NETHERLANDS GLOBAL HEALTH POLICY AND HEALTH SYSTEMS RESEARCH (GPHSR) PROGRAMME

FINAL EVALUATION

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EXECUTIVE SUMMARY

Background

Global Health Policy and Health Systems Research (GPHSR) is focused on understanding the relationships between health policies, health systems and the broader determinants of health on health outcomes, with an emphasis on low- and middle-income countries. The development of this multi- and transdisciplinary field of research has been strongly driven by a global shift away from vertical disease-focussed approaches towards health systems thinking.

In 2009, the Netherlands Ministry of Foreign Affairs and NWO-WOTRO provided funding for the creation of a dedicated GPHSR programme that supported research and bilateral cooperation between the Netherlands and low-income countries (LICs). The development and management of this programme were entrusted to NWO-WOTRO. The programme had three strategic objectives:

• To support research for strengthening health systems in LICs
• To strengthening research capacity in LICs
• To strengthening collaboration in the Dutch research and knowledge community to enhance use and international competitiveness of Dutch research capacity

Through three competitive funding calls, €7.3m was allocated to nine projects. In 2017, the last projects were concluded. As part of the agreement with the ministry, an independent final evaluation was commissioned. Its purpose was to assesses the performance of the programme in terms of effectiveness, relevance and adequacy, and utility.

Methodology

The evaluation relied on a combination of methodologies and data sources. First, a review of available internal documentation was conducted. Interviews were carried out with members of the steering and programme committee, with principal (co-)investigators and policy makers in countries where projects had taken place. This was complemented by a questionnaire to parties with a direct involvement in the programme and various other parties considered of interest.

Programme management

The evaluation finds that the GPHSR programme responded to a clearly defined knowledge gap in the field of research for GPHS in the Netherlands. It was a timely, relevant addition to the funding portfolio of NWO-WOTRO, that was aligned with the major priorities in global health and development at the time. The programme had various distinctive and innovative features, designed to ensure the relevance of supported research to policy and practice in LICs. This included a requirement to involve knowledge institutions from LICs and other local stakeholders, such as policy makers or health practitioners to support local needs-driven research. Their involvement was embedded in various stages of the project, from initial project design to dissemination of results. Projects were designed as transdisciplinary projects, focussed on complex research questions. Throughout the programme, there has been close involvement by the programme’s governance bodies to help shape the programme and, where necessary, provide guidance at both the programme and project level.
Sufficient flexibility was provided to allow adjustments not only in the design and implementation of the programme but also to the rules and regulations as applied by NWO-WOTRO. These features all impacted the effectiveness and relevance of the programme in various ways. The programme’s relevance was further promoted by ensuring linkages to the international GHPHSR community, via the composition of the SC and PC and by high-level participation in international meetings and conferences.

Programme and project outputs

Under the first two calls, eight research projects were funded, clustered in three thematic areas: antenatal and maternal health, health financing and community empowerment. The third call supported a cross-cutting project aimed at knowledge translation, KT-Net. Together, the nine projects involved over 25 universities and research institutes across Africa and the Netherlands, and were set in eight African countries.

Thus far, the GHPHSR programme has generated a commendable average of 10 published peer-review articles per project, including various publications in high-impact journals. The programme has also been remarkable in its emphasis on non-scientific but policy relevant outputs.

Project results and impacts

In each of the main objectives of the programme some measure of success has been achieved. The three different thematic areas have all produced insights that can be taken forward in their respective fields of policy and practice. The programme has helped to underline the interconnectedness of different parts of a health system and emphasised the need for demand-led priority setting and community ownership of interventions. With the highly valuable support of KT-Net to the eight projects, by the introduction of methods of knowledge translation and dissemination, numerous policy briefs and other forms of publications have been generated and disseminated. Many of the results have been successfully brought to the attention of relevant stakeholders, such as national health policy makers or local health practitioners. However, whilst various projects have already had an impact on policy and decision-making, the step from research results to policy remains large. Effective implementation at systems level is often frustrated by more generic policy conditions that are not easily changed within the context of a research project, but that require efforts in the wider environment.

