



**WOTRO Science for Global Development**

# **Global Health Policy and Health Systems**

**Second call for full proposals**

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# 1 Introduction

**NWO/ WOTRO and the ministry of Foreign Affairs of the Netherlands invite selected coalitions composed of representatives from academic and public interest organisations, from both the Netherlands and low-income countries, to submit full proposals for the second call of the Global Health Policy and Health Systems (GPHS) research programme.**

This research programme is a joint initiative of WOTRO Science for Global Development, the Netherlands Platform for Global Health Policy and Health Systems Research and the Ministries of Foreign Affairs and of Health, Welfare and Sports. The GPHS research programme funds high quality health policy and health systems research. Five programmes were awarded as a result of the first call for proposals, which was launched in 2009.

This second call will give priority to research that demonstrates how health policy and/ or health systems can be improved, and how improved health policy and health systems can contribute to better health, with emphasis on reaching United Nations Millennium Development Goal (MDG) 5: reducing maternal mortality ratios and/ or improving maternal health, including enhancing equitable access to reproductive health services. Health policy research will be preferred in this call.

To enhance effective use of the proposed research, the uptake of its results and its benefit to society, the research proposed should be transdisciplinary. Relevant stakeholders in health policy and systems development and implementation from outside the scientific community (either government agencies, NGOs, private sector partners or consultants) are expected to be engaged in all phases of the proposed programme: from its inception to sharing emerging results. Proposals clearly committed to translation of results into policy and/ or practice will be preferred.

Applications for this call must be a collaborative effort of researchers from one or more low-income countries<sup>1</sup> (LICs) and from the Netherlands (NL). Initiatives from researchers from LICs in collaboration with Dutch partners (i.e. based in the Netherlands) are highly welcome and LIC researchers may act as main applicant.

Please see paragraph 6.3 for a full description of the background, domain and key themes of the GPHS research programme. Please note that this call document only applies to the second call for full proposals within the GPHS research programme.

A third call of the GPHS research programme, to be issued in 2011 or 2012, will be aimed at networking activities between the different programmes awarded in the first and second call, and at embedding the research coalitions within global, north-south and south-south structures. Proposals that already include activities to prepare for this will be preferred.

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<sup>1</sup> For a full list of eligible partner LICs, please see paragraph 6.2.

## 2 Aim

**The aims of the Global Health Policy and Health Systems research programme are to 1) contribute to better health by conducting research aiming at strengthening health systems in LICs, 2) strengthen research capacity in LICs and 3) strengthen collaboration in the Dutch research and knowledge community in order to enhance utilisation of Dutch research capacity.**

The *central strategic challenge* of the research programme is to contribute to enhancing equitable access to health in quality health systems. This includes the following interlinked and mutually dependent key themes:

- Organisation and delivery of essential and quality health services;
- Financial and human resources;
- Governance and decision-making;
- Global influences and their impact on national health systems.

Please see paragraph 6.3 for more information on the background, domain and key themes of the programme.

This second call specifically aims at encouraging initiatives from LICs and equality of the research partnership between the applicants is very important. The call also explicitly aims at involvement of relevant policy makers and practitioners from the inception of the programme onwards and at collaboration between LICs.

In addition, this call aims at encouraging 'systems thinking' and synergy between the six building blocks of health systems that were identified by WHO (see paragraph 6.3). Proposals including community participation and scaling up small successful programmes are highly welcome. Furthermore, applicants are explicitly encouraged to incorporate issues such as global influences, leadership and (creative reflections on) governance, linkages between practice and policy, evidence-informed policy, or health information systems, into their proposal.

## 3 Guidelines for applicants

### 3.1 Who can apply

A proposal can be submitted by a research coalition<sup>2</sup> drawn from at least four different partner institutes and comprising at least two from (one or more) LICs and two based in the Netherlands. Types of partner institutes that are eligible include those with an academic or public interest, such as universities, research institutes, think tanks, government departments, NGOs, etc. The coalition nominates a single coordinator (a senior researcher with a PhD degree, based in either an LIC or in the Netherlands), who will act as the main applicant. Relevant stakeholders in health policy and systems development and implementation from outside the scientific community (either government agencies, NGOs, private sector partners or consultants) should be represented in the coalition. These partners should be engaged in all phases of the programme. Thus, the development of the proposal, as well as carrying out the research programme, should be performed jointly.

### 3.2 What can be applied for

A GPHS research programme can focus on several activities:

- knowledge sharing: making existing knowledge available and accessible for stakeholders; analysing existing knowledge to benefit policy making; integrating and synthesizing various sources of knowledge to create 'new' knowledge;
- research: any research proposed should be transdisciplinary: crossing disciplinary boundaries and involving scientific knowledge and knowledge from beyond the scientific community. Research components may include short term, medium term and long term projects. The involvement of MSc and PhD students is not a prerequisite and research components conducted by post-doc and senior researchers will be preferred.

In this second call, a budget of maximally € 2.2M is available for minimally three to maximally six high quality programmes. The maximum duration of a programme is 5 years. For proposals with this duration, a maximum budget of € 800,000 is available. However, shorter-term proposals with more limited budgets are equally welcome. Because health policy research can often rely on secondary data, it usually requires a relatively modest budget.

#### Budget

Unless explicitly stated otherwise in this brochure, the research budget and financial control of the expenditures should meet the administrative guidelines of NWO (please see NWO terms and conditions<sup>3</sup>). The grant should be viewed as

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<sup>2</sup> The word coalition is used here to indicate a group of researchers who work together to achieve a particular purpose. In some texts used globally, the word consortium is also used to describe this type of groups.

<sup>3</sup> Weblink to NWO terms and conditions:

[http://www.nwo.nl/nwohome.nsf/pages/SPES\\_5VEDDR\\_Eng](http://www.nwo.nl/nwohome.nsf/pages/SPES_5VEDDR_Eng).

a contribution to the total costs associated with the proposed research activities. Please note that research programmes supported by NWO commonly receive additional funding from other sources.

To ensure correct spending of ODA funds, at least 50% of the budget needs to be spent in LICs (infrastructure, activities and/ or personnel costs of team members from low-income countries). Significantly higher percentages to be spent in LICs would also be welcome.

**Reimbursable costs** are:

- Personnel costs. The budget should specify clearly the input of personnel in terms of type of personnel, FTE appointment, and salary level. Personnel costs of post-doc, senior and PhD researchers as well as non-scientific associates can be covered by: salaries<sup>4</sup>; living allowances<sup>5</sup>; bench fees<sup>6</sup>.
- Knowledge and research costs (travelling expenses, durables, consumables, research assistance, training for LIC researchers);
- Specific activities to enhance knowledge sharing that do not require research: costs of joint activities and the dissemination of results;
- Costs for monitoring and evaluation.

**Reimbursable costs in LICs** but non-reimbursable in the Netherlands are:

- Overhead costs: office space, basic facilities, overhead and depreciation costs;
- Consumables or administrative and technical assistance which the host institutions may be expected routinely to provide;
- External advisors (for example NGO's or consultants) working in LICs.

**Non-reimbursable costs** are:

- Costs of accommodation, with the exception of the expenses incurred in the short trips of supervisors or researchers directly related to the research (<3 months per trip).

**Programme activities**

The programme budget should include all costs necessary for carrying out the proposed programme, with the exception of costs already covered by the bench fee. For some budget headings, certain conditions or maximum amounts of funding are attached:

- Knowledge and research costs: max. € 14,000 on average per year for a full-time researcher;
- Overhead costs in LICs: max 8% of the total budget;

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<sup>4</sup> NWO-VSNU regulations are applicable for salary costs of post-doc and PhD researchers to be affiliated with an institution in the Netherlands. On a full-time basis the amounts (subject to change) are: for post-doc researchers: € 128,938 / 2 years; for senior researchers: € 90,300 / year (including final payment: 'EPV'). For researchers to be affiliated with institutes outside the Netherlands, national standards and regulations apply.

<sup>5</sup> Minimum standards for living costs of countries of residence have to be respected.

<sup>6</sup> A bench fee of max. € 5,000 (on a fulltime 4-year basis) is made available for each programme staff member engaged for at least one year. This is a contribution to the personal costs, for example tuition, courses, a desktop or laptop computer, conference visits, books, the publication of a thesis, etc.

- Specific activities to enhance knowledge sharing that do not require research: costs of joint activities and/ or the dissemination of results: min 5% and max 15% of the total budget;
- Budgets of approximately € 10,000 for the mid-term review and approximately € 30,000 for the final evaluation should be included in the proposal.

Please note that the maximal budget of € 800,000 includes the costs of the joint workshop to develop the full proposal mentioned in paragraph 3.5. Please contact the WOTRO office if you have any queries.

### 3.3 When can applications be submitted

Full proposals can be submitted until **1 September 2011, 12.00 CET**. The entire evaluation and selection procedure takes about 9 months and is split into two stages. It is compulsory to submit a preliminary application. For an overview of the procedure, please see paragraph 4.1.

### 3.4 Drawing up an application

Applicants are advised to write their applications for a broad audience: proposals should be clear and comprehensible for colleagues from different backgrounds.

