine measurement of the quality of maternal and newborn care	Tanzania	Ifakara Health Institute	SickKids Centre, Toronto	10/17	10/20	483,300

Implementation Research Grants

Grant	Country	PI Institution	Canadian Co-PI Institution	Start	End[1]	Grant Amount
108547: Mama na Mtoto: Barriers and Enablers to Gender, Equity and Scale-up in Tanzania	Tanzania / Uganda	Catholic University of Health and Allied Sciences, Tanzania / Mbarara University of Science and Technology, Uganda	University of Calgary	10/17	10/20	487,400
108548: Leadership and Managerial Capacity Strengthening for Quality Pregnancy and Newborn Outcomes in Tanzania	Tanzania	Tanzanian Training Centre for International Health	Dalhousie University	09/17	09/20	492,700
108549: Statistical Alliance for Vital Events: Strengthening Reporting and Program uses of Facility-based Child and Maternal Mortality Data in Ethiopia and Mozambique	Ethiopia, Mozambique	Addis Ababa University	Centre for Global Health Research, Toronto	10/17	10/20	500,000
108550: How Can a Gender Lens Enhance Maternal and Child Health Social Enterprises in Africa?	Uganda / Kenya	BRAC Africa	Cape Breton University	10/17	09/20	487,900
108551: Synergies in video edutainment: child spacing and regional training for rollout in Bauchi	Nigeria	Federation of Muslim Women's Associations in Nigeria	McGill University	09/17	09/20	484,700
108552: Responding to the challenge of Adolescent Perinatal Depression	Nigeria	University of Ibadan	Jewish General Hospital, Montreal	10/17	10/20	401,600
108553: Examen des effets de l'abolition des frais d'utilisateurs pour les femmes et les enfants au Burkina Faso	Burkina Faso	Société d'Études et de Recherches en Santé Publique, Burkina Faso	Université Laval & Université de Montréal	10/17	10/20	490,300

HPRO Grants

Grant	Region	Institution	Start	End	Grant Amount
107892: Moving Maternal, Newborn and Child Health Evidence into Policy in West Africa	West Africa	West ROealth Organisation (WAHO) (Burkina Faso)	11/14	10/20	2,600,000
107893: Moving Maternal, Newborn and Child Health Evidence into Policy in East Africa	East Africa	African Population and Health Research Centre (APHRC) (Kenya) Partners in Population and Development (PPD) (Uganda) East, Central and Southern African Health Community (ECSA) (Tanzania)	11/14	10/20	2,600,000

ANNEX 3. THE IMCHA LOGIC MODEL

ULTIMATE OUTCOME	Improved maternal, newborn and child health outcomes in targeted countries.[1]		
INTERMEDIATE OUTCOMES	1. Enhanced production, analyses and syntheses of health systems implementation research prioritizing gender and equity.[2]	2. Enhanced partnering and collaboration between decision makers and researchers on health systems strengthening in the selected[3] countries.[4]	3. Enhanced integration of health systems research findings into primary health care policies and practice in selected countries.
IMMEDIATE OUTCOMES	100. Strengthened capacity of researchers and research organizations to conduct gender and equity informed health systems implementation research.	200. Strengthened partnerships and alliances between African researchers, decision-makers and Canadian researchers.	300. Increased awareness and understanding of research evidence by decision makers at the primary healthcare level.
OUTPUTS	110. Funding provided to IRTs to conduct policy relevant gender and equity sentitive health systems implementation research. 120. Funding provided to research teams that include emerging researchers. 130. Synergistic research opportunities[5] identified and supported. 140. Training, networking and exchanges of HPROs and IRTs is undertaken to strengthen the capcity of organizations funded through IMCHA.	210. Collaborative mechanisms established between IRTs and HPROs. 220. HPROs and IRTs facilitate regional and national decision makers to engage in IMCHA implementation research. 230. Linkages formed outside of the IMCHA initiative by HPROs, IRTs with like-minded organizations. 240. Research teams lead by African researchers and decision makers and Canadian co-PIs are funded.	310. Evidence based policy and practice promoted by IRTs and HPROs. 320. Knowledge translation activities and products targeting relevant local, national and regional decision makers conducted.

[1] The IMCHA initiative is not responsible for reporting on the ultimate outcome. Many factors outside the scope of activities in this initiative will contribute to health outcomes in the targeted countries.
[2] The theory of change in this column is that by doing research, individual and institutions will gain research skills. This in turn leads to stronger analysis and syntheses.
[3] Selected countries includes the target countires and additional countries where IRTs and HPROs work.
[4] Intermediate outcomes 2 and 3 are closely linked. It is understood that intermediate outcome 2 (relationships between researchers and decision makers) contributes to intermediate outcome 3 (integration of research into policy and practice).
[5] The synergy grants will fill research gaps that the Implementation Research Teams do not cover, and/or will build on the funded implementation research. Health Policy and Research Organizations will work with decision makers, researchers and IDRC to identify relevant topics for health systems research on Maternal Newborn and Child Health that will complement the portfolio of research being done by the Implementation Research Teams. The focus will continue to be policy relevance and potential for impact. . Given the regional mandate of HPROs and in the spirit of working in Sub-Saharan Africa as a whole work in the entire region, research taking place in any country or countries in the region will be eligible.

ACTIVITIES	**IMCHA** Strategic program design to support capacity strengthening efforts. Ongoing support to HPROs and IRTs to maximize health systems, gender and equity based implementation research. Grants and synergy grants prioritized and funded with analysis of composition of institutions represented. **HPROs** 100.3 Strengthen situational analysis and synthesis of heatlh systems implementation research. 130.1 HPROs identify synergy research opportunities. 140.1 Training of IRTs and other stakeholders undertaken and completed. 140.2 Networking and exchange opportunities supported and tracked. **IRTs** 110.1 Conduct policy relevant gender sensitive health system implementation research using primary health care as an entry point. 120.2 IRTs involve emerging researchers. 130.1 IRTs identify synergy research opportunities. 140.1 Training of IRTs and other stakeholders undertaken and completed. 140.2 Networking and exchange opportunities supported and tracked.	**IMCHA** Strategic program design informing partnership and collaboration at country, regional and global levels. Enhance partnership and collaboration opptunities for HPROs and IRTs with technical committee members and other stakeholders. 240.1 Ensure and support the collaboration between Canadian researchers, African researchers and African decision makers. **HPROs** 210.1 HPROs to maximize communication and support with IRTs. 230.1 Establish strategic connections for HPROs and IRTs with organizations outside of IMCHA. **IRTs** 200.1 Maximize collaboration and expertise amoung members of implementation research team. 220.1 Establish ongoing linkages with appropriate decision-makers. 230.1 Establish strategic connections for HPROs and IRTs with organizations outside of IMCHA.	**IMCHA** Strategic program design supporting integration of research into policy and practice. Ensure support to HPROs and IRTs to maximize uptake of research into policy and practice platforms. Augment and maximize knowledge translation opportunities for HPROs and IRTs. **HPROs** 300.2 Recommendations from formative analysis acted upon. 310.1 HPROs work with relevant stakeholders to build and support evidence-based policy and practice. 320. 1/320.2 Knowledge translation activities are conducted targeting relevant national and regional decision makers. **IRTs** 300.1 Maximize sharing of evidence and uptake by decision-makers and other stakeholders. 310.1 Promote sharing of evidence for influence on policy and practice. 320.1 Knowledge translation activities are conducted targeting relevant local and national stakeholders.

ANNEX 4. IMCHA PMF INDICATORS AND TARGETS[2]

Expected Results	Indicators	Targets
Ultimate Outcome		
Improved maternal, newborn and child health outcomes in targeted countries.	**Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services**	50% of the implementation research demonstrate improvement in any of the 11 accountability indicators
Intermediate Outcomes		
1. Enhanced production, analyses and syntheses of health systems implementation research prioritizing gender and equity	**1.1 Proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions.** **1.2 Proportion of health systems research outputs and syntheses that is gender and equity focused.**	All research projects have > 75 % (three of four processes) adequate gender and equity dimensions. 75% of outputs include gender and equity focused analysis/synthesis
2. Enhanced partnering and collaboration between decision makers and researchers on health systems strengthening in the selected countries/regions.	**2.1 Number of total projects per country that demonstrate high level of collaboration with decision maker (documented by project, country and regional levels).**	Minimum of one per country
3. Enhanced integration of health systems research findings into primary health care policies and practice in selected countries.	**3.1 Number (type) of influence of IMCHA research projects on policy and programming per project**	20
Immediate Outcomes		
100. Strengthened capacity of researchers and research organizations to conduct gender and equity informed health systems implementation research	**100.1 Proportion of total research projects that have adequately detailed gender and equity dimensions** 100.2 Proportion of recommendations from formative analysis of HPROs acted upon.	75 percent of research projects have adequate mechanisms identified to support gender and equity analysis. ≥75 % of total recommendations acted on
200. Strengthened partnerships and alliances between African researchers, decision-makers and Canadian researchers.	**200.1 Proportion of implementation research projects that demonstrate effective collaboration and management.**	75 percent of research projects demonstrate good practices in governance and coordination
300. Increased awareness and understanding of research evidence by decision makers at the primary healthcare level.	**300.1 Proportion of IRT decision-makers' follow up on recommendations from research into health systems planning forum(s).**	100 % of decision makers follow up on recommendations from research
Outputs		
110. Funding provided to IRTs to conduct policy relevant gender and equity sensitive health systems implementation research.	110.1 Number (and title) of health systems analysis and synthesis that is gender and/or equity focused produced by IRTs.	20

[2] The indicators identified in the PMF to be reported against by the Summative Evaluation are **bolded**

Expected Results	Indicators	Targets
120. Funding provided to research teams that include emerging researchers.	120.1 Number of funded IRTs housed in research institutions.	20
	120.2 Number of emerging researchers involved in the IRT research.	35
130. Synergistic research opportunities identified and supported.	130.1 Number of synergistic research opportunities identified and funded (West and East Africa separately)	WA: three funded EA: three funded
140. Training, networking and exchanges of HPROs and IRTs is undertaken to strengthen the capacity of organizations funded through IMCHA	140.1 Number of individuals who received training/networking and exchange opportunities (by type and by participant).	40
	140.2 Number of networking and exchange opportunities supported through IMCHA	10
210. Collaborative mechanisms established between IRTs and HPROs.	210.1 Number of type of communication between IRTs and HPROs.	Quarterly contact
220. HPROs and IRTs facilitate regional and national decision makers to engage in IMCHA implementation research.	220.1 Number of new partnerships/collaborations between decision-makers and researchers on health systems strengthening.	20
	220.2 Number of existing partnerships/collaborations enhanced between decision-makers and researchers on health systems strengthening.	15
230. Linkages formed outside of the IMCHA initiative by HPROs, IRTs with like-minded organizations	230.1 Number of times HPROs and/or IRTs established connection with organizations outside of IMCHA (West and East Africa separately).	Number not defined – to track cumulative efforts
240. Research teams lead by African researchers and decision makers and Canadian co-PIs are funded.	240.1 Number of IRTs with at least one Canadian researcher, one African researcher and one African decision maker.	100 % aligned representation
310. Evidence based policy and practice promoted by IRTs and HPROs	310.1 Number (and description) of evidence-based policy and practice promoted by IRTs and HPROs (for East and West Africa).	Minimum of one per research project funded
320. Knowledge translation activities and products targeting relevant local, national and regional decision makers conducted.	320.1 Frequency (by type) of knowledge translation activities (at national and regional levels).	Yearly exchange at country and regional levels.
	320.2 Number (by type) of activities organised by HPROs to promote IRT research (for East and West Africa separately).	One or more regional exchange platform per year

ANNEX 5. IMCHA RESEARCH PUBLICATIONS (05/2020)

PROJECT	PUBLICATION	JOURNAL	YEAR
107892	An assessment of maternal, newborn and child health implementation studies in Nigeria: implications for evidence informed policymaking and practice	Health Promotion Perspectives	2016
107892	An Assessment of National Maternal and Child Health Policy-Makers' Knowledge and Capacity for Evidence- Informed Policy-Making in Nigeria	International Journal of Health Policy Management	2016
107892	Improving maternal and child health policymaking process in Nigeria: an assessment of policymakers' needs, barriers and facilitators of evidence-informed policymaking.	Health Research Policy and Systems	2017
107892	Promoting research to improve maternal, newborn, infant and adolescent health in West Africa: the role of West African Health Organisation.	Health Research Policy and Systems	2017
107892	Spanning maternal, newborn and child health (MNCH) and health systems research boundaries: conducive and limiting health systems factors to improving MNCH outcomes in West Africa.	Health Research Policy and Systems	2017
107892	An assessment of policymaker's engagement initiatives to promote evidence informed health policy making in Nigeria.	The Pan African Medical Journal	2017
107892	Assessment of policy makers' individual and organizational capacity to acquire, assess, adapt and apply research evidence for maternal and child health policy making in Nigeria: a cross-sectional quantitative survey.	African Health Sciences	2017
107892	Using equitable impact sensitive tool (EQUIST) to promote implementation of evidence informed policymaking to improve maternal and child health outcomes: a focus on six West African Countries	Globalization and Health	2018
107892	A review of the process of knowledge transfer and use of evidence in reproductive and child health in Ghana	Globalization and Health	2018
107892	Promoting evidence informed policymaking for maternal and child health in Nigeria: lessons from a knowledge translation workshop	Health Promotion Perspectives	2018
108023	Perceptions on male involvement in pregnancy and childbirth in Masasi District, Tanzania: a qualitative study	Reproductive Health	2018
108023	Why do pregnant women in Iringa region in Tanzania start antenatal care late? A qualitative analysis	BMC pregnancy and childbirth	2020
108026	Promoting Respectful Maternity Care in Rural Tanzania: Nurses' Experiences of the "Health Workers for Change" Program	BMC Health Services Research	2018
108026	Community member and policy maker priorities in improving maternal health in rural Tanzania	International Journal of Gynecology and Obstetrics	2018
108027	Knowledge acquisition of Helping Babies Survive in rural Tanzania.	International Health	2018
108028	Perceptions and experiences related to health and health inequality among rural communities in Jimma Zone, Ethiopia: a rapid qualitative assessment	BMC International Journal for Equity in Health	2018

PROJECT	PUBLICATION	JOURNAL	YEAR
108028	Narrative depictions of working with language interpreters in cross-language qualitative research	International Journal of Qualitative Methods	2018
108028	Talking health: Identifying trusted health messengers and effective ways of delivering health messages in rural Ethiopia	Archives of Public Health	2019
108028	Maternity waiting areas – serving all women? Barriers and enablers of an equity-oriented maternal health intervention in Jimma Zone, Ethiopia	Global Public Health	2019
108028	Subnational health management and the advancement of health equity: a case study of Ethiopia	Global Health Research and Policy	2019
108028	A quality assessment of Health Management Information System (HMIS) data for maternal and child health in Jimma Zone, Ethiopia	PLOS One	2019
108028	Factors associated with maternity waiting home use among women in Jimma Zone, Ethiopia: a multilevel cross-sectional analysis	BMJ Open	2019
108030	Barriers and enablers of implementing bubble Continuous Positive Airway Pressure (CPAP): Perspectives of health professionals in Malawi	PLOS One	2020
108030	Assessing quality of newborn care at district facilities in Malawi	BMC Health Services Research	2020
108030	Health workers' views on factors affecting caregiver engagement with bubble CPAP	BMC Paediatrics	2020
108030	Barriers and facilitators to implementing bubble CPAP to improve neonatal health in sub-Saharan Africa: a systematic review	Public Health Reviews	2020
108031	Improving the standards-based management recognition initiative to provide high quality, equitable maternal services in Malawi: an implementation research protocol	BMJ Global Health	2016
108032	Mothers' perceptions of the practice of kangaroo mother for preterm neonates in sub-Saharan Africa: A qualitative systematic review protocol	JBI Database of systematic reviews and implementation reports	2019
108032	Health policy mapping and system gaps impeding the implementation of reproductive, maternal, neonatal, child, and adolescent health programs in South Sudan: a scoping review	Conflict and Health	2020
108032	"Midwives do not appreciate pregnant women who come to the maternity with torn and dirty clothing": institutional delivery and postnatal care in Torit County, South Sudan: a mixed method study	BMC pregnancy and childbirth	2020
108033	Knowledge, Attitude, and Practice and service barriers in a tuberculosis programme in Lakes State, South Sudan: a qualitative study	South Sudan Medical Journal	2018
108033	How culture shapes the sexual and reproductive health practices among adolescent girls in Eastern Equatoria, South Sudan.	South Sudan Medical Journal	2018
108033	Using livelihoods to support primary health care for South Sudanese refugees in Kiryandongo, Uganda	South Sudan Medical Journal	2019

PROJECT	PUBLICATION	JOURNAL	YEAR
108033	Gender and health social enterprises in Africa: a research agenda	International Journal of Equity in Health	2019
108037	Effect of interrupting free healthcare for children: Drawing lessons at the critical moment of national scale-up in Burkina Faso.	Social Science and Medicine.	2017
108037	Sociocultural determinants of nomadic women's utilization of assisted childbirth in Gossi, Mali: a qualitative study	BMC pregnancy and childbirth	2018
108037	Impact evaluation of seasonal malaria chemoprevention under routine program implementation: A quasi-experimental study in Burkina Faso	American Journal of Tropical Medicine and Hygiene	2018
108037	Analysis of the quality of seasonal malaria chemoprevention provided by community health Workers in Boulsa health district, Burkina Faso	BMC Health Services Research	2019
108037	Longitudinal analysis of the capacities of community health workers mobilised for seasonal malaria chemoprevention in Burkina Faso	Malaria Journal	2020
108038	Improving quality of maternal health services in Malawi's Public Health sector	Health Policy and Planning	Sep-19
108038	Donor-funded project's sustainability assessment: a qualitative case study of a results-based financing pilot in Koulikoro region, Mali	BMC Globalization and health	2017
108039	Impact of universal home visits on maternal and infant outcomes in Bauchi state, Nigeria: protocol of a cluster randomized controlled trial	BMC Health Services Research	2018
108039	The impact of universal home visits with pregnant women and their spouses on maternal outcomes: a cluster randomised controlled trial in Bauchi State, Nigeria	BMJ Global Health	2019
108041	Systematic review of obstetric care from a women-centred perspective in Nigeria	International Journal of Gynecology and Obstetrics	2016
108041	Unlocking the Benefits of Emergency Obstetric Care in Africa	AJRH (African Journal of Reproductive Health)	2016
108041	Perceptions of women on workloads in health facilities and its effect on maternal health care: A multi-site qualitative study in Nigeria	Midwifery	2017
108041	Prevalence and risk factors for maternal mortality in referral hospitals in Nigeria: a multicenter study	Reproductive Health BMC Reproductive Health	2017
108041	Women's perceptions of reasons for maternal deaths: Implications for policies and programs for preventing maternal deaths in low-income countries	Health Care for Women International.	2017
108041	Maternal death review and outcomes: An assessment in Lagos State, Nigeria	PLOS One	2017
108041	Prevalence and determinants of childhood mortality in Nigeria	BMC Public Health	2017
108041	Increasing women's access to skilled pregnancy care to reduce maternal and perinatal mortality in rural Edo State, Nigeria: a randomized controlled trial	BMC Global Health Research and Policy	2018
108041	Predictors of women's utilization of primary health care for skilled pregnancy care in rural Nigeria	BMC Pregnancy and Childbirth	2018