Development of capacity for conducting GHPHSR has been most successful at the individual level, where the programme has benefitted both junior and senior-level researchers from LICs. By participating in collaborative and transdisciplinary research, researchers at all levels have gained skills in novel research techniques. They have also been able to add skills in knowledge translation and dissemination to their toolset. These skills they will be able to bring to bear within their further careers, either in academic positions or within other, oftentimes governmental, positions from which they can influence health policy and practice. In this way, individual capacity development is benefitting capacity at the institutional level as well.

Whilst the GHPHSR programme has succeeded in attracting new institutions and researchers to the Dutch GHPHSR community and improving collaboration, this has not materialised to the extent that was hoped for. The community remains relatively small without a clear network structure beyond individual collaborations. For the most part, the different objectives of the programme supported and reinforced each other rather than that significant compromises had to be made.
Relevance and utility

The GHPHSR programme was a highly relevant and timely addition to the Dutch research landscape as it offered a relatively unique funding opportunity for complex, transdisciplinary health-research projects. The focus on funding research with relevance for strengthening of health systems was in keeping with the identified priorities globally and in the Netherlands for global health and development, most notably the MDGs. On a local level, it was determined that most of the projects were relevant for the local context and the emphasis on bilateral research collaboration, engagement with policy-makers, and community-based approaches all added to its relevance. The focus of the programme remains highly relevant in the era of the SDGs, where the emphasis on holistic system-based approaches is arguably even stronger.

Research fairness

Special consideration was given to research fairness, i.e. fairness in the interactions between researchers (and research funders) in the North vis-à-vis research partners, stakeholders and communities in the South. It is found that significant steps were taken at the level of the programme and the projects to promote fairness of research and that overall the collaborations were generally perceived as fair. Nonetheless, there is room for improvement in areas such as managerial and financial ownership of projects by Southern institutions, demand-led research and greater clarity on mutual roles and responsibilities.

Cross-cutting observations

The GHPHSR programme is characterised by a large degree of complexity due to the complex nature of research itself, the design of the projects and the complexity of health systems as a whole. The programme’s main challenges and limitations relate to this complexity. Whilst some complexity is arguably both necessary and unavoidable in the field of GHPHSR, the programme offers some insights into how the resulting risks can be mitigated. It was shown that a combination of careful progress monitoring and adaptability both by the researchers and by the funder is an essential factor for success.

Conclusions and recommendations

Overall, it is concluded that the programme has achieved some noteworthy successes. The scale of results and impacts is necessarily limited, but the programme should be viewed as having demonstrated the potential for research of this kind in the Netherlands rather than as a programme designed to result in substantial, sustainable health system reforms.

Some of the critical factors for the success of research such as that funded by the GHPHSR programme, are that policy-relevant research requires academics to become more familiar with effective stakeholder engagement and communication. This can be done by providing support for knowledge translation, especially at the initial stage of the research.

Large, complex research with multiple stakeholders requires clear leadership and coordination, with regular reporting and monitoring of progress in order to make timely adjustments to protocols and work plans to mitigate emerging risks and flexibility to adjust projects during implementation.

Several operational and strategic recommendations have been offered to inform future research programming in this field such as;
The priority setting for future GPHHSR programme should be more clearly demand driven, led by researchers and other stakeholders from the South for proper understanding of local contexts, conditions and expectations, with an emphasis on the prioritisation of national (health) research agendas of LICs where available.

The transition from the MDGs to the Sustainable Development Goals which marks a further shift towards integrated health systems and thinking beyond the traditional confines of healthcare systems should be taken into account in further programming for GPHHSR in the Netherlands. Although the focus of the Netherlands Ministry of Foreign Affairs has in recent years shifted towards sexual and reproductive health and rights, the emphasis on maternal and child health remains important within this agenda and research around issues affecting adolescents, and on health security in fragile contexts could be of interest.

Sustainable and institutional capacity development for GPHHSR in LICs requires the exploration of more dedicated modalities for capacity development and a longer time-horizon for funding and support. Individual level research capacity development through participation in research should remain a component of funding programmes.

