GOVERNANCE, EQUITY AND HEALTH
EVALUATION REPORT 2006-2011

Governance, Equity and Health Program
International Development Research Center
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LIST OF ACRONYMS

- CIDA: Canadian International Development Agency
- COHRED: Council on Health Research for Development
- DfID: United Kingdom Department for International Development
- Ecohealth: Ecosystem Approaches to Human Health
- EQUINET: Regional Network on Equity in Health in Southern Africa
- EU: Evaluation Unit
- GEH: Governance, Equity and Health
- GGP: Globalization, Growth and Poverty
- GHRI: Global Health Research Initiative
- HRCS Health Research Capacity Strengthening
- HRWeb: Health Research Web
- IDRC: International Development Research Center
- INCLEN: International Clinical Epidemiology Network
- LMICs: Low and middle income countries
- NEHSI: Nigeria Evidence-Based Health System Initiative
- PEPFAR: US President's Emergency Plan for AIDS Relief
- REACH: Regional East African Community Health Policy Initiative
- RHE: Research for Health Equity
- RITC: Research for International Tobacco Control
- RM: Research Matters
- SDC: Swiss Agency for Development and Cooperation
- SID: Special Initiatives Division
- WAHO: West Africa Health Organization
- WT: Wellcome Trust
- ZAMFOHR: Zambian Forum for Health Research

1. BACKGROUND

The Governance, Equity and Health (GEH) program has produced this final report as part of an International Development Research Centre (IDRC) external review, in conformity with IDRC Evaluation Unit guidelines[1]. This report will be submitted both to a panel of three external evaluators and to the 21 members of the IDRC's Board of Governors. While ensuring accountability to the IDRC's Board, this external review supports a learning process that is helping to guide GEH's next programming phase.

The GEH program began with an exploratory phase (2002-2006). This report covers 2006-2011 - an increasingly focused, collaboratively rich, and policy-relevant second phase of GEH. Phase II embraced research in health systems governance[2] and equity as they relate to the strengthening and financing of health systems. With a resurgence of vertical, disease-specific programs including the Global Fund to Fight AIDS, Tuberculosis and Malaria, and the US President's Emergency Plan for AIDS Relief (PEPFAR), GEH was among the first funding institutions to focus on the need to broadly strengthen public health systems in low and middle income countries (LMICs). Maternal health also emerged as a salient research area. To achieve its increasing focus on health systems research, GEH strives for a critical balance between using the lens of governance and equity for health systems research, with listening to recipients, and with adjusting to the realities on the ground. Such flexibility makes for more intentional and effective programming.

During the first four years of Phase II (April 2006 – March 2010), the program managed 97 projects, with recipient institutions in 34 countries. Total funding from IDRC was CAD 21.5 million. In addition, GEH successfully attracted a further CAD 54.84 million in funding for these projects from seven donor partners.

Figure 1 – GEH At-a-Glance
Phase II (April 2006 – March 2010)

9	Program officers in GEH in 2010
21.5	GEH total budget in millions (CAD, internal funds)
54.8	GEH total partnership budget in millions (CAD, external funds)
91	Recipient institutions in 34 countries
76	Percentage of project leaders from the South
97	Projects funded by GEH
30.6	Average duration of projects in months
326	Average budget per project in thousands (CAD, IDRC funds)

[1] IDRC Evaluation Unit, *Scope of Work for External Reviews at IDRC: revised process*, January 26, 2009.
[2] For GEH's definition of governance, see: GEH, *Governance, Equity and Health Prospectus, April 2006 – March 2011*, 13-14.

GEH's approach to grant-making is based on the IDRC's "Grants Plus"[3] model. GEH supports Southern researchers and institutions committed to democracy, health equity and social justice[4] by enabling knowledge-generation and exchange, and by influencing how research on health systems is conducted and applied, especially in the context of health reforms. GEH supports health researchers around the world to cultivate local understanding of specific situations, problems and solutions. GEH aims to create evidence that stimulates measurable improvements in local, regional and national health outcomes.

1.1 Structure of the Report

Section 1 of this report describes GEH and its aims within the overall development research setting.

Section 2 presents some of GEH's key research findings, selected primarily according to the thematic entry points of governance, health systems and financing, as reflected in the GEH Phase II prospectus.

Section 3 summarizes GEH's three most significant interlinked program outcomes in sub-sections entitled Power and Voice, Capacity Development, and Practice and Action. Brief reflections on the challenges faced in relation to each of these three outcome categories are included at the end of each sub-section.

Section 4 summarizes lessons learned for GEH, and offers a concluding synthesis.

1.2 Summary of Objectives of GEH Phase II

During Phase II, GEH focussed on the following objectives:

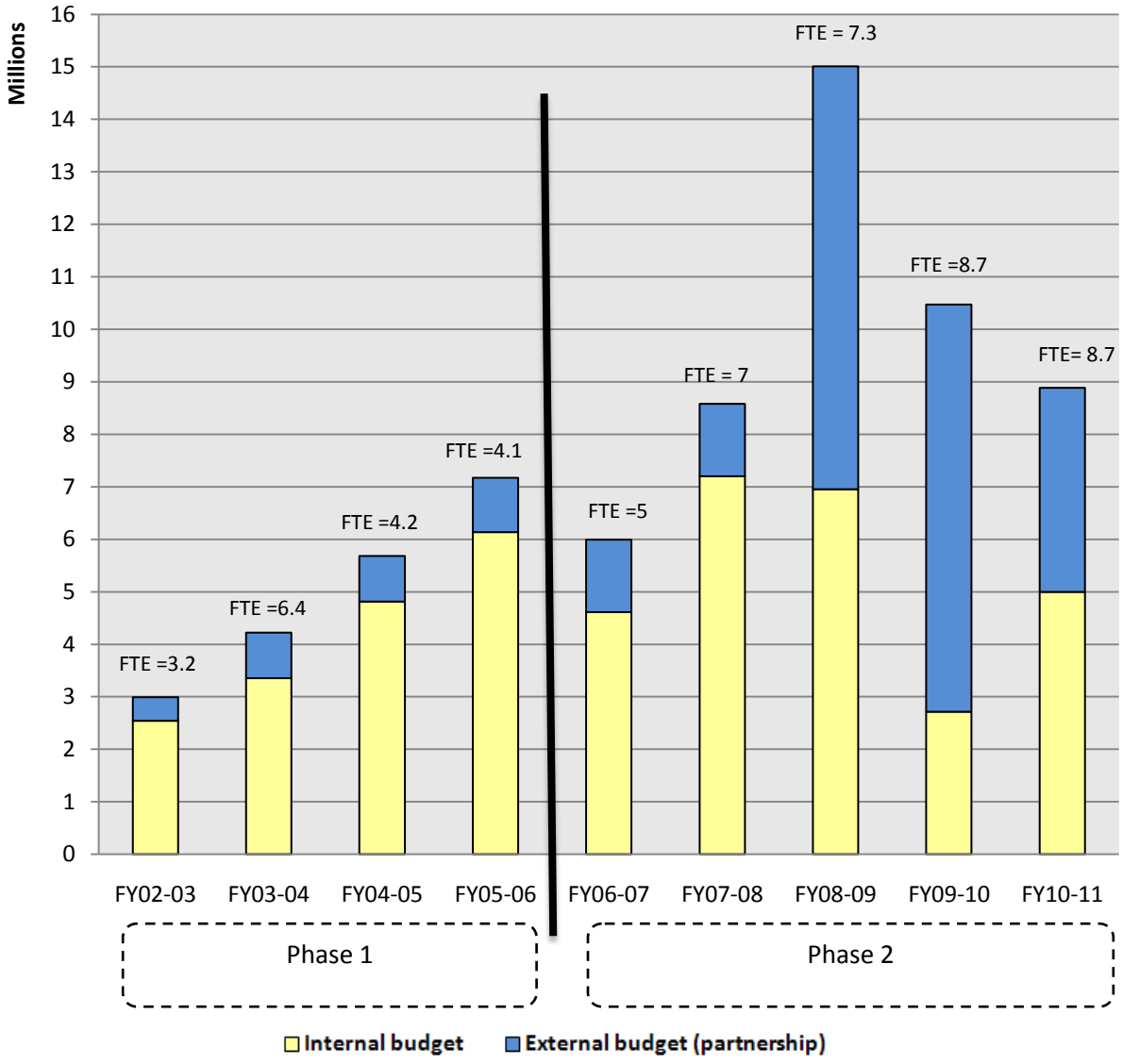
- *Making a difference on the ground*: To inform and support, through research-derived evidence, the development and implementation of a GEH vision of health policy and health systems, in specific LMIC contexts.
- *Informing global policy debates*: To influence, in Canada and globally, the arenas of global health policy, research and systems by informing policy dialogue related to areas of GEH thematic focus, particularly by supporting a stronger voice for Southern health researchers and research institutions.
- *Institutionalizing a GEH approach*: To develop research capacities, build a GEH Community of Practice, and support the adoption of a GEH approach to health systems research and policymaking beyond the IDRC[5].