PROJECT	PUBLICATION	JOURNAL	YEAR
108041	Assessing the knowledge and skills on emergency obstetrics care among health providers: Implications for health systems strengthening in Nigeria	PLOS One	2019
108041	Gender Inequality as Barrier to Women's Access to Skilled Pregnancy care in Rural Nigeria: A Qualitative Study.	International Health	2019
108041	Maternal near miss morbidity: Is this evidence of maternal health quality in sub-Saharan Africa.	BJOG	2019
108041	Decomposing the rural-urban gap in the factors of under-five mortality in sub-Saharan Africa. Evidence from 35 countries.	BMC Public Health	2019
108041	Why rural women do not use primary health centres for pregnancy care: evidence from a qualitative study in Nigeria	BMC Pregnancy and Childbirth	2019
108041	A qualitative study of community elders' perceptions about the underutilization of formal maternal care and maternal death in rural Nigeria	Reproductive Health	2019
108041	Men's perception of barriers to women's use and access of skilled pregnancy care in rural Nigeria: a qualitative study	Reproductive Health	2019
108508	Maternal and Newborn Mortality: Community Opinions on Why Pregnant Women and Newborns are Dying in Natikiri, Mozambique.	International Journal of Research	2019
108551	Factors associated with short birth interval in low- and middle-income countries: a systematic review	BMC pregnancy and childbirth	2020
108558	National user fee abolition and health insurance scheme in Burkina Faso: How they can be integrated on the road to universal health coverage without increasing health inequities?	Journal of Global Health	2020

Note: All publications in this database are authored by researchers participating in IMCHA grants but not all acknowledge IMCHA funding, do not address the issues of the IMCHA-funded project, nor are based on data collected under the project or evidence generated by the project. We suggest that IMCHA management review and clean this database

ANNEX 6. RECOMMENDATIONS OF THE HPRO SITUATION ANALYSES

COUNTRY/ INSTITUTION	RECOMMENDATIONS OUTLINED IN SITUATION ANALYSES
West Africa - regional	• Improve capacity to prepare data syntheses, systematic reviews and strategic briefing notes • Build capacity for requesting, accessing, evaluating, adapting and using evidence • Establish frameworks regulations and guidelines for systematic use of data • Support the development of policy briefs; support to existing platforms for transfer and exchange of knowledge to promote consultative or deliberative processes informed by evidence during the strategic programming and planning process • Advocate better use of evidence
West Africa – gender & equity	• Target disadvantaged populations that continue to be overlooked in the region. • Governments should pursue the scale-up of existing programmes, while modifying them to best serve those who possess the greatest needs. • Support capacity building for the various actors, integration of gender issues in MNCH policy documents, the operationalisation of gender policies in countries, advocacy for gender mainstreaming and equity in MNCH interventions, equity in evaluations of policies/strategies and plans in countries and the empowerment of women (education, health, education for women, etc.)
Mali	• Formalise the transfer of knowledge in MNCH through the establishment of a national mechanism under the leadership of Mali's national health directorate • Train key research actors on the production of easily consumable "products" for policy makers • Promote action research and the establishment of a national bibliography of research • Create a regular space or framework for discussion between researchers and policy makers • Establish a web platform that will integrate all research findings in the field of MNCH in Mali and the policy decisions made based on these findings.
Nigeria	• The policymakers were emphatic about the need for capacity building on use of research in policy formulation, appropriate dissemination of the research findings to relevant stakeholders, and involvement of policymakers in research.
Senegal	• There is a strong need to build capacity on knowledge translation • Need to set up a platform where all stakeholders can interact and share evidence

COUNTRY/ INSTITUTION	RECOMMENDATIONS OUTLINED IN SITUATION ANALYSES
Ethiopia	• Evidence synthesis: The HPRO can support development of dissemination materials that communicate the research findings/evidence such as video testimonials. • Networking and alliance building. Create networks within the forums organised under the Health Sector Development Program (HSDP's). The IRTs need to work closely with national/regional taskforces, technical working groups, advisory committees which are forums where evidence can be disseminated to influence policy action. • Support for national research uptake. The HPRO can advocate on MNCH issues by working with IRT policymakers in national consultations such as professional associations, periodic discussions in annual conferences among other forums. HPRO can support IRTs in translating research outputs into actions and decisions that are simple and easy to disseminate through various tools such as policy briefs, infographics, blogs, and posters among others. • To increase the level of research uptake within stakeholders. HPRO working with IRTs can facilitate media engagement by providing training for journalists and editors who have a keen interest in reporting health issues. This will increase the journalists' understanding on how to report on MNCH issues from a research and policy perspective, thereby acting as advocates for the sector. • Ensuring greater impact. The HPRO will work with the IRTs on how to collaborate with existing KT networks to prioritise the MNCH agenda nationally. It seems policies in this area are linked to bigger international initiatives.
Malawi	• Evidence synthesis: Since national research dissemination workshops are funded by the National Commission of Research, National AIDS Commission and College of Medicine, the IRTs supported by the HPRO can partner with these three institutions to convene a similar meeting with the aim of disseminating IMCHA research. • Networking and alliance building. The IRTs can participate in the technical working group of the Quality Management Unit, a Knowledge Translation Platform Steering Committee and national research dissemination workshops to share findings from their research as well as influence MNCH policy through this forum since it is responsible for streamlining the health care system and creating quality of care monitoring structures. • Support for national research uptake. The HPRO working with the IRTs can advocate for the prioritisation of MNCH issues in the national research agenda through the current IMCHA work. The HPROs/IRT can join the Communities of Practice which are under the Knowledge Translation Platforms Steering Committee and can engage the Ministry of Health on IMCHA research and inform/influence policy through its findings. It also a good platform to disseminate findings through various publications.

COUNTRY/ INSTITUTION	RECOMMENDATIONS OUTLINED IN SITUATION ANALYSES
Mozambique	• Entry points to influence MNCH policy making and implementation in Mozambique: a) Technical working groups (TWGs) in Mozambique should be considered as ideal entry points where in-country research can influence policy-making especially in light of the opportunities for research organizations to be represented in these TWGs and directly influence MNCH policy-making. b) Research and advocacy organisations should use the same TWGs as forums where research evidence can be used to inform and reinforce the implementation of MNCH strategies and action plans. c) The TWGs should also be used as forums where the activities of the numerous donors, implementing partners and other stakeholders are discussed, coordinated and aligned. This coordination will reduce duplication of efforts and thus enhance the impact that will be realized using the existing resources. • Enhancement of the transfer of knowledge to key research consumers and stakeholders a) Research organisations and other producers of research evidence need to enhance the dissemination of research evidence to key stakeholders (including policymakers) to increase their awareness of the existence and value of the research evidence. b) The MoH needs to develop and institutionalize knowledge transfer mechanisms between the central government level and health units. This is important to ensure that research evidence (most of it received by the central government level) and the policies it informs is communicated to health units across the country. • Capacity building and strengthening of MNCH research advocacy. While research organisations can generate research, there is merit in capacity building of these research organisations with regards to their communications and advocacy expertise. This is important to ensure that research evidence (which is often scientific and technical) is communicated appropriately to policymakers (some of whom do not have a scientific or technical background). This recommendation presents an opportunity for future funding towards the enhancement of the research evidence in MNCH policymaking in Mozambique. • Capacity building for knowledge translation. While the minimal influence of local context in the overall MNCH policy-making process is in part attributable to high donor dependence, it is also due to the limited knowledge translation capacity of in-country stakeholders. In this light, it is recommended that future investments in MNCH policy landscape in Mozambique should focus on building the knowledge translation capacity of in-country stakeholders.

COUNTRY/ INSTITUTION	RECOMMENDATIONS OUTLINED IN SITUATION ANALYSES
Mozambique (cont.)	• Financing. Domestic financing for health in general and MNCH in particular in Mozambique is low. While research organizations are aware of and align their work with the National Agenda of Research, there is no financing earmarked for the realization of this agenda. There is merit that future investments in MNCH policy context in Mozambique should focus on generating funding or aligning existing funding with the National Agenda of Research by: a) Developing investment cases to make a case of enhanced funding towards MNCH by the Government of Mozambique. In light of competing needs that the Government of Mozambique has to prioritize there is merit in developing investment cases that motivate enhanced domestic financing towards MNCH. These investment cases will enable MNCH to compete favorably for local government funding against other financing priorities presented to the Government of Mozambique. b) Improving dialogue between donors and the MoH to ensure that priorities of the MoH / Government are regularly communicated to the donors, so that donor financing is aligned with the National Agenda of Research. This alignment will also reduce redundancies and duplication of funding and initiatives in MNCH by the numerous donor-funded implementing partners in Mozambique.
Tanzania	• Evidence synthesis. The HPRO can support IRTs through systematic review trainings so that they do not have to rely solely on evaluations to generate evidence to inform policy. • Networking and alliance building. The IRTs can indicate which forums dealing with health and MNCH issues they are involved in to ensure they do not work in isolation but instead participate in the existing platforms. It is expected that eventually, IRTs will be able to disseminate their findings and recommendations in these platforms. The IRTs and the HPRO can participate in key national research and policy engagement forums to understand the direction of strategies being implemented to address MNCH issues in Tanzania. • Support for national research uptake. The HPRO will work with the IRTs to strengthen their capacity in knowledge translation, working with various policy engagement tools such as policy briefs and understanding their impact. This will enable IRTs have a strategy of engagement whenever they are involved in various policy platforms. Since there are many MNCH stakeholders the six IRTs should work closely with the stakeholders through the various technical working groups. The policymakers within each team can distribute their participation based on proximity of some of the meetings and relevance to their research area. Tanzania is quite receptive to research and the IRTs being supported by the HPRO can engage effectively in these forums and also disseminate their findings with the hope of informing some of the Ministry of Health strategies.

COUNTRY/ INSTITUTION	RECOMMENDATIONS OUTLINED IN SITUATION ANALYSES
Uganda	• Evidence synthesis. The IRTs can work with NIMR to engage stakeholders as well as research consumers in identifying which areas of IMCHA programme research can inform national research priorities. • Networking and alliance building. The IRTs can begin engaging with the existing technical working groups and meetings in the country. The HPRO can support them by working with them to refine their presentations and key messages. • Support for national research uptake. The HPRO will work with the IRTs to strengthen their capacity in knowledge translation, working with various policy engagement tools such as policy briefs and understanding their impact. This will enable IRTs have a strategy of engagement whenever they are involved in various policy platforms.
South Sudan	• Subscribing to scientific journals • Training on research methods • Developing collaboration with research institutions and universities (international and local) • Discuss evidence within the Ministry of Health • Providing financial support to attend conferences, scientific events, webinars, subscription to scientific journals • Finding mechanisms to disseminate the findings from the studies which are taking place in South Sudan • Strengthening the use of the website of the Ministry of Health • Improving the infrastructure of the Ministry of Health (power, internet, archives) • Do more lobbying to the health committees at the parliament • Fund research • Finding mechanisms to disseminate the findings of research at the State and County levels • Strengthening the use of South Sudan Medical journal

ANNEX 7. RECOMMENDATIONS OF THE IMCHA MIDTERM EVALUATION

7.1 FOR THE REMAINDER OF IMCHA:

GENERAL RECOMMENDATION

1. Hold country-level meetings among the research teams, including the decisionmakers, 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.
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 AND 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 Africa 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 crosscutting lessons, or collaborating on dissemination materials to be shared across the region, including to potential future donors.

7.2 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 preproposal 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.

ANNEX 8. EVALUATION MATRIX

The evaluation matrix follows the structure of Section 2.2.4 of the RfP. The numbered headings 1-4 are transformed into overarching questions defining the four evaluation areas. The numbered headings A to G, as well as some of the bulleted questions under heading 2-4 are transformed to main evaluation questions. All other bulleted questions are transformed into sub-questions. The bullet list in the RfP include further specifications and sub-sub questions that are not picked up in the matrix but that will nevertheless be addressed in the data collection and analysis.

Evaluation Questions	Sub-questions	Evaluation Axis	Indicators	Sources of evidence	Methods
Evaluation Area 1: What are the achievements of IMCHA in relation to the Performance Measurement Framework as well as policy uptake and scale-up of successful interventions?					
What is the outcome of IMCHA in terms of improved maternal newborn and child health in targeted countries?	What are the achievements of IMCHA in relation to the eleven CoIA MNCH indicators? Which unexpected outcomes including gender-related outcomes were achieved? What were the main strategies to obtain the achievements? How appropriate are these for achieving the intended outcomes?	• Research projects	• Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services	• Research teams; PIs & Co-PIs • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports, reports to GAC	• Document reviews • On-line survey • KIIs
Has IMCHA enhanced the production, analysis and synthesis of health systems implementation research prioritising gender and equity?	How were gender and equity dimensions integrated by the IMCHA research teams? How did HPROs contribute to the integration of gender and equity in research activities, capacity building and knowledge translation? How did IMCHA management contribute to the integration of gender and equity? Did the Midterm Evaluation influence the understanding of gender and equity issues in the research projects?	• Research projects • HPROs • IMCHA management	• Proportion of projects that have at least 75% (three of four processes) adequate gender dimensions • Proportion of health systems research outputs and syntheses that is gender focused • Proportion of projects that have at least 75% (three of four processes) adequate equity dimensions • Proportion of health systems research outputs and syntheses that is equity focused	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports • Midterm evaluation report	• Document reviews • On-line survey • RQ+ evaluation • KIIs

Evaluation Questions	Sub-questions	Evaluation Axis	Indicators	Sources of evidence	Methods
To what extent has there been enhanced partnering and collaboration between researchers and decision-makers on health systems strengthening?	How have the research teams and/or HPROs demonstrated collaboration with decision-makers? How has IMCHA management contributed to this work? How did recommendations from the Midterm Evaluation influence this work? What unexpected outcomes including gender-related outcomes were achieved?	• Research projects • HRPOs • IMCHA management	• Number of projects that demonstrate a high level of collaboration with decision makers (documented by project, country and regional levels)	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports • Midterm Evaluation Report	• Document reviews • On-line survey • RQ+ evaluation • KIIs
To what extent has there been enhanced integration of health systems research findings into primary health care policies and practice in the selected countries, and scale up?	How have research teams and HPROs demonstrated influence on policy and programming? How successful have research teams and HPROs been in scaling the research results? How has IMCHA management contributed to this work? How did recommendations from the Midterm Evaluation influence this work? What unexpected outcomes including gender-related outcomes were achieved?	• Research projects • HRPOs • IMCHA management	• Number (type) of influence of IMCHA research projects on policy and programming per project	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports • Midterm Evaluation Report	• Document reviews • On-line survey • KIIs
To what extent was the capacity of researchers and research organisations strengthened to conduct gender and equity informed implementation research?[3]	How have the HPROs acted on the recommendations from the formative/situation analyses they conducted? What unexpected outcomes including gender-related outcomes were achieved?	• HPROs	• Proportion of research projects that have adequately detailed gender and equity dimensions • Proportion of recommendations from formative analyses of HPROs that were acted on	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports • Formative/situation analyses	• Document reviews • On-line survey • KIIs

[3] According to the RfP, this question specifically and exclusively refers to Indicator 100.2: "Proportion of recommendations from formative analysis of HPROs acted upon"

Evaluation Questions	Sub-questions	Evaluation Axis	Indicators	Sources of evidence	Methods
To what extent were partnerships and alliances between African researchers, decision makers and Canadian researchers strengthened?	How has the collaboration between African and Canadian researchers evolved since the Midterm Evaluation? What unexpected outcomes including gender-related outcomes were achieved?	• Research projects	• Proportion of implementation research projects that demonstrate effective collaboration and management.	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports	• Document reviews • On-line survey • KIIs
To what extent are decision-makers better aware and able to use research evidence?	How were the findings of IMCHA research communicated to the project Co-PI decision maker? How has the Co-PI decision maker used this information? What unexpected outcomes including gender-related outcomes were achieved?	• Research projects	• Proportion of IRT decision-makers' follow up on recommendations from research into health systems planning fora	• Research teams • HPROs • IMCHA management • IMCHA PMF • Grantee publications, reports • Field reports	• Document reviews • On-line survey • RQ+ evaluation • KIIs
Evaluation Area 2: How effective has the management of the Initiative been and what difference has that made to IMCHA achievements?					
How has support from the IMCHA management team and the M&O Committee contributed to the efforts of the research teams, the HPROs, and the Initiative overall?	How has IMCHA management implemented the recommendations of the midterm evaluation? What difference has this made in IMCHA achievements?	• IMCHA management	• Stakeholder views on the extent to which the support of the IMCHA management team has contributed to their work • Proportion of Midterm Evaluation recommendations that were implemented by IMCHA management • Donor partner views on the effectiveness of the M&O Committee	• Research teams • HPROs • IMCHA management • IMCHA donors • Midterm Evaluation report	• On-line survey • KIIs
	How has the M&O Committee influenced IMCHA management and achievements?	• IMCHA governance			

Evaluation Questions	Sub-questions	Evaluation Axis	Indicators	Sources of evidence	Methods
Evaluation Area 3: How well has IMCHA been operationalised and how could it be improved on in future undertakings?					
How did the IMCHA model contribute to the performance of the initiative?	What new lessons can be learnt regarding the design and implementation of the model of the research teams? What new lessons can be learnt regarding the design and implementation of the model of HPROs? What worked well in the Synergy Grants? What were the challenges?	• Research projects • HPROs • IMCHA management	• Stakeholder perceptions on the effectiveness of the IMCHA model • Documented evidence on aspects of the IMCHA model and implementation that should be improved in future	• Research teams • HPROs • IMCHA management • IMCHA donors	• On-line survey • KIIs
	What new lessons can be learnt regarding the design and implementation of the partnership between CIHR, GAC and IDRC? How relevant would an initiative such as IMCHA continue to be to address the needs of the donor partners and their alignment with Government of Canada priorities?	• IMCHA governance	• Donor perceptions on the design and implementation of the partnership	• IMCHA donors	• KIIs
Evaluation Area 4: How is the work of IMCHA documented and does it contribute to the legacy of the Initiative?					
How have the research teams, HPROs, the IMCHA management team and the donor partners documented their work to contribute to the IMCHA legacy?	How could this be improved in a future initiative?	• Research projects • HPROs • IMCHA management • IMCHA governance	• Evidence on documentation of work beyond publications and regular reporting.	• Research teams • HPROs • IMCHA management • Donor partners	• Document reviews • On-line survey • KIIs

ANNEX 9. METHODOLOGY

9.1 APPROACH

In the inception phase, the evaluation team eliminated duplications from the TOR list of 38 evaluation questions and organised the remaining in a matrix of 32 sub-questions under 10 main questions in four areas of inquiry corresponding to the objectives of the evaluation. For each of these questions, the team adopted a results-oriented evaluation approach, assessing the performance of IMCHA against the targets of the performance monitoring framework (PMF), as well as a reflexive approach, drawing lessons from the processes of project and programme implementation.

Data to answer the evaluation questions were collected by three main methods and triangulated to generate findings responding to each question:

- Document reviews
- An on-line survey of researchers and decisionmakers
- Key informant interviews conducted during project visits, attendance of the IMCHA learning workshop in January 2020, a mission to Ottawa and remotely using a voice over internet protocol (VOIP)

A planned evaluation of the quality of project outputs using the IDRC Research Quality Plus (RQ+) methodology was cancelled on advice of IDRC, because an agency-wide RQ+ assessment including IMCHA projects was commissioned at about the same time as the evaluation. Results from this assessment were not yet available at the time of preparing the IMCHA evaluation report.

The evaluation covered the entire period of IMCHA implementation from the launch in 2014 to the end of data collection in May 2020. More weight was, however, assigned to the period following the publication of the midterm evaluation report in October 2018. Data collection for the evaluation commenced in January and ended in early May 2020.

9.2 DATA COLLECTION

DOCUMENT REVIEWS

A library of technical and administrative IMCHA documents was provided by IDRC including annual programme reports, project approval documents (PADs), implementation plans, project progress reports, workshop reports and presentations, monitoring (trackify) and financial databases, technical reports and project outputs. Additional documents were collected by the evaluation teams during project visits or requested from informants interviewed by VOIP. In total, the evaluation collected 385 documents and entered them into the analysis.