A central point of organisation and coordination of the Dutch GPHHSR community, to regularly bring together researchers from different disciplines and foster communication, is recommended. Finally, fairness in research should be a central tenet of any funding programme for research and some guidance on how to achieve this development and endorsement of the RFI can be extremely valuable.
1 Background

1.1 What is Global Health Policy and Health Systems Research (GHPHSR)?

Health policy and systems research is a discipline that is focused on understanding how health policies can shape – and in turn be shaped by – health systems and the broader determinants of health for the purpose of achieving better health outcomes. It thus is concerned with how different actors interact in health-related policy and decision-making processes, and with how health care services are organised, financed and delivered. Within this broad discipline, a sub-stream of research is concerned with global health.

Global health is generally considered to be a combination of activities taken with the aim of addressing the health needs of people in all parts of the world, crossing geographical or socio-economic borders. However, whilst global health in theory may concern all countries and all health conditions, in practice it is most frequently associated with the health issues afflicting low- and middle-income countries (LMICs) and the organisation of health systems in these countries. By its very nature, Global Health Policy and Health Systems Research (GHPHSR) is inter-disciplinary, bringing together research questions and techniques from fields such as medicine, public health, epidemiology, sociology, anthropology, political science, and economics. It is therefore a highly complex field of study in which many stakeholders play an important role.

GHPHSR is a relatively young discipline, that gained most of its momentum in the last ten to twenty years. An important driver in the development and maturation of GHPHSR has been a global shift from vertical, disease-focused approaches towards health systems thinking. This shift was grounded in a recognition that the vertical approaches were not achieving their goals because of weaknesses in the broader underpinning systems. Insufficient progress was being made in attainment of the health-related Millennium Development Goals (MDGs) that the international community had agreed on in 2000. In 2009, the World Health Organisation published the report “Systems Thinking for Health Systems Strengthening”, refocussing attention on health systems. Many large development organisations and donors moved in this direction as well. For instance, in 2007 The Global Fund, founded in 2002 to lead the global fight against HIV, TB and Malaria, opened up its funding calls to allow applicants to request funding for health systems strengthening.

1.2 GHPHSR in the Netherlands

In the Netherlands, the call for increased attention for health systems and policy research was spearheaded by the Netherlands Platform of Global Health Policy and Health Systems Research. This platform was set up in 2007 to bring together academic and non-academic knowledge centres, non-governmental and development organisations, state departments and research financiers with the aim to contribute to better health systems in the developing countries. The Platform was created in response to the observation that, at the time, there was little attention for multidisciplinary ‘systems research’ within the Dutch health research community. Rather, most global health research done in the Netherlands was focussed on biomedical interventions.

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1 [http://www.who.int/alliance-hpsr/about/hpsr/en/]
Against this backdrop of national and international activity, the Netherlands’ Ministry of Foreign Affairs and Ministry of Health, Welfare and Sports were willing to provide funding for a dedicated Global Health Policy and Health Systems Research programme that supported research and bilateral cooperation between the Netherlands and low-income countries (LICs). Thus, in 2009 the Netherlands Global Health Policy and Health Systems Research programme was created. The development and management of this GHPHSR programme were entrusted to NWO-WOTRO Science for Global Development, a division of the Netherlands Organisation for Scientific Research (NWO). The division funds and monitors innovative research on global issues, with a focus on sustainable development and poverty reduction, through various research programmes.

The aim of the GHPHSR programme has been to contribute to better health in low income countries (LICs) by supporting research with the following objectives:

- Strengthening health systems in LICs
- Strengthening research capacity in LICs
- Strengthening collaboration in the Dutch research and knowledge community to enhance use and international competitiveness of Dutch research capacity

1.3 Evaluation aim and scope

In 2017, the last of the funded GHPHSR projects were concluded. As part of the agreement with the Ministry of Foreign Affairs, an independent final evaluation was commissioned. This is the final report of this evaluation. The evaluation focuses on the programme-level final review of eight GHPHSR funded research projects and an additionally funded knowledge translation project, which was put in place to help the funded researchers facilitate the translation of research findings into practical policy recommendations and has both a retroactive and a prospective component. First, it assesses the performance of the programme in terms of effectiveness, relevance and adequacy, and utility. This aspect of the evaluation serves the purpose of accountability towards the sponsors of the programme. Next, it identifies lessons from the programme conceptualisation and implementation to formulate recommendations for future research programming in this field of research.
2 Methodology

This evaluation has relied on a combination of methodologies and data sources.

First, to gain better understanding of the programme and the projects funded, a review of available internal documentation was conducted.