All applications will be evaluated according to a fixed set of criteria: Scientific Quality, Relevance for Development and Quality of Collaboration. For a detailed overview of the criteria used to evaluate the preliminary proposals, please see paragraph 4.2.

For details regarding the application form, please see paragraph 6.1.

### 3.5 Specific conditions

Applications must fulfil the [General Terms and Conditions of NWO Grants](#) and *all* of the following formal criteria in order to be admitted to the competition:

#### Research partnerships

A proposal is directed by a coalition composed of a limited number of policy relevant, competent and credible partners. These are drawn from at least four different institutes comprising at least two from (one or more) LICs and at least two based in the Netherlands. Types of partner institutes that are eligible include those with an academic or public interest, such as universities, research institutes, think tanks, government departments, NGOs, etc. Relevant stakeholders in health policy and systems development and implementation from outside the scientific community (either government agencies, NGOs, private sector partners or consultants) should be represented in the research coalition. The research coalition representatives will steer the process of demand articulation, translate demands into relevant knowledge and research questions, coordinate and undertake high quality research, and support the application of new knowledge and insights. Apart from that, the research coalition will actively involve other stakeholders (as a second layer around the core group of research coalition partners) in identifying demands and setting

priorities, translating these into knowledge and research questions, advising on research, and applying new knowledge and insights.

One representative of a member institute of the research coalition, who is a senior researcher with a PhD degree, will be nominated as coordinator. This institute will take the responsibility of the programme secretariat, the day-to-day management and financial affairs. The coordinator represents the research coalition and will act as main applicant. He or she acts as the point of contact with NWO/ WOTRO.

### **Joint programme formulation**

The research programme and proposal development must be the result of a collaborative effort of all research partners and other relevant stakeholders involved. A stakeholder analysis (including relevant government agencies, the Royal Netherlands Embassies in the countries involved, as well as the private sector if relevant) should be part of the full proposal. Please see paragraph 6.4 for suggestions on how to perform a stakeholder analysis.

In addition, it is an obligatory part of the development of the full proposal to organise a multi-stakeholder workshop to enhance collaboration with and input of research partners and other stakeholders from LICs (such as policy makers or other policy environment experts). This workshop will preferably be held in (one of) the LIC concerned. A summary report of this workshop is required for the full proposal.

### **Eligible countries and alignment**

Eligible countries are those countries that are ranked as 'least developed countries' in the 2008 OECD/DAC list of ODA recipients. In addition, partner countries for Dutch development cooperation – listed in Table 1 of the Dutch Ministry of Foreign Affairs Policy Memorandum "Our common concern", dated 16 October 2007 – where development cooperation is not phased out over the next 4 years, are eligible to participate in the research programme. Please see 6.2 for a comprehensive list of eligible partner countries. If required to ensure adequate LIC research capacity, applicants may additionally include a maximum of one country not mentioned on this list. This should be clearly motivated in the proposal.

In order to be eligible for funding, research and research outcomes must benefit and strengthen the effectiveness of programmes in support of health improvement that are supported by Dutch development aid. The applicants should clearly explain the link between the proposed programme and health improvement programmes supported by Dutch development aid in their application.

In addition, applicants must provide documentation explaining the relation of the proposed programme with the health and/ or research policy of the country or countries concerned.

### **Transdisciplinarity**

The research proposed should be transdisciplinary to enhance effective use, the uptake of its results and the benefit it will have on policy and practice.

Transdisciplinarity is used here as meaning research that does not only cross disciplinary boundaries (and thus is interdisciplinary) but also involves knowledge from beyond the scientific community. It integrates scientific knowledge and extra-scientific knowledge, experience and practice in problem-solving and seeks to transform or improve the problem area by addressing its

full complexity. Thus, relevant stakeholders from outside the scientific community (for example NGOs, consultants, or others) should be engaged in all phases of the programme: from its inception to sharing emerging results.

### **Communication, Monitoring and Evaluation**

A communication plan directed at the uptake, translation and application of relevant research results, as well as research plans and progress, with stakeholders from outside traditional scientific communities must be part of the research programme. In addition, a results-based summary of a monitoring & evaluation plan is part of the full proposal.

The progress of the research programme will be checked against the envisioned work plan as described in the full proposal and the Communication and Monitoring & Evaluation Plan. Input, progress, outcome and impact will be monitored by means of a mid-term review – about two years after the start of the programme - and a final evaluation. The mid-term review should include an internal workshop of involved project parties organised by the main applicant, including a discussion of preliminary research results with stakeholders from outside the scientific community, resulting in a mid-term financial and progress report. A budget of approximately € 10,000 should be included in the proposal for this. The final evaluation will consist of an external evaluation organised by the main applicant in close coordination with the funding organisations in advance of submission of the final report and account. A budget of approximately €30,000 should be included in the proposal for that purpose.

Next to the formal criteria (above) to be allowed into the competition, applicants are advised to consider the issues below as well.

### **Thematic issues**

Within the research programme and especially within this second call for proposals, women of reproductive age deserve special attention as a target group. The sexual and reproductive health and rights of women and girls in relation to access to functional health systems are particularly important. Applications should clearly explain how the proposal will contribute to health policy and/ or health systems strengthening. Furthermore, applications should indicate how this health policy and health systems strengthening will contribute to reducing maternal mortality ratios and/ or improving maternal health, including enhancing equitable access to reproductive health services.

Please note that geographic priority is given to Africa (with a preference for Sub-Saharan Africa). In the first call for proposals of the GPHSR programme, research programmes in Ghana, Ethiopia, Rwanda and Uganda were awarded. In this second call, preference will be given to programmes in other countries.

Applicants to this second call are encouraged to include 'systems thinking' and synergy between the six building blocks of health systems that were identified by WHO. Proposals including community participation (including higher level CSO's) and scaling up small successful programmes are highly welcome. Especially health policy research (including comparative effectiveness) will be preferred. Furthermore, applicants are explicitly encouraged to incorporate issues such as global influences, leadership and (creative reflections on) governance, linkages between practice and policy, evidence-informed policy, or health information systems, into their proposal. Proposals clearly committed to translation of results into policy and/ or practice will be preferred.

Proposals submitted in this second call that already include networking activities among different research coalitions, or activities aimed at embedding the coalitions within global, north-south and south-south structures will be preferred.

The budget available for this second call will be used to award high-quality proposals meeting the above-mentioned preferences. However, in case a part of the available budget remains unspent, additional high quality proposals that only partially meet the above-mentioned preferences, but do provide significant added value (considering the scope of all proposals received and direct contribution of the additional proposals to the aims of the programme) could be awarded as well.

**Ethical aspects**

Applicants are advised to clearly explain the way in which they intend to deal fairly with ethical issues associated with the research proposed in their proposal.

**Start of the programme**

Please note that research awarded with a grant should start within three months after the granting date.

### 3.6 Submitting an application

The application should be made on the correct programme application form, be filled in completely, and must fulfil all criteria with respect to format, length of text, etc.

The application must be electronically submitted through the Iris account of the main applicant. The Iris system can be accessed on the NWO website ([www.iris.nwo.nl](http://www.iris.nwo.nl)). Iris will confirm the receipt of your application by email. In case of an LIC main applicant, please consult the Iris guidelines for LIC main applicants available on the programme website [www.nwo.nl/wotro/healthpolicyandsystems](http://www.nwo.nl/wotro/healthpolicyandsystems) (under 'documents').

All applications will be screened for compliance with the formal criteria as mentioned above and in paragraph 3.5. Applicants will receive written confirmation of receipt within two weeks after the submission deadline, stating whether the application has been accepted into the competition or not.

## 4 Assessment procedure

### 4.1 Procedure

The entire evaluation and selection procedure will take about 9 months and is split into two stages. It is compulsory to submit a preliminary application.

#### First stage

The preliminary applications were evaluated and ranked by the Programme Committee. All applicants were informed of the outcome of the preliminary selection procedure in writing. Applicants of the preliminary applications ranking highest were invited to elaborate their application into a full proposal. Invited applicants receive a financial contribution for organising the obligatory multi-stakeholder workshop to develop this full proposal in collaboration with research partners and other stakeholders from LICs.

#### Second stage

Each full proposal will be reviewed by two to four anonymous expert peer reviewers. These peer reviewers will be independent international researchers with recognised academic excellence in the fields covered by the application and with experience with policy and/ or practice in LICs. In addition, advice regarding the programme application will be sought from the Royal Netherlands Embassies in the countries of research. Research coalitions will have the opportunity to respond to the issues raised in the review reports.

The Programme Committee will evaluate and rank all full proposals based on the proposal, review reports, and the coalition's response to these review reports. The Steering Committee will take a final decision on funding, based on the recommendations received from the Programme Committee. All coalitions will be informed in writing of the outcome of the final selection procedure. The final funding decision will depend on the outcome of the budget negotiations with the coalition.