ONLINE SURVEY

An online survey questionnaire was developed in December 2019 closely matching the two questionnaires for researchers and decisionmakers used in the midterm evaluation. A single questionnaire was used for the final evaluation, however it split after initial identification questions into two distinct sections for researchers and decisionmakers. The questionnaire was reviewed by

IMCHA Management and pretested by hera associates. It was launched in English and French on January 6th on the SurveyMonkey platform. A reminder e-mail to invited respondents was sent on February 6th and the survey was closed on February 18th.

Invitations were sent to 131 researchers and decisionmakers who participated in IMCHA-funded projects. Researchers of Health Policy and Research Organisations (HPROs) were not invited to participate in the survey. An additional 35 invitations were sent on January 23rd to contact addresses obtained during the IMCHA learning workshop in Kigali, bringing the total to 166. Respondents were assured anonymity. The invited respondents included

- Current and former Principal Investigators (PIs) and researchers in African institutions
- Current and former Canadian Co-Principal Investigators (Co-PIs) and researchers
- Current and former Co-PI decisionmakers

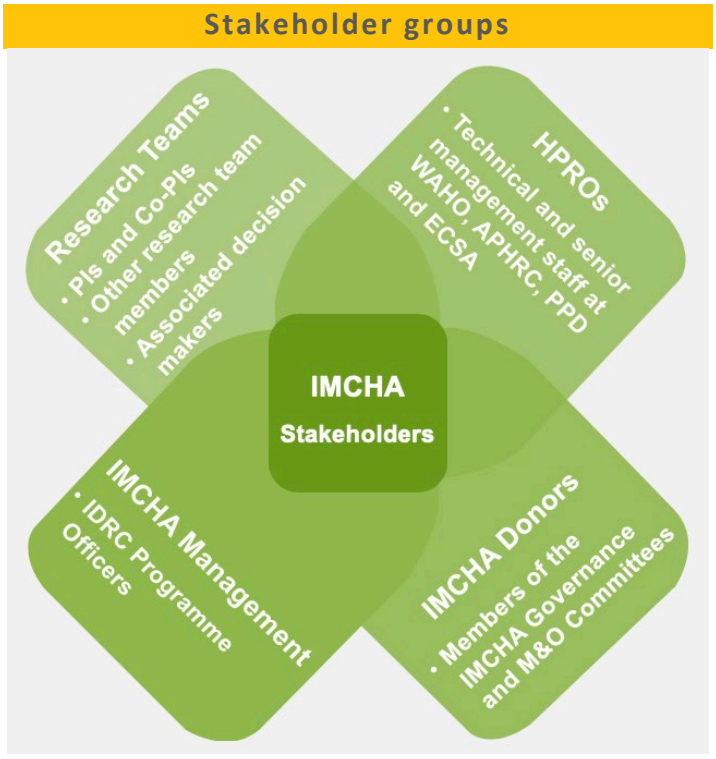
Of the 166 e-mail invitations, three were returned because the e-mail address was no longer valid or there was an automated message that the person had retired or left the organisation.

- The invitation was successfully sent to 163 potential respondents
- The survey was opened by 72 respondents (overall response rate: 44%)
- 13 respondents only completed the profile portion of the survey. They were removed from the analysis, which left 59 valid responses (valid response rate: 36%)

Further information on the profile of respondents is provided in **Annex 11**.

KEY INFORMANT INTERVIEWS

The evaluation team interviewed 97 stakeholders (47 female and 50 male) in individual or group interviews in person or via VOIP. The interviews were semi-structured on the basis of the evaluation questions, adapted to each of the four main stakeholder groups, and further adapted to each individual interview context and position of the informant. The scripts were provided to the interviewee in advance and the interviews were recorded for transcription after consent was obtained. Respondents were assured anonymity.



Key informants in each group were sampled by purposive sampling that aimed at reaching data saturation for each evaluation question. Researchers,

decisionmakers and HPRO staff were interviewed individually or in groups during project visits. Gaps were filled with VOIP interviews. All current IDRC staff involved in IMCHA management as well as all current members of the IMCHA M&O Committee were interviewed individually or in groups during a mission to Ottawa. Only one member of the Governance Committee was available for an interview.

Projects for site visits were selected by convenience sampling based on travel logistics. Country visits were planned by favouring countries with the most projects. The team visited Tanzania, Nigeria and Uganda and conducted interviews with APHRC staff in Kenya. A planned visit to one project in Nigeria was not authorised by IDRC for security reasons and plans to interview the WAHO team and to visit one project in Senegal were abandoned when the West Africa mission had to be cut short because of Covid-19 travel restrictions. To fill this gap, additional VOIP interviews were conducted. Sixteen of 28 implementation research and synergy projects were included in the site visits and interviews. Scheduling VOIP interviews with researchers and decisionmakers was difficult as most were already deeply involved in the response to Covid-19. Three Co-PI decisionmakers, two PIs, and one Canadian Co-PI did not respond to invitations for VOIP interviews. The following projects were visited or covered in VOIP interviews. Sixteen Canadian Co-PIs and researchers were interviewed during the mission to Ottawa, in the context of the IMCHA learning workshop, or using VOIP.

Project interviews

Grant	Country	PI Institution	
108020 / 108546	Tanzania	Ifakara Health Institute	On-site
108022	Tanzania	Ifakara Health Institute	On-site
108023	Tanzania	University of Dar es Salaam	On-site
108024 / 108547	Tanzania	Catholic University of Health and Allied Sciences	On-site
108027 / 108548	Tanzania	Tanzanian Training Centre for International Health	On-site
108028	Ethiopia	Jimma University	VOIP
108033 / 108550	Uganda	BRAC Africa	On-site
108037 / 108553	Burkina Faso	Société d'Etudes et de Recherche en Santé Publique	VOIP
108040 / 108552	Nigeria	University of Ibadan	On-site
108041	Nigeria	Women's Health and Action Research Centre	On-site
107892 (HPRO)	Burkina Faso	West African Health Organisation	VOIP
107893 (HPRO)	Kenya	African Population and Health Research Centre	On-site
107893 (HPRO)	Uganda	Partners in Population and Development	On-site
107893 (HPRO)	Tanzania	ECSA Heath Community	On-site

Research Team PIs and Co-PIs contacted and interviewed

PIs	I	N.R	Canadian Co-PIs	I	N.R	Decisionmaker Co-PIs	I	NR
Abel Bicaba		X	*Anne Cockcroft*			*Adamu Ibrahim Gamawa*		
Angelo Nyamtema	X		*Christina Zarowsky*			*Ahmed Julla*		
Bwire Chirangi		X	*David Goldfarb*			*Alexander Dimiti*		
Celso Belo			**Gail Webber**	X		**Anna Nswilla**	X	
Dismas Matovelo	X		**Jenn Brenner**	X		*Biratu Yigezu*		
Elijo Omoro			**John LeBlanc**	X		*Francis Mwanisi*		
Ellen Chirwa			**Karen Yeates**	X		*Fannie Kachale*		
Emmanuel Ochola			**Kevin McKague**	X		**Godfrey Mtey**	X	
Fatuma Manzi Kabanywanyi	X		**Manisha Kulkarni**	X		**Josef Okware**	X	
Friday Okonofua	X		*Oumar Mallé Samb*			**Julie Erhabor (new Co-PI)**	X	

PIs	I	N.R	Canadian Co-PIs	I	N.R	Decisionmaker Co-PIs	I	NR
Jenipher Twebaze	X		**Phyllis Zelkowitz**	X		**Kunuz Hajibedru**		X
Kondwani Kawaza			*Prabhat Jha*			*Mamadou Ba*		
Lakew Abebe Gebretsadik	X		*Ronald K. Siemens*			**Mamadou Namory Traoré**		X
Laurence Touré			*Ronald Labonte*			*Munira Abudou*		
Muhammad Yagana			**Sanni Yaya**	X		*Oumar Sarr*		
Oye Gureje	X		**Sian Fitzgerald,**	X		*Oumou Diarra*		
Robert Tillya	X		**Slim Haddad**		X	**Pierre Yameogo**		X
Rosalie A. Diop			*Valery Ridde*			*Queen Dube*		
Stephen Maluka	X		*Zubia Mumtaz*			**Robert Salim**	X	
Thomas Druetz	X		**Zulfiqar Bhutta**	X		**Sylvia Mamkwe**	X	
Wubegzier Mekonnen						**Thomas Rutachunzibwa**	X	
						Tunde Olatunji	X	

I = Interviewed; N.R. = No Response

9.3 Data analysis

The on-line survey responses included Likert and ranking scales as well as narrative responses. The data derived from scales were tabulated, proportions were calculated were appropriate and compared to proportions reported in the midterm survey.

The narrative survey responses, the interview transcripts and the collected documents were analysed using the qualitative content analysis software MAXQDA. A system of codes and sub-codes for the data analysis was developed on the basis of the evaluation matrix using both deductive and inductive coding. Main codes and first level sub-codes were based on the evaluation questions. After the development of a coding matrix and data import, all interview transcripts and documents were coded. Further analysis of retrieved segments was done by the team member responsible for the section using methodologies that depended on the number of segments.

- In the case of large datasets additional sub-sub-codes were established by inductive coding to further disaggregate the retrieved data. For instance under the code of 'influence on policies and programmes' 45 sections were retrieved which were further sub-categorised by informant type and level of influence.
- In the case of small datasets, for instance of only 11 segments retrieved under the code of 'M&O Committee', the segments were extracted into an Excel file and individually inspected for possible grouping into sub-categories.

While we did not count the numbers of similarities of responses, experiences and reactions systematically in all interview transcripts, the methodology allowed us to filter the responses by stakeholder type, into those that were unanimous or nearly unanimous, those that were expressed by a majority of informants, and those that were expressed by a minority, including single informants. Quotes, where relevant, were extracted from the retrieved response segments. They were used in the report to either document majority views, views of informants in unique positions to provide the most relevant information, or, in some cases outlier opinions. In each case this was indicated in the text of the evaluation report.

Cross-checking of coded segments by an independent analyst to confirm correct coding was not possible because of budget and time constraints of the evaluation. However, each of the four evaluation team members read all interview transcripts and reviewed all sections of the report. The draft report was reviewed for consistency and internal logic by the Quality Assurer, the Executive Director of hera.

9.4 LIMITATIONS

Data collection among decisionmakers was challenging. Among the 11 decisionmaker Co-PIs of the 16 sampled projects, only eight could be joined for interviews, and only 5/29 decisionmakers invited to the online survey responded. Changes of designated Co-PIs over the project period as well as changing priorities due to the response to Covid-19 towards the end of the evaluation period were likely reasons. All but one (newly appointed) interviewed Co-PIs were highly engaged in their project team while this may not have been the case among those who did not respond to the survey or to interview invitations thereby generating a selection bias.

All teams of the sampled projects were engaged in final data collection and analysis at the time of the evaluation and could not share data on MNCH or service outcomes. Interim data were available for several projects but not in a form that could be aggregated across projects. The same applied to research publications, with all teams still working on planned or draft documents.

While some projects could document policy influence at different levels, most knowledge translation activities were ongoing at the time of the evaluation missions, with several teams stating that they would increase these activities once the research findings were analysed and documented. Policy change has a different time frame from implementation and research, and it was arguably too early in the programme to expect a documented impact of the research evidence on health policies.

Limitations due to the differences in the sampling frames for the online surveys conducted for the midterm and the final evaluations are discussed in **Annex 11**.

ANNEX 10. ON-LINE SURVEY QUESTIONNAIRE

This survey is part of the final evaluation of the IMCHA programme, co-funded by Global Affairs Canada (GAC), the Canadian Institutes of Health Research (CIHR), and the International Development Research Centre (IDRC). Its aim is to assess the overall performance and value added of IMCHA.

The survey will not take longer than 30 minutes of your time. Please complete the survey as soon as possible and before February 15, 2020. Depending on your position and your knowledge of the programme, you may find questions that you cannot answer. In this case, please mark 'don't know' and move on to the next question.

By starting the survey, you are agreeing to participate. Your participation is voluntary, and you can stop at any time. There are no known risks to participate in this survey. All responses will remain anonymous and the information will be saved in a password protected database to be used only for the purpose of the IMCHA summative evaluation. If you have questions about your participation in the survey, please contact the administrator hera@hera.eu.

1. In which role or team did you participate in the IMCHA project

- PI or researcher in an African research team ☐
- Co-PI or researcher in the Canadian research team ☐
- Co-PI decision-maker or researcher in a health authority (*automatic skip to Question 37*) ☐

2. In which country is/was your research team located? (select only one main country)

Burkina Faso	☐	Malawi	☐	Senegal	☐
Canada	☐	Mali	☐	South Sudan	☐
Ethiopia	☐	Mozambique	☐	Tanzania	☐
Kenya	☐	Nigeria	☐	Uganda	☐

Other (specify) _____

3. Did your team receive a synergy grant?

Yes ☐ No ☐ We did not apply ☐ I don't know ☐

4. How successful is/was your collaboration with your Canadian / African research partner?

- Very successful ☐
- Somewhat successful ☐
- Neither successful nor unsuccessful ☐
- Somewhat unsuccessful ☐
- Very unsuccessful ☐

Please comment:

---

5. How successful is/was your collaboration with your decision-maker research partner?

- Very successful ☐
- Somewhat successful ☐
- Neither successful nor unsuccessful ☐
- Somewhat unsuccessful ☐
- Very unsuccessful ☐

Please comment:

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6. How helpful is/was your <u>decision-maker</u> research partner with the following aspects of the research?

	Very helpful	Somewhat helpful	Minimally helpful	Not helpful	Do not know / not applicable
Grounding the research in local context					
Connecting you to other decision-makers					
Integrating gender considerations					
Integrating equity considerations					
Encouraging the use of research findings in policies and practices					
Scaling up the research results					
Other (specify below)					

---

7. What barriers are you experiencing / did you experience in the implementation of the research?

	Very important barrier	Somewhat important barrier	Minimally important barrier	Did not experience this barrier	Do not know / not applicable
Insufficient engagement or availability of PI					
Insufficient engagement or availability of Canadian Co-PI					
Insufficient engagement or availability by the decision-maker Co-PI					
Insufficient human resources					
Insufficient financial resources					
Insufficient connection to decision-making authorities					
Other barriers (specify below)					

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8. What are the most important factors that aid the collaboration between African and Canadian research institutions in your research project?

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9. What are the most important factors that aid the collaboration between researchers and decision-makers in you research project?

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10. Is there anything you would have changed in the collaborative relationship between you and your co-researchers or your decision-maker Co-PI?

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11. Which HPRO supports your research project?

WAHO ☐ APHRC/PPD/ESCA ☐ I do not know ☐

12. How do you rate the effectiveness of the following HPRO activities in support of your project?

	Very effective	Somewhat effective	Minimally effective	Not effective	Do not know / not applicable
Research methods training					
Implementation science training					
Gender sensitivity training					
Equity sensitivity training					
Grounding the research in the local context					
Connecting the team to decision-makers					
Supporting your team to network and share with other teams					
Contributing to knowledge translation of your research					
Other (specify below)					

---

13. What else do you suggest the HPRO could do/ could have done to support your research?

---

14. Are / were the efforts by the HPROs and by IDRC for facilitating knowledge sharing across East and West African research teams sufficient?

By IDRC: Yes ☐ No ☐ I don't know ☐

By the HPRO: Yes ☐ No ☐ I do not know ☐

Please comment:

---

15. Do you recommend that IDRC include an HPRO type component in future research programmes?

Yes ☐ No ☐ I do not know ☐

Please comment:

---

16. Has the IMCHA project contributed to developing the capacity of your institution?

	To a major extent	Somewhat	Minimally	Not at all	Do not know / not applicable
Capacity in preparing grant applications					
Capacity in project monitoring and supervision					
Capacity in research methods					
Capacity in implementation science					
Capacity in knowledge translation					
Capacity in gender analysis and mainstreaming gender in research					
Capacity in equity analysis and mainstreaming equity in research					
Capacity in financial management					
Other capacity gains (specify below)					

---

17. Did you participate in a gender and/or equity analysis training during IMCHA?

Gender analysis:		**Equity analysis**:	
Yes		Yes	
No		No	
I don't know		I do not know	

18. Has your research project included the following aspects or activities related to gender equality?

	Yes, consistently	Yes, to some extent	No	Do not know / not applicable
Incorporated gender sensitivity training?				
Brought specific gender expertise into the project?				
Ensured that women and girls are beneficiaries of the project?				
Ensured that women and girls are consulted while designing and implementing the project?				
Ensured that women on the team take part in decision-making within the project?				
Included a reference to gender considerations in a research question?				
Incorporated other measures to integrate gender considerations? (Please describe below)				

---

19. What are/were the barriers to integrating gender equality considerations in your project?

---

20. How helpful is/was the HPRO in integrating gender equality considerations into your project?

Very helpful	☐
Somewhat helpful	☐
Not helpful	☐
I do not know / not applicable	☐

Please comment:

---

21. Which of these statements about equity apply best to your project?

All intended beneficiaries of the research are vulnerable and the "equity lens" is therefore automatically applied	☐
There are differences among potential beneficiaries of the research and efforts are made to focus on the most vulnerable	☐
Equity considerations are not relevant to my project	☐
None of these statements apply (please comment below)	☐

---

22. Has your research project included the following aspects or activities related to equity?

	Yes, consistently	Yes, to some extent	No	Do not know / not applicable
Incorporated equity training?	☐	☐	☐	☐
Brought equity expertise into the project?	☐	☐	☐	☐
Ensured that the project reaches the vulnerable populations in your context?	☐	☐	☐	☐
Consulted vulnerable populations while designing and implementing the project?	☐	☐	☐	☐
Incorporated other measures to integrate equity considerations? (Please describe below)	☐	☐	☐	☐

---

23. What are/were the most important measures by your project for the integration of equity considerations?

---

24. What are/were the barriers for the integration of equity considerations?

---

25. How helpful is/was the HPRO in integrating equity considerations into your project?

Very helpful	☐
Somewhat helpful	☐
Not helpful	☐
I do not know / not applicable	☐

Please comment:

---

26. Were you able to translate your findings into policies and practices?

- Yes ☐
- No ☐
- No, but there are prospects for the future ☐

27. *[If yes is chosen in previous question, user will be asked the following question]***: Please elaborate at what level your research findings were translated into policy and practice and give examples**

- Sub-national level ☐
- National level ☐
- Regional level ☐

Please describe the changes ion policies or practices:

---

28. Did your project succeed in scaling up the findings of your research?

- To district level ☐
- To regional/state level ☐
- To national level ☐
- We did attempt to scale-up but were not successful ☐
- Scaling was not an objective of our project (*skip to question 31*) ☐

29. What approaches, did you take to scale up the findings of your research?

---

30. If your ability to scale up the research findings were hindered, can you rank the factors responsible? (where 1 is the most important and 7 the least important factor)

- The decision-maker Co-PI was not sufficiently engaged/involved in the project ☐
- The researchers (PI and Canadian Co-PI) were not sufficiently engaged/ interested in scaling up ☐
- Insufficient connections to decision-making authorities ☐
- Insufficient funding ☐
- Insufficient human resources ☐
- Insufficient knowledge within the team about how to scale up ☐
- Changes in national priorities or policies ☐
- None of these factors apply / I do not know ☐

31. Did your project contribute to an improvement in any of the 11 global monitoring indicators for MNCH in your research area or beyond? Which ones?