[3] IDRC, *Innovating for Development: Strategic Framework 2010-2015*, October 2009, 2-2 – 2-4.
[4] For GEH understanding of health equity and social justice, see GEH Prospectus, 1.
[5] GEH Prospectus, 8.

1.3 Summary of Achievements of GEH Phase II

Considering the small size of the ten-person GEH program team (nine program officers; one research officer) and the modest programming budget, progress during Phase II has been substantial. The funding support from donor partners displays notable external confidence vested in GEH. (See Figure 2 below, *Evolution of the GEH Budget*). Many of the strategic themes that propelled GEH through Phase I and II have gained in importance both in Canada and globally, suggesting that GEH is effectively conveying its perspective on health systems research and reform into the policy and funding mainstream.

Figure 2: Evolution of the GEH Budget

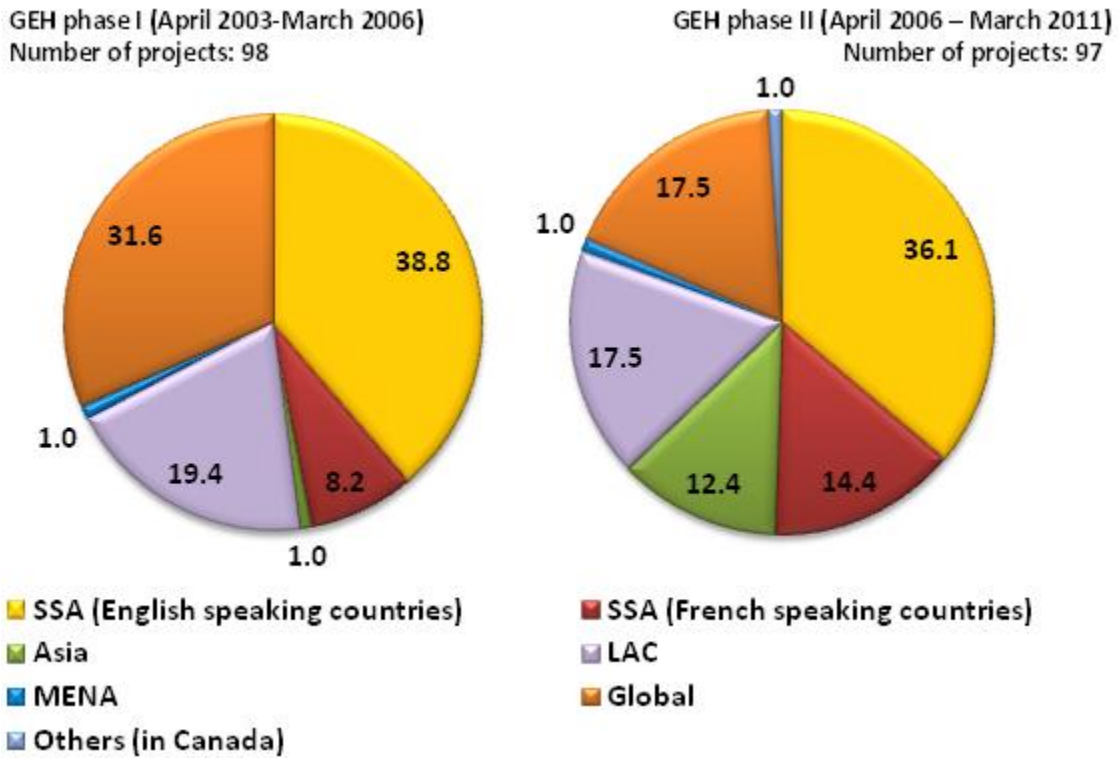


FTE = Full Time Employee (including only GEH program officers)

GEH Phase II achieved solid progress in four ways:

- Convergence of research projects addressing governance and equity themes around primary health care systems.
- Better integration and linkages with social justice in order to redress health inequities.
- Wider geographic spread and increasing global reach of projects. (See Figure 3 below, *Geographic Distribution of GEH's Projects*)
- Increased understanding of governance and health systems equity among GEH recipients as well as the broader research and policy arena.

Figure 3 - Geographic Distribution of GEH's Projects



1.4 Mapping of GEH Portfolio and Evolution of GEH Phase II

During Phase II there were significant changes within IDRC which led to a redefinition of GEH objectives. After an initial period of uncertainty about the status of health-related research within IDRC, health evolved from being included within the Social and Economic Policy Program Area to being formally recognised, from the spring of 2009, as a dedicated program area named Research for Health Equity (RHE). This gave GEH an institutional home with a formal channel to senior management through which to articulate its programming strategy. In addition, the creation of RHE also made it possible for the Research for International Tobacco Control (RITC) program and the Global Health Research Initiative (GHRI) to be considered as stand-alone program initiatives. Previously, both were housed within the GEH program.

During this period, there was a change in program leadership and gradual growth of the team (from three to ten), accompanied by a reorganization of the GEH strategy and activities. In February, 2008, GEH embarked on a "3 C's" strategy, with greater emphasis on Communication, Collaboration and Consolidation[6].

Several mechanisms were implemented to improve communication among team members, and between GEH and the Centre. Regularly scheduled meetings provided an opportunity for team members to coordinate travel and monitoring visits and for increased collaboration in developing new areas of work. In addition, regular sessions for reviewing proposals were scheduled approximately every six weeks.

In order to achieve common goals and to increase funding available for Southern research, GEH developed key collaborations with external partners (CIDA, WT, SDC, DfID). Fruitful partnerships within IDRC also flourished, (including SID, Ecohealth, GGP, EU, WRC and GHRI). These bolstered the ability of GEH to influence discussions in health systems research beyond what might otherwise have been possible.

A consolidation exercise aimed at deepening specific themes while creating opportunities for programming in new areas. The introduction in February, 2008, of individual strategy papers from program officers started the consolidation process. This took program officers through a process where each identified new project areas for development. Subsequently, GEH consolidated its project portfolio, deepening its focus on key themes (governance and equity, maternal health, primary health care and social protection[7]), while covering a wider geographic area.

The focus on maternal health in this prospectus period allowed GEH to engage in an area of work that is starting to yield important findings. In light of recent announcements identifying this as a priority area for new Canadian foreign policies, it is hoped that GEH's well-developed work in this area will be of special utility to the government.

2. RESEARCH FINDINGS

This section highlights some key research findings from GEH grant-making as well as partnership-based programming. The findings contribute to an understanding of the interactions between social, political and technical dimensions of health systems embodied in the GEH approach. They have been categorised within the themes of Governance, Health Systems, and Financing as outlined in the GEH Prospectus, and they also reflect the geographic spread of all GEH-supported projects.

At the outset, it is important to note that many health system changes require sustained research support over long time-frames before significant findings begin to appear.

[6] Memo seeking clarification on GEH Strategy, February 2008: http://irims.idrc.ca/getDocument.asp?documentNumber=246008
[7] GEH Country Strategy: http://irims.idrc.ca/ViewDocument.asp?Key=GEH+122%2D03%2D6+UNC+233639. See also GEH Work plan 2009: http://intranet.idrc.ca/en/ev-104364-201-1-DO_TOPIC.html

Some examples cited in the sections below are drawn from projects only part way through their research cycles. Given the relatively short period under review, many of these findings should, therefore, be considered as preliminary.

Please see Annex II for a list of the key documents, including publication outcomes for each project referenced in the Findings Section.

2.1 Governance Findings

The findings presented below contribute to understanding governance processes to strengthen health systems, and improve health outcomes.

- Equity and quality gaps resulting from emerging private sector influence

In Southern Africa, to address questions of governance issues related to citizenship participation and responsibility, the *Municipal Services and Health in Southern Africa* (101644) found that privatisation of basic services like electricity not only failed to deliver the services that were promised, but also increased socio-economic inequities. In the current phase of the project, (Phase III – 105141)[8] the inter-disciplinary research team is identifying alternatives to privatisation in health, electricity and water/sanitation that will deliver the services, be accountable, and bridge equity gaps. See also *Municipal Services and Health in Southern Africa* (101644 and 105306)[9]*; Private Healthcare and Sexually Transmitted Infections in South Africa* (101939); *Labour Disputes and Governance of the Health Sector* (103699)[10].

- Health policies for internally displaced groups

Policy relevant, GEH-supported research made important contributions to the understanding of social protection, both at local and national levels. This was well demonstrated in one project spanning several countries with important findings in each *(Extending Social Protection in Health in LAC: Building Research and Practice Phase II* – 102107*)*[11]. For example, in Colombia, where the majority of a large, internally-displaced population was excluded from accessing the health system, the project was critical to developing Bogota's municipal district health policies for the displaced. These, together with findings from other countries, will be relevant in other settings with internally-displaced populations.