Second, a questionnaire was sent out to parties with a direct involvement in the programme and various other parties considered of interest. The purpose of the questionnaire was to sound out perceptions of the relevance and added value of the programme, its effectiveness and impact.

Last, interviews were conducted with members of the steering and programme committee, with principal (co-)investigators and policy makers in countries where projects had taken place.

Each of the above data collection methods is discussed in further detail in the following sections

2.1 Document review

The document review consisted of a review of available internal documentation including among others; 1) programme documentation, 2) project documentation, and 3) general documentation for context analysis.

Programme documentation

- Annual plans, budgets and reports for the years 2010 through 2017
- Programme contracts
- Calls for proposals (Rounds 1–3)
- Minutes of the meetings of the Programme Committee and Steering Committee, including assessment of project applications
- Governance plan of the GPHSR programme
- Overview of the Monitoring & Evaluation approach of the GPHSR programme
- Final publication GPHSR Programme 2016

Project documentation

For each project:

- Proposals
- Award letters and contracts
- Progress reports and Mid-Term Reports (MTRs),
- Documents regarding project revisions (where applicable)
- Aggregated overview of outputs reported to NWO across all projects
General:

- Relevant documents for the contextualization of the evaluation finding, including reports of international health organisations and scientific articles.

2.2 Questionnaire

The questionnaire to the programme stakeholders contained 11 questions, asking about the background of the respondent, their familiarity with the programme, knowledge of programme activities, anticipated future priority areas for GPHHSR and any other feedback. Within the questionnaire there was routing, such that respondents who indicated having limited to no prior knowledge of the programme were not asked about their perceptions of the programme's results and impacts. Where appropriate responses were stratified to determine whether the degree of familiarity with the programme influenced respondent’s perceptions of the relevance thereof.

An invitation with a link to the questionnaire was sent to 80 people, including relevant health (policy/systems) researchers, policymakers, practitioners and research councils, GPHHSR funded researchers (PIs and Co-PIs), and members of the Netherlands GPHHSR Platform. A total of 24 people responded to at least one of the survey questions.

Most responses came from researchers who had been directly involved in the programme (Figure 1, left). The countries of origin of the respondents correlate significantly with those in which the research projects took place ((Figure 1, right). Among respondents, the self-described level of awareness of and familiarity with the programme was high, consistent with the fact that most had either participated in a funding call, or were directly involved with the programme in other ways (e.g. through membership of the programme or steering committee) (Figure 2)

*Figure 1 Left: Type of survey respondents. Right: Country of origin of survey respondents*
2.3 **INTERVIEWS**

Interviews were held with several broad categories of interviewees:

- (Co-)Principal investigators associated with knowledge institutions in the Netherlands
- (Co-)Principal investigators associated with institutions in LICs
- Selected members of the programme and steering committees
- Selected health policy makers in countries where GHPHSR funded projects took place

Initially, it was anticipated that external GHPHSR experts would be interviewed as well to gain their perspective on the relevance of the programme and alignment with international activities. This was eventually not done for logistical reasons. However, several of the members of the SC and PC were interviewed who, because of their linkages to the international GHPHSR community, could bring in this broader perspective. Additionally, independent external experts have also been involved in the mid-term reviews. Their views are thus incorporated into the analysis of the reports thereof.

A total of 24 interviews, with 26 individual interviewees, took place. The interviews were conducted using semi-structured interview guides that were tailored to the broad categories mentioned above.

Interviews were performed either face-to-face or by telephone (in the case of interviewees who were based outside of the Netherlands or who were otherwise unavailable for face-to-face interviews) and usually lasted around one hour.

Common questions across all interviews were:

- Nature and extent of personal familiarity with the programme
- Perspectives on the objectives and scope of the programme
- Strengths and weaknesses of the programme design

Researchers were asked to reflect on issues such as:

- Deviations in the project implementation compared to initial project proposals
• Necessity of the GPHHSR programme, alternative funding options and opportunities for follow-up funding
• Nature of the collaborations formed, their effectiveness and (anticipated) sustainability beyond the project duration
• Impact of research on capacity development
• Reflections on the relevance, uptake and sustainability of project results and impacts
• Experiences with involvement of local policy makers, NGOs and other non-academic stakeholders