- Maternal mortality ratio ☐
- Under five child mortality rate ☐
- Chronic childhood malnutrition rate (height for age) ☐
- Met need for contraception ☐
- Antenatal care coverage (at least 4 times) ☐
- Antiretroviral coverage to prevent mother-to-child transmission of HIV ☐
- Skilled attendance at birth ☐
- Postnatal care for mothers and babies within 2 days ☐
- Exclusive breastfeeding for 6 months ☐
- DPT 3 vaccine coverage among children 12-23 months old ☐
- Antibiotic treatment coverage for children under 5 with suspected pneumonia ☐
- Any other public health outcome, including outcomes related to gender equality (please specify) ☐

---

32. Did you receive support from IDRC (as the manager of IMCHA) in the following areas / activities?

	Yes	No	Do not know / not applicable
Assistance in refining the research protocol and implementation plan			
Assistance in networking			
Assistance in promoting, publishing and/or presenting the research			
Problem solving of technical or ethical issues you faced during your research			
Assistance in addressing gender equality issues and gender mainstreaming			
Assistance in addressing equity issues			
Assistance in financial reporting			
Assistance in seeking additional research funding for this or future projects			
Other assistance (please specify below)			

33. How helpful was the support from IDRC in the following areas / activities?

	Very helpful	Somewhat helpful	Minimally helpful	Not helpful	Do not know / not applicable
Preparing the implementation plan					
Preparing technical reports					
Preparing financial reports					
Monitoring visits by IDRC Programme Officers					
IMCHA workshops (e.g. Dakar April 2017, Tanzania March 2019, etc.)					
Efforts to optimise performance (e.g. technical support by consultants)					
Other (please specify below)					

34. Please indicate your level of agreement or disagreement with each of the following statements about your project

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Do not know / not applicable
The research topic is a key health priority of the country/region						
I am happy with the outcomes of the research						
The collaboration between the African PI and Canadian Co-PI has been important to meet the objectives of the project						
The African PI and Canadian Co-PI collaborate as equals						
The involvement of the decision-maker co-PI has been important to meet the objectives of the project						
The HPRO has been important to meet the objectives of the project						
Gender considerations are well-integrated into the project						
Equity considerations are well-integrated into the project						
IMCHA provides opportunities to learn about advances in MNCH from other African countries						
IDRC has done a good job in monitoring and supervising this project						

35. IMCHA will soon be ending. What do you think could have been done to improve this initiative?

36. Do you have any additional questions or comments about IMCHA or about this survey?

[Automatic skip to end of survey]
Questions for Co-PI Decision-makers start

37. In which country are you working / did you work with the IMCHA project?

Burkina Faso	☐	Mali	☐	South Sudan	☐
Ethiopia	☐	Mozambique	☐	Tanzania	☐
Kenya	☐	Nigeria	☐	Uganda	☐
Malawi	☐	Senegal	☐	Other (specify)	☐

38. At what level of government do you work?

Local level ☐ State/Regional level ☐ National level ☐ Other (please specify) ☐

39. How long have you been involved as a Co-PI in the IMCHA project?

Since the start ☐ About 3 years ☐ 1 to 2 years ☐ Less than 1 year ☐

40. Did your research team receive a synergy grant?

Yes ☐ No ☐ We did not apply ☐ I don't know ☐

41 How successful is/was your collaboration with your PI and Canadian Co-PI research partners?

Very successful	
Somewhat successful	
Neither successful nor unsuccessful	
Somewhat unsuccessful	
Very unsuccessful	

Please comment:

---

42. How helpful has your participation in the project been in the following aspects of the research?

	Very helpful	Somewhat helpful	Minimally helpful	Not helpful	Do not know / not applicable
Grounding the research in local context					
Connecting the project to decision-making institutions					
Integrating gender considerations					
Integrating equity considerations					
Encouraging the use of research findings in policies and practices					
Scaling up the research results					
Other (specify below)					

---

43. What barriers are you experiencing / did you experience in the implementation of the research?

	Very important barrier	Somewhat important barrier	Minimally important barrier	Did not experience this barrier	Do not know / not applicable
Insufficient engagement or availability of the PI					
Insufficient engagement or availability of the Canadian Co-PI					
My own limited engagement or availability to participate					
Insufficient human resources					
Insufficient financial resources					
Insufficient connection to decision-making authorities					
Other barriers (specify below)					

---

44. What are the most important factors that aid your collaboration with the African and Canadian research institutions in this project?

---

45. Is there anything you would have changed in the collaborative relationship between you and the research institutions?

---

46. How regularly were you informed on the progress and findings of the research??

On a monthly basis (or more frequently)	☐
On a quarterly basis	☐
On a yearly basis	☐
Ad hoc	☐
Whenever I asked for it	☐
Not at all informed	☐

47. Have you been able to use information from the research in your work so far?

Yes	☐
No	☐

Please provide examples:

---

48. How do you rate the effectiveness of the following HPRO activities in support of your project?

	Very effective	Somewhat effective	Minimally effective	Not effective	Do not know / not applicable
Research methods training					
Implementation science training					
Gender sensitivity training					
Equity sensitivity training					
Grounding the research in the local context					
Connecting the team to decision-makers					
Supporting your team to network and share with other teams					
Contributing to knowledge translation of your research					
Other (specify below)					

---

49. What else do you suggest the HPRO could do/ could have done to support your research?

---

50. Are / were the efforts by the HPROs and by IDRC for facilitating knowledge sharing across East and West African research teams sufficient?

By IDRC:		**By the HPRO**:	
Yes	☐	Yes	☐
No	☐	No	☐
I don't know	☐	I do not know	☐

Please comment:

---

51. Do you recommend that IDRC include an HPRO type component in future research programmes?

Yes	☐
No	☐
I do not know	☐

Please comment:

---

52. Did you participate in a gender and/or equity analysis training during IMCHA?

Gender analysis:		**Equity analysis**:	
Yes	☐	Yes	☐
No	☐	No	☐
I don't know	☐	I do not know	☐

53. Has your research project included the following aspects or activities related to gender equality?

	Yes, consistently	Yes, to some extent	No	Do not know / not applicable
Incorporated gender sensitivity training?	☐	☐	☐	☐
Brought specific gender expertise into the project?	☐	☐	☐	☐
Ensured that women and girls are beneficiaries of the project?	☐	☐	☐	☐
Ensured that women and girls are consulted while designing and implementing the project?	☐	☐	☐	☐
Ensured that women on the team take part in decision-making within the project?	☐	☐	☐	☐
Included a reference to gender considerations in a research question?	☐	☐	☐	☐
Incorporated other measures to integrate gender considerations? (Please describe below)	☐	☐	☐	☐

---

54. What are/were the barriers to integrating gender equality considerations in your project?

---

55. Which of these statements about equity apply best to your project?

All intended beneficiaries of the research are vulnerable and the "equity lens" is therefore automatically applied	☐
There are differences among potential beneficiaries of the research and efforts are made to focus on the most vulnerable	☐
Equity considerations are not relevant to my project	☐
None of these statements apply (please comment below)	☐

---

56. Has your research project included the following aspects or activities related to equity?

	Yes, consistently	Yes, to some extent	No	Do not know / not applicable
Incorporated equity training?				
Brought equity expertise into the project?				
Ensured that the project reaches the vulnerable populations in your context?				
Consulted vulnerable populations while designing and implementing the project?				
Incorporated other measures to integrate equity considerations? (Please describe below)				

57. What are/were the most important measures by your project for the integration of equity considerations?

58. What are/were the barriers for the integration of equity considerations?

59. How were you involved in promoting the use of research findings for policies and practices?

60. Did your project succeed in scaling up the findings of your research?

To district level	
To regional/state level	
To national level	
We did attempt to scale-up but were not successful	
Scaling was not an objective of our project (*skip to question 63*)	

61. What approaches, if any, have you taken to scale up the findings of the research?

62. If your ability to scale up the research findings have been hindered, can you rank the factors responsible? (where 1 is the most important and 7 the least important factor)

You were not sufficiently engaged/ involved in the project	
The researchers (PI and Canadian Co-PI) were not sufficiently engaged/interested in scaling up	
Insufficient connections to decision-making authorities	
Insufficient funding	
Insufficient human resources	
Insufficient knowledge within the team about how to scale up	
Changes in national priorities or policies	
None of these factors apply / I do not know	

63. Please indicate your level of agreement or disagreement with each of the following statements about your project

	Strongly agree	Agree	Neither agree nor disagree	Disagree	Strongly disagree	Do not know / not applicable
The research topic addresses a key health issue of my country, region or district						
My involvement has been important to meet the objectives of the project						
The collaboration between the African PI and Canadian Co-PI has been important to meet the objectives of the project						
The HPRO has been important to meet the objectives of the project						
Gender considerations are well-integrated into the project						
Equity considerations are well-integrated into the project						
IMCHA provides opportunities to learn about advances in MNCH from other African countries						
IDRC has done a good job in monitoring and supervising this project						

64. IMCHA will soon be ending. What do you think could have been done to improve this initiative?

---

65. Do you have any additional questions or comments about IMCHA or about this survey?

Thank you for taking your time to complete this survey

ANNEX 11. ON-LINE SURVEY RESULTS

11.1 OVERVIEW

The on-line survey was launched in English and French on January 6th with an invitation to 131 researchers and decisionmakers who participated in IMCHA-funded projects. An additional 35 respondents were invited to the survey on January 23rd following the IMCHA meeting in Rwanda, bringing the total to 166. The list was assembled as follows:

- Current and former Principal Investigators (PIs) and researchers in African institutions
- Current and former Canadian Co-Principal Investigators (Co-PIs) and researchers in Canadian institutions
- Current and former Co-PI decisionmakers or researchers in health authorities

Researchers of Health Policy and Research Organisations (HPROs) were not included.

The list was prepared from information and contact details provided by IMCHA Management and by PIs and Co-PIs of all projects contacted by the evaluation team. A reminder e-mail to all invited respondents was sent on February 6th with a final closure of the survey on February 18th.

Of the 166 e-mail invitations, three were returned because the e-mail address was no longer valid or there was an automated message that the person had retired or left the organisation.

- The invitation was successfully sent to 163 potential respondents
- The survey was opened by 72 respondents (**overall response rate: 44%**)
- 13 respondents only completed the profile portion of the survey. They were removed from the analysis, which left 59 valid responses (**valid response rate: 36%)**

After the identification questions, the survey questionnaire split into two distinct sections, one for African and Canadian researchers, the other for decisionmakers. The analysis covered responses from both researchers and decisionmakers.

Respondents were assured full anonymity of their responses. Where identification questions (location of the project, role, sex of the respondent, etc.) could be used to identify individual respondents, they were assured that data will only be accessible to the evaluation team and will be anonymised in the analysis. Nevertheless, some respondents chose to not answer some of these questions in order to assure the anonymity of their response.

11.1.1 ALIGNMENT WITH THE MIDTERM EVALUATION SURVEY

For the midterm evaluation, two surveys were conducted in March 2018. One survey was sent to 44 PIs and Canadian Co-PIs, and a separate survey to 19 Co-PI decisionmakers. A total of 48 responses were received, 36 from PIs and Canadian Co-PIs, and 12 from decisionmakers for an overall response rate of **76 percent**.

Survey questions and Likert scales of the midterm and final evaluation surveys were closely aligned. The comparability of survey results was, however, limited because of differences in the sampling frames of the two surveys. The midterm evaluation team surveyed all active PIs and Co-PIs. The units

of data collection and analysis were IMCHA projects. The final evaluation team included all members and former members of research teams who could be identified in the sampling frame. The units of data collection and analysis were therefore all implementers of IMCHA-funded research projects. The decision was based on the attempt to give a voice on processes and outcomes of IMCHA-funded research to all implementers. Especially on questions about capacity-building this choice mitigated the risk of a selection bias, although it also reduced the possibility of analysing results on the basis of projects because the numbers of respondents differed among the projects. The differing approaches partially explains the lower response rate to the survey conducted for the final evaluation, although the total number of responses was higher (59 versus 48). A comparison of the responses to the two surveys is nevertheless presented where relevant, although the limitations of the comparability should always be kept in mind.

11.1.2 PRESENTATION OF SURVEY RESPONSES

Responses to questions formulated in the form of Likert scales are presented in tables with the responses to identical questions at midterm added in italics. Proportions are calculated from the tables where relevant and presented in the text following the tables. Narrative responses and comments of survey participants were extracted into a separate file and analysed together with data from document reviews and KIIs using qualitative content analysis. They are summarised in this report.

11.2 PROFILE OF SURVEY RESPONDENTS

Responses were received from researchers and decision-makers working in all ten IMCHA programme countries. Several projects were implemented in two countries but for only four projects (two in Mali/ Burkina Faso and two in Uganda/ South Sudan) the names of researchers or decisionmakers in both countries were available. Two survey respondents did not state the country of their research work.

PROJECT COUNTRY*	PROJECTS	INVITATIONS	RESPONSES				RESPONSE RATE
			AFR	CAN	DM	TOTAL	
Burkina Faso / Mali	3	17	5	3	0	**8**	47%
Ethiopia	3	15	3	4	0	**7**	47%
Malawi	2	21	2	2	0	**4**	19%
Mozambique	2	14	0	2	0	**2**	14%
Nigeria	5	28	6	5	2	**13**	46%
Senegal	1	8	1	2	0	**3**	38%
Tanzania	10	46	10	3	3	**16**	35%
Uganda / South Sudan	3	14	3	1	0	**4**	29%
Country not stated	-.-	-.-	1	1	0	**2**	-.-
Total	**29**	**163**	**32**	**22**	**5**	**59**	**36%**

** Countries for which team members in two countries of at least one multi-country project were invited are aggregated.*
Afr= researchers in African institutions; Can= researchers in Canadian institutions; DM= decisionmakers

For the two projects in Malawi and in Mozambique, the Canadian Co-PIs provided a large number of contact names for Canadian researchers and students (10/21 in Malawi and 8/14 in Mozambique) who did not respond to the survey, accounting for the low overall response rate from teams working in these two countries. Furthermore, the survey was not offered in Portuguese and we received no responses from the Mozambiquan partner.

The distribution of response received per region (57% East Africa & 43% West Africa) reflected the distribution of research teams (58% East & 42% West). The response rates of researchers working in African institutions and in Canadian institutions was about equal; the response rates among decisionmakers invited to the survey was, however, much lower.

ROLE OF RESPONDENTS	INVITATIONS	RESPONSES	RESPONSE RATE
Researchers in an African institution	80	32	40%
Researchers in a Canadian institution	54	22	41%
Decisionmakers	29	5	17%
Total	**163**	**59**	**36%**

Compared to the midline evaluation survey, the consolidated response rate among researchers in African and Canadian research institutions fell from 82 percent to 40 percent which was expected as the midline survey was targeted at persons with leadership roles in the projects who could easily be identified and personally encouraged to participate. Reasons for the sharp decrease in the response rate by decisionmakers from 63 percent to 17 percent are less clear. Many invited decisionmakers had changed position in their administration and were no longer involved in the project but were included in the survey. It was anticipated that they were unlikely to participate. Nevertheless, the total number of responses from decisionmakers fell from 12 at mid-line to only 5 at end-line which cannot be explained by their mobility alone. It does, however, increase the potential response bias of the findings. The decisionmakers who are actively engaged with the research projects are more likely to respond to the survey than those who are less engaged. This fact would have already biased the findings at midterm when 12 of 18 decisionmaker Co-PIs responded. This bias would have been even stronger at the final evaluation with only 5 of 29 responding.

Among those who completed the survey, nearly half (49%) received a synergy grant for their project. A large proportion of respondents (19%) did not know whether they received a synergy grant or not, and seven percent of respondents reported not applying. A quarter of respondents did not receive synergy grants despite applying.

DID YOU RECEIVE A SYNERGY GRANT? (N=59)	
Yes	29 (49%)
No	15 (25%)
We did not apply	4 (7%)
Unknown	11 (19%)
Total	**59**

11.3 ANALYSIS OF SURVEY RESPONSES

Most survey questions asked for scoring responses using Likert scales to ensure the survey could be completed in 30 minutes. The respondents also had the opportunity to provide comments related to each topic. These comments were integrated into the qualitative analysis alongside data from document reviews and key informant interviews (KIIs).

11.3.1 COLLABORATION BETWEEN CANADIAN AND AFRICAN RESEARCH

Canadian and African PI/Co-PIs and researchers were asked '*How successful is/was your collaboration with your Canadian or African research partner?*'. Fifty-three respondents selected one of five options and one respondent was not able to choose. Researchers in African and Canadian research institutions rated the collaboration equally with 74 percent of African researchers rating it as very successful and 26 percent as somewhat successful compared to 73 and 27 percent of Canadian researchers. No respondent selected a lower rating.

COLLABORATION BETWEEN AFRICAN AND CANADIAN RESEARCH INSTITUTIONS	AFRICAN RESPONDENTS	CANADIAN RESPONDENTS	TOTAL
Very successful	23 (74%)	16 (73%)	39 (74%)
Somewhat successful	8 (26%)	6 (27%)	14 (26%)
Total	**31**	**22**	**53**

The results are comparable to the results of the survey of PIs and Canadian Co-PIs conducted at midterm. At midterm, 75 percent rated the collaboration as very successful and 19 percent as somewhat successful. However two respondents rated it as somewhat unsuccessful and Canadian Co-PIs provided a slightly higher rating than the PIs.

Thirty-eight respondents provided additional comments in answer to this question. Two respondents pointed out that they had previously worked together and that this contributed to a productive collaboration in IMCHA. Supporting these statements was a comment from a respondent working in a new partnership:

- *Le début fut difficile car nous avons des façons de travailler qui sont tout à fait différents. Il a fallu faire beaucoup d'efforts pour arriver à trouver des compromis de façons de faire.*

Most of the comments confirmed the Likert ratings of successful cooperation. Some examples are:

- *The two teams had been working together even before IMCHA project. So it created a smooth continuity as we worked together on this project. The preceding understanding of each other's way of work and philosophy about the research work made it easier to coordinate. We knew each other's strength and weaknesses. There was harmony and clear demarcation about each other's role. The consultative decision making and implementation on ground worked very well. We capitalised on each other's strength.*
- *Une parfaite collaboration du début jusqu'à la fin du projet*
- *C'était une expérience très enrichissante pour moi sur le plan professionnel, pour l'utilisation des logiciels d'analyse tels que STATA, QDA Miner*
- *It was a great learning experience*
- *Fantastic collaboration between our teams--we all learned so much from each other and throughout the project, communication was extremely open and smooth.*

A smaller number of respondents mentioned that they experienced constraints of a logistic or organisational nature:

- *There were frequent changes of staff in the Canadian partner's institution*

- *Poor internet in the remote site made discussions between us very difficult; we needed face-to-face meetings to really get things done.*
- *While there was a willingness to collaborate on the research and share ideas, there were severe practical constraints to do this effectively when the two teams were not physically in the same place. Internet connections and language barriers made communication over e-mail/Skype close to impossible. I think that severely hindered progress and our ability to realise the full potential of the project.*

There were only two truly negative comments on the collaboration, both from African researchers who had rated the collaboration as 'somewhat successful':

- *Lack of openness from the partner. No full participation in project matters e.g. meetings and activities*
- *It turned out not a very good collaboration as it ended up creating a feeling of using us to become Professors! It was clear that all my collaborators wanted was data. I am blocked from accessing anything being worked from our data!*

Researchers and decisionmakers were asked to provide a narrative response to the question about the most important factors aiding the cooperation between African and Canadian researchers. Fifty-two responses were provided by researchers and all five decisionmakers answered this question. Most responses highlighted mutual respect, common goals and transparency as the most important elements of cooperation. Four respondents mentioned that this was aided by an existing preestablished partnership:

- *Joint work to develop proposal. Good communication. Previous experience of working together. Clarity about each other's role.*
- *Previous collaboration and shared interests*
- *Prior relationships that have established trust among the different partners*
- *We already had an established collaboration and great working relationship before this current project*

The presence of Canadian researchers at the implementation sites in field visits and placement of students was also mentioned by several researchers and by one decision maker. In addition, some respondents referred to communications technology:

- *The use of Zoom and WhatsApp for regular IRT meetings enhanced implementation of the project*

Complementarity of expertise was another factor mentioned:

- *Complementarity of areas of expertise. They were good in the quantitative component and we were good in the qualitative component*
- *Clear and timely communication. Complementary expertise*

And finally, two respondents mentioned the programme management as a factor supporting the cooperation:

- *The follow-up and guidance of the HPRO and of IDRC funder was very useful in ensuring the continuity of the project. Otherwise, it would have closed.*
- *Les facteurs financiers et techniques c'est à dire l'accompagnement*

11.3.2 COLLABORATION BETWEEN RESEARCHERS AND DECISIONMAKERS

Decisionmakers were asked: "How successful is/was your collaboration with your PI and Canadian Co-PI research partners?"; and the African and Canadian researchers were asked: "How successful is/was your collaboration with your decisionmaker Co-PI?" They were provided with five response options. All five decisionmakers and 50/54 researchers answered the questions. The responses at midterm are provided in brackets.