[8] Outputs table: http://irims.idrc.ca/getDocument.asp?documentNumber=117742
[9] 105306: Report on the provision of STI services in the private sector :http://irims.idrc.ca/irims/ViewDocument.asp?Key=WAPRG+232%2D01%2D02%2D101939+UNC+109051
[10] Final technical report : http://irims.idrc.ca/getDocument.asp?documentNumber=171167
[11] Final narrative report: http://irims.idrc.ca/getDocument.asp?documentNumber=90325

- Transparency to help address system leakage

During the planning phase of the *Nigeria Evidence-Based Health System Initiative* (NEHSI – 102436)[12], it was found that capturing community perspectives was very important in rectifying discrepancies between policy and practice. Households were found to be paying higher health charges higher than those legislated. When presented to state policy-makers, data on this finding sparked action. The introduction of user-fee cards listing services and their costs allowed patients to begin questioning unfair pricing and stopped unofficial out-of-pocket payments. See also *NEHSI Implementation* (104613)[13]*; Demonstration Community-based Audit of Health Services in Two Districts in Afghanistan* (104963)[14].

- Investment gaps in health research

The *Strengthening National Health Research Systems* project (COHRED – 102852)[15], found a critical link between the strength of a health system and the degree of investment in sustainable research infrastructure and human resources. This study revealed a lack of donor investment in research despite donor rhetoric about the need to prioritise national health research *(Health Research Capacity Strengthening Initiative: Inception Phase* – 103760) *& Implementation and Learning Phase* – 104959)[16]. See also: *REACH (Regional Capacity for Evidence-based Health Policy in East Africa* (102750, 104972)[17]; *Mexico-Canada Knowledge Translation Partnership* (104374)[18].

2.2 Health Systems Findings

Health systems are complex and it can be difficult to understand and measure their weaknesses and strengths. Researchers, managers, decision-makers and communities need evidence to inform appropriate interventions. The research findings below speak to the diversity of GEH approaches to health systems strengthening.

- Improved nursing services

Recognition amongst funders is growing that vertical, disease-specific responses need to incorporate a systems-wide appreciation if they are to be helpful in circumstances where existing health systems are fragile. GEH supported a number of projects in Southern Africa in response to the HIV/AIDS pandemic that demonstrated the importance of going beyond the single disease silo to considering the broader impact on

[12]Hard copies of fee cards available from NEHSI program officers.
[13] Final narrative report : http://irims.idrc.ca/getDocument.asp?documentNumber=244823
[14]Main findings of a demonstration social audit of health service in Bagrami and Qarabagh districts: http://irims.idrc.ca/getDocument.asp?documentNumber=244826
[15] Please refer to COHRED's website: www.cohred.org
[16] Mapping of the health research architecture in Kenya: http://irims.idrc.ca/irims/ViewDocument.asp?Key=ESAPRG+232%2D01%2D01%2D103760+UNC+130259
[17] Final technical report: http://irims.idrc.ca/getDocument.asp?documentNumber=99810
[18] Interim technical report : http://irims.idrc.ca/getDocument.asp?documentNumber=231248

the health systems. *Impact of HIV/AIDS on Health Service Capacity at the Primary Health Care Level* (101938)[19] found that, despite the crucial role nurses play in delivering primary health care services, AIDS greatly impacted on their working conditions. Failure to consider AIDS's system-wide impact created specific challenges (training gaps, lack of supportive supervision, and inadequacies of the community referral systems) that severely impacted nurses' ability to deliver basic services. Relevant management tools were developed to address these issues.

- More efficient antiretroviral drug (ARV) roll-out

In addition to improved nursing services, research clearly demonstrated how a more comprehensive systems approach greatly improved overall HIV/AIDS service delivery with better outreach training and improved supervision that could be applied beyond HIV/AIDS. Projects included *Community Views of Antiretroviral Therapy in southern Africa* (102834)[20]; *The Public Sector Anti-Retroviral Treatment in Free State – Phase II* (102770)[21]. These projects and their findings resulted in the implementation of more effective nursing practices in the context of the HIV/AIDS crisis, and improved educational outreach training. Increased access to ARVs in South Africa's Free State, and tailored policies and guidelines for ARV roll-out at state and national levels were also achieved.

Improving Maternal Health

While maternal health is an additional component of the current GEH 2006-2011 Prospectus, GEH undertook exploratory work in this area because of its importance in flagging the failure of health systems to deal with largely preventable causes of mortality and morbidity. A useful set of research findings in Africa and South Asia is emerging from the GEH initiatives.

- Better quality information and concrete referral criteria decrease maternal mortality.

Public Policy and Protection from Exclusion Phase III (103861)[22] demonstrated a significant decrease in maternal mortality rates at district level in Benin, Burkina Faso, Ivory Coast, Mali and Senegal among women referred for emergency obstetric care when compared to non-referred women. In Mali, nearly half (47.5%) of the reduction in deaths was attributable to better management of haemorrhage at referred centers. This finding has important implications for how patients are currently being managed at many district centres. *Strengthening the Health System through Maternal Death Review in Kenya and Zimbabwe* (103201)[23] showed the importance of death reviews in improving

[19] Final report : http://irims.idrc.ca/irims/ViewDocument.asp?Key=PPB+232%2D01%2D02%2D101938+UNC+110290
[20] Final technical report: http://irims.idrc.ca/getDocument.asp?documentNumber=69029
[21] Narrative reports: http://irims.idrc.ca/getDocument.asp?documentNumber=63987
[22] Pierre Fournier *et al*., "Improved access to comprehensive obstetric care and its effect on institutional maternal mortality in rural Mali", *Bulletin of the World Health Organization,* 2009; 87: 30–38: http://irims.idrc.ca/getDocument.asp?documentNumber=191754
[23] Zimbabwe country report August 2008 : http://irims.idrc.ca/getDocument.asp?documentNumber=245433

quality of maternal care, increasing institutional deliveries and decreasing maternal mortality. The need to meet data quality challenges was also underlined.

- Women negotiating the right to better maternal services

Negotiating Rights – Building Coalitions for Improving Maternal Health Services in Uttar Pradesh, India (105005)[24] found that though many government health providers are well-informed about the main causes of maternal deaths, many feel powerless in improving maternal health. This challenges the health system through an inability to improve staff motivation and a failure of incentive schemes to impact quality of care. A project in Maharashtra state *(Fostering Reforms in Public and Private Healthcare in India* - 103234*)*[25] identified an unusually high rate of hysterectomies and Caesarean sections, pointing to a need for further research in understanding the reasons why these poor communities are being subjected to such excessive medical interventions.

- The "fallacy of coverage"

It is well-known that immunization is effective in reducing childhood mortality. Six research studies across Latin America, West Africa and South Asia revealed inconsistencies in immunization coverage rates. GEH characterised this as "the fallacy of coverage" which questions previous assumptions about the adequacy of coverage. The *Canadian International Immunization Initiative – Phase II* (102172)[26] demonstrated that children in developing countries were consistently under-immunized and not immunized on time. True vaccination rates were lower than generally reported. This was attributed to a variety of reasons: timeliness of age-appropriate immunization; social and gender inequities; vaccine efficacy; limited understanding of demand-side issues; and national averages masking actual district level coverage rates.

2.3 Financing Findings

Health financing affects health service delivery, and access – especially among the poor. The following research findings contribute to understanding the key factors and barriers to achieving universal health coverage and social protection.

- User-fee exemption

In West Africa, several GEH-supported projects demonstrate important findings on social protection. *Public Policy and Protection from Exclusion Phase III* (103861)[27] showed that implementing a new health fee exemption system in Côte d'Ivoire improved access and overall social protection. It also highlighted that, because there was no accompanying health budget shift to incorporate the new demands on the health

[24] Project technical report : http://irims.idrc.ca/getDocument.asp?documentNumber=242397
[25] Interim technical report : http://irims.idrc.ca/getDocument.asp?documentNumber=245446
[26] Mhatre, S. and Schryer-Roy, A., "The fallacy of coverage: uncovering disparities to improve immunization rates through evidence".
[27] Project technical report : http://irims.idrc.ca/getDocument.asp?documentNumber=223283

delivery system, the new policy risked failure. In Burkina Faso, a community-based process for selecting beneficiaries of user-fee exemptions proved that communities are capable of setting unbiased selection criteria that target those most in need *(Exemption communautaire du paiement des services de santé au Burkina Faso* - 103858)[28].

Extending Social Protection in Health in Latin America and Caribbean (102107) in Jamaica provided evidence of the negative impact of user-fees on access to health care, helping lead subsequently to abolishing user-fees as part of the national health policy.