<b>First stage: preliminary application</b>	
Application forms for preliminary application available via the WOTRO website ( <a href="http://www.nwo.nl/wotro/grants">www.nwo.nl/wotro/grants</a> )	Early December 2010
Deadline for the submission of preliminary applications	<b>8 March 2011</b>
Evaluation and selection of preliminary applications by Programme Committee	April 2011
Invitation sent to selected applicants to submit full proposal. Application forms for full proposal available on <a href="http://www.nwo.nl/wotro/grants">www.nwo.nl/wotro/grants</a>	Early May 2011
Workshop and further joint elaboration of full proposal with LIC partners	May – August 2011

<b>Second stage: full application</b>	
Deadline for the submission of full proposals	<b>1 September 2011</b>
Peer review procedure	September - October 2011
Receipt of reviews, opportunity for response	End October 2011
Evaluation and selection of full proposals; applicants notified	December 2011
Check and formal determination of budgets for awarded programmes, formal letter of approval	December 2011

### **Appeals procedure**

If a research coalition objects to a decision taken by the Steering Committee, it can lodge a complaint with the NWO Appeals Committee. Any written appeal against a decision taken by the Steering Committee must be lodged within six weeks from the day on which the notice of this decision was sent.

## **4.2 Criteria**

All applications are evaluated according to a fixed set of criteria: Scientific Quality, Relevance for Development and Quality of Collaboration. Only high quality proposals (scoring excellent or very good for all three criteria) are eligible for awarding. The scores for Scientific Quality, Relevance for Development and Quality of Collaboration are equally important.

### **Evaluation criteria for full proposals**

#### I Scientific quality:

- Originality, including the novelty of the integrative approach;
- Adequacy and effectiveness of the approach, including the coherence of the research questions and the integration of disciplinary perspectives, data, methods and results;
- Feasibility, including the appropriateness and suitability of the methodology.

#### II Relevance for development:

- Quality in identifying problems and opportunities for strengthening health policy and/ or health systems related to attaining MDG 5;
- Extent to which the research questions and intended research results are aimed at and capable of providing answers to the identified development or societal problem/opportunity;
- Potential of getting research results into policy or practice.

#### III Quality of collaboration:

- Synergy and added value in the Dutch and international scientific and stakeholder collaboration, including potential for strengthening the scientific capacity of LICs;
- Synergy and added value in the national and international stakeholder collaboration, including the participation of NGO's and/ or consultancy organisations in the execution of research;
- Quality of communication, dissemination and implementation plan.

### **4.3 Composition of committees**

The Programme Committee is composed of approximately seven independent international senior experts, who will jointly assess and rank the proposals for selection.

Chaired by an independent high-level expert, the Steering Committee is composed of four high-level representatives from relevant international, bilateral or research organisations.

The Steering Committee is mandated by the WOTRO Board to decide on the awarding and financing of the research proposals, based on the recommendation of the Programme Committee.

The compositions of the Programme Committee and Steering Committee are published on the website [www.nwo.nl/wotro/healthpolicyandsystems](http://www.nwo.nl/wotro/healthpolicyandsystems).

# 5 Other information

## 5.1 Contact and information

WOTRO Science for Global Development

Website: [www.nwo.nl/wotro/healthpolicyandsystems](http://www.nwo.nl/wotro/healthpolicyandsystems)

For specific questions:

Phone +31 70 3440763

Email:

- General email address: [healthpolicyandsystems@nwo.nl](mailto:healthpolicyandsystems@nwo.nl)
- Ms Dr Eva Rijkers, [e.rijkers@nwo.nl](mailto:e.rijkers@nwo.nl) *Programme coordinator and academic secretary*
- Ms Lisette den Heijer, [l.denheijer@nwo.nl](mailto:l.denheijer@nwo.nl) *Programme secretary: General information and forms*
- Ms Leny Schröter, [c.schroter@nwo.nl](mailto:c.schroter@nwo.nl) *Financial controller: research budgets and accounting (available from 9.00–12:30 hrs on working days)*

*Postal address:*

- NWO–WOTRO
- PO Box 93120
- 2509 AC The Hague
- The Netherlands

*Visiting address:*

- NWO–WOTRO
- Laan van Nieuw Oost-Indië 300
- 2593 CE The Hague
- The Netherlands

# 6 Annexes

## 6.1 Instructions for application

### General remarks

The form must be completed in English, using the Arial 10 pt font. For some items on the form, a maximum number of words or pages are stated. Do not exceed this number and fill in the word count. Note that your application may be disqualified if you exceed the maximum number of words or pages stated. The application must be submitted in electronic form using the Iris system. The Iris system can be accessed on the NWO website ([www.iris.nwo.nl](http://www.iris.nwo.nl)). Please note that the application must be submitted through the Iris account of the main applicant of the research programme. Some additional remarks:

- The electronic application consists of two parts: a fact sheet and the full proposal application form. You can copy the requested information from your application form into the fact sheet when you submit the application via Iris;
- The fact sheet concerns the basic details of the applicant and the application. Note that the fact sheet can only contain plain ASCII characters and no formulas or layout formats can be used. These may be used in the application form;
- The completed application form should be uploaded in Iris as attachment to your application. *Note that a PDF format is required for this attachment.* If you do not know how to convert your completed application form from a Word file to PDF format then please allow extra time for obtaining help from your own computer support department or from the Iris helpdesk at NWO ([www.iris.nwo.nl](http://www.iris.nwo.nl));
- Iris will confirm the receipt of your application by email;
- During the evaluation of the applications, you may check the progress of the procedure via Iris;
- In case of an LIC main applicant, please consult the Iris guidelines for LIC main applicants (available from the programme website [www.nwo.nl/wotro/healthpolicyandsystems](http://www.nwo.nl/wotro/healthpolicyandsystems), under 'Documents').

Explanatory notes for each question on the application form are provided below (the numbers refer to the questions on the application form).

### Registration

A number of details presented in this section should also be completed/ copied in the application details for the Iris system. These are indicated on the fact sheet.

### 1 Programme

Please indicate:

- Which key theme is addressed by the research programme. Please indicate a priority if more than one theme is covered. Please explain the motivation for your choice in no more than 150 words;
- The number of subprojects that are part of the research programme (post-doc, senior researcher, PhD student);
- Programme duration (expressed in months);
- Country where the research will be carried out. If there is more than one country involved, all countries should be listed;

- Whether the proposal has been submitted elsewhere as well. If yes, specify where the proposal has been submitted, as well as the amount requested.

## 2 Title

The programme title must state the country or countries where the research will be carried out.

### 3a Research team: Applicants

Main applicant and co-applicant

- The main or co-applicant must be a senior researcher from a LIC. Please provide all the details requested;
- The co- or main applicant must be a senior researcher from the Netherlands. Please provide all the details requested;
- The main applicant will be the future programme coordinator. Main and co-applicant cannot be one of the proposed PhD or post-doc researchers (if any).

### 3b Research team: Other collaborators

Provide a list of all other collaborators involved in the Netherlands, LICs and other countries affiliated with the participating scientific institutes and key stakeholders' organisations. The list should include all the supervisors of the PhD students. Please provide all the details requested.

### 3c Research team: Researchers

If known, provide the requested details of the researchers involved responsible for carrying out the various project or programme tasks.

### 3d Research team: External advisors/ other experts

If applicable, provide the details of external advisors and other experts, neither of whom are affiliated with one of the involved institutes/ organisations.

## 4 Non-technical summary of the proposal

Provide a non-technical summary of your research proposal that will be easily understood by a broad, non-scientific audience (for example, interested newspaper readers). The summary should briefly describe the health policy or health system opportunity and/or problem addressed, the main objective(s), research question(s) and approach(es) and anticipated results in no more than 400 words. If your proposal is successful, this summary will be published on the WOTRO website. Please specify the number of words used.

## 5 Description of the programme

The description of the overall programme should not exceed the maximum of 2500 words. Please specify the number of words used.

### 5a Description: Rationale and background

Describe at least:

- the developmental opportunity and / or problem addressed;
- context of the opportunity and / or problem addressed: present a stakeholder analysis and describe how this is related to relevant international or local policy and/or research agendas;
- why and how the research links up to themes, challenges, debates or approaches;
- which research gaps are addressed and why existing knowledge/insights or current research efforts are insufficient;

- how the proposed research and research outcomes benefit and strengthen the effectiveness of programmes in support of health improvement that are supported by Dutch development aid;
- how ethical issues associated with the research proposed in the proposal will be dealt with.

#### **5b Description: Programme outline**

Please provide the hypothesis/research question(s) and methodology, as well as the main objectives and expected results. Specify and describe the main objectives, expected results for the scientific, developmental and collaborative perspectives and indicate how the anticipated outcomes will have potential for impact on academic debates, development policy or practice and knowledge and scientific capacity development. Note that Section 11 - the keyword summary - must reflect the information presented in this Section and vice versa. A careful tuning of the programme description with the keyword summary may enhance the clarity and conciseness of the programme.

#### **5c Description: Interdisciplinarity and integration**

Please describe the interdisciplinary and integrative approaches in terms of e.g. central concept or frame used, how the research stands together as a coherent whole, which and how perspectives are woven together and disciplinary insights are intertwined. Include the methodological aspects of integration of research activities and results.

#### **5d Description: Innovative aspects**

Please indicate the innovative aspects of the programme, e.g. idea, approach, methods used. Both the scientific and the developmental perspective should be addressed.