COLLABORATION BETWEEN RESEARCHERS AND DECISIONMAKERS	DECISION-MAKERS	AFRICAN RESEARCHERS	CANADIAN RESEARCHERS	ALL RESEARCHERS
Very successful	4	20 *(10)*	6 *(4)*	52% *(39%)*
Somewhat successful	1	11 *(6)*	8 *(7)*	38% *(36%)*
Neither successful nor unsuccessful		0 *(1)*	4 *(5)*	8% *(17%)*
Somewhat unsuccessful		0 *(1)*	0 *(2)*	-.- *(8%)*
Unsuccessful		0 *(0)*	1 *(0)*	2% *(-.-)*
Total	**5**	**31 *(18)***	**19 *(18)***	**50 *(36)***

While all decisionmakers and 90 percent of researchers rated the collaboration as very successful or somewhat successful, there was a marked difference between the respondents from Canada and those working in Africa. Four of 19 Canadian researchers (21%) were ambivalent about the success of the collaboration, and one even rated it as unsuccessful.

The question was not asked of decisionmakers in the midterm survey. Among researchers, however an increase in the appreciation of the collaboration was noted. The proportion of researchers who rated the collaboration as very or somewhat successful increased from 75 to 90 percent, primarily due to increased ratings by Canadian researchers.

Thirty-seven respondents provided additional comments, many of them positive about the collaboration:

- *The [decisionmaker] involved himself very closely into the development of proposal as he was keenly interested to learn how the project produces an impact so he could use this evidence to roll-out the intervention. With the evidence on impact available [the health authority] has endorsed to use the approach and methods for a roll-out of the intervention in the form of a micro plan including budget.*
- *[The decisionmakers] have been a pillar on how to navigate with policy makers and shed insights on the same*
- *Always there for advice, and a good link between the project and the government.*
- *Très satisfaisante - dans le cadre du volet équité, elle nous a permis de mener ensemble une recherche action sur la base des résultats de la recherche dans la perspective d'amender la politique nationale et de rendre le processus plus efficace.*

Some of the assessments were more constrained or highlighted the need to build partnerships with decisionmakers at the most functional level:

- *The decisionmakers in the hospitals were easy to access and available all the time. At district level, because of multiple activities, meetings were often postponed*
- *L'utilisation des évidences produites n'est pas encore dans les habitudes des décideurs*
- *We partnered with provincial health but in the end, it would have been better to involve a national health decision maker*

The mobility of decisionmakers was commented on as a constraint of the collaboration by several respondents:

- *[The decisionmaker] was instrumental in designing a project that would be useful to national policymakers and in meeting with them periodically. He was also very wise and understood the politics, both regional and national, about scaling up the intervention. [But] he retired soon after we were funded and [we did not hear much of him since]. I would have appreciated more continuous involvement*
- *We had intermittent contact and inconsistent counterparts*

Only two respondents noted a negative experience to the extent of even questioning the model of cooperation itself:

- *Bien que le décideur déclare partout vouloir utiliser les résultats de recherche. Sa démarche semble aller plutôt en sens inverse dans le sens qu'il ne semble pas du tout se baser sur les résultats de recherche pour prendre ses décisions*
- *Decision-makers were very busy with their routine work and they didn't pay attention very seriously towards the intervention.*

The decisionmakers generally commented on a successful cooperation:

- *I was very close to the PI most of the time, but very rarely with the Canadian Co-PI*
- *Worked very closely as a team*

Researchers were asked to provide a narrative response to the question about the most important factors aiding their cooperation with decisionmakers. Fifty-one respondents answered this question. Many mentioned the alignment of the research theme with government priorities and the importance of a shared vision between researchers and decisionmakers. Having regular team meetings with participation of the decisionmaker was also considered a factor of successful cooperation by several respondents. A previously established relationship and an involvement of the decisionmaker in the design of the project was mentioned frequently:

- *Mutual understanding and previous engagement*
- *Prior relationships that have established trust among the different partners*
- *Close historical relationship between decision-maker and research team*
- *The longstanding relationship between researchers and decision-makers*
- *Decision-makers being involved in the design or the project*

- *Joint planning of the project, oversight and regular communication/ability to assess findings and data*
- *Involvement of the decision maker right away from inception to the end of project*
- *Having the decision-makers involved from the onset was helpful*

One respondent mentioned the role of the HPRO in supporting the cooperation:

- *The HPRO, through constant calls and follow ups and also especially through trainings, kept the team together*

Decisionmakers were asked whether they could use the information from the research in their work. Those who answered (3/5) mentioned that they were able to share the findings with decision-making authorities at higher (national) level.

11.3.3 CONTRIBUTION OF DECISIONMAKERS

Researchers were asked to rate the contribution of decisionmakers to aspects of the project work, and decisionmakers were asked to rate their own contributions. Aspects included the grounding of the research in local context, the connection to other decisionmakers, the integration of gender and social equity aspects in the research, the encouragement of the use of research findings in policy- and decision-making, and the scaling of project results. Response options were provided on a four-point Likert scale. The same questions were asked at midterm, but a fifth response option, "not helpful yet but expect future help" was provided that seemed less relevant for the final evaluation. Responses at midterm are provided in brackets.

CONTRIBUTION OF DECISIONMAKERS:	VERY HELPFUL	SOMEWHAT HELPFUL	MINIMALLY HELPFUL	NOT HELPFUL	NOT YET BUT MAYBE IN FUTURE
GROUNDING RESEARCH IN LOCAL CONTEXT					
Researchers [51 *(35)]*	38 *(21)*	11 *(9)*	2 *(5)*	0 *(0)*	-.- *(0)*
Decisionmakers [5 *(12)*]	5 *(9)*	0 *(3)*	0 *(0)*	0 *(0)*	-.- *(0)*
CONNECTING TO OTHER DECISIONMAKERS					
Researchers [50 *(33)*]	26 *(12)*	16 *(14)*	7 *(6)*	1 *(1)*	-.- *(0)*
Decisionmakers [5 *(12)*]	3 *(8)*	2 *(4)*	0 *(0)*	0 *(0)*	-.- *(0)*
INTEGRATING GENDER CONSIDERATIONS					
Researchers [46 *(33)]*	16 *(6)*	15 *(7)*	11 *(12)*	4 *(5)*	-.- *(3)*
Decisionmakers [5 *(12)*]	3 *(7)*	2 *(4)*	0 *(1)*	0 *(0)*	-.- *(0)*
INTEGRATING EQUITY CONSIDERATIONS					
Researchers [48 *(32)*]	19 *(8)*	19 *(8)*	9 *(11)*	1 *(5)*	-.- *(0)*
Decisionmakers [5 *(12)*]	2 *(6)*	3 *(5)*	0 *(1)*	0 *(0)*	-.- *(0)*
ENCOURAGING THE USE OF RESEARCH FINDINGS IN POLICIES AND PRACTICES					
Researchers [52 *(34)*]	31 *(13)*	16 *(10)*	4 *(6)*	1 *(0)*	-.- *(5)*
Decisionmakers [5 *(12)*]	4 *(9)*	1 *(3)*	0 *(0)*	0 *(0)*	-.- *(0)*
SCALING UP THE RESEARCH RESULTS					
Researchers [45 *(33)*]	20 *(7)*	19 *(12)*	4 *(4)*	2 *(2)*	-.- *(8)*
Decisionmakers [5 *(12)*]	5 *(8)*	0 *(2)*	0 *(1)*	0 *(0)*	-.- *(1)*

Across all six areas of cooperation, half of the surveyed researchers (51%) rated the contribution of decision-makers as very helpful and 84 percent rated them very and somewhat helpful. This was an increase from the ratings at midterm of 36 percent and 69 percent respectively. At midterm, however, nine percent of respondents anticipated that the contribution of decisionmakers may declare themselves in future, an expectation that appears to have been realised according to the repeat survey. In all six areas, the proportion of researchers who rated the contribution of decisionmakers as very helpful increased between 14 and 22 percentage points.

Surveyed decisionmakers rated their contribution somewhat higher, although the calculation of proportions is unstable because of small numbers. Three quarters (73%) rated their contribution as very helpful, and 100% as very and somewhat helpful. These proportions also increased since midterm where they were 65 and 94 percent respectively.

Researchers rated the contribution of decisionmakers highest for 'grounding the research in local context' (very effective: 60% at midterm and 75% at final evaluation) and lowest for 'integrating gender considerations' (very effective: 18% at midterm and 35% at final evaluation). Among decisionmakers, the contribution with the lowest proportion of self-assessed high effectiveness was in the area of 'integrating equity considerations' (50% at midterm and 40% at final evaluation). The self-assessment in the area of 'integrating gender considerations' was only slightly higher.

Other contributions of the decisionmakers noted by the researchers included:

- *Suggested other areas that ought to be considered in the study*
- *Providing material support to ensure project implementation*
- *Dissemination of the research findings*

Decisionmakers commented on their own contributions to the project:

- *Working with political leaders to know the priorities of the community members*
- *Scale up the results for other districts/ areas and later be owned by the districts teams*
- *Sharing findings with federal authorities*

Both the researchers and the decisionmakers were asked whether anything should change in the way the collaboration among the researchers and between them and the decisionmakers were conceived and implemented. Many of the comments and suggestions were very specific to the relationships within the project with some African researchers commenting on poor relationships with their Canadian partners:

- *The Canadian lead investigator took a very authoritarian approach throughout the project and in my opinion did not respect the African co-investigators or decision-maker Co-PI.*

Several Canadian researchers commented on insufficient research capacity in the African teams or insufficient involvement in the setup of the project. A need for capacity strengthening was also mentioned by one decisionmaker.

- *The imbalance in terms of capacity (especially research skills and research management skills) was evident and posed a major challenge.*

Specific issues were also mentioned such as visa denials by Canadian missions to African researchers for meetings in Canada, and one respondent mentioned delays in the release of funds. Three respondents took issue with the lack of transparency in the way the research grants were split between the two partners:

- *IDRC should ensure that we are copied on each other's financial reports. We don't have to have a say on how they are constructed or spent but it is good to have another set of eyes and we won't be surprised by new initiatives. I imagine this sharing occurred in teams that have a natural collaboration but what about the teams where the PI is more authoritarian than collaborative?*
- *In spite of being funded separately, partners should have one common financial report to increase transparency and accountability.*
- *La gestion des fonds uniquement d'un côté (que ce soit africain ou canadien) est un problème.*

Some respondents, however, noted that they would not change anything:

- *Not really. The model is excellent, but I think it is individuals.*
- *Non. Nous avons une longue tradition de collaboration et tout se passe bien en équipe*

11.3.4 BARRIERS TO RESEARCH IMPLEMENTATION

Survey respondents and decisionmakers were asked to rate the importance of barriers experienced in the implementation of the projects using a four-point Likert scale. The types of barriers and the scale options were identical to those used in the midterm survey. The responses are summarised in the table, with midterm results in italics.

BARRIERS:	VERY IMPORTANT	SOMEWHAT IMPORTANT	MINIMALLY IMPORTANT	NOT A BARRIER
INSUFFICIENT ENGAGEMENT OR AVAILABILITY OF PI				
Researchers [50 *(32)]*	2 *(5)*	5 *(8)*	4 *(4)*	39 / 78% *(15 / 47%)*
Decisionmakers [5 *(9)*]	1 *(0)*	0 *(3)*	1 *(1)*	3 / 60% *(5 / 56%)*
INSUFFICIENT ENGAGEMENT OR AVAILABILITY OF CANADIAN CO-PI				
Researchers [43 *(29)*]	2 *(1)*	5 *(6)*	3 *(7)*	33 / 77% *(15 / 52%)*
Decisionmakers [4 *(11)*]	0 *(1)*	1 *(2)*	0 *(3)*	3 / 75% *(5 / 45%)*
INSUFFICIENT ENGAGEMENT OR AVAILABILITY BY THE DECISIONMAKER CO-PI				
Researchers [50 *(33)]*	3 *(2)*	6 *(10)*	12 *(6)*	29 / 58% *(15 / 45%)*
Decisionmakers [5 *(11)*]	0 *(1)*	0 *(1)*	1 *(4)*	4 / 80% *(5 / 45%)*
INSUFFICIENT HUMAN RESOURCES				
Researchers [51 *(33)*]	6 *(6)*	10 *(11)*	12 *(5)*	23 / 45% *(11 / 33%)*
Decisionmakers [5 *(10)*]	0 *(2)*	2 *(4)*	1 *(2)*	2 / 40% *(2 / 20%)*
INSUFFICIENT FINANCIAL RESOURCES				
Researchers [47 *(33)*]	6 *(7)*	6 *(10)*	12 *(5)*	23 / 49% *(11 / 33%)*
Decisionmakers [5 *(10)*]	0 *(2)*	2 *(5)*	1 *(2)*	2 / 40% *(1 / 10%)*
INSUFFICIENT CONNECTION TO DECISION-MAKING AUTHORITIES				
Researchers [49 *(33)*]	1 *(5)*	10 *(7)*	13 *(8)*	25 / 51% *(13 / 39%)*
Decisionmakers [5 *(10)*]	0 *(3)*	0 *(4)*	1 *(1)*	4 / 80% *(2 / 20%)*

At midterm and for the final evaluation, human resources and financial constraints were identified as the most important barriers by researchers and decisionmakers. Among researchers, 31 percent rated human resources shortages, and 26 percent financial resources shortages as very or somewhat important; at midterm, it was 52 percent for both. On average, only half as many researchers noted very important or somewhat important barriers to implementation on any of the issues at the final evaluation compared to midterm (21% versus 40%). An identical pattern was observed among the responses of decisionmakers, although the small number of respondents in both surveys makes the calculation of proportions highly unstable.

Additional constraints mentioned by the researchers in narrative comments related primarily to financial and human resource constraints. A decisionmaker also commented on insufficient funds to finance his or her participation in all project activities. Security issues were also mentioned by two respondents and the difficult logistics of reaching the project communities by one. Other comments were:

- *During the last phase of the project we faced some difficulty due to financial constraints faced by the government for its commitment on sustainability. This is a key barrier in resource constraint settings for sustaining and scaling research interventions even if they show a clear significant impact.*
- *We had delays with implementing our study and had to work hard to catch up with the shortfalls*
- *Earmarking of funds which restricted us from approaching this maternal child health project in a holistic and community-centred way*
- *From what I gather the structure of the funding system hindered progress more than facilitated it. I'm not sure that the HPRO was of much use. Perhaps using those funds to enable a longer duration for implementation studies would have yielded better results.*

11.3.5 HPRO Effectiveness

Researchers and decisionmakers were asked about the effectiveness of HPRO support. Only in the final evaluation survey, respondents were asked to select the collaborating HPRO. Further sub-categorising the group of five decisionmakers who responded to the survey is, however, not useful. Furthermore, the available database from the midterm survey does not include data on the project country or the relevant HPRO. The table therefore combines the responses relating to both HPROs. The Likert scale at midterm included one additional option of future effectiveness.

Support from HPROs:	Very effective	Somewhat effective	Very & Somewhat %	Minimally effective	Not effective	Maybe in future
Research methods training						
Researchers [37 *(33)*]	11 *(11)*	16 *(14)*	**73% *(45%)***	4 *(1)*	6 *(4)*	*(3)*
Decisionmakers [5 *(11)*]	4 *(8)*	0 *(2)*	**80% *(91%)***	1 *(1)*	0 *(0)*	*(0)*
Implementation science training						
Researchers [36 *(30)*]	12 *(7)*	14 *(13)*	**72% *(67%)***	2 *(3)*	8 *(4)*	*(3)*
Decisionmakers [5 *(9)*]	3 *(5)*	2 *(3)*	**100% *(89%)***	0 *(1)*	0 *(0)*	*(0)*
Gender sensitivity training						
Researchers [35 *(28)*]	14 *(4)*	11 *(12)*	**71% *(57%)***	6 *(5)*	4 *(4)*	*(3)*
Decisionmakers [5 *(11)*]	3 *(6)*	0 *(3)*	**60% *(82%)***	2 *(0)*	0 *(1)*	*(1)*
Equity sensitivity training						
Researchers [34 *(30)*]	12 *(4)*	10 *(11)*	**65% *(50%)***	7 *(5)*	5 *(6)*	*(4)*
Decisionmakers [5 *(11)*]	3 *(5)*	1 *(4)*	**80% *(82%)***	1 *(0)*	0 *(1)*	*(1)*
Grounding the research in the local context						
Researchers [39 *(31)*]	18 *(9)*	9 *(12)*	**69% *(68%)***	4 *(4)*	8 *(4)*	*(2)*
Decisionmakers [5 *(11)*]	3 *(8)*	1 *(2)*	**80% *(91%)***	1 *(1)*	0 *(0)*	*(0)*
Connecting the team to decisionmakers						
Researchers [41 *(33)*]	19 *(14)*	11 *(8)*	**73% *(67%)***	5 *(4)*	6 *(5)*	*(2)*
Decisionmakers [5 *(12)*]	2*(8)*	3 *(4)*	**100% *(100%)***	0 *(0)*	0 *(0)*	*(0)*
Supporting your team to network and share with other teams						
Researchers [45 *(33)*]	20 *(9)*	11 *(12)*	**69% *(64%)***	6 *(4)*	8 *(7)*	*(1)*
Decisionmakers [5 *(12)*]	3 *(7)*	2 *(5)*	**100% *(100%)***	0 *(0)*	0 *(0)*	*(0)*
Contributing to knowledge translation of your research						
Researchers [44 *(32)*]	22 *(10)*	10 *(9)*	**73% *(59%)***	6 *(4)*	6 *(4)*	*(5)*
Decisionmakers [5 *(12)*]	4 *(9)*	1 *(2)*	**100% *(92%)***	0 *(0)*	0 *(0)*	*(1)*

Overall, a greater proportion of researchers rated the HPRO support as very effective or somewhat effective in the final evaluation survey than in the midterm survey (71% versus 64%). However nine percent of respondents at midterm anticipated that effectiveness of HPRO support would improve over time. At the final evaluation, HPRO support for 'connecting the team to decision-makers' and 'contribution to knowledge translation' was ranked highest, closely followed by 'research methods training'. At midterm, 'grounding the research in the local context' was followed by 'connecting the team to decisionmakers' and then by 'networking and sharing with other teams'. Support for 'equity sensitivity training' received the lowest proportion of scores for effectiveness.

Decisionmakers responding to the final and midterm survey found the support of the HPROs generally effective. The effectiveness of gender sensitivity training was scored lowest, but meaningful calculations of responses are not possible because of the small number of respondents.

Narrative comments in response to this question did not offer any additional activity or area of HPRO effectiveness. Many Canadian respondents noted that they did not know enough about the work of the HPROs in order to comment on their effectiveness.

Although the East and West Africa HPRO worked under identical terms of reference, they had very different institutional structures. We therefore analysed the responses from all respondents (African researchers, Canadian researchers and decisionmakers) about their perception of HPRO effectiveness by region of their project.