- National health insurance programs

In Colombia, *Governance and Evidence-based Decision-making* (102228; 104627)[29] identified that, despite a national health insurance system with clear exemption guidelines, the goal of universal coverage was still not met. Even with a six-fold increase in health expenditures, there was a general deterioration in public health services, with service access heavily dependent on whether people contributed to, or were subsidized by, their health insurance scheme. These findings were presented in a series of consultations with regional health actors and members of Congress, and eventually incorporated into legislated health performance incentives for administrators, insurers and health providers.

*Health Insurance to Address Health Inequities in Ghana, South Africa and Tanzania (*SHIELD – 103457*)*[30] undertook a critical analysis of the existing health systems in three African countries that exposed inequities in health financing. This analysis demonstrated that the fragmentation of different health care financing mechanisms weakens income and risks cross-subsidies within the overall health systems. These findings have important implications for current policy debates about potential mechanisms for bridging the health care financing gap in African countries. This is particularly true as financing strategies that further fragment health systems, such as community-based health insurance and private voluntary health insurance, are promoted.

3. GEH OUTCOMES

GEH has synthesized outcomes into three subsections: Voice and Power; Capacity Development; and Practice and Action. These three outcome themes are interlinked: Effective practice and action largely depends upon levels of research capacity development, as well as upon researchers' ability to exercise voice and power. Gains in

[28] Valery Ridde *et al*., "A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso"; *Journal of Epidemiology Community Health,* published online August 19, 2009: http://irims.idrc.ca/getDocument.asp?documentNumber=217605
[29] Final report :http://irims.idrc.ca/irims/ViewDocument.asp?Key=LACPRG+232%2D01%2D02%2D102228%2D001+UNC+94770
[30] Final report: http://irims.idrc.ca/irims/ViewDocument.asp?Key=PPB+232%2D01%2D02%2D103457+UNC+108810

these outcomes lead over time to strengthened health systems and improved health outcomes. (See Figure 4 “GEH Approach”, Annex I)

3.1 Voice and Power

Southern voices and power are increasingly reflected in local, national, regional and global health policy debates. This helps to build strong and equitable health systems, and to improve health outcomes.

GEH has built its programming around evidence that health systems -- characterised and strengthened by the concepts of equity and governance -- are essential to improving health outcomes. Given that people living in poverty are often spoken for and spoken about by others, GEH’s work is directed at addressing systemic power arrangements in health, and encouraging Southern recipients to drive changes and speak for themselves.

GEH recognises that explicit efforts at all levels are needed to ensure that issues of power and voice are addressed. It also recognises that changes in policies, programs and organisational behaviour are incremental. Some emerging trends have been noted, however. They are discussed below.

Collecting data from and analysing the conditions of the marginalised

There is an enhanced role for evidence in program development in situations where data „reflects’ the voice of marginalised and underserviced populations. GEH has attempted to integrate marginalised voices into health information systems to document evidence of exclusion and describe the reality of vulnerable, underserved communities in numerous studies outlined below.

--A review of maternal death in Zimbabwe and Ethiopia (*Strengthening the Health System through a Maternal Death Review* – 103201) created a data set that made women who died while giving birth in hospitals visible, and highlighted problems related to quality of care.

--*Access to Healthcare and Basic Minimum Services in Kerala/Vulnerability and Health in Wayanad, Kerala, India* (103335) created evidence focused on health vulnerabilities, particularly for tribal groups, and showed how they can be addressed by community health insurance.

--In Uttar Pradesh, evidence highlighted issues of maternal quality of care, despite the use of financial incentives for institutional births. *(Negotiating Rights- Building Coalitions for Improving Maternal Health Services in Uttar Pradesh India* –105005*)*.

--In Nigeria, the NEHSI project is supporting the Nigerian federal ministry and two state ministries of health to strengthen the existing health information systems to collect, analyse, interpret, and use health service and community-based data revealing

maternal health priorities of vulnerable women in order to plan effective primary health care interventions (*NEHSI- Planning phase* –102436*, NEHSI- Implementation* – 104613).

--In Ethiopia, the International Clinical Epidemiology Network (INCLEN) group incorporated qualitative approaches in addition to traditional quantitative epidemiological approaches to examine governance of maternal health issues, particularly for vulnerable women. Researchers are now exploring how to disseminate the data to influence policy (*Governance, Maternal Mortality and Health Systems: INCLEN pilot study* –104222).

--In Botswana, Namibia and Swaziland *AIDS Prevention for the Underserved Majority of the AIDS Epidemic: the Choice Disabled. A Randomized Clinical Trial (RCT) of Prevention Interventions in Southern Africa* (105053) is not just focussing on the technology related to HIV/AIDS prevention (condoms, microbicides, circumcision, etc.). Rather, it is observing the underserved majority who have been most affected by HIV/AIDS, particularly women, to understand their reality. These women are referred to as the „choice-disabled'. By identifying the best set of interventions, the project is enabling a better understanding of how to tackle the HIV epidemic by focusing on enhancing the ability of women to make choices and improve uptake of existing AIDS prevention strategies.

Bringing in diverse groups to frame research questions

Even in cases where strong evidence reveals health inequities, it is increasingly recognized that decision and policy-making processes are not necessarily evidence-based. The specific political context of decision-making is important to understand.

To influence the policy-development process, GEH encourages stakeholders to advocate for positions based on credible data and evidence about marginalized groups. The findings of the Canadian International Immunization Initiative research project (*CIII2* –102172) directly challenged the notion – supported by some international funders – that more vaccines will automatically lead to increased coverage[31]. By focusing on unvaccinated children, new findings have revealed gaps in policy and have helped to deepen understanding about the interface between demand and supply.

Enabling Southern researchers and institutions to engage in national and global policy fora

Earlier findings speak to the importance of Southern researchers and research institutions as the best advocates for the results of their own research.

GEH has reserved funding to facilitate recipient participation in conferences and meetings. By using its convening power, GEH has helped Southern researchers share

[31] Mhatre, S. and Schryer-Roy, A., "The fallacy of coverage: uncovering disparities to improve immunization rates through evidence", *BMC International Health and Human Rights* 2009, 9(Suppl 1):S1.

their research findings, boost the profile of their institutions, become better-known internationally and influence global agendas. GEH support for Southern-led knowledge networks on health systems (*WHO Commission on Social Determinants of Health: Health Systems Knowledge Networks* -103297; *Social Determinants of Health: International Meeting* -104722) ensured that Southern voices were brought to bear on the WHO Commission on Social Determinants of Health findings[32]. Additional support enabled 15 recipients to participate in the Ministerial Summit in Bamako in October 2008[33], enabling an amplification of Southern voices at this high-visibility event.

By pursuing such approaches, GEH has, on occasion, faced some tensions with other funding donor partners who hold different views with respect to engagement with Southern recipients (*Health Research Capacity Strengthening* - 104959)[34].

Reflections and challenges

These experiences have enabled GEH to change some of its own practices and to create more space for internal reflection (for example: *Consolidation, synthesis, tools and networking to support Knowledge Translation, Evaluation and Learning in GEH Phase II* - 106113). The team identified a need for better internal understanding of social and gendered analysis, and dedicated some time during its retreat in 2009 to examine this[35].

Concerted efforts were also made to decrease barriers against direct funding to Southern recipients. With the *Health Research Capacity Strengthening* project in Kenya (*HRCS Implementation and Learning* – 104959)[36], GEH supported in-country institutional capacity for funding calls rather than using external mechanisms. Similarly, when supporting the *Canadian International Immunization Initiative* study, where the traditional approach would have been to channel all the funds through a Northern partner, a decision was taken to make funds directly available to Southern recipients wherever possible.

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[32] Follow-up from the Commission on Social Determinants: http://irims.idrc.ca/getDocument.asp?documentNumber=258649
[33] Profile of participants and IDRC partners: http://www.idrc.ca/en/ev-131995-201-1-DO_TOPIC.html.
[34]Letter from Jo Mulligan (DFID) about IDRC's Role in the HRCS Kenya Project: http://irims.idrc.ca/getDocument.asp?documentNumber=258545. Letter from Jimmy Whitworth [WT] about IDRC involvement in incubation and partnership: http://irims.idrc.ca/getDocument.asp?documentNumber=258555. IDRC answer to WT letter regarding financial aspects: http://irims.idrc.ca/getDocument.asp?documentNumber=258554. Working in Harmony: Development of the WT-DFID-IDRC Health Research Capacity Strengthening Initiative 2004-08: http://irims.idrc.ca/getDocument.asp?documentNumber=238622 FW: London Meeting Minutes and Action Items: http://irims.idrc.ca/getDocument.asp?documentNumber=257631 Final Incubation Report to 2 March 2010 & Incubation Progress Report at 2 March 2010: http://irims.idrc.ca/getDocument.asp?documentNumber=255284.
[35] Program Documentation, section on Program Evaluations and External Reviews: http://irims.idrc.ca/getDocument.asp?documentNumber=246111.
[36] Withdrawal from Incubation, 15 January, 2010: http://irims.idrc.ca/getDocument.asp?documentNumber=255302. Approval for Research Leadership Grants funding by IDRC - Response from Denys Vermette to LK analysis: http://irims.idrc.ca/getDocument.asp?documentNumber=255332.