#### **6. Description of the sub-projects**

Please present the details for each of the research projects to be carried out by senior researchers within the programme: title of the project, name(s) of (main) supervisor(s), name and titles of the researcher (if known), and a brief description of each project. The description of each the projects should not exceed the maximum of 500 words. Please specify the number of words used.

#### **7 Time table**

Provide a detailed work plan and time schedule of the programme. Project and overall programme activities, e.g. approaches for achieving the objectives, milestones concerning communication, monitoring, publication or production of scientific and non-scientific output and dissemination, must be included. Assure cross reference with the keyword summary and communication plan (Section 11 and 12).

This Section should not exceed the maximum of 1 page A4.

#### **8 Partnership and track record**

This Section should not exceed the maximum of 4 pages A4.

#### **8a Partnership: previous collaboration**

Provide details on previous collaboration between all scientific and non-scientific stakeholders.

**8b Partnership: workshop**

Include a one A4 page summary of the objectives, results and conclusions of the workshop organised to elaborate the preliminary application into a full proposal. Details should be annexed to the application (max. 2 pages A4). Provide a list of participating institutes or organisations by filling in the table provided in the form. If applicable, specify the future involvement with the programme of these stakeholders.

**8c Partnership**

Explain the role and specific contribution of each of the collaborators listed in Section 3, also in terms of complementarities. Describe the arrangements put in place to ensure that collaboration with partners is effective and sustainable.

**8d Partnership: recent publications**

You may include a maximum of 5 recent relevant publications for each of the research groups and collaborators' organisations. Include whenever possible joint publications. For scientific manuscripts only refer to those that have been accepted for publication or that have already been published in recognised scientific literature. Please provide the following details in full: author(s), year, title, journal or series in which the publication appeared, volume, pages, and (if applicable) publisher and place.

Section 8d should not exceed the maximum length of 1 page A4.

**8e Partnership: NWO research funding**

Include references to current or past NWO funded research.

**9 Management and Monitoring & Evaluation**

Please describe how the programme will be managed. Explain agreements made regarding financial arrangements between (the institute of) the main applicant and (the institutes of) the co-applicant and other collaborators. In addition, please provide a result-based summary of how the monitoring and evaluation of the progress against the objectives and anticipated results will be ensured. This Section should not exceed the maximum 500 words.

**10 Literature references**

The reference list should have a maximum length of 2 pages A4. Provide the following details in full: author(s), year, title, journal or series in which the publication appeared, volume, pages, and (if applicable) publisher and place.

**11 Keyword summary**

This section has changed since the call for preliminary proposals. It is now aligned with the overall aims of the programme, to allow for easier measurement of the contribution of the research programme to the overall programme aims, if funded. The current format allows for clear use of the keyword summary as planning, monitoring and evaluation tool. Please see paragraph 6.4 for suggestions on how to use the workshop to develop this logical framework.

Please specify the overall objective of the programme. Please specify one specific objective and up to three results for each of the following three aims: a. Contribute to better health by conducting research aiming at strengthening health systems in LICs; b. Strengthen research capacity in LICs; and c. Strengthen collaboration in the Dutch research and knowledge community in order to enhance utilisation of Dutch research capacity (under the item 'Brief

Narrative Summary'). Experience has shown that focussing on one objective per perspective improves the conciseness and focus of the logframe. However, one additional specific objective per perspective is allowed if needed (in that case, please copy and paste the row).

For each specific objective and result, please provide indicators, means of verification and assumptions. In addition, please specify the main programme activities aimed at each of the results.

#### **11a Contribute to better health by conducting research aiming at strengthening health systems in LICs**

What is the programme meant to accomplish with regard to research for LIC health systems strengthening? Please indicate the specific objective of the programme. Indicate a maximum of three expected main results (e.g. insights, new theories/ paradigms, knowledge, changes in policy/ practice) aimed at research relevant for LIC health system strengthening. For each of the results, indicators, means of verification and assumptions should be mentioned. In addition, please indicate main activities aimed at these results.

#### **11b Strengthen research capacity in LICs**

What is the programme meant to accomplish with regard to LIC research capacity strengthening? Please indicate the specific objective of the programme. Indicate a maximum of three expected main results appropriate for the programme's specific capacity strengthening objectives. For each of the results, indicators, means of verification and assumptions should be mentioned. In addition, please indicate main activities aimed at these results.

#### **11c Strengthen collaboration in the Dutch research and knowledge community in order to enhance utilisation of Dutch research capacity**

What is the programme meant to accomplish with regard to collaboration and enhanced utilisation of Dutch capacity? Please indicate the specific objective of the programme. Indicate a maximum of three expected main results (e.g. networking or joint activities) appropriate for the programme's specific objective. The results should be aimed at effective and sustainable scientific and scientific/non-scientific partnerships. For each of the results, indicators, means of verification and assumptions should be mentioned. In addition, please indicate main activities aimed at these results.

Section 11 should not exceed the maximum of 4 pages A4.

### **12 Communication, dissemination and implementation plan**

Please present a summary of the communication, dissemination and implementation plan. Indicate target groups, communication objectives, which research products, outputs and other research issues will be communicated, and how these products will be communicated using which means of communication. The communication objectives should contribute to the programme's specific objectives (and consequently, also to the overall objective) identified in the keyword summary.

Please refer to:

- Key stakeholders: the scientific and non-scientific collaborators, targeted users, beneficiaries or other stakeholders who are directly involved to use or take the results to further stages in getting the research into practice and policy.

- International research collaboration: intended communication with communities, networks and platforms who would be interested in linking up with the research partners.
- Scientific output: the anticipated results in terms of publications and other output, as well as enhanced scientific capacity and skills.
- Broader public: target beneficiaries or audience who could benefit from or would be interested in being informed on the research activities, progress and results.

This Section should not exceed the maximum of 2 pages A4.

### **13 Funds requested from WOTRO**

Please consult paragraph 3.2 of the brochure before completing this section. Please note that 50% of the budget will need to be spent in LICs (activities, infrastructure and/ or researchers from LICs). Please indicate the percentage of the budget spent in LICs where requested. Specify the budget items as detailed as possible and present details on the calculations (e.g. price per unit, number, frequency). Please note the restrictions and certain maximum amounts that apply to the WOTRO contribution to the total programme costs (indicated in paragraph 3.2 of the brochure).

#### **13a Overall budget**

Please provide a summary of the total budget by providing an overview of the totals from the itemised detailed budget as requested below.

#### **13b Detailed budget personnel**

List the funds requested from WOTRO. Provide a detailed itemised and reasoned budget.

I Costs of temporal employees at a Dutch institution:

Note the total number of f.t.e. of researchers to be affiliated as temporary employee at a Dutch institute.

II Allowances for LIC researchers:

Specify the costs of support for LIC researchers to be provided with a living allowance (net grant). The number of months per year to be spent in the Netherlands and in the LIC must be specified.

#### **13c Knowledge and research costs**

Present estimations of the research costs per year and list the budget items according to the following budget lines: travelling costs (including plane tickets for researcher and supervisor(s), travel in the field/the Netherlands and costs of accommodation and travel for short visits); durables (research equipment); consumables, research assistance and training for LIC researchers.

#### **13d Costs of joint activities and dissemination**

Present an overview of the costs of the joint programme activities, including the cost of coordinating and integrating the (scientific and non-scientific) participants' contributions to the programme, costs of contributing to relevant communication and network platforms, the costs of dissemination and transfer of knowledge, and the mid-term review and final evaluation. This budget should amount to min. 5% and max. 15% of the total budget.

**13e Overhead in LICs**

Please specify overhead costs in LICs if needed (max. 8% of the total budget). List the budget items according to the following budget lines: office space, basic facilities, overheads, depreciation costs; administrative assistance; external advisors in LIC. Please note that overhead costs in countries not mentioned in paragraph 6.2 are not eligible for reimbursement.

**13f Additional financial sources**

If the research funding required exceeds the maximum contribution from WOTRO, the additional sources and the amount should be indicated. Note that guarantees in writing must be sent along with the application.

**14 Explanation of the requested budget**

Please provide a brief explanation of the requested budget, covering the main budget items.

This Section should not exceed the maximum of 400 words.

**Annexes**

Please provide a list with the details of the following mandatory annexes:

- Letters of support from scientific/non-scientific collaborators;
- Explanation of the relation of the proposed programme with the health and/or research policy of the country or countries concerned (max. 2 pages A4);
- Financial guarantees from other organisations (if applicable);
- Workshop report (max. 2 pages A4).

Note that no other annexes are allowed.

*Signature*

The application must be signed by the main applicant, the co-applicant and the main collaborators (promoters, main supervisors, key stakeholders). Faxed, electronic or scanned signatures are accepted.

**6.2 Eligible partner countries**

Eligible partner LICs are the countries that are ranked 'least developed countries' in the 2008 OECD/ DAC list of ODA recipients, and partner countries for Dutch development cooperation where development cooperation is not phased out over the next four years (as mentioned in table 1 of the policy memorandum 'Our common concern', dated 16<sup>th</sup> October 2007). If required to ensure adequate Southern research capacity, applicants may additionally include a maximum of one country not mentioned on this list. This should be clearly motivated in the proposal.