Project Region	Very effective	Somewhat effective	Minimally effective	Not effective
Research methods training				
West Africa [18]	28%	33%	17%	22%
East Africa [24]	42%	42%	8%	8%
Implementation science training				
West Africa [19]	32%	37%	5%	26%
East Africa [22]	41%	41%	5%	14%
Gender sensitivity training				
West Africa [15]	50%	17%	17%	17%
East Africa [19]	36%	36%	23%	5%
Equity sensitivity training				
West Africa [18]	44%	28%	0%	28%
East Africa [21]	33%	29%	38%	0%
Grounding the research in the local context				
West Africa [19]	42%	21%	5%	32%
East Africa [25]	52%	24%	16%	8%
Connecting the team to decisionmakers				
West Africa [20]	40%	20%	15%	25%
East Africa [26]	50%	38%	8%	4%
Supporting your team to network and share with other teams				
West Africa [20]	40%	25%	15%	20%
East Africa [30]	50%	27%	10%	13%
Contributing to knowledge translation of your research				
West Africa [20]	55%	10%	15%	20%
East Africa [29]	52%	31%	10%	7%

Researchers and decisionmakers in East Africa generally perceived the HPRO support to be more effective than in West Africa. However there were nuances. For instance the gender and equity training provided in West Africa was perceived as more effective. The largest differences were reported for research methods and implementation science training which was perceived as much more effective in East than in West Africa, a response that does not surprise as the East Africa HPRO consortium was led by a research institution.

Researchers and decisionmakers were asked for suggestions of what else HPROs could do in support of the research projects. Thirty-eight researchers and four decisionmakers answered this question. None of them suggested any additional role or activity except for one respondent who though that HPROs should have a role in monitoring and evaluation of the projects. Several Canadian researchers commented that they would have liked to have more information about HPRO activities. Most

comments by African researchers and decisionmakers asked for the HPROs to work closer with the projects, and especially with decision-making authorities:

- *More proactive role in facilitating liaison at national and regional level especially directly with government policy makers to ensure lessons learnt from the projects and successful interventions with impact are taken up for national and regional roll-out and sustained within the mainstream government system*
- *Site visit, Regular meeting, involve more stakeholders during their meeting, PI could suggest the topic/training,*
- *Being closer to the projects by e.g. visiting individual teams and sites*
- *Help us connect nationally sooner*
- *More engagements with state and federal authorities for more publicity*

All respondents were then asked about their opinion on whether to include an HPRO-type component in future implementation research programmes. Fifteen Canadian researchers answered this question, four of them admitting that they did not have sufficient information about the work of the HPROs. Another nine were supportive, however all but one with some limitations:

- *I think there is room for improvement, but it seems like a worthwhile investment.*
- *Yes, but I think too much funding was given to the HPRO's for training that took our staff away from research duties. I think the balance should be on funding for the projects with less funding for HPRO's*

Two Canadian respondents did not see much use in the HPRO model:

- *Given financial constraints, I think the budget for the HPRO might have been more usefully shared across the funded sites.*
- *Il faut plutôt appuyer les équipes de recherche et les décideurs entre eux et ne pas passer par ces HPRO dont la bureaucratie non efficiente fait perdre de l'argent à une recherche et une prise de décision qui en aurait besoin*

Among the 16 African researchers who answered this question, ten gave the HPRO a strong endorsement, as did the two decisionmakers who responded:

- *This is an excellent model in terms of supporting implementation, challenges that develop in project implementation and guidance in influencing policy with the research project*
- *Oui, pour plus de succès dans le déroulement et des attentes du projet*

The remaining six comments were also positive but suggested improvements in HPRO performance:

- *Their participation in research programmes supports the positive collaboration with other research teams in the country and with national decision makers but they need to improve on this.*

11.3.6 IMCHA CONTRIBUTION TO CAPACITY-DEVELOPMENT

Survey questions on the IMCHA contribution to institutional capacity differed between the midterm survey and the survey for the final evaluation, although the capacity fields or areas were identical.

While at midterm, the PIs and Canadian Co-PIs were asked to indicate if there was a contribution to capacity by marking a field associated with each area, in the final evaluation survey the respondents were given a choice to rate the contribution on a four-point Likert scale from 'not at all' to 'a major extent'. Among the African researchers who responded to this question, only one or two selected the option 'not at all' in some of the areas, and none selected the option 'minimally' in any area. Although the results of the two surveys are presented in the same table, they cannot be compared because:

- Respondents in 2020 included African researchers at all levels in the projects and not only the PIs as in 2018;
- The formulation of the question differed and the response option of 'some contribution' in the 2020 survey is not considered in the table; and
- It is not clear whether the respondents who did not mark the field in the 2018 survey meant that there was no contribution, or that they did not know; i.e. the denominator is uncertain.

For the results of the final evaluation, only the proportions of those who responded that capacity was strengthened 'to a major extent' are listed in the table. For the midterm survey, the proportion of respondents who marked that capacity was built in this area is listed. The number of respondents is indicated in brackets.

CAPACITY IN …	STRENGTHENED / MAJOR EXTENT (% RESPONDENTS 2020)	STRENGTHENED (% RESPONDENTS 2018)
… preparing grant applications	70% [27]	50% [18]
… project monitoring and supervision	70% [30]	56% [18]
… research methods	74% [31]	72% [18]
… implementation science	82% [38]	61% [18]
… knowledge translation	74% [31]	33% [18]
… gender analysis / mainstreaming	41% [29]	56% [18]
… equity analysis / mainstreaming	38% [29]	39% [18]
… financial management	50% [28]	33% [18]

While there are limitations of comparison, the responses to the final evaluation survey indicate that among African researchers, there is a perception that IMCHA contributed to capacity-strengthening to a major extent in most areas, but only moderately in the areas of gender and equity analysis and mainstreaming. There appears to be scope for further support in these areas.

Additional capacity gains were listed by eight African researchers, including in publishing research results in high-impact journals, in networking and sharing experience across the region and with decisionmakers, electronic data collection and systematic review methods. Canadian research team members were less positive about capacity gains with most stating that they had competent teams and did not expect to build further capacity through IMCHA. One Canadian researcher, however, responded that '*IMCHA was helpful by emphasising the partnership with decisionmakers right from the beginning*'.

11.3.7 GENDER ANALYSIS AND MAINSTREAMING

All respondents were asked about the extent to which their project included aspects or activities related to gender equality. The three response options for each activity were 'no', 'to some extent', and 'consistently'. At midterm the same question was asked, however the response options were 'no', 'yes', and 'plan to do so in future'. The table presents the combined responses of all researchers and decisionmakers.

	2020 SURVEY				2018 SURVEY			
	NO	SOME	CONSISTENT	N	NO	YES	IN FUTURE	N
Gender sensitivity training	13	13	27	**53**	10	28	6	**44**
Include gender expertise in team	8	20	27	**55**	10	29	6	**45**
Women / girls as beneficiaries	1	10	46	**57**	0	33	3	**36**
Women / girls consulted	4	21	28	**53**	4	35	2	**41**
Women in decision-making in proj.	5	12	39	**56**	3	41	1	**45**
Include gender in research quest.	3	13	39	**55**	3	39	2	**44**

The responses to both surveys indicate an awareness of respondents about actions to strengthen gender integration their research projects. At midterm, between 64 and 91 percent of respondents declared that these aspects were included in their projects, and between two and 14 percent planned to do so in future. At the final evaluation survey, between 75 and 95 percent declared that these aspects were included at least to some extent, while consistent inclusion was less ranging from 51 to 81 percent. A clear trend cannot be inferred from these data.

Twenty-one respondents to the final evaluation survey listed additional methods for integrating gender considerations in their project. Several of them, however, were only precisions of the answers provided in the table. Two respondents referred to the gender balance in the research teams, and seven respondents mentioned that they included men in the research population:

- *We included the concerns of men in women's decision to seek maternity care, and worked with men to promote women's use of skilled pregnancy care*

Some interesting comments included in the responses were:

- *Inclusion of elderly women in the study sample*
- *Alors que cela n'est pas toujours facile ; beaucoup de femmes de notre projet sont des femmes [?]*
- *Our project explicitly focused on studying gender issues in health social enterprises*

Researchers were asked in the final evaluation survey about the extent to which HPROs were helpful in integrating gender equality considerations in their project. Only about a third of respondents (31%) rated the support from HPROs as very helpful. Among African researchers it was about 40 percent while it was only one out of 11 Canadian respondents.

WERE HPROS HELPFUL FOR GENDER INTEGRATION?	NOT HELPFUL	SOMEWHAT HELPFUL	VERY HELPFUL
African researchers [25]	3	12	10
Canadian researchers [11]	5	5	1
Total [31]	**8**	**17**	**11**

To some extent these assessments may have been influenced by exposure to gender training, which was provided by HPROs following the midterm evaluation, but also by IMCHA Management at the inception and midterm workshops. 15/28 (54%) of African researchers stated that they had participated in a training workshop on gender while it was only 7/24 (29%) of Canadian researchers. Only three Canadian research team members provided additional comments on HPRO support in gender integration with one of them noting that the gender training provided by the HPRO was *'rather constrained in approach and not very helpful - in some ways, it was confusing for the participants*.' Most African researchers who provided additional comments mentioned the gender analysis training workshops without, however, including statements about their quality. The only other two comments about the helpfulness of HPROs in gender integration were rather negative:

- *The HPRO dwelt a lot on policy issues and networking. Gender equality was not discussed very much, probably because our groups had women as the focal point and the HPRO thought that it was not necessary to emphasise too much on male issues.*
- *L'appui de l'HPRO dans ce domaine comme dans d'autres est resté très épisodique et anecdotique.*

Researchers and decisionmakers were asked to mention barriers they experienced in the gender integration in their project. The largest proportion noted that they experienced no barriers, but the responses documented considerable insecurity and differences in understanding of concepts such as gender analysis, gender integration or gender equality. This was also expressed in the comment of one Canadian researcher:

- *Gender equality might not mean the same thing for researchers in Canada and Africa or the people participating in the study.*

Five researchers in African and Canadian teams noted that they lacked training or guidance on how to integrate gender considerations in their project, while one member in a Canadian team noted that the Canadian Co-PI considered gender issues irrelevant and actively supressed efforts in gender analysis.

- *I think for me it is more because I never had that training to make it easier to do so*
- *Lack of familiarity with how to do this.*

Four researchers noted that it was difficult to reach men with their project activities. This supports the impression that among some teams, inviting men to participate in maternity and childcare was considered a key intervention for gender integration:

- *Reluctance by male partners to participate in group activities*
- *We believe we focussed on gender equality. Trying to engage men was a challenge.*

The lack of clear definitions and the unease with the concept of gender integration and its application is reflected in the response of one researcher who mentioned that *'talking about "gender" without*

acknowledging the power dynamics of gender differences in the project area' was a barrier to gender integration. The lack of clarity about gender integration in the conceptualisation of the projects was noted by one respondent:

- *The design was not clear on gender issues since the beginning. It was a bit challenge to introduce gender issues along the way.*

Others mentioned social and cultural factors in a very general way, and two respondents thought that male dominance in the investigation teams constituted a barrier to gender integration. One decisionmaker mentioned insufficient funds as a barrier to gender integration.

11.3.8 EQUITY ANALYSIS AND MAINSTREAMING

In order to assess how respondents viewed the relevance of integrating an equity dimension in their project, they were asked about their agreement with three statements.

	AGREE
1. All intended beneficiaries are vulnerable and the "equity lens" is therefore automatically applied	28
2. There are differences among beneficiaries and efforts are made to focus on the most vulnerable	25
3. Equity considerations are not relevant to my project	1

Five respondents marked that none of these statements applied to their project. There was a difference in the responses of Canadian researchers, African researchers and decisionmakers. While all decisionmakers and the majority of the Canadian researchers (10/19) selected the first statement, a majority of African researchers (17/30) selected the second.

Among the five researchers who responded that neither of the three statements applied, one noted that there was awareness of social inequities, but that they were not analysed, while another noted that the project's aim to achieve universal coverage was a solution to overcome social inequities.

Similar to the question about gender integration, all respondents were asked about the extent to which their project included aspects or activities related to social equity. The three response options for each activity were 'no', 'to some extent', and 'consistently'. At midterm the same question was asked, however the response options were 'no', 'yes', and 'plan to do so in future'. The table presents the combined responses of all researchers and decisionmakers.

	2020 SURVEY				2018 SURVEY			
	NO	SOME	CONSISTENT	N	NO	YES	IN FUTURE	N
Incorporated equity training in the project	16	16	14	**46**	16	19	8	**43**
Brought equity expertise into the project	13	20	15	**48**	11	25	5	**41**
Ensured that vulnerable populations were reached	2	7	43	**52**	0	34	2	**36**
Consulted vulnerable populations in design and implementation	7	13	29	**49**	6	32	4	**42**

The responses to both surveys indicate an awareness of respondents about actions to strengthen the social equity dimensions of their research projects. At midterm, between 44 and 94 percent of respondents declared that these aspects were included in their projects, and between six and 19 percent planned to do so in future. Overall, this was just slightly lower than for the aspects of gender integration. At the final evaluation survey, between 65 and 86 percent responded that these aspects were included at least to some extent, while consistent inclusion was less ranging from 30 to 83 percent. In both surveys, almost all respondents declared that their project reached vulnerable populations, correlating with the agreement with the statements listed in the preceding question. Social equity expertise and equity training were reported by a much smaller proportion of respondents indicating scope for work in the future.

Among the ten respondents who reported the inclusion of other aspects or activities related to social equity in their project, four mentioned data collection and analysis.

- *We collected data on multiple measures of social equity so that we can conduct analyses to identify associations between multiple factors and our study outcomes.*

Two respondents mentioned the promotion of male involvement in maternity care and other project activities, confirming the finding at midterm that grantees had difficulties differentiating between the concepts of gender and equity integration.

The question on the most important measures taken for the integration of equity considerations was answered by 41 researchers and decisionmakers, with some replies of *'I don't remember'* or *'I don't know'*. Other responses were already covered in the four options provided in the table of social integration such as contracting experts with expertise in the area or ensuring that vulnerable groups are reached; and others again mentioned the involvement of men in maternity service provision. A research focus on social inequity was explicitly mentioned by six respondents:

- *We considered different stratifiers such us wealth, residence type, distance to facility at the analysis stage.*
- *We collected data through cross-sectional surveys to generate a household wealth index. We also collected data on religion, ethnicity, geographic location, social support and decision-making. We further collected qualitative data on perceptions of health equity, barriers and challenges.*

In response to the questions about barriers for the integration of equity considerations in the project, 37 researchers and decisionmakers entered comments, 11 of them noting that they did not experience any barriers. Social and cultural factors were mentioned by five without further details. Two respondents noted that project funds for meaningful research in social equity were insufficient:

- *More time and appropriate funding as well as better intervention design would have allowed a more meaningful consultation with the community about how best the interventions could address women/families' health care service access issues.*

Logistic barriers to reach highly vulnerable communities or groups were mentioned by five respondents, one of them also linking this to resource constraints:

- *Travel to the most remote communities presents logistic and security challenges.*

- *L'insécurité dans certaines zones du pays a nécessité des ajustements.*

A lack of interest in exploring social equity issues in MNCH services by some project partners were mentioned by three respondents:

- *Negative attitude of some local leaders who had high expectation of financial gains from the project.*
- *Not everybody is interested in promoting social equity.*
- *Opportunities for gathering relevant information were consistently missed because of a lack of interest by the lead Canadian researcher.*

Researchers were asked in the final evaluation survey about the extent to which HPROs were helpful in integrating social equity in their project. Perceptions of the helpfulness of HPROs in equity integration was somewhat lower than perceptions about gender integration. Only about a quarter of respondents (26%) rated the support from HPROs as very helpful, among African researchers it was about one third (32%) and among Canadian researchers only one out of nine.

WERE HPROS HELPFUL FOR EQUITY INTEGRATION?	NOT HELPFUL	SOMEWHAT HELPFUL	VERY HELPFUL
African researchers [22]	5	10	7
Canadian researchers [9]	6	2	1
Total [31]	**11**	**12**	**8**

Fewer researchers reported that they attended equity training than those who attended gender training. Among African researchers it was 10/24 (42%) and among Canadian researchers 4/24 (17%). The few narrative comments on the question of HPRO helpfulness all referred to training opportunities.

11.3.9 KNOWLEDGE TRANSLATION AND SCALING

All African and Canadian researchers stated that their research findings were either already translated into policies or practices (27/53) or that there were prospects of translation for the future (26/53). Among the 27 who already reported knowledge translation, 11 mentioned the regional level, ten mentioned the national level and six a sub-national level. Among the five decisionmakers who responded, four stated that they had already used information provided by the research in their work.

The five decisionmakers who participated in the survey stated they were involved in translating the research findings into policies and practice by disseminating and sharing information. Twenty-eight researchers provided details on how their research findings were translated into policies or practice. While many of them noted that policy changes were still under discussion or in preparation, several mentioned results that had already been achieved:

- *[The health service authority] adopted the home visit methods and strategy to develop a micro-plan for state-wide roll-out of the scheme.*
- *The Ministry of Health has adopted the curriculum for CEmONC [piloted by the project] for training care providers in the whole country*

- *Le équipes cadre de district supervisent désormais les formations des Distributeurs communautaires par les infirmiers chefs de poste avant le début de chaque campagne de chimio-prévention du paludisme saisonnier.*
- *At the district level, the government has started to incorporate birth kit distribution which we started in our project.*
- *Mental health is now integrated into PHC services.*

In answer to the question about successful scaling of the research findings, the reported numbers for each level appear very high and do not correlate with the reports on successful knowledge translation. The question may not have been understood in the same way by all respondents. Multiple responses were allowed

DID YOUR PROJECT SUCCEED IN SCALING UP THE FINDINGS OF YOUR RESEARCH?	
To district level	20
To provincial or state level	9
To national level	17
To regional level	9
We did attempt to scale-up but were not successful	2
Scaling was not an objective of our project	13

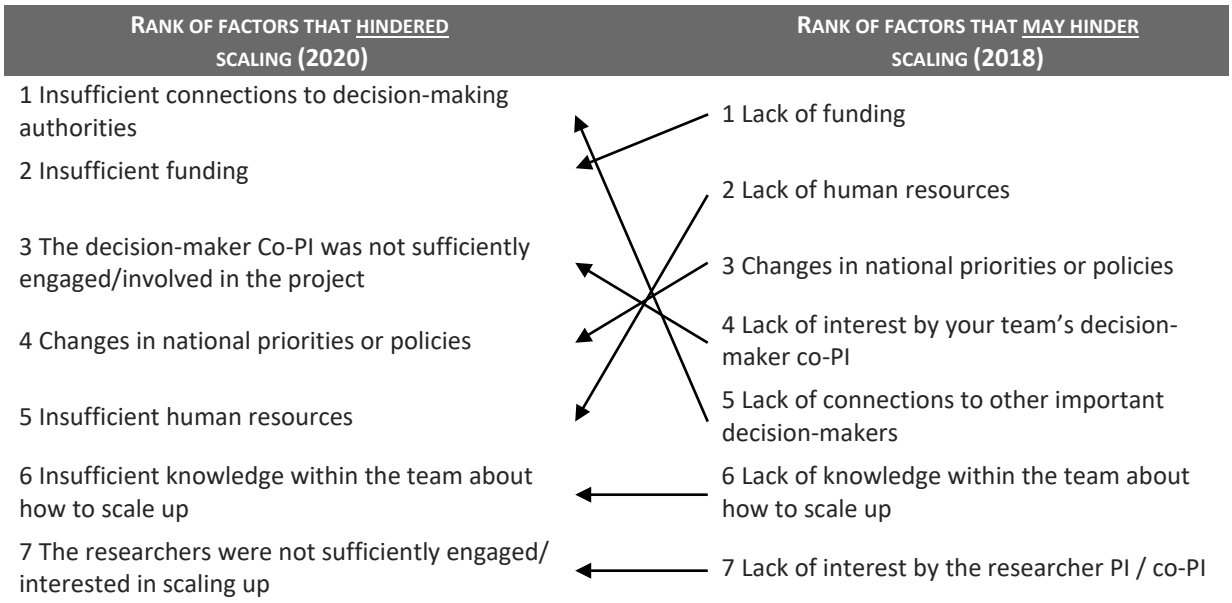
When asked about what approaches were taken to scale up the project results, 12 researchers referred to the final dissemination of results in workshops and publications, several of them noting that it was too soon as data analysis had still not been completed. Five respondents highlighted the continued engagement with policy- and decisionmakers throughout the project as an approach to successful scaling:

- *The project team shared the successes and failures with the decisionmakers and managers at regional and district levels every 6 months.*
- *The government was strongly involved at all stages, from planning onwards. They took over management of the intervention in one area during the life of the project.*
- *We have continued to meet with policy makers at district and regional level to ask them to consider how to scale up the findings from the project.*
- *Nous avons impliqué une personne ressource du PNLP dans notre équipe afin d'assurer un partage continu des résultats mais aussi de tenir compte des besoins du PNLP [National Malaria Programme]*

Capacity-building of service providers was mentioned by two respondents, while two also mentioned formal agreements with health service authorities to promote application of results at scale:

- *We have a memorandum of understanding with the policymakers at state level to work with the state in mental health integration.*

One decisionmaker and 17 researchers, ten African and seven Canadian, reported that they encountered barriers to scaling. Among them 12 ranked the factors that hindered their efforts in order of importance. At midterm, 31 of 36 researchers answered this question, ranking factors that may hinder scaling by importance as follows:



11.3.10 CONTRIBUTIONS TO ULTIMATE OUTCOMES

The researchers were asked whether their project contributed to improvements in the 11 ultimate outcome indicators of IMCHA. Multiple choices were possible. The 54 researchers in African and Canadian institutions selected the indicators they felt were improved by their project with frequencies ranging from nine to 59 percent. African researchers generally rated the contribution higher than Canadian researchers. Eleven researchers (5 African and 6 Canadian) did not select any of the indicators, stating that they either had not yet analysed their data or that the achievement of these outcomes was not an objective of their project:

- *Too early to tell, as changes based on findings are still to be determined*
- *Ce n'était pas l'objectif de ce programme de recherche*

CONTRIBUTION TO INDICATOR IMPROVEMENT	AFRICAN (N=32)	CANADIAN (N=22)	ALL (N=54)
Maternal mortality ratio	22 (69%)	10 (45%)	**32 (59%)**
Under 5 mortality rate	21 (66%)	10 (45%)	**31 (57%)**
Antenatal care coverage (4 times)	18 (56%)	11 (50%)	**29 (54%)**
Skilled attendance at birth	18 (56%)	11 (50%)	**29 (54%)**
Postnatal care within 2 days	17 (53%)	11 (50%)	**28 (52%)**
Exclusive breastfeeding for 6 months	12 (38%)	6 (27%)	**18 (33%)**
DPT3 vaccine coverage	7 (22%)	6 (27%)	**13 (24%)**
Met need for contraception	9 (28%)	3 (14%)	**12 (22%)**
Chronic childhood malnutrition	8 (25%)	2 (9%)	**10 (19%)**
ARV coverage for prevention of mother-to-child HIV transmission	5 (16%)	0 (0%)	**5 (9%)**
Antibiotic treatment of children with suspected pneumonia	3 (9%)	2 (9%)	**5 (9%)**

Twenty researchers included statements of additional outcomes including

- *Improved spousal communication on pregnancy and childbirth related issues*

- *Reduced domestic violence and intimate partner violence*
- *Improved attitudes of health workers towards women in antenatal and maternity services*
- *Reduced neonatal and perinatal mortality*
- *Increased male involvement in maternal and child health*

11.3.11 IMCHA MANAGEMENT

To collect views of the research teams on the management of IMCHA, the respondents were asked what assistance and support they received from IDRC Programme Officers.[4] The responses were compared to those provided in the midterm survey which are presented in italics.

ASSISTANCE OR SUPPORT RECEIVED IN …	YES	NO	% YES
… refining the research protocol and implementation plan	31 *(18)*	8 *(15)*	79% *(55%)*
… networking	34 *(26)*	6 *(9)*	85% *(74%)*
… promoting, publishing and/or presenting the research	37 *(21)*	5 *(12)*	88% *(64%)*
… solving of technical or ethical issues you faced during your research	18 *(-)*	15 *(-)*	55% *(-)*
… team problem solving	- *(15)*	- *(18)*	- *(45%)*
… addressing gender equality issues and gender mainstreaming	27 *(-)*	8 *(-)*	77% *(-)*
… addressing equity issues	17 *(-)*	11 *(-)*	61% *(-)*
… financial reporting	30 *(23)*	7 *(12)*	81% *(66%)*
… seeking additional research funding for this or future projects	13 *(-)*	15 *(-)*	46% *(-)*

For all parameters for which data at midterm and final evaluation were available, respondents noted an increase in support or assistance from IDRC. The highest level of assistance was reported for publishing and presenting research findings, which did, of course, increase as the research projects reached higher levels of maturity towards the end of the IMCHA initiative.

Respondents were also asked to rate the helpfulness of the means and the content of the support or assistance from IDRC on a four-point Likert scale. At midterm, the same areas were covered but a five-point scale was used. The midterm responses are presented in italics, and the proportion of 'very helpful' ratings are compared between the midterm and the final evaluation survey.

HELPFULNESS OF THE ASSISTANCE PROVIDED IN/THROUGH …	NOT HELPFUL	MINIMALLY HELPFUL	NEUTRAL	SOMEWHAT HELPFUL	VERY HELPFUL	% VERY HELPFUL
… preparing the implementation plan	3 *(3)*	4 *(3)*	- *(3)*	8 *(7)*	25 *(20)*	63% *(56%)*
… preparing technical reports	1 *(1)*	5 *(3)*	- *(4)*	9 *(11)*	26 *(17)*	63% *(47%)*
… preparing financial reports	2 *(1)*	4 *(4)*	- *(2)*	7 *(11)*	25 *(18)*	66% *(50%)*
… monitoring visits by IDRC Prog. Officers	1 *(1)*	6 *(17)*	- *(4)*	8 *(3)*	17 *(11)*	53% *(31%)*
… IMCHA workshops	1 *(2)*	2 *(3)*	- *(3)*	7 *(9)*	25 *(18)*	71% *(51%)*
… optimising performance (technical support)	3 *(1)*	4 *(1)*	- *(9)*	4 *(9)*	22 *(9)*	67% *(31%)*
… communication with IDRC Prog. Officers	- *(1)*	- *(0)*	- *(4)*	- *(10)*	- *(20)*	- *(57%)*

[4] In the review of the evaluation report, IMCHA management stated that management was provided by IMCHA POs rather than IDRC POs. We did not change the wording, however, because it reflects the wording used in the questionnaires used at midterm and for the final evaluation.

As with the proportion of respondents who reported that they received assistance from IDRC, the rating of the helpfulness of this assistance also increased. Workshops were rated most often as very helpful as a means of supporting the research projects. Monitoring visits were rated the lowest, but this would also have been influenced by the fact that several projects in conflict areas were never visited because of Canadian government travel regulations.

Few additional comments on the helpfulness of IMCHA management were provided by respondents, two expressing appreciation about assistance in networking with global actors and two commenting on the general responsiveness and support provided by IDRC Programme Officers. One respondent, however, felt that IDRC was '*too intrusive*'.

11.3.12 Overall IMCHA experience

All respondents were asked to note their level of agreement with a number of summary statements about the IMCHA initiative. Some statements were formulated differently for researchers and decisionmakers as per the midterm survey. Options to state the level of agreement were provided on a five-point Likert scale. Responses from the midterm survey are provided in italics.

Researchers and Decisionmakers					
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	% agree or strongly agree
The research topic is a key health priority of the country/region					
0 *(0)*	0 *(0)*	0 *(0)*	12 *(6)*	46 *(38)*	100% *(100%)*
The collaboration between African and Canadian researchers was key					
0 *(0)*	1 *(1)*	3 *(1)*	16 *(15)*	38 *(27)*	93% *(95%)*
The HPRO was important to meeting the objectives of the project					
5 *(1)*	5 *(6)*	11 *(11)*	14 *(14)*	15 *(12)*	58% *(59%)*
Gender considerations were well-integrated in the project					
0 *(2)*	3 *(1)*	7 *(2)*	19 *(18)*	28 *(21)*	82% *(89%)*
Social equity considerations were well-integrated in the project					
0 *(1)*	2 *(1)*	6 *(3)*	24 *(22)*	26 *(17)*	86% *(89%)*
IMCHA provided opportunities to learn about advances in MNCH from other African countries					
1 *(0)*	1 *(2)*	6 *(4)*	16 *(12)*	28 *(26)*	85% *(86%)*
IDRC has done a good job in monitoring and supervising this project					
1 *(0)*	1 *(1)*	2 *(7)*	22 *(14)*	28 *(22)*	93% *(82%)*

Decisionmakers only					
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	% agree or strongly agree
My involvement has been important to meet the objectives of the project					
0 *(0)*	0 *(0)*	0 *(1)*	0 *(2)*	5 *(5)*	100% *(88%)*

Researchers only					
Strongly disagree	Disagree	Neither agree nor disagree	Agree	Strongly agree	% agree or strongly agree
I am happy with the outcomes of the research					
0 *(0)*	2 *(2)*	2 *(3)*	18 *(17)*	30 *(14)*	92% *(86%)*
The African PI and Canadian Co-PI collaborated as equals					
1 *(1)*	3 *(4)*	6 *(1)*	11 *(8)*	29 *(22)*	80% *(83%)*
The involvement of the decision-maker co-PI was important to meet the objectives of the project					
0 *(0)*	2 *(3)*	5 *(6)*	20 *(11)*	25 *(16)*	87% *(75%)*

All respondents were asked about their opinion of what could have been done to improve the IMCHA initiative. Two respondents entered unqualified endorsements for the excellence of the IMCHA initiative (*'everything was excellent'*), while twelve respondents noted that the initiative should have a longer timeframe and more funding. One respondent noted that the long process of developing the implementation plans took valuable time from research implementation.

More meetings and opportunities to share experiences across projects were mentioned as potential improvements by several respondents.

More clarity in the funding expectations from the start would, according to one respondent have improved the outcomes, specifically the need to incorporate gender and economic analyses from the outset.

HPROs were mentioned by five respondents, with two asking for a more active engagement of the HPROs in research projects, one noting that the role of HPROs should be better defined, and two indicating that the funds allocated to HPROs could be better spent.

The partnership between African and Canadian research institutions and the selection of these partners was the subject of six comments. Two respondents thought that more effort should be invested in assuring the quality of the Canadian Co-PIs and their availability to invest time in the project. More clarification about the role of each partner was asked for by one respondent, while another stated that a sustainable partnership between African and Canadian institutions could only be achieved by funding and working directly through Canadian institutions. On the other hand, one respondent asked for a stronger focus on South-South partnerships.

Three respondents mentioned the need for a sustainability plan, while another three commented on the reporting systems and tools which, according to them, were not adapted to the context and not suitable for a research programme.

Greater sponsorship and participation of students and inclusion of support for a PhD programme was mentioned by three respondents.

11.3.13 Final comments

Final comments on the IMCHA initiative were largely very positive. Here are just some excerpts:

- *IMCHA has been a valuable contribution to MCH in Africa*
- *Thankful for the opportunity to be part of the IMCHA family. It has been a great experience*

- *IMCHA was wonderful regarding flexibility in terms of budgets and technical support*
- *IMCHA touches the core maternal and child health problems and provide solutions through research findings*
- *C'est une initiative exceptionnelle. Alors que tous les organismes se focalisent sur des solutions de type "magic bullet", le CRDI a encore l'audace de financer des projets qui renforcent les systèmes de santé, améliorent l'équité, cherchent des solutions aux problèmes fondamentaux de genre*
- *Nous avons beaucoup apprécié la grande souplesse du CRDI concernant les modifications budgétaires d'un semestre à l'autre (changement de lignes et autres), cela nous a permis de nous adapter au mieux aux réalités et situations rencontrées, pour plus d'efficacité*
- *Overall, I think this is a great initiative*
- *I think the way IMCHA was designed should be maintained as it brings decision makers and researchers on the same table and agreeing on issues that will be of benefit to respective communities*

ANNEX 12. KEY INFORMANTS INTERVIEWED

NAME	PROJECT / STAKEHOLDER GROUP	INSTITUTION / POSITION	TYPE OF INTERVIEW
Adamu Charles	108024/108547/Tanz.	Bugando Hosp	Group
Adrijana Corluka	IDRC/GAC/CIHR	IDRC / Programme Officer	Group
Alaba Oyekan	108040/108552 Nigeria	Univ. of Ibadan / Supervisor	Group
Alla Shayo	108027/108548/Tanz.	TTCIH/ Anaesthesia Training	Group
Angelo Nyantema	108027/108548/Tanz.	TTCIH / Senior Lecturer	Face-to-face
Anna Nswilla	108020/108546/ Tanz.	Gov of Tanzania / AD Health Serv.	Face-to-face
Annah Konugisha	108033 Uganda	BRAC / Field Researcher	Group
Arjan De Haan	IDRC/GAC/CIHR	IDRC / Dir. Inclusive Economies	Face-to-face
Asteria Mathias	108024/108547/Tanz.	-	Group
Aziz Ahmad	108020/108546/ Tanz.	Ifakara / Research Officer	Face-to-face
Benedict Eilegbogan	108041 Nigeria	Chief Ewatto Ward	Group
Bonifacio Maendeleo	108024/108547/Tanz.	CUHAS / Lecturer	Face-to-face
Brian Igboin	108041 Nigeria	WHARC / Programme Officer	Group
Catherine Francis	108024/108547/Tanz.	-	Group
Catherine Kyobutungi	107892 / HPRO East	APHRC / PI	Face-to-Face
Chakupewa Joseph	108023/Tanzania	Univ. Dar es Salaam / PHD Stud.	Group
Chioma Ekwo	108041 Nigeria	WHARC / Programme Officer	Group
Cosmas Masolwa	108024/108547/Tanz.	-	Group
Dismas Matovelo	108024/108547/Tanz.	Bugando Hosp. / PI	VOIP
Dolapo Abiona	108040/108552 Nigeria	Univ. of Ibadan / Supervisor	Group
Dominique Charron	IDRC/GAC/CIHR	IDRC / VP Prog. & Partnerships	Face-to-face
Dorcas Mandera	108033 Uganda	BRAC / Field Supervisor	Group
Edward Kataika	107893/HPRO East	ECSA / Director of Programmes	Face-to-face
Elibariki Mkumbo	108020/108546/ Tanz.	Ifakara / Research Officer	Group
Ermel Johnson	107892 HPRO West	WAHO	VOIP
Eva Nakimula	107893 HPRO East	PPD / Co-PI	Face-to-Face
Fatuma Manzi	108023/Tanzania	Ifakara / Professor	Face-to-face
Frank Magofi	108023/Tanzania	NHI Dodoma / Prog. Officer	Phone
Friday Okonofua	108041 Nigeria	WHARC / PI	Face-to Face
Gail Weber	108026/108545/Tanz.	Univ. of Ottawa / Researcher	Face-to-face
Girles Shabari	108024/108547/Tanz.	CUHAS / R, M&E	Face-to-face
Godfrey Mtey	108027/108548/Tanz.	TTCIH	Group
Heidi Monk	IDRC/GAC/CIHR	IDRC / Programme Officer	Face-to-face
Issiaka Sombié	107892 HPRO West	WAHO / PI	VOIP
James Ward Khakshi	108033 Uganda	BRAC / Researcher	Group
Janeth Bulemela	108027/108548/Tanz.	TTCIH / Paediatrician	Group
Jenipher Musoke	108033/108550 Uganda	BRAC / PI	Face-to-Face
Jennifer Hatfield	108024/108547/Tanz.	Univ. of Calgary / Associate Dean	VOIP
Jennifer Mitchel	108024/108547/Tanz.	Univ. Calgary / Professor	VOIP
Jesca Nsungwa	108033 Uganda	MOH Uganda	Face-to-Face
John Le Blanc	108027/108548/Tanz.	Dalhousie University / Professor	Face-to-face

Name	Project / Stakeholder Group	Institution / Position	Type of Interview
Josef Okware	108033 Uganda	MOH Uganda	Face-to-Face
Joyce Mathias	108024/108547/Tanz.	-	Group
Joyce Seto	IDRC/GAC/CIHR	GAC/ M&O Committee	Group
Julie Erhabor	108041 Nigeria	Edo State PHCDA / Co-PI	Group
Julieth Kabirigi	108024/108547/Tanz.	CUHAS / Paediatrician	Group
Karen Yates	108022/Tanzania	Queen´s University / Professor	VOIP
Kevin McKague	108033/108550 Uganda	Cape Breton University / Can Co-PI	VOIP
Lakew Gebretsadik	108028/Ethiopia	Jimma University / Ass Prof.	VOIP
Lauren Gelfand	107892 / HPRO East	APHRC / (ex) PI	Face-to-Face
Livingstone Makanga	108033 Uganda	MOH Uganda / Co-PI	Face-to-Face
Lola Kola	108040/108552 Nigeria	Univ. of Ibadan / Co-PI	Group
Loretta Ntiomo	108041 Nigeria	WHARC / Research Coordinator	Group
Lynette Kamau	107892 / HPRO East	APHRC / Project Officer	Face-to-Face
Manisha Kulkarni	108028/Ethiopia	Univ. of Ottawa / Can Co-PI	Face-to-face
Marie-Gloriose Ingabire	IDRC/GAC/CIHR	IDRC / Programme Officer	Group /VOIP
Mohamed Mdaraka	108027/108548/Tanz.	TTCIH/ Accountant	Group
Montasser Kamal	IDRC/GAC/CIHR	IDRC / Programme Leader MCH	Face-to-face
Mwanaidi Malakuzi	108020/108546/ Tanz.	Ifakara / Research Officer	Group
Nafissatou Diop	IDRC/GAC/CIHR	IDRC (IMCHA)/ Programme Officer	Group
Neda Faregh	108040/108552 Nigeria	Jewish General Hosp. / Researcher	Group
Nicole Bergen	108028/Ethiopia	Univ. of Ottawa / PhD Student	Face-to-face
Ogungbagbe Julius	108041 Nigeria	WHARC / Data Analyst	Group
Omary Kilume	108027/108548/Tanz.	TTCIH	Group
Omowumni Oluwaseun	108041 Nigeria	WHARC / Programme Officer	Group
Oye Gureye	108040/108552 Nigeria	Univ. of Ibadan / PI	Group
Pascale Bruneau	IDRC/GAC/CIHR	IDRC / Grants Administrator	Face-to-face
Paul Japhet	108023/Tanzania	Univ. Dar es Salaam / PHD Stud	Group
Pendo Ndaki	108024/108547/Tanz.	CUHAS / Lecturer	Face-to-face
Peter Okembe	108041 Nigeria	Chief Okpeke Ward	Group
Phyllis Zelkowitz	108040/108552 Nigeria	JGH / Research Director / Can Co-PI	Group
Qamar Mahmod	IDRC/GAC/CIHR	IDRC / Programme Officer	Group
Rachelle Desrochers	IDRC/GAC/CIHR	CIHR / M&O Committee	Face-to-Face
Rober Masasila	108024/108547/Tanz.	-	Group
Robert Salim Mahimbo	108023/Tanzania	Iringa Region / Reg. Med. Off.	Face-to-face
Robert Tillya	108022/Tanzania	Ifakara / PI	Face-to-face
Rosalia Arope	108020/108546/ Tanz.	Mtwara Region / Rep. Hlth. Coord.	Face-to-face
Salma Mang´ong´o	108020/108546/ Tanz.	Ifakara / Research Officer	Group
Sana Naffa	IDRC/GAC/CIHR	IDRC (IMCHA)/ Programme Officer	Group
Sanni Yaya	108041 Nigeria	Univ. of Ottawa / Can Co-PI	Face-to-Face
Sarah Harrison	108550 Uganda	Consultant	VOIP
Sian Fitzgerald	108023/Tanzania	HealthBridge / Can Co-PI	VOIP
Stephen Maluka	108023/Tanzania	Univ. Dar es Salaam / Professor	Face-to-face
Sylvia Mamkew	108020/Tanzania	Mtwara Region / Reg. Med. Off.	Face-to-face

Name	Project / Stakeholder Group	Institution / Position	Type of Interview
Thomas Druetz	108553 Burkina Faso	Univ. Montreal / Can Co-PI	VOIP
Thomas Rutachunzibwa	108024/108547/Tanz.	Mwanza Region / Reg. Med. Off.	Face-to-face
Trina Loken	IDRC/GAC/CIHR	GAC / M&O Committee	Group
Tunde Ayinde	108040/108552 Nigeria	Univ. of Ibadan / Psychiatrist	Group
Tunde Olatunje	108040/108552 Nigeria	Oyo State PHC Dev. Board / Co-PI	Face-to-Face
Veronica Joseph	108024/108547/Tanz.	-	Group
Victoria Yohani	108024/108547/Tanz.	CUHAS / Researcher	Group
Wilson Imongan	108041 Nigeria	WHARC / Executive Director	Group
Yusufu Kionga	108020/108546/ Tanz.	Ifakara / Research Officer	Group
Zamo Yoni Julius	108020/108546/ Tanz.	Ifakara / Research Officer	Group
Zawadi Mboma	-	Ifakara / Grants Officer	Group
Zebron Abel	108027/108548/Tanz.	TTCIH / ICT Manager	Group
Zulfikar Bhutta	108028/108546	SickKids Centre / Can Co-PI	VOIP

ANNEX 13. QUESTIONS / THEMES FOR KEY INFORMANT INTERVIEWS

The following table lists the questions and themes to be included in semi-structured interviews with key informants in different relationships to the Initiative. It is based on the evaluation questions in the terms of reference. Not all questions are relevant for each respondent. Interviews will be time-limited, and the interviews will prioritise the collection of in-depth over comprehensive data. Final interview scripts for each stakeholder group will therefore be developed after a document review and a preliminary analysis of on-line survey responses.