There will continue to be challenges to maintaining a focus on voice and power in GEH work. With increasing partnerships, as was learned in *HRCS Implementation and Learning* (104959), there is need to constantly review and make explicit this issue. GEH remains committed to systematically applying a focus on voice and power across its programs.

3.2 Capacity Development

Stakeholders' capacity for generating, exchanging, and applying policy-relevant knowledge is strengthened in order to build health systems and to improve health outcomes.

Capacity development for IDRC and GEH is defined as "the long-term process by which individuals, networks, institutions and societies increase their ability to identify and analyze development challenges, and to have the ability to conduct, manage, communicate, and use research that addresses these challenges over time and in a sustainable manner"[37].

The GEH approach to capacity development is based on an analytical framework of good practices for capacity development[38]. It utilizes a flexible and sensitive programming approach harnessing existing capacities and is driven by the priorities and needs of recipients in LMICs. GEH has targeted its capacity development activities at different levels – individual, network, institutional and societal – the outcomes of which are outlined below.

The GEH program has contributed to improving and extending the pool of competent researchers and research supervisors through various mechanisms such as formal training programs, mentoring, linkage of senior and junior researchers, and peer assistance. Networks of researchers and research-users have flourished. They have been supported through joint projects, comparative research, mentoring, supervision, workshops and conferences. At the institutional and societal levels, GEH contributes to research capacity through multi-stakeholder dialogue, the sharing of technical tools and frameworks, the establishment of new organizations, and the sharing of evidence. These mechanisms have all contributed to enhanced research capacity. They have also contributed to enhanced research use for evidence-informed policy-making and decision-making geared towards efficient, sustainable and equitable health systems.

- Capacity development at the individual level

The GEH capacity development efforts are aimed at increasing the supply of in-country researchers to mitigate brain-drain, and to improve the quality and responsiveness of research efforts. This is done by addressing priority setting, skills enhancement,

[37] Adapted from Stephanie Neilson and Charles Lusthaus, *IDRC-Supported Capacity Building: Developing a Framework for Capturing Capacity Changes*, Universalia, February 2007: http://www.idrc.ca/uploads/user-S/11762347991CB-Developing_Framework_Capturing_Capacity_Changes_FINAL.pdf

[38] Stephanie Neilson and Charles Lusthaus, February 2007.

adapted curriculum, strong mentorship and wide scale networking – including with decision-makers and policy-makers. Early evidence shows that GEH is making good progress to realize these aims.

GEH's recipients have increased their skills and competencies in health systems research through their involvement with the program. These increased skills and competencies have led to the production and publishing of high quality research findings in local and national newspapers and academic venues, in national or international peer-reviewed journals and as book chapters and entire books (for a list of publications by project, see Annex II).

With GEH's technical and funding support, both seasoned and young researchers and health system managers have been enabled to develop and apply innovative methodologies and approaches to conduct health systems research.

Specific examples that illustrate these achievements include the *African Doctoral Dissertation Research Fellowships* (104655) which is contributing to increasing and sustaining the capacity for health systems research by increasing the pool of doctoral students at African universities, with a specific focus on health systems research.

The program helps students to complete their research by funding the writing of their dissertations in order to accelerate completion and minimize drop-outs. It will result in a total of 55 PhD graduates over the next three years. This project has already improved the quality of research supervision of doctoral candidates as well.

Increasing health research capacity in Francophone Africa continues to be a concern for GEH. The contribution of Francophone Africa to global research continues to be relatively weak. The capacity development project *Renforcement des capacités en Afrique Francophone* (103355) conducted by AREFOC, a Malian research institute, is aimed at rectifying this situation. The institute offered training in teaching skills, applied research and evaluation to ten health professionals over two years. Participants recruited from Francophone West African countries received high-level research training. Priority has been given to managers employed in target countries so as to counter the brain drain and contribute effectively to solving priority problems in the health sector within the region.

A recently approved capacity development project (106129) in Burkina Faso is collaborating with IDRC's Special Initiatives Division to train African master students in health systems and policy analysis. This program aims to graduate 39 students over a three-year period.

In the *HRCS Kenya/Malawi Partnership* project (103760 and 104959), funding of country-specific plans is geared towards improved health research coordination and management at a national level in both countries. In Kenya, the implementation of a Consortium for National Health Research will improve career pathways for emerging

researchers. A recent series of Calls for Proposals[39] address funding of research teams directed by recognized research leaders. Selected postgraduate researchers receive direct mentorship and supervision combined with specifically-tailored modular training courses.

- Capacity development through networks[40]

The establishment of networks as a new and innovative way of working on research problems is generating new coordination skills and strengthening South-South collaborations and exchanges. Networks established or supported by GEH are producing high quality research, and facilitating information-exchange amongst researchers, and between organizations. These multidisciplinary networks cost-effectively promote regional capacity development. Networks are largely sustained via virtual communication, with some face-to-face interactions.

GEH-supported networking activities include information and methodology-sharing at workshops and conferences, joint and comparative analysis, and mentoring and supervision. These activities have resulted in improved quality and greater interest in research. They have also improved and extended researcher pools. More dialogue between researchers, communities and policy-makers and decision-makers has been established, along with increased engagement between researchers and implementers.

A good example of such interaction is the INDEPTH Network study on *Understanding the Demographic and Health Transitions* (105727) in LMICs using health system and demographic surveillance data. Through this project, sites strong in biostatistical and analytical skills are called upon to share expertise and learning with other sites to enable skills transfer and capacity development across the network's membership. In the NEHSI project, new software development and increased analytical capacity will enhance research skills within Nigeria. Better data-sharing capabilities will also be facilitated through this process.

Other examples of capacity-development for health systems research within South-South Networks come from the GEH health financing research networks in Asia, Africa and Latin America: *EQUITAP* in Asia (105231) with 15 countries, *Health Financing Latin America Network in Latin America* (103905) with 12 country teams and *SHIELD* (103457) in three African countries. These three networks have separately conducted comparative analyses and successfully shared methodologies. Meanwhile, they have mentored young researchers through ongoing implementation of the projects, short training sessions, workshops and conferences.

- Capacity development of institutions and society

[39] Series of Calls for Proposals: http://cnhrkenya.org/Downloads/Guidelines%20for%20Applicants%20of%20RLG.pdf .
[40] IDRC and GEH define a network as social arrangement of organizations and/or individuals linked together around a common theme or purpose, working jointly but allowing members to maintain their autonomy as participants: http://www.idrc.ca/en/ev-91258-201-1-DO_TOPIC.html .

GEH programming has improved the technical and functional capacities of research institutions and governments. The *Research Matters* (RM) initiative (104024) has contributed to enhancing research institutions' communication and dissemination capacity. Through RM, GEH has supported the planning and early implementation of the Regional Knowledge Transfer Platform in East Africa, and the creation of the Zambia Forum for Health Research (ZAMFOHR), a knowledge translation institute in Zambia which also gained the support of organizations like CCGHR, AHPSR and WHO.

Collaborative efforts have enhanced knowledge, understanding and analytical capabilities of government actors, facilitating the use of evidence in policy/decision-making. For example, the IDRC West Africa Regional Office's series of researcher-decision-maker workshops, which provided the space to build trust and collaboration between researchers and policy-makers, has been scaled up with GEH support (104961) in Benin and also in many ECOWAS (Economic Community of West and Africa States) countries to facilitate the use of evidence. In addition, the *Southern Cone Countries Multi-Center Study in Primary Health Care* (104376) has contributed to strengthening health systems research in Paraguay. This is being done through a new organization specifically dedicated to the task of developing a research agenda, and to networking with decision-makers and carrying out relevant research.

GEH support for capacity development at general societal levels include the *Ethnicity, Poverty, and Health Inequities project in Peru* (103211), which has provided data and analyses highlighting existing inequities in accessing health services for indigenous populations in Peru. This evidence is being used to support the work of advocacy groups of indigenous populations and the Ombudsman Office in Peru to address the health inequities related to ethnicity. In Senegal, *Corruption and Good Governance in the Health Sector* (101914) resulted in the development of an ethical charter and high-level political support, resulting in a number of hospitals adopting procedural changes to their recruitment policies and improving the efficiency and efficacy of the health system.