Please note that geographic priority is given to Africa (with a preference for Sub-Saharan Africa). In the first call for proposals of the GPHSR programme, research programmes in Ghana, Ethiopia, Rwanda and Uganda were awarded. In this second call, preference will be given to programmes in other countries.

**List of eligible partner countries for the Global Health Systems and Health Policy Research Programme**

Afghanistan	Madagascar
Angola	Malawi

Bangladesh	Maldives
Benin	Mali
Bhutan	Mauritania
Bolivia	Moldava
Burkina Faso	Mongolia
Burundi	Mozambique
Cambodia	Myanmar
Cape Verde	Nepal
Central African Rep.	Nicaragua
Chad	Niger
Colombia	Pakistan
Comoros	Palestinian Territories
Congo, Dem. Rep.	Rwanda
Djibouti	Samoa
Egypt	Sao Tome and Principe
Equatorial Guinea	Senegal
Eritrea	Sierra Leone
Ethiopia	Solomon Islands
Gambia	Somalia
Georgia	South Africa
Ghana	Sudan
Guatemala	Suriname
Guinea	Tanzania
Guinea-Bissau	Timor-Leste
Haiti	Togo
Indonesia	Tuvalu
Kenya	Uganda
Kiribati	Vanuatu
Kosovo SC Res.1244	Vietnam
Laos	Yemen
Lesotho	Zambia
Liberia	

### 6.3 Description of programme background and themes

#### Global health: today's challenges

In the past 50 years there have been marked improvements in global health, and life expectancy at birth has increased by almost 20 years in this period. However, at the same time there is disturbing evidence of widening gaps in health worldwide as, particularly in sub-Saharan Africa, the price of continuing poverty and conflict can be seen in stagnating and even deteriorating health indicators. Overall, 35% of African children are at higher risk of death than they were 15 years ago. The main causes are depressingly recognizable: the perinatal conditions closely associated with poverty; malnutrition; diarrhoeal diseases; pneumonia and other respiratory tract diseases; and malaria. Those who make it past childhood are confronted with adult death rates that exceed those of 35 years ago. Life expectancy, always shorter here than almost anywhere else, is shrinking. In some African countries, it has been cut by 20 years mostly as a result of the HIV/AIDS pandemic, which is now the world's leading cause of death in adults aged 15-59 years. In addition, for women of reproductive age, complications during pregnancy and childbirth still lead to unacceptably high maternal mortality ratios and disability. Simultaneously, an

increase in mortality due to non-communicable diseases such as cardio-vascular diseases and cancers is occurring for men and women, adding to the daunting challenges already facing many low-income countries, the so-called double disease burden. Not only between countries, but also within countries health inequities between poor and rich populations, between urban and rural populations are persisting and have even been growing. This phenomenon is occurring in many countries worldwide, albeit at different levels and with different magnitudes.

There is a growing recognition that health is central to the global agenda of reducing poverty as well as an important measure of human well-being. The WHO Commission on Macroeconomics and Health (CMH) made a strong case for investment in health, and health is at the heart of the United Nations Millennium Development Goals (MDGs), adopted in 2000. Health is represented in three of the eight goals: MDG 4 on reduction of child mortality, MDG 5 on improving maternal health and MDG 6 on combating HIV/AIDS, tuberculosis and malaria. Importantly, these goals focus on problems which disproportionately affect the poor. In addition, health makes an acknowledged contribution to the achievement of the other MDGs, in particular those related to the eradication of extreme poverty and hunger, education, environmental sustainability (water and sanitation) and gender equality.

Two thirds of the way towards to the benchmark year of 2015 there now are serious concerns about the rate of progress towards these goals and even doubts about their ultimate attainability. Several reports and initiatives identify a common cause: progress is greatly hampered by weak, poorly functioning or in some cases non-existent health systems. While many of the necessary medical techniques and procedures are known, health system barriers are the principle barriers to scaling-up of critical health services and to achieving public health goals. For example, were it possible to ensure that all pregnant women accessed and complied with effective antenatal care and delivery services, then maternal mortality would fall sharply.

In conclusion, the grand challenge in the field of global health is to establish equitable, accessible and quality health systems that are able to provide cost-effective health promotion, disease prevention, curative and rehabilitative services responsive to real health needs. These health systems should be tailor-made for local circumstances and at the same time be flexible to external influences.

### **Health system barriers and strengthening health systems**

WHO defines a health system as encompassing all the organizations, institutions and resources that are devoted to producing health actions whose primary intent is to improve health. The universal objectives of a health system are to improve population health and to prevent and control disease, while also responding to people's expectations and offering financial protection.

The most concrete manifestation of the health system is usually the pyramid of government funded health facilities in a country. While this is clearly one aspect of the health system, health systems also comprise public health laws and regulations, financing mechanisms such as social health insurance and user fee schemes, the actions taken by households and communities to promote health, and of course the often substantial private health sector composed of both formal and informal providers.

The WHO 'Framework for Action' (2007) on health systems further identifies six building blocks of health systems:

- *Service delivery* – addressing how services are organized and managed, to ensure access, quality, safety and continuity of care across health conditions, across health facilities and over time.
- *Information and evidence* – the generation and strategic use of information, evidence and research on health and health systems in order to strengthen management, leadership and performance.
- *Medical products and technologies* – ensuring equitable access to essential medical products and technologies of assured quality, safety, efficacy and cost-effectiveness, and their scientifically sound and cost-effective use.
- *Health workforce* – managing dynamic labour markets, to address entry into and exits from the health workforce and improve the distribution and performance of existing health workers.
- *Health financing* – raising adequate funds for health in ways that ensure people can use needed services and are protected from financial catastrophe or impoverishment associated with having to pay for them.
- *Leadership and governance* – ensuring that strategic policy frameworks exist and are combined with effective oversight, coalition-building, regulation, attention to health-system design issues and promotion of accountability in order to protect the public interest in health.

WHO identifies three 'grand challenges' that must be tackled across these building blocks in order to improve the performance of health systems: 1) ensuring that safe, proven, and affordable interventions reach those in need; 2) improving the distribution of health services and ensuring that achieving the MDG targets does not widen the equity gap; and 3) protection and safety in relation to the quality and cost of receiving care.

Health systems strengthening interventions are those that address barriers and constraints at different levels of the health system including the private sector. At the central level, a common barrier is low priority for health as measured by a low proportion of GDP spent on health. Within central Ministries of Health, inadequate health worker salaries or constraints linked to inflexible administrative structures can prevent the retention and motivation of qualified staff. Among regional or local health management, resource barriers such as irregular cash flow or shortages of qualified staff weaken the performance of the health system. At all levels political constraints to prioritize health care for the poor may equally be at play. At the facility level, health workers might not know clinical guidelines or simply fail to put them into practice because of perverse incentives within the organisational or financing system. Households might not routinely seek preventive care because they do not see its value or low quality services prevent them from seeking care. They might also utilize practitioners that do not adhere to minimum standards.

In summary, there are multiple systemic barriers that prevent health systems worldwide from reaching their goals and potential. In most African countries these barriers are particularly grave, among which very low levels of financial, infrastructural, human and material resources, and historically weak governance and accountability structures. At the same time there is large potential for improvement as the continent has the highest external resource flows, and there are numerous local and (inter)national health system development initiatives aiming to strengthen health systems and collaboration. Unfortunately, remarkably little is known about how best to address health system constraints

through effective and efficient interventions. The key questions concern how best to approach strengthening, and what specific types of action or reforms are appropriate to specific types of settings. Health policy and systems research can help to provide answers.

### **The domain of health policy and health systems research**

*Health policy and systems research* is defined broadly as the production of new knowledge to improve how societies organize themselves to achieve health goals. The prime focus of health policy and systems research is the health system as a whole, and *health systems research* addresses any or several of the six building blocks of health systems with the ultimate objective to promote the coverage, quality, efficiency and equity of health systems. *Health policy* research is concerned with understanding how different actors interact in the policy process to contribute to national health outcomes.

Health policy and system research can sometimes adopt a disease or service-specific focus as sometimes specific diseases or services can, alone, raise major challenges for the health system. For example, several health systems research studies have addressed the scaling up of antiretroviral therapy which entails significant health system demands.

Another complementary approach to understanding the field of health policy and health systems research is to consider the unit of analysis. Health policy and systems research focuses primarily upon the more downstream aspects of health care: it focuses upon policies, organizations and programs, and needs to take into account countries' political and social structures, and the heterogeneity of health system structures. Health policy and health systems research does not address basic human biology, medical/clinical - or pharmaceutical research.

### **Global health policy and health systems research: the international context**

The past 15 years have seen new international scientific collaboration initiatives and increased political commitment in health policy and health systems research, which is triggered by the increasing realization that without adequate health and research systems it is impossible to achieve sustainable improvements in health. Among the most important international initiatives are the UN/ World Bank/ WHO program on research for Diseases of Poverty (TDR), the Council on Health Research and Development (COHRED), the Global Forum for Health Research (GFHR) and the Alliance for Health Policy and Systems Research. A common concern of these initiatives is the need to strengthen health research and research capacities in LICs, with particular emphasis on Africa. This is urgent due to the so-called "10-90" gap, which acknowledges that far too small a proportion of scientific research is addressed to the health needs and conditions of a large majority of people and countries.