Members of the GPHHSR committees were asked about, for instance:
• Ways in which the programme objectives were determined and the programme was structured
• Their expectations for the programme and the extent to which these have been met
• Modifications to the programme made during its implementation

With national health policy makers, the interview questions focused predominantly on the following issues:
• Familiarity with the outcomes of research conducted through the programme
• Relevance of these research findings to health systems and policies in their countries (including alignment with local needs and knowledge gaps)
• Mechanisms for dissemination and uptake of research findings in local context

All interviews were conducted on the basis of confidentiality. This report therefore does not include references that would allow one to attribute observations to specific individuals. For every interview, comprehensive notes were prepared, based on which the analysis was conducted. Analysis focussed on identifying recurring themes, and understanding both convergent and divergent opinions. Where possible and relevant, information from interviews was triangulated with other sources, such as project and programme documentation.

2.4 RESEARCH FAIRNESS

At the onset of this evaluation, the evaluators were made aware of the interest of the GPHHSR programme secretariat to consider inclusion of elements of the methodology of the Research Fairness Initiative (RFI), developed by the Council on Health Research for Development (COHRED). The RFI was developed as a reporting system to encourage, among others, research funders, implementers, and others to make explicit what steps they take to create “trusting, lasting, transparent and effective partnerships in research and innovation” between LMIC institutions and HIC institutions. It was agreed between the evaluators and the programme secretariat to, where possible and relevant, integrate elements of the RFI methodology into that used for the evaluation.

The RFI framework is constructed around three domains, with 15 topics and 45 indicators. The evaluators discussed with a team from COHRED which domains and topics to prioritise for this evaluation, as it was not considered feasible to include all. In their final consideration of which topics or indicators to include, and in what way these would be included, the evaluators took into account that:
a) One should not impose post-hoc criteria to an evaluation. In other words, an evaluation should consider the programme’s achievements against its intended and stated objectives. Lack of alignment between the programme’s (explicit) objectives and the RFI indicators meant that inclusion of certain indicators could not be justified.

b) The requested evaluation was to take place at the level of the GPHSR programme. It was neither to be an institutional evaluation of NWO-WOTRO as a whole, nor of the research institutions that had been involved in the programme (either in the Netherlands, or in the LICs). Therefore indicators pertaining to the institutional level were not explored in-depth.

c) Priority was to be given to the agreed evaluation questions. Inclusion of RFI indicators, to the extent that these went beyond the primary questions, was done only when time and resources permitted.

d) The administrative burden on participants in the evaluation was to be minimised. In practice, this meant that interviewees were not requested to provide evidentiary proof to support their statements and the evaluators relied on self-reporting.

Incorporation of RFI elements into the evaluation resulted in a substantial change to the agreed upon work plan: in the initial plan joint interviews between the Dutch and African (Co-)PIs had been planned. Following discussions with COHRED, however, the evaluators recognised the limitations of this approach in obtaining meaningful answers on aspects of research fairness. It was thus agreed to interview these parties separately.

The selected domains and topics that were incorporated into the methodology used, were as follows:

1. Fairness of opportunity
   - Relevance to local communities
   - Early engagement of all parties
   - Fair contracting
2. Fair process
   - Fair local hiring, training and sourcing
   - Data ownership, storage, access and use
3. Fair sharing of benefits, costs and outcomes
   - Research system capacities
   - Research management

2.5 Study limitations

There are several limitations to the study that impact on the extent to which the observations can be generalised. First, whilst the relative response rate to the questionnaire is not unusual in evaluations of this kind (where potential respondents have no direct incentive to participate), the total number of responses is modest. It was, furthermore, noted that among respondents a substantial number have close familiarity with the programme. There may thus be a degree of response bias. However, the questionnaire was primarily included to assess opinions on relatively high-level issues, such as alignment between the programme’s objectives and global health priorities. The assessment of the programme’s effectiveness has been based
mostly on document review and stakeholder interviews. Therefore, the impact of such bias is not considered substantial.

Whilst for each of the projects, at least one of the senior researchers involved was interviewed, for several projects not all of the (co-)PIs were available to participate. Therefore, the richness of information varies across projects. The evaluators also tried to involve a number of health policy makers from the countries in which the research had been conducted, to get their perspective on the relevance of the projects and on how the collaboration between researchers and