	PI & Canadian Co-PI	Decision-maker Co-PI	HPROs	IMCHA management	IMCHA donors
1. Briefly explain how and since when you have been involved in the IMCHA Initiative	✓	✓	✓	✓	✓
2. What are the main achievements of IMCHA in relation to MNCH? *[probe for 11 CoIA indicators]*	✓	✓	✓	✓	✓
3. What were the main strategies to achieve these outcomes?	✓	✓	✓	✓	
4. Were any unexpected outcomes achieved? Any outcomes in relation to gender?	✓	✓	✓	✓	
5. Was your capacity to conduct gender and/or equity informed implementation research improved as a result of the IMCHA Initiative? How?	✓	✓			
6. How did you integrate gender dimensions in your project/the HPRO activities/the overall IMCHA Initiative?	✓	✓	✓	✓	
7. Which strategies were successful and why?	✓	✓	✓	✓	
8. What helped or hindered integration of gender dimensions?	✓	✓	✓	✓	
9. How did you integrate equity dimensions in your project/the HPRO activities/the overall IMCHA Initiative?	✓	✓	✓	✓	
10. Which strategies were successful and why?	✓	✓	✓	✓	
11. What helped or hindered integration of equity dimensions?	✓	✓	✓	✓	
12. Did the midterm evaluation influence the way in which you integrated either gender or equity dimensions?	✓	✓	✓	✓	
13. Did IMCHA management contributed to improved integration of either gender or equity dimensions?	✓	✓	✓		
14. How has your collaboration with African/Canadian [*select relevant category*] researchers evolved in the last year?	✓	✓			
15. What factors helped or hindered this collaboration and why?	✓	✓			
16. How and at what level did you collaborate with decision makers?	✓				
17. What factors helped or hindered collaboration with decision makers?	✓		✓		
18. Did the MTR influence the way in which you collaborated with decision makers?	✓		✓		
19. Did IMCHA management contributed to improved collaboration with decision makers?	✓	✓	✓		
20. Were there any unexpected outcomes in relation to collaboration and partnering? [*probe for gender related outcomes*]	✓	✓	✓		

	PI & Canadian Co-PI	Decision-maker Co-PI	HPROs	IMCHA management	IMCHA donors
21. How were the research findings communicated to Co-PI decision makers?	✓	✓	✓		
22. Were the findings used? How did the findings influence policy and programming in your country or region?	✓	✓	✓		
23. What factors helped or hindered integration of research findings in policies and practices?	✓	✓	✓		
24. Did the MTR influence the way in which the research findings were used to influence policy and practices?	✓	✓	✓		
25. Did IMCHA management contributed to influencing policy and practices?	✓	✓	✓		
26. Were any unexpected outcomes achieved? [*probe for gender related outcomes*]	✓	✓	✓		
27. How has the support from the management team facilitated your work?	✓	✓	✓		
28. Did you notice any change in the support provided by the management team after the findings from the midterm evaluation? *[if yes, ask what difference it made in relation to achievements]*	✓	✓	✓		
29. How effective was the IMCHA Management & Operations committee at influencing the overall management and achievements of the Initiative?					✓
30. What and how did specific components of the IMCHA model (RTs, HPROs, collaboration between both, Synergy grants) contribute to IMCHA achievements?	✓	✓	✓	✓	✓
31. What worked well in the Synergy Grants? What were the challenges?	✓	✓	✓	✓	✓
32. What aspect of the IMCHA model can/should be improved for future initiatives?	✓	✓	✓	✓	✓
33. What aspect of the IMCHA partnership do you value most?					✓
34. Does an initiative such as IMCHA continue to be aligned with your organisational priorities?					✓
35. How can the partnership be strengthened for a future initiative?					✓
36. How have you documented the work realised through IMCHA, beyond publications and regular reporting?	✓	✓	✓	✓	✓
37. How could documentation of work be improved in a future initiative?	✓	✓	✓	✓	✓

ANNEX 14. ASSESSMENT OF OUTCOME-LEVEL RESULTS OF THE IMCHA PMF

EXPECTED RESULTS	INDICATORS	INDICATOR DEFINITIONS	TARGETS	ASSESSMENT
Ultimate Outcome Improved maternal, newborn and child health outcomes in targeted countries	Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services	Any of the 11 accountability indicators improved	50% of the implementation research demonstrate improvement in any of the 11 accountability indicators	**The target was met:** Project contributions or potential contributions to improved maternal and child health outcomes could not be measured directly for many projects, while others were still in the final data collection and analysis phase and data were not yet available. However, all projects provided sufficient information to infer such contributions.
Intermediate Outcomes 1. Enhanced production, analyses and syntheses of health systems implementation research prioritising gender and equity	1.1 Proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions	Review of research design, data collection tools, data analysis and dissemination tools that appropriately integrate gender and equity dimensions.	All research projects have >75 % (three of four processes) adequate gender and equity dimensions	**The target was not met:** 15/28 projects (54%) integrated adequate gender dimensions, and 7/28 (25%) adequate equity dimensions in at least three research processes.
	1.2 Proportion of health systems research outputs and syntheses that are gender and equity focused	Nature of contribution of the IRT research to the field	75% of outputs include gender and equity focused analyses/syntheses	**The target is not likely to be met:** Research outputs, including gender and equity analyses were still being generated at the time of the evaluation. Among 98 outputs from 22 projects that were available for analysis, 44 (46%) included a gender focus and 21 (22%) an equity focus.

EXPECTED RESULTS	INDICATORS	INDICATOR DEFINITIONS	TARGETS	ASSESSMENT
2. Enhanced partnering and collaboration between decisionmakers and researchers on health systems strengthening in the selected countries/regions	2.1 Number of total projects per country that demonstrate high level of collaboration with decision maker (documented by project, country and regional levels)	Documentation of 'best practices' or stories of effective collaborations as a result of IMCHA at country or regional levels. with the national focal point for MNCH	Minimum of one per country	**The indicator as defined was not assessed:** The decisionmaker is defined as the '*national focal point for MNCH*'. Most projects communicated their activities and preliminary results at this level, but for others this was not the main respondent at national government level.
3. Enhanced integration of health systems research findings into primary health care policies and practice in selected countries	3.1 Number (type) of influence of IMCHA research projects on policy and programming per project	Includes documentation (formal and informal) of reference to research findings/ recommendations in country-led technical decision-making platforms	20	**The target was likely met:** Although it was too early in the programme to assess this outcome, the target of 20 was already reached. All sampled projects had made presentations of research results in national fora and most had plans for further discussions once final research results were available.
Immediate outcomes 100. Strengthened capacity of researchers and research organisations to conduct gender and equity informed health systems implementation research	100.1 Proportion of total research projects that have adequately detailed gender and equity dimensions	As determined by technical review (expert opinion) of gender and equity dimensions in the research design, tools and analyses	75 percent of research projects have adequate mechanisms identified to support gender and equity analyses	**It was too soon to assess the performance against this indicator:** Information on design and tools was available for 20/28 projects. Among these 19 (95%) included data collection plans or tools for gender analysis and seven (35%) for equity analysis. Outputs from 22/28 projects were available. Among these 18/22 (82%) had produced at least one output that included a gender dimension and 5/22 (23%) an equity dimension. However, several teams were planning further gender and equity analyses.

EXPECTED RESULTS	INDICATORS	INDICATOR DEFINITIONS	TARGETS	ASSESSMENT
	100.2 Proportion of recommendations from formative analyses of HPROs acted upon	Based on tracking of recommendations and follow up actions	≥75 % of total recommendations acted on	**Recommendations that were directed at HPROs were acted on and the target was therefore met:** The formative analyses issued 46 recommendations with many sub-recommendations, not all of them directed at IMCHA partners and not all of them actionable. Quantifying the proportion of all recommendations that were acted upon is therefore not possible. Recommendations and actions were not formally tracked, however, actionable recommendations directed at HPROs (aggregated in six main groups) were acted on.
200. Strengthened partnerships and alliances between African researchers, decisionmakers and Canadian researchers.	200.1 Proportion of implementation research projects that demonstrate effective collaboration and management	Reflects quality of engagement among implementation research team members and stakeholders against objectives and outcomes of research projects	75 percent of research projects demonstrate good practices in governance and coordination	**The target is a compound target. It was met, depending on how it is interpreted:** The collaboration between African and Canadian researchers was rated as successful by 74% of African and 73% of Canadian researchers. Engagement between PIs and Canadian Co-PIs in all sampled projects (16/28 projects; 9/20 Canadian Co-PIs; 10/21 PIs) ranged from strong to acceptable. **However**, none of 8 interviewed decisionmaker Co-PIs stated that they had a direct engagement with Canadian Co-PIs and only 2/9 interviewed Canadian Co-PIs mentioned a strong engagement with decisionmaker Co-PIs.

EXPECTED RESULTS	INDICATORS	INDICATOR DEFINITIONS	TARGETS	ASSESSMENT
300. Increased awareness and understanding of research evidence by decisionmakers at the primary healthcare level.	300.1 Proportion of IRT decision-makers' follow up on recommendations from research into health systems planning forum(s)	The focus of this engagement will be detailed in the Implementation Plan and will have formal or informal outputs documented	100 % of decision makers follow up on recommendations from research	**The 100% target was reached among the decisionmakers for whom contacts could be established by the evaluation, but many could not be reached**: 7/8 interviewed decisionmaker Co-PIs stated that they followed up or intended to follow up on the research evidence. (One was new and not very aware of the project). However, not all decisionmakers responded to requests for interviews and only 5 responded to the on-line survey.

ANNEX 15. PMF WITH COMMENTS ON STATUS AT THE MIDTERM EVALUATION

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
Ultimate Outcome Improved maternal, newborn and child health outcomes in targeted countries.	Proportion of funded implementation research that improved maternal and child health outcomes and access to primary health care services	Any of the 11 accountability indicators improved [1]*	50% of the implementation research demonstrate improvement in any of the 11 accountability indicators	Interview evidence indicated that IMCHA had contributed to improved antenatal care coverage and more skilled attendants at birth
Intermediate outcomes 1. Enhanced production, analyses and synthetises of health systems implementation research prioritizing gender and equity	1.1 Proportion of total projects that have at least 75% (three of four processes) adequate gender and equity dimensions.	Review of research design, data collection tools, data analysis and dissemination tools that appropriately integrate gender and equity dimensions.	All research projectshave> 75%(threeof four processes) adequate gender and equity dimensions.	Survey results found that 92%of researcherssaidthey ensured that women and girls are beneficiaries of the project; 89% said women and girls are consulted while designing and implementing the project; 86% said they included a reference to gender considerations in a research question. For equity, 94% of respondents said they had ensured that the project reaches vulnerable populations; 69% said that they ensured that vulnerable populations are consulted while designing and implementing the project; and 63% said they brought equity expertise to the project.
	1.2 Proportion of health systems research outputs and syntheses that is gender and equity focused.	Nature of contribution of the IRT research to the field2	75% of outputs include gender and equity focused analysis/synthesis	Too early to estimate.

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
2. Enhanced partnering and collaboration between decision makers and researchers on health systems strengthening in the selected countries/regions.	2.1 Number of total projects per country that demonstrate high level of collaboration with decision maker (documented by project, country and regional levels).	Documentation of 'best practices' or stories of effective collaborations as a result of IMCHA at country or regional levels. with the national focal point for MNCH	Minimum of one per country	Survey results showed that 44% of researchers strongly agreed with the statement that 'The involvement of decision-maker co-PI has been important to meet the objectives of the project' and 31% agreed with the statement.
3. Enhanced integration of health systems research findings into primary health care policies and practice in selected countries.	3.1 Number (type) of influence of IMCHA research projects on policy and programming per project	Includes documentation (formal and informal) of reference to research findings/recommendations in country-led technical decision-making platforms.	20	Survey results showed that all but one researcher had plans in place to translate the findings into policies and practices. Interview evidence showed that a few projects already had accomplished that.
Immediate outcomes 100. Strengthened capacity of researchers and research organization s to conduct gender and equity informed health systems implementation research	100.1 Proportion of total research projects that have adequately detailed gender and equity dimensions	As determined by technical review (expert opinion) of gender and equity dimensions in the research design, tools and analysis.	75 percent of research projects have adequate mechanisms identified to support gender and equity analysis.	While the survey showed that attempts were being made to incorporate gender and equity dimensions, interview evidence showed that those attempts were at times superficial, and were not likely to empower women and vulnerable groups.
	100.2 Proportion of recommendations from formative analysis of HPROs acted upon.	Based on tracking of recommendations and follow up actions.	>75 % of total recommendations acted on	Survey results showed that only 11% of researchers felt that the HPROs had been very effective in gender sensitivity training while 33% felt they had been effective.

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
200 Strengthened partnerships and alliances between African researchers, decision--- makers and Canadian researchers.	200.1 Proportion of implementation research projects that demonstrate effective collaboration and management.	Reflects quality of engagement among implementation research team members and stakeholders against objectives and outcomes of research projects.	75 percent of research projects demonstrate good practices in governance and coordination	Survey results found that 75% of the research respondents felt that the collaboration between the African PIs and the Canadian co---PIs was very successful. An additional 19% said it was successful. The survey results showed that 39% of the researchers felt their collaboration with decision-maker co-PIs was very successful and an additional 36% felt it was successful.
300. Increased awareness and understanding of research evidence by decision makers at the primary healthcare level.	300.1 Proportion of IRT decision--- makers' follow up on recommendations from research into health systems planning forum(s).	The focus of this engagement will be detailed in the Implementation Plan and will have formal or informal outputs documented	100 % of decision makers follow up on recommendation s from research	Interview and survey evidence showed that the decision-maker co-PIs were starting to promote implementation of IMCHA results in their ministries. Many projects are still producing evidence, so these activities are not yet in full force.
Outputs **110. Funding provided to IRTs to conduct policy relevant gender and equity sensitive health systems implementation research.**	110.1 Number (and title) of health systems analysis and synthesis that is gender and/or equity focused produced by IRTs.	Analyses and syntheses include peer--- review and working papers produced.	20	Not included in the mid---term evaluation.
120. Funding provided to research teams that include emerging researchers.	120.1 Number of funded IRTs housed in research institutions.	Based on type of organizations in funded research.	20	Not included in the mid---term evaluation.

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
	120.2 Number of emerging researchers involved in the IRT research.	Emerging researchers include students and those who are relatively new to the health systems field. (< 5 years pursuing research agenda from most recent qualifying degree). In reporting template – masters, PHD, Post docs, new investigators.	35	The mid---term evaluation showed that IMCHA had a strong capacity---building focus, but it did not count the number of emerging researchers involved in IRT research.
130. Synergistic research opportunities identified and supported.	130.1 Number of synergistic research opportunities identified and funded (West and East Africa separately)	Number of grants submitted and funded per region and source of origin.	WA: three funded EA: three funded	Not included in the mid---term evaluation.
140. Training, networking and exchanges of HPROs and IRTs is undertaken to strengthen the capacity of organization s funded through IMCHA	140.1 Number of individuals who received training/networking and exchange opportunities (by type and by participant).	Differentiated by IRT and HPRO in East Africa/West Africa (by type of training and by type of participant).5	40	Not included in the mid---term evaluation.
	140.2 Number of networking and exchange opportunities supported Through IMCHA	Differentiate by who is funding exchange and who is supported in Exchange (number and type).	10	The interview evidence emphasised that IMCHA had played an important networking role.

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
210. Collaborative mechanisms established between IRTs and HPROs.	210.1 Number of type of communication between IRTs and HPROs.	Communication may include skype/phone/e mail and in--- country visits (formal and informal). Needs to document substantive issues.	Quarterly contact	Not included in the mid---term evaluation.
220. HPROs and IRTs facilitate regional and national decision makers to engage in IMCHA implementation research.	220.1 Number of new partnerships/collaboration s between decision--- makers and researchers on health systems strengthening.	Formal or informal collaborations with MOU or supporting documents with aggregation per country and per region	20	All IMCHA projects involve partnerships/collaborations between decision---makers and researchers on health systems strengthening. Interview evidence showed some of them pre---dated the IMCHA initiative.
	220.2 Number of existing partnerships/collaboration s enhanced between decision--- makers and researchers on health systems strengthening.	Supporting documentation for change in collaboration – formal or informal per country and per region.	15	Not included in the mid---term evaluation.
230. Linkages formed outside of the IMCHA initiative by HPROs, IRTs with like- minded organizations	230.1 Number of times HPROs and/or IRTs established connection with organizations outside of IMCHA (West and East Africa separately).	Formal linkages with supporting documents or description of engagement (i.e. minutes of meeting, agenda, email). To be aggregated for East and West Africa (and as appropriate by country).	Number not defined – to track cumulative efforts	Not included in the mid---term evaluation.

Expected Results	Indicators	Indicator Definitions	Targets	Comments on status at midterm
240. Research teams lead by African researchers and decision makers and Canadian co- PIs are funded.	240.1 Number of IRTs with at least one Canadian researcher, one African researcher and one African decision maker.	Review the status of PI, co-PI and decision-maker against the criteria in the call for proposals	100 % aligned representation	All of the IRTs had at least one Canadian researcher, one African researcher and one African decision---maker.
310. Evidence based policy and practice promoted by IRTs and HPROs	310.1 Number (and description) of evidence---based policy and practice promoted by IRTs and HPROs (for East and West Africa).	Documentation (formal or informal) of example of evidence---based policy and practice promoted at country or regional level.	Minimum of one per research project funded	Several projects reported that they had contributed to evidence-based policy and practice.
320. Knowledge translation activities and products targeting relevant local, national and regional decision makers conducted.	320.1 Frequency (by type) of knowledge translation activities (at national and regional levels).	Knowledge translation activities are defined as any purposeful engagement of decision-makers – this can be formal and informal.	Yearly exchange at country and regional levels.	Not included in the mid---term evaluation.
	320.2 Number (by type) of activities organised by HPROs to promote IRT research (for East and West Africa separately).	Activities reported here may overlap with the connections reported on under 320.1 and 230.1 but are expected to measure a distinct aspect of HPROs support.	One or more regional exchange platform per year	Both HPROs provided interview evidence of frequent activities to promote research in their regions.