At the political level, the Ministerial Summit in Mexico in 2004 discussed the critical role of knowledge in strengthening health systems. The Ministers of Health stressed in the *Mexico Statement on Health Research* that strong national health systems are needed to deliver health care interventions, amongst others to achieve the health-related MDGs, and to improve health and health equity in general. They also acknowledged that "research has a crucial but under-recognized part to play in strengthening health systems, improving the equitable distribution of high quality health services, and advancing human development". The World Health Assembly adopted the Ministerial Statement

as resolution WHA 58.34, in 2005 and recommended an international programme on health systems research and a search for more effective mechanisms to bridge the production and use of knowledge (the “know-do-gap”).

At the Mexico Summit, the WHO convened Task Force on Health Systems Research identified 12 broad topic areas as priorities for primary research and systematic reviews, summarized under 4 main headings. These are: 1) *Financial and human resources*: community-based financing and national health insurance, and human resources for health at the district and national levels; 2) *Organization and delivery of health services*: community involvement, equitable, effective, and efficient health care, approaches to the organization of health services, and drug and diagnostic policies; 3) *Governance, stewardship, and knowledge management*: governance and accountability, health information systems, priority setting and evidence-informed policy-making, effective approaches for intersectoral engagement in health; and 4) *Global influences*: effect of global initiatives and policies (including trade, donors, international agencies) on health systems. The 2008 Global Ministerial Forum on Research for Health in Bamako – Mali focused on the need for health research to be more closely linked with ongoing developments in science, technology and innovation, with research on social determinants of health, and with the broader research community. Particular attention was paid to strengthening the research capacity in Africa, through joint efforts of Ministries of Health and Ministries of Research (Science, Technology, Innovation).

#### **Global health policy and health systems research: the Dutch policy agenda**

The Dutch contribution to global health is strongly related to the MDG agenda. In 2007, the “*Cabinet Agenda 2015: realization of the MDGs*” called for increased governmental and societal efforts to foster progress towards achieving the MDGs and to stimulate *pro-poor* growth. The Cabinet commits to increasing the scope (up-scaling) and effectiveness of interventions aiming to reduce maternal and child deaths (MDGs 4 and 5), and to better aligning of horizontal and vertical initiatives with a priority to strengthening health systems as a whole – public, private and civil initiatives – (MDG 6). In the subsequent 2007 policy memorandum “*Our Common Concern: investing in development in a changing world*” the government of the Netherlands is opting for a more politically oriented development aid focused on equity and better accessibility to essential services, including health care. In this policy letter, the government announces greater emphasis on growth and equity, which includes attention to cash transfer to the poor populations and strengthening health insurance initiatives, increased policy focus on the problems of MDG achievement in fragile states, and special attention to equal rights and opportunities for women, and sexual and reproductive health and rights (MDG 3 & 5).

Policy guidance on global health policy and health systems research is formulated by the Netherlands Organization for Scientific Research (NWO) / ‘Science for Global Development’ (WOTRO), in close consultation with the stakeholder community in the Netherlands and overseas. In line with the global agenda, the “*Science for International Development. WOTRO 2007-2010 Strategy Plan*” encourages the enhancement of international (North-South) research partnerships to strengthen the local scientific capacity. In addition, WOTRO aims to re-focus the scientific community in the Netherlands on the MDG-related problems. This is relevant as the health systems research capacity in the Netherlands has an excellent international scientific reputation, but it is rather scattered and mainly employed towards health systems problems in the

Netherlands. The strategy also identifies global health and health systems as one of the 4 focus themes, where WOTRO encourages studies aimed at improving the quality of health systems of LICs. Three perspectives are mentioned as a guidance for health policy and health systems research.

*Innovative approaches to improve access*

While extensive research has been conducted to describe social, cultural and economic barriers to and constraints on the effectiveness of health strategies, this has not led to sufficiently improved access to or performance of health systems. Therefore, research should move beyond description to analysis and intervention. WOTRO wishes to stimulate research that builds on existing knowledge, and leads to innovative approaches to improve the quality of health services as well as access to them.

*Innovative and applicable tools and assets*

The sustainable implementation of health programmes may also call for new or adjusted tools. Interventions exist for most health problems, including those that especially burden developing countries. But for some there still is a lack of affordable, culturally acceptable and safely applicable interventions, strategies, diagnostics or other assets. WOTRO pays special attention to the application of these approaches in finding solutions to health problems that specifically affect LICs.

*Global context*

Global processes, policies and strategies are increasingly influencing national health systems in LICs. This means that health improvements in LICs cannot be achieved without understanding the relationship between global policies and national or regional policies, between traditional and western health care, and between public and private health care systems. WOTRO considers research addressing these relationships important.

**Research Program**

The trends and domain described, combined with the international and Dutch agenda on global health policy and health systems research, are translated into the following three goals for the research programme, which are to:

- support to better health by conducting research aiming to strengthening health systems in LICs;
- support to strengthening the research capacity in LICs;
- support to strengthening collaboration in the Dutch research and knowledge community in order to enhance utilization of the Dutch research capacity in LICs.

The research program gives priority to health policy and health systems research which demonstrates how health systems can be improved, and practically how improved health systems can contribute to reaching the MDGs. Given the potentially large impact on poverty reduction and health-related MDGs, special attention in the research deserves the target group of women of reproductive age, in particular the sexual and reproductive health and rights of women and girls in relation to access to functional health services. Geographic priority is given to Africa, although not restricted to.

The *central strategic challenge* of the research programme is contributing to enhancing equitable access to health in quality health systems. This includes the following inter-linked and mutually dependent key themes, which are:

1. Organization and delivery of essential and quality health services
2. Financial and human resources
3. Governance and decision-making
4. Global influences and their impact on national health systems.

### **Strategic research theme: equitable access to quality health systems**

There is a long history of concern about the degree to which health systems meet the needs of different social groups. At the international level this concern was expressed in the "primary health care" concept formulated in Alma Ata (1978) and more particularly in its subsequent "health for all" strategy adopted by the World Health Assembly in 1981. A number of LICs have achieved substantial health improvements by ensuring that people have access to affordable and effective basic health services, but interest in this issue waned for a time. Nowadays, the issue of equitable access has risen to the top of the international development agenda with the return of poverty reduction and the global recognition that health systems in many countries, particularly in LICs, are far from achieving reasonable levels of access to essential health care. Basic health services intended for and traditionally believed to be reaching the poor are in fact not doing so, which suggests that inequitable access produces systematic differences between population groups in the use, experience and outcomes of health care.

Research into equitable access can, in an integrated way, identify the presence of major health disparities, help to create understanding of the underlying causes and provide potential solutions to be tested, verified and scaled up. So far, with a few notable exceptions, there has been insufficient systematic empirical work directed to the measurement of improving equitable access to services, and to the evaluation of policies aimed at promoting equitable access. Studies claiming to evaluate access are usually conducted in high-income countries and are focusing often on utilization rather than on access or (any of) its dimensions: availability, affordability and acceptability.

The research challenge is to show how the extensive knowledge on effective tools and efficient organization for prevention, management and control of disease can be integrated and synthesized into the societal goal of comprehensive and essential quality health services that are addressing the major health problems and that are accessible to all, which inherently means raising the accessibility of poor and vulnerable groups. Related to the target group of women of reproductive age, the research challenge is to illuminate how expanding access to sexual and reproductive health services (incl. information) contributes to reducing poverty and improving equitable growth, and how this can be achieved.

### **Key theme 1: organization and delivery of essential and quality health services**

In most countries, achieving the health-related MDGs will require a dramatic expansion in the delivery and coverage of essential and quality health services, which includes: public health, health promotion and (population-based) prevention programmes and services, and appropriate physical and mental care, cure and rehabilitation for the local population. The obstacles to increasing coverage of essential and quality health care are fairly well known and exist at all levels. What remains missing from the evidence base is the knowledge on how to make interventions aimed at improving coverage and accessibility to essential health services work in practice. There is a very weak research and evidence-base about what strategies, approaches, performance incentives, organizational changes and institutional arrangements work and what do not

work, particularly in LICs, and in which way the community can be involved and healthy behaviour be promoted (including policy measures of both supply- and demand-financing). The consequence is that policy-makers and managers are often unable to make informed decisions.

The research challenge here is to show in which way essential and quality health services identified in the local context, for example through clinical and organizational audits, can achieve higher coverage and accessibility through effective and efficient implementation, and how this will benefit the general population and different societal groups, most notably the poor, women, children, people in remote areas and slum dwellers.

## **Key theme 2: financial and human resources**

### *Sustainable and equitable financing*

Current health system funding is grossly inadequate to strengthen health systems: most governments do not allocate an adequate portion of government spending to their health systems and donor funds in developing countries are often erratic, disorganized and opaque. However, the disadvantages of a financing system based largely on out-of-pocket payments are well-known, as there is growing evidence that some households (even middle-income ones) slide into poverty when faced with health care payments, especially when combined with the loss of income due to ill-health. In addition, illness-related costs diminish the likelihood that already-poor families will be able to move out of poverty. Mitigation of the income-erosion effect of illness is thus an essential pre-requisite for alleviation of poverty, especially for the poorest households in low-income countries.