Reflections and Challenges

The GEH approach, aligned with the IDRC framework of good practices for capacity development, constitutes the key foundations for developing capacity.

Because capacity development necessitates a long term commitment, the success of these efforts will need to be reviewed in subsequent years when the impact of these capacity development programs may be more conclusively reported. A sustained investment is necessary to maintain and improve the achievements in this area as they are still fragile.

West Africa continues to present challenges for GEH capacity development initiatives. Despite several projects in the region (*Programme de renforcement des capacités en analyse des politiques et systèmes de santé en Afrique Subsaharienne - 106129; West African candidates with African Doctoral Dissertation Research Fellowships - 104655*) there was limited sustainable capacity development with the recipients.

It appears that there is an overdependence on northern research teams to manage development and implementation of these projects. Experience with the Canadian International Immunization Initiative and *Programme de renforcement des capacités en analyse des politiques et systèmes de santé en Afrique Subsaharienne (106129)* indicated that GEH program officers and administrative staff must provide intense and continuing guiding support with West African teams in order to achieve project completion. Difficulties continue in producing and retaining competent researchers in LMICs and/or working on health systems issues.

The GEH experience in West Africa underlines the need for action at multiple levels – from the individual to the state, societal and international levels – to develop capacity in regions with limited health research resources.

3.4 GEH Practice and Action

Changes in practice and action have contributed to inform policy at local and national levels, to modify donor practices, and to improve health service delivery practices. These are leading to strengthened health systems and improved health outcomes.

To assess and document our achievement of this outcome, the following section utilizes the framework of Lucy Gilson *et al*. (2008), as a benchmark for changes accomplished through programming in the three entry points identified in the GEH prospectus: governance, health systems, and financing.

Governance entry point

Change at the individual level in terms of capacity development is detailed in Section 3.2. At the institutional level, GEH works with prospective researchers to ensure that the design of the research involves research users, including civil society decision-makers, and health providers. This broadens the space for inter-sectoral action facilitating the use of research to inform policy and practice.

The imperative to change practice is evident in several projects. In *Public Sector Antiretroviral treatment in the Free State* (102770) the research design, process and results catalyzed political and bureaucratic will for effective ARV roll-out in one province in South Africa .The evidence generated from this study also encouraged change in how prescribing protocols and task-shifting in nursing were adapted and scaled-up in other provinces in the country.

Long-term GEH support to the *Municipal Services Project* (101644) in South Africa changed practice on the role of privatisation in providing basic electrical services in municipalities through improved articulation of the needs and demands of civil society. Initially, the project focused on civic engagement around water and electricity services. Subsequent GEH support encouraged the project to make health outcome linkages

more explicit. A recent grant to this group (105141), took such inter-sectoral action beyond Africa to include Asia and Latin America.

Another example of change of practice in terms of how governance plays out in the health sectors in countries is evident in Benin (*Gouvernance et qualité des soins au Bénin* - 103085). With GEH's support, policy-makers and researchers were brought together to discuss maternal health results, with support from cabinet-level officials. Subsequently, the process was institutionalised through the establishment of a national sub-committee which facilitated the translation of research findings for use in the policy and planning processes. Specifically, this sub-committee developed a targeted research agenda for maternal health, and won additional funding from USAID.

In Latin America, the GEH portfolio of projects resulted in changes to practice in cases where stakeholders' understanding of governance informed implementation of various programs and policies. For example in Argentina (*Governance Analytical Framework: an Approach to Health Systems Research* - 103998), project results informed the implementation of maternal and child health insurance. In Guatemala, findings informed development of a locally-led surveillance system (*Strengthening Governance through Improvements in Equity and Accountability in Health Systems of Latin American Countries* - 103887). By rising understanding of governance, in Brazil (*Southern Cone Countries Multi-Centre Study in Primary Health Care* – 104376) this contributed to a more regionalised approach for a unified health system across the Amazon region.

As part of changing practice, GEH has contributed to raising the level of discourse regarding health systems change. For example, engagement of leaders in the health system debate was fostered in GEH's support for work in Zambia (103650). Through the evidence generated from the *Equity Gauge* project, researchers and parliamentarians were brought together for the first time to acknowledge and address key equity concerns in their national poverty reduction strategic plans. This strategy to engage parliamentarians brought equity issues into the Zambian Parliament. Zambians then played a central role in integrating these experiences into the EQUINET strategy – spreading this approach to other countries in eastern and southern Africa.

As part of changing practice, GEH emphasised the importance of Southern-led governance, leadership and civic engagement. GEH support for COHRED, HRCS, the Global Forum for Health, and the Centre for Global Development led to changes in how these institutions work. By encouraging COHRED (105097) to decentralize to the country level, research activities became more relevant to many of the African recipients – as reflected in a new focus on human resources for health. GEH also encouraged links to other recipients such as ZAMFOHR, WAHO, REACH and HRCS that led to in-country initiatives like HRWeb project (105097), which aims to be a clearinghouse of national health research for more effective policy formation.

When the Center for Global Development approached GEH with the excellent idea of tracking HIV funding in Africa from three major funders (Global Fund, PEPFAR, World Bank), GEH worked to include Southern researchers as part of the research team. The

project has influenced the practice of these funders, and conversations with the Center for Global Development team have indicated that this made for richer evidence, and an increasing recognition of the importance of considering the impacts of such approaches[41].

GEH's ability to attract partnerships is another testimony to the success of the GEH approach, and to the strong technical expertise of the team. In turn, GEH's long-standing engagement with other health donors has influenced their practice and action – further enhancing the reach of GEH's programming. GEH was one of the first program initiatives within IDRC to have large collaborative external donor support. Starting with the Swiss Development Corporation (CAD 3.2 million over 7 years), this has evolved into substantive partnerships with CIDA (CAD 21.5 million: NEHSI, CIII2, Haiti), followed by DfID/Wellcome Trust (CAD 20.6 million[42]).

GEH's influence in changing donor practice and action is evident in how research funders address the issue of ethics. GEH's approach works at various levels, starting from a requirement that recipients specify at the outset how they propose to address ethical issues that may arise from their research. Program officers work with projects to ensure deliberation on ethical issues in keeping with acceptable ethics requirements, especially in countries where ethical review systems are weak. For example, GEH has set up various ethics review committees (102770 and 104613).

For GEH, ethics issues go beyond the traditional confidentiality and anonymity issues to include issues of culture and gender equity. From the grant-making side, GEH has worked with IDRC legal counsel to detail ethics guidelines that are part of the Memorandum of Grant Conditions, including requiring ethics approval prior to any release of funds. This template is now being used by the Global Health Research Initiative (GHRI) and other IDRC initiatives[43].

In changing donor practice, GEH has played a central role in the development of the GHRI, working closely with CIDA and the Canadian Institutes of Health Research to increase collaborative support for global health research (*Building Canadian Support for Global Health Research* -102660, 103147, 104771, 105543; *Relationship Building with CIHR* - (2002/2005) 100443 and (2002)101365, *GHRI Core Funding* (2004) - 102885; *Teasdale-Corti Grants Competition Development* (2005/2006) -103478).

Supporting the establishment of GHRI helped some Canadian agencies overcome existing constraints in supporting Southern-led development related research projects. This significantly expanded Canadian investment in global health research (e.g. CAD2.5

[41] Third technical progress report: http://irims.idrc.ca/getDocument.asp?documentNumber=175958
[42] As of December 2009, this partnership has been reviewed and the revised total budget is now of 2.5 million.
[43] Draft framework for discussing ethical issues in research, November, 2007: http://irims.idrc.ca/getDocument.asp?documentNumber=258040

million for immunization through CIII2 – 102172), and health systems strengthening (Teasdale-Corti program; CAD 12.7million)[44].

By engaging with CIDA over the years, GEH has tried incrementally to influence how CIDA views issues of governance, ownership and sustainability within its grant-making and project implementation. For example, through its involvement with the NEHSI project in Nigeria, GEH was able to convince CIDA of the importance of using research findings to inform implementation and make changes to the project design (102436).

- *Health systems entry-point*

Through the health systems entry-point, GEH was able to change practice and action to address on-the-ground issues in the immunization of children, in HIV/AIDS treatment, and in human resource capacity in dealing with the AIDS pandemic. It also examined maternal health issues from various perspectives in trying to strengthen local health systems addressing the problem. Supporting initiatives to strengthen more informed decision-making, and helping countries to identify their own research priorities, are important strategies for sustainable capacity development.

To achieve improved health outcomes, and as part of addressing the Millennium Development Goals, GEH has supported various projects on maternal health – especially from the perspectives of governance and equity – to examine how work in this area could contribute to health systems strengthening. In collaboration with UNICEF in Kenya and Zimbabwe, GEH supported strengthening information systems related to the causes of maternal death (103201). This was essentially a hospital-based system to improve institutional quality and standards of care. The Garissa District Hospital institutionalized this process showed improvements in the quality of care and initial with the utilization of health services[45].

The idea of strengthening maternal health services through the health information system has been extended to the NEHSI project in Nigeria. In responding to government priorities for health, the existing health information and surveillance system is not able to meet the priority information needs. NEHSI aims to improve the quality of information related to maternal care in order to inform resource allocation for better health outcomes – especially lowered maternal death rates. Although this is just now being initiated, state governments have responded enthusiastically to these efforts[46].

In Ethiopia, GEH supported the International Clinical Epidemiology Network (INCLEN) and the University of Addis Ababa (104222) in building local capacity, and in strengthening governance systems to improve maternal health outcomes. Although the

[44] The overall objective of the Teasdale-Corti Program was to contribute to improving health and strengthening health systems in Low and Middle Income Countries, particularly in Africa, by supporting innovative international approaches to integrating health knowledge generation and synthesis through research, health research capacity development, and the use of research evidence for health policy and practice.
[45] Trip report to Ethiopia and Kenya, December 2007: http://irims.idrc.ca/getDocument.asp?documentNumber=258668
[46] See minutes of February 25, 2010 Project Advisory Committee Meeting (will be available in May 2010).

results from this project are still forthcoming, early evidence indicates improvement in capacity as well as in maternal health services.

In South Asia, GEH supported a project (105005) in Uttar Pradesh, one of the states with the highest maternal mortality in India[47]. The project headed by a local NGO, SAHAYOG, initially was focused on expanding inter-sectoral action and research that identified weaknesses in the health system as a major barrier to improving maternal health. With GEH support, SAHAYOG is working with the state government and the National Rural Health Mission to work with mid-level managers to strengthen the health system. This project has also given the issue increased prominence among leading politicians in India. Project leaders have met the Indian President and key MPs to highlight maternal health issues in the country.

GEH support, development, and oversight of *CIII2* (102172), involving six research teams from South Asia and West Africa, has been directed at strengthening health systems to increase immunization coverage. Through competitive operational research grants, researchers working with health workers and communities introduced innovative approaches to improving immunization uptake among hard-to-reach groups, and facilitated more evidence-based decision-making. In one particular case, in the Lasbela district of Pakistan, the operational research project demonstrated how a low-cost intervention could double the odds of measles vaccination and triple the odds of full DPT vaccination.[48]

By working at the interface of supply and demand within the health system, researchers provided the impetus and evidence to better target immunization programs. In part this was done by demonstrating what GEH calls “the fallacy of coverage” – in which numerous discrepancies with current coverage information were revealed. These related to the timeliness of immunization, social and gender inequities, vaccine efficacy, understandings of the demand-side issues necessary to tailor interventions, and national data sets that mask lower district level coverage rates. By revealing the “fallacy of coverage”, researchers are now capable of opening a dialogue for addressing these discrepancies[49].

GEH supported a one-and-a half year planning phase (2005-2007) for the Nigeria Evidence-based Health System Initiative to better inform efforts to improve the health information system, and to incorporate this into the implementation strategy for developing a fair, effective and efficient primary health care system in two states in Nigeria: Bauchi and Cross River. The expectation is that improvements in the health information system and improved capacity to interpret, use and analyze information will lead to better delivery of primary health care services. This project, now in its second

[47] Kranti S. Vora *et al.*, “Maternal Health Situation in India: A Case Study”*, Journal of Health Population and Nutrition*, April 2009, 27 (2): 184-201.
[48] Andersson *et al*., “Evidence-based discussion increases childhood vaccination uptake: a randomized cluster controlled trial of knowledge translation in Pakistan”, *BMC International Health and Human Rights* 2009; 9: Suppl 1, S8.
[49] Andersson *et al*., “Evidence-based discussion increases childhood vaccination uptake: a randomized cluster controlled trial of knowledge translation in Pakistan”.

year of implementation, is showing encouraging signs of increased uptake among federal and state level decision-makers. As witnessed at the last project advisory committee meeting[50], senior decision-makers are rebranding the initiative as "theirs", and identifying the initiative as the approach that is needed for evidence-based planning in other parts of the country as well.

To close the loop from information-generation to utilization of evidence and information in planning, GEH has worked through its Research Matters (RM) arm to facilitate translation and exchange of research findings to improve uptake among health policy-makers and planners. Several discussions between RM staff and WHO's EVIPNet program resulted in reworking a WHO proposal that included more African participants in leading roles (105666)[51].

Through RM, GEH's emphasis on evidence-informed decision-making has been included in all donor partnerships to the extent that we now see derivatives of these partnerships - such as the Kenyan Consortium for National Health Research (CNHR) and the GHRI Teasdale-Corti project – incorporating a knowledge transfer or research communications angle in their strategies. Emerging influences on media have opened new possibilities for the exchange of research findings between researchers and decision-makers. RM's support contributed to a change in media approaches from being passive recipients of information to becoming active seekers of researcher input in radio programming on health financing, for instance in EQUINET (104024-012)[52]. As a result of intensive, recurrent and supportive discussions between GEH program officers and the BBC World Service Trust's *Kimasomaso* project, radio programming on reproductive health and youth issues now relies on researchers as sources of validation. Researchers are introducing the notion that reproductive health services for youth must link into the larger health system (104024-015)[53].

RM support has added value to existing GEH projects. Radio spots on essential services provision raised the profile of the issue of privatization of water, electricity and health in South Africa within the local government (*Municipal Services and Health in Southern Africa* – 101644; 105141; 105306*)*. RM-supported videos in the Equity Gauge Zambia project captured the importance to robust health care delivery of amicable and respectful relationships between the various strata of the health system. This has improved relations between clinical practitioners and the public.

To confront the challenges in health services in the context of the HIV/AIDS epidemic, GEH focussed its support on the role of nurses and what could be done to strengthen this cadre of health workers to deliver more effective health services, especially where fragile health systems are being further overburdened by dealing with HIV care provision.

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[50] See minutes of February 25, 2010 Project Advisory Committee Meeting (will be available in May 2010).
[51] EVIPNet final proposal: http://irims.idrc.ca/getDocument.asp?documentNumber=224182
[52] Project progress report: http://irims.idrc.ca/getDocument.asp?documentNumber=237611
[53] Proposal to RM: http://irims.idrc.ca/getDocument.asp?documentNumber=240656 Research Matters Update Report No. 14 - January - December 2009: http://irims.idrc.ca/ViewDocument.asp?Key=ESAPRG+232%2D01%2D02%2D104024+UNC+243555

In the Western Cape in South Africa (*Impact of HIV/AIDS on Health service capacity at primary care level* - 101938), strategies to improve leadership, decrease the work-loads and increase the quality of supervision of nurses were developed and successfully implemented. This resulted in the development of an improved audit and management tool for use by nurse managers to strengthen service provision and management of these front-line care-givers[54].

In addition, the results from this project and from the *Public Sector Anti-Retroviral Treatment in Free State South AfricaPhase II* (102770) showed that for HIV programs to be taken to scale, for most efficient service delivery they need to be incorporated into existing primary care programs. Treating HIV/AIDS care independently of the health system risked fragmenting and further overburdening the system. Remarkably, this strategy received extensive support initially throughout the province and later was adopted nationally[55].

The outcomes from projects described above indicate that the health systems research focus of GEH is contributing to important advances that have been acknowledged in policy and program uptake at local, national and regional levels.

Health financing entry point

In the area of health financing, GEH's efforts have targeted equity gaps that impede universal health coverage. This work spanned „fair financing' initiatives in Africa and Asia and attempts by health insurance schemes to cover the health needs of marginalized and poor people. SHIELD (103451) revealed inequities in health financing schemes in Southern Africa resulting from the limited reach and risk-pooling capacity of the various insurance programs supported within the various countries. With support from IDRC, the recipients received a large grant from the European Union. This extended SHIELD activities beyond simply the analysis of financing and equity issues in order to enable further development of innovative and equitable financing options to redress inequities.

EQUINET (105675) and SHIELD researchers have provided input into an upcoming WHO report on health financing directed at helping government officials to build an understanding of fair financing practices and how these can be implemented[56].

The issue of user-fees is clearly a challenge to health systems strengthening. GEH has supported various projects to inform policy change on this issue and to specifically establish evidence to manage the policy change of removal of user fees in developing countries. For example, the evidence from the *Extending Social Protection in Health in LAC* (102107) project demonstrated that user fees have a negative impact on

[54] Final Report: http://irims.idrc.ca/irims/ViewDocument.asp?Key=PPB+232%2D01%2D02%2D101938+UNC+110290
[55] Two other IDRC program initiatives built on these projects: the Program Initiative for Africa with the *Free State HIV Therapy Database (ART-HIV)* (102411) in South Africa and GHRI with the African Health Systems Initiative (105366) in Malawi.
[56] Health Systems Financing Unit - WHO, Report on Health Financing, under review - upcoming 2010.

preventive care. This has informed policy change in Jamaica and was part of the rationale behind the decision of the Jamaican Ministry of Health to remove user fees. In addition, in West Africa (Burkina Faso, Mali and Niger) GEH supported projects (103861; 105309) are contributing to the debate to remove user fees.

With the appointment of a new program officer specializing in health financing research, efforts are being made to deepen this area of work and to increase the linkages between GEH health financing projects on different continents. This will maximize synergies with other projects, for example integrating financing research into GEH primary health care research initiatives.

Reflections and Challenges

The evidence presented here documenting changes in practice and action fits with the features identified by Gilson to achieve an equitable health system. It reveals that through GEH's established entry points, the program has influenced practice. This has been done by implementing IDRC's grants-plus model, through team members' participation at various forums, through the recognition of the importance of power and voice, through capacity development, and through GEH's convening ability.

Changes in practice and action occurred at various levels. These ranged from informing policy at local and national levels to changing donor practices, to changing health service delivery practices. GEH is working with various organizations (COHRED, Global Forum) to ramp-up some of the consolidated results for policy change, and to improve understanding of how research is a key intervention for improving access to health.

4. LESSONS AND CONCLUSIONS

Over the last four-and-a-half years, the GEH program has made significant contributions to global health research and development. Through its twin guiding perspectives of governance and equity, the GEH focus on promoting research that strengthens the ability of health systems to improve health outcomes has proven productive in sheer volume of research initiatives, adaptive to a complex and finely-nuanced range of research needs, and attractive to a wide range of high-calibre collaborators.

In addition to CAD $21.5 million in Parliamentary appropriations from IDRC, GEH has attracted CAD $54.84 million from other international donors. It is similarly reassuring testament to the appeal and acceptance of GEH's work that its team members serve on many high level decision-making committees globally (see Figure 1 "GEH at a Glance", Annex I). 97 GEH projects evolved during this period, either as carry-overs from Phase I, or newly-initiated within Phase II. The GEH program continues to vibrantly grow and change in response to emerging health status indicators, as well as in response to a range of demographic and socio-political events in numerous settings.

What has not changed is that GEH continues to make a difference by recognizing and supporting the critical importance of ways to address issues of voice and power. These issues impact upon recipients' capacity to develop and use new research, and to change health care practice and policy. Meanwhile, GEH continually endeavours to become a better learning organization and to extend its programming reach by building team capacities through communication, collaboration and consolidation.

After reviewing the program in preparation for this external review, GEH believes its practice can be strengthened in important ways. GEH aims to more systematically apply the GEH approach across all its projects and to more consistently promote emerging good practice. Identified gaps, relating to the recipients' research capacities, the inconsistent involvement of policy-makers, and the need for better understanding of the local context, can all be addressed. While this is resource-intensive both in time and staff, it can be done, for example, through negotiating ideas around journal supplement and article production, through active engagement with policy-makers, and through deepened discussion and understanding of health systems.

GEH has worked with a plurality of stakeholders to achieve relevant findings and outcomes where research-driven health changes are urgently needed. GEH will continue to better communicate its approach, building on the growing momentum and interest around health systems research in collaboration with project recipients.

Research findings from GEH-sponsored projects have revealed important information about major health systems issues. The list of research results is long and varied. Methods to help displaced populations have been elaborated. Problems with user fees have been identified and addressed. The privatization of basic services has undergone scrutiny. Gaps between research investment and health systems integrity have been identified. The need to move beyond disease-specific healthcare has been reinforced. Inconsistencies in vaccination coverage have been revealed. Many more findings and outcomes could also be highlighted.

GEH follows IDRC's long tradition as an international leader in supporting innovative research in some of the world's most challenging settings. It has nourished a vibrant network of individuals and organizations with deep expertise and indigenous knowledge to confront the challenges of strengthening health systems to improve health outcomes. This network is a strong foundation to work with during the next programming cycle.

GEH is determined to be attentive and responsive to longstanding issues, and new shifts in research, including maternal and child health, and non-communicable diseases. The research findings, outcomes, and critical feedback from program recipients all reinforce the GEH program's dedication to programming on governance, health systems and health financing.

GEH has made important strides towards the development of effective, efficient, equitable and sustainable health systems. A strong foundation has been built for the next programming cycle.

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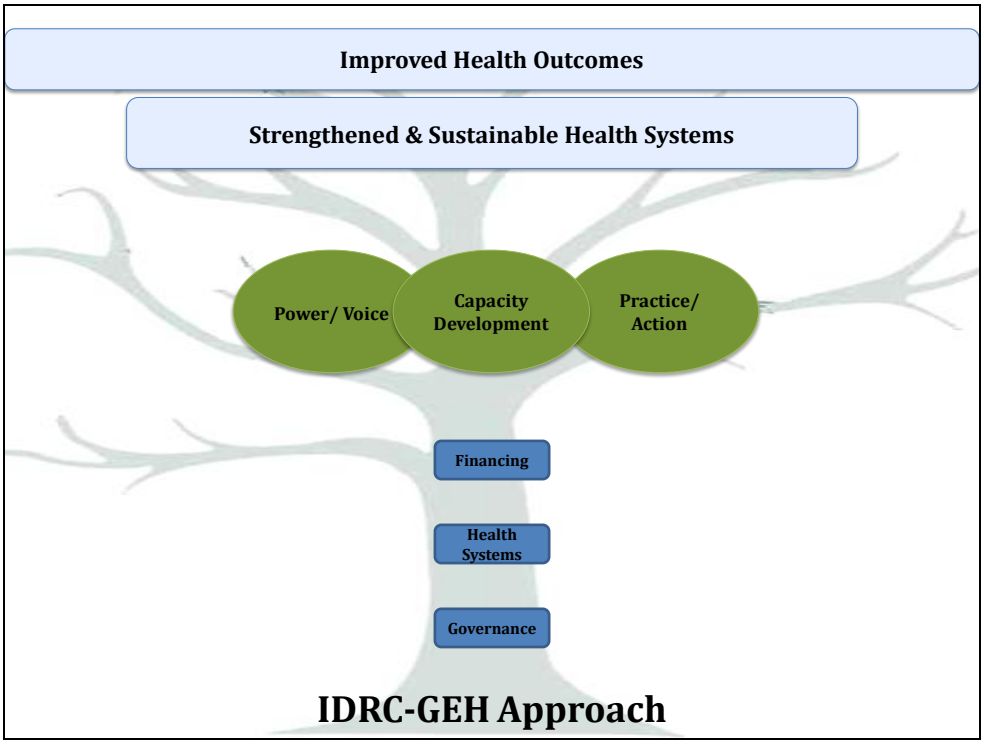
6. ANNEXES

Annex I: Figure 4 - GEH Approach

The GEH approach is represented by a tree (Figure 4) and is described below.



The image of a tree was purposefully selected by GEH team members to emphasise the organic, multi-tiered nature of health systems strengthening. The tree is also representative of the long-term, complex, perennial nature of systems, where the cycle follows growth, decay, and then renewal.

In this case, the „trunk' which acts as the body for the GEH approach combines the three thematic entry-points of **governance, health systems and financing** described in the GEH Prospectus as:

- Governance: evidence to support effective, accountable and participatory *governance of plural health systems*, with an emphasis on the stewardship role of the state and active civic engagement;
- Health systems: tools and evidence to *support effective and equitable systems performance* and strengthen the design, development and *integration of interventions into comprehensive, evidence-informed health policies and systems*; and
- Financing: research-based evidence to inform and evaluate financing approaches for effective, efficient, equitable and sustainable public health systems.

The prospectus defines governance as *the institutions, processes and traditions which determine how power is exercised, how decisions are taken, and how citizens have their say* – at all levels, from households and communities to the global architecture; and health systems as *the policies, activities, and institutions put in place with the primary goal of improving health.*

These entry-points give rise to, and support, the inter-linked, „branched' outcomes of **power/voice, capacity development, and practice/action**. Strengthening health systems requires building space for power to be distributed, where Southern voices are amplified and infuse the development of capacities, and where these strengthened capacities at different levels across health systems lead to improved practice and action. These outcomes allow for the burgeoning of strengthened and sustainable health systems – and ultimately result in improved health outcomes.

Annex II: Key documents

Some key documents have been indicated in the footnotes throughout the report. For more information on each project cited in this report and the list of publications (outputs) by project, please refer to the following document "2- Project documentation GEH phase II April 2006 March 2011 PCRs Revised.xlsx":
http://irims.idrc.ca/getDocument.asp?documentNumber=248206

Annex III: Key informants

See separate document.