Under these circumstances it is necessary for policy- and decision-makers to redefine what sustainable financing means, and how this can be strengthened. Important choices will need to be made in relation to, for example, the desired balance of public, private (incl. out-of-pocket) and other financial sources (including fiscal space and other macro-economic options and constraints), the design and organization (public, private, civil) of pre-financing mechanisms in relation to risk protection and risk pooling, and strategies to measure and increase the efficiency and equity of current expenditures. Different types of intervention are suggested for meeting the health care needs of the poor and for contributing to achieve the MDGs such as: universal coverage, cash transfers, voucher systems, exemption, community-based insurance, and other strategies such as contracting out services to the private or NGO sector. Integrated models of health insurance and social protection measures combined with economic resources and capability development typical of microcredit programmes are also being tested. However, there is little evidence of the impact of these interventions on accessibility, quality and utilization of health services, as well as on promoting equity and the health of the poor. Additional research is needed in these areas, which could support designing evidence-informed program set-up involving among others in-depth studies of the many barriers faced by the poorest households, under different schemes, when they need medical care.

In addition, there is a large gap between plans and implementation. Financial barriers are key, as existing evidence indicates that providing health services for the poorest is more expensive than the average cost in any population due to a number of reasons such as the cost of targeting, varied service needs and acceptable quality of care to attract people for service use. Poor planning and

implementation capacities, as well as vulnerability to external risks, are other important constraints. There is a role for intervention and implementation research to test innovative approaches – among which effective risk mitigation strategies – aiming to improve the coverage, quality and the impact of those schemes. This would include research into the fiscal and budget constraints of public institutions charged with responsibilities for such schemes.

#### *Adequate human resources*

Human resources for health are central to delivering and managing health services, and for achieving health gains and the MDGs. Yet human resources are in crisis in many LICs, particularly across Africa. Several forces are responsible for this situation: increasing disease burdens in poorer countries ('double burden of disease'); accelerating migration of doctors and nurses from countries already suffering chronic labour shortages; and the legacy of chronic under-investment in human resources. Evidence indicates that more effective management, including that of human resources, is essential to mitigate the impact of these forces and thus strengthen health system performance. Insufficient understanding exists on a number of important factors related to the functioning of labour markets in health care and human resource management. Research is needed to develop, monitor and evaluate evidence-based human resource interventions aimed at improving working conditions in LICs, and at developing and retaining an effective and quality workforce to deliver health services at the community, local, district and country levels.

### **Key theme 3: governance, stewardship and decision-making**

For many countries the governance and stewardship will be a key factor in balancing sustainability against short-term crises. Response to this challenge in LICs will likely shape the equity and efficiency of health care systems for decades to come, and will thus contribute to MDG-achievement. However, research has suggested that weak governance and poor accountability are surprisingly widespread in many health sectors. In many countries this seriously undermines the performance of health systems. One of the most important constraints is the crippling effect of corruption and power imbalances on health sector performance, as this affects mostly the weak health systems in LICs and hits the poor population hardest. Other main related barriers and constraints facing health systems worldwide are, for example, poor priority-setting and policy-making, poor monitoring, auditing and information systems, weak education and research structures, and the availability and use of unsafe diagnostics, therapies and medicines, including all the challenges in the pharmaceutical and medical technology sub-sectors.

Health policy and health systems research can play an important role in supporting policy- and decision-makers to design and implement effective and efficient health system governance and accountability structures by analysing the way in which the health system is legally and practically organized (incl. public-private mix) and guided by the most important agencies (stewardship), how different health-sector entities are governed, which types of accountability (financial, performance and democratic) are applied in the health system, and which types of strategies and best-practices may best be employed to improve governance and accountability. By so doing, the research challenge is to determine the impact of these governance and accountability structures on the accessibility, utilization, quality and safety of local health services in both public and private sectors, and to practically show how the application of better governance and accountability mechanisms can promote intersectoral and

community engagement in health and improve the overall health system's performance.

#### **Key theme 4: global influences and their impact on local health systems**

Achieving good health has become an accepted international goal, and this goal increasingly depends on the process of globalization: as the geographic scale of important communicable and non-communicable health issues increases, countries and their health systems are progressively dependent on each other in establishing good health and reaching the MDGs. Global factors are also increasingly impinging on national health policies and systems. Among the most important factors are: 1) the policies of international health agencies and development banks, large donors and international programs such as the Global Fund for AIDS, Tuberculosis and Malaria; and 2) international trade agreements, trade relations and the role of industry.

In relation to the first factor, the research challenge is to contribute to understanding the impact of funders' policies, large international programs and health sector development projects on country-level health systems, in terms of agenda- and priority-setting, resource planning and utilization, and how horizontal and vertical programming by donors and local governments can be deployed best at country level to improve health and create sustainable health systems.

In relation to the second factor, the impact of trade relations & trade agreements on health systems needs further research, particularly where it relates to trade in drugs and trade in health services. In addition, the role of the health industry in the sponsorship of research, continuing medical education activities, and its marketing and advertising programmes in LICs will need to be assessed. The research challenge is to show how trade agreements and the role of the industry influence accessibility, quality and utilization of health services and products, and which strategies can be implemented to create win-win situations by making best use of the capacities and resources of commercial firms while addressing the obvious negative effects.

#### **Literature**

Cabinet agenda 2015: realising the millenium development goals. Dutch Ministry of Foreign Affairs. The Hague, June 2007.

Global forum update on research for health volume 3: combating disease and promoting health. Global Forum for Health Research. Geneva, 2006.

Global forum update on research for health volume 4: equitable access: research challenges for health in developing countries. Global Forum for Health Research. Geneva, 2007.

Health and the millenium development goals. WHO. Geneva, 2007.

Health system strengthening interventions: Making the case for impact evaluation. Alliance for Health Policy and Systems Research, briefing note 2. Geneva, June 2007.

Our common concern, investing in development in a changing world; policy letter to the House of Representatives. Ministry of Foreign Affairs of the Netherlands. The Hague, 16 October 2007.

Population health through health systems strengthening – the domain of international health policy and health systems research – round table consensus. Temporary Expert Working Group of Universities & Knowledge Institutes, Civil Society Agencies, and Ministries in the Netherlands. The Hague, May 2007 (unpublished document).

Report from the ministerial summit on health research 2004; identify challenges, inform actions, correct inequities. WHO, 2004.  
Science for international development. WOTRO 2007-2010 strategy plan. Netherlands Organisation for Scientific Research. The Hague, June 2006.  
Strengthening health systems: the role and promise of policy and systems research. Alliance for Health Policy and Systems Research. Geneva, 2004.  
The millenium development goals will not be attained without new research addressing health system constraints to delivering effective interventions. Report of the Task Force on Health Systems Research. WHO, March 2005.  
What is health policy and systems research and why does it matter? Alliance for Health Policy and Systems Research; Briefing note 1. Geneva, June 2007.  
World health report 2003 – shaping the future. WHO. Geneva, 2003.  
World health report 2007 – a safer future. WHO. Geneva, 2007.

## 6.4 Suggestions for a participatory workshop

### Introduction

The present “Suggestions for a participatory workshop” aim to support applicants who were invited by WOTRO to submit a full proposal for one of the WOTRO grants.

WOTRO gives the applicants the possibility to organize a workshop with the most important stakeholders of the programme before finalizing the full proposal for the programme. The purpose of this workshop is to enable the applicants to better tune their proposal to local circumstances and to take a variety of perspectives on the problem the programme intends to tackle into consideration. In order to meet with the criterion on relevance for development, some of the researchers will have to leave their “natural environment” and the knowledge and experience of important stakeholders will help them to improve the quality of the proposal. In addition, stakeholder involvement from the very beginning has other positive effects that go beyond the design phase of a programme: it creates ownership, helps to develop skills, improves the probability of influencing development practice and policy and thus enhances the uptake of research results and its benefit to society.

The present suggestions are resources the applicants can draw on when preparing the workshop. They don't prescribe, but rather describe methods that applicants might want to use to involve stakeholders at the design stage of a programme.

### Some principles of participation

Participatory methodologies in development aim to involve people, communities and organizations at different stages of the programme cycle (analyzing, planning, implementing and reviewing). Stakeholder participation can have different levels of “intensity” that range from a passive participation (mainly information on what is happening in the programme) to more active forms of participation (consultation, joint decision-making and, finally, handing over control).

Before the workshop, it might be useful to reflect on the level of stakeholder participation in each stage of the programme you are aiming at. To what extent can which stakeholders at which stage of the programme be involved? The

workshop itself is an event at the analyzing and planning stage of the programme, and some of the answers to this question will only emerge during the workshop. However, it is helpful to be clear about your own preferences and about limits that the programme set-up might pose. Communicating your position to the stakeholders helps to avoid false expectations.

During the workshop, the facilitator can actively influence the level of participation – a few suggestions:

- Meaningful participation depends on the level of **information** the participants have. Give the participants sufficient information on all relevant aspects of the programme.
- The stakeholders come from different backgrounds. Communicate in a **language** that will be understood by all of them.
- Meaningful participation needs **time**: Carefully select and focus on the issues you want to share with the stakeholders. Give them enough time for analysis and for formulating their suggestions.
- **Listen** and be prepared to accept other people's ideas.

After the workshop, you might want to assess with the core team of the programme this first intense contact with the stakeholders. You can do that using the format of a quick AAR (after action review) with some simple questions like: What was supposed to happen, what actually happened and why were there differences? What worked? What didn't? How can we further improve our relation with the stakeholders?

## Using participatory tools

### Stakeholder analysis

#### What is a stakeholder?

"A stakeholder is any individual, community, group or organisation with an interest in the outcome of a programme, either as a result of being affected by it positively or negatively, or by being able to influence the activity in a positive or negative way." (DfiD 2003:15)

#### Why do stakeholder analysis?

A stakeholder analysis helps to identify the most important stakeholders of a programme or project and it helps to get ideas on how to involve them. It also enables the planners to see potentials for conflicts and risks.

#### How to do stakeholder analysis in the workshop?

A first identification of stakeholders of the programme has to be done for the preliminary proposal – the participants of the workshop belong to this group of already identified stakeholders. For the full proposal, a detailed stakeholder analysis is required. It may be useful to undertake this detailed stakeholder analysis during the workshop. The basic steps in this detailed analysis are:

1. Review the list of the already identified stakeholders of the programme;
2. Assess the importance and influence of each of these stakeholders;
3. Gather ideas on how they should be involved in the programme.

Before using the below described tools, explain to the participants what stakeholders are and why it is important to involve them.

#### Identification of key stakeholders

The following grid can help to get a complete list of stakeholders, looking at different sectors. You can do the exercise in the plenary, if the group is not too big (not more than ten). Otherwise, split the plenary in working groups and give them at least 30 min to do the exercise. The groups then present their completed grids to the plenary, where common ground is identified.

Private sector stakeholders	Public sector stakeholders	Civil society stakeholders
<i>(for example businesses, banks, etc.)</i>	<i>(for example local governments, ministries, civil servants, elected representatives, etc.)</i>	<i>(for example local NGOs, international NGOs, trade unions, churches, foundations, etc.)</i>

#### Stakeholder importance and influence matrix

Organize the identified stakeholders in the following matrix, according to their influence and importance. An influential stakeholder has the power to facilitate or impede the achievement of the programme's objectives. An important stakeholder is a stakeholder the programme is intended for, whose needs and interests the programme wants to satisfy. High importance/High influence stakeholders are the main target group for partnership building.

Depending on the number of participants, it might be appropriate to divide the participants into groups and give them sufficient time (one hour might be adequate) to do a stakeholder analysis using the matrix. The groups then present their findings to the others and the plenum agrees on a single stakeholder importance and influence matrix.

High Importance/ Low influence stakeholders	High importance/ High influence stakeholders
Low importance/ Low influence stakeholders	Low importance/ High influence stakeholders

Use the final stakeholder importance and influence matrix to brainstorm in the plenum on possibilities of collaboration with the most important stakeholders.

#### **Problem tree & objectives tree**

##### What is a problem tree?

A problem tree is a diagram that shows causes and effects of a problem. The diagram can be converted into an objectives tree that shows a solution scenario.

##### Why do a problem analysis using a problem/objectives tree?

The problem tree helps to get clarity on the problem and, consequently, on the focus of the intervention. It also helps to discuss the whole context of the problem, and to identify different causes, going from the more obvious to the more "hidden" ones. The objectives tree helps to see a variety of interventions that might contribute to a solution and helps to decide on a specific "route" to take.

How to do the exercise with the problem/objectives tree in the workshop?

The problem/objectives tree analysis is best carried out in a group of about five to ten people, coming from different backgrounds and having different perspectives on the problem. This may mean that the core team of the programme prepares this problem/ objectives tree before the workshop and stakeholders comment on the draft problem/ objectives tree during the workshop. It is handy to use post-its or cards for drawing up the problem/objectives tree, as they can easily be arranged and re-arranged during the discussion. Actually, the discussion itself is the most important aspect of the whole exercise. Joining the different perspectives on the problem, each participant will get a deeper insight into the issue at stake.

Problem tree:

- Agree on the problem to be analysed (suggest the one presented in the preliminary proposal, it may have to be adapted) – it becomes the “trunk” of the tree.
- Identify the causes for the problem, they become the roots. It is often useful to look at different categories of causes, such as policy constraints or constraints in legislation, lacking institutional capacity, cultural norms, lacking knowledge (research), etc. Try to look at a deeper level, don't stop at the first, most obvious causes. Has a cause been identified, search for further, underlying causes. Keep asking “What causes that?”.
- Identify the effects of the problem, they become the branches.

Objectives tree:

- Reformulate all the problems in the problem tree into positive conditions (objectives).
- Select the objectives that might fall within the scope of your programme – they are starting points for designing the logframe.

**Logical framework**What is a logical framework?

The term “logical framework” or “logframe” usually refers to the logical framework matrix, the most common tool for planning and monitoring development interventions. Basically, it is a 4x4 matrix which links activities to a hierarchy of objectives on the vertical axis and involves indicators of performance, means of verification and risks and assumptions on the horizontal axis. A logframe matrix can be designed on its own, but the full logical framework approach includes certain analytical steps before the design of the logframe (for example, stakeholder analysis and problem/objective tree).

Why use a logical framework?

A well designed logframe is a document that gives outsiders a quick insight into the programme rationale and that can be used by the implementers as a basic tool that helps to plan an intervention and to stay on track during the implementation. Therefore, WOTRO uses the log frame matrix in the application form.

However, the logframe has its limitations: it can be a quite rigid tool because reality does not adapt to the logframe. Its utility for planning and monitoring complex processes that are prone to unpredictability or are intrinsically unpredictable (f.e. social development or research) has therefore been discussed. However, the logframe can be turned into a more flexible tool by reviewing (and if necessary, altering) the logframe at regular moments in the

programme cycle. Stakeholder involvement in the design of the logframe will also have positive effects on its utility: the logframe will be more realistic, more understandable by a wider range of people and there will be more ownership in relation to the intended results and objectives of the programme as formulated in the logframe. Designing a logframe should actually be a teamsport.

How to use the workshop to improve the logical framework of the programme?

A first logframe of the programme has been designed for the preliminary proposal. At the workshop, this first logframe will undergo a revision and adaptation to the new format. Analytical exercises undertaken with participation of stakeholders (stakeholder analysis, problem/objectives tree) will provide useful information for the final design of the matrix.

Some suggestions for designing a logframe with the participation of stakeholders:

1) Make sure that all participants know what a logframe is (explain purpose and structure) and introduce the format WOTRO is using. To make sure that the participants are not intimidated by typical logframe expressions, such as overall objective, specific objectives, results, indicators, etc. explain their meanings. The following grid may help:

Terminology	Definition	Tips for formulation
Overall objective	The long-term goal that the programme is making a contribution towards. A future <b>positive scenario</b> .	One sentence, one overall objective. Describe a future condition, not an activity.
Specific objective	The medium-term change that the programme will support. The programme contributes towards this change, but cannot be held directly accountable for it.	Describe a future condition, not an activity. It may help to use a verb expressed in the past tense. For example: "Improved knowledge on x", "Policies on x reformed"
Results	Direct results of the programme activities. The programme is responsible for their achievement.	For example: "Scientific articles completed and submitted for publication"
Activities	Actions that have to be carried out to achieve the intended results.	Start with a verb, for example: "Organize a training".
Narrative summary	A short statement that describes the specific objective, results or activities.	Keep it simple and understandable.
Indicators	Quantitative measures or qualitative judgements that show change. Indicators should be SMART: Specific, measurable, achievable, realistic and time-bound.	Specify quantity and/or quality (number of, quality of, % of, extent of) and time. For example: "x civil servants trained on y, two years after programme start"
Means of verification	Sources or tools that can be used to verify if the intended changes actually happened.	Sources such as: reports, databases, minutes of meetings, etc. Tools such as: surveys, expert peer reviews, etc.
Assumptions	Conditions that are necessary for results to lead to specific objective.	For example: "Low turn-over of trained staff."

2) It might be wise to focus on certain aspects of the logframe that you want to conclude during the workshop. The development of a whole logframe matrix can be very time-consuming. Make sure that you, at least, develop a common view on the overall objective of the programme and the specific objectives and results.

3) Start with the overall objective of the programme (the trunk of the problem/objectives tree should be useful for formulating the overall objective), continue with the specific objectives in each of the three areas, then do the results. If the number of participants is high (>12), consider splitting them up into three groups, according to the three areas.

### **References**

Bradley, Dan (2004) *Participatory Approaches: A facilitator's guide*, VSO, London.

Dearden, Philip et alii (2003): *Tools for development: A handbook for those engaged in development activity*, DfiD, London.

Hovland, Ingie (2007): *Making a difference: M&E of policy research*, Working Paper 281, Overseas Development Institute, London.

Kasturiarachchi, Asoka et alii (2009): *Handbook on planning, monitoring and evaluating for development results*, UNDP, New York.

Schnell, Anna and Coetzee, Erika (2007): *Monitoring government policies: A toolkit for civil society organizations in Africa*, CAFOD, Christian AID, Trocaire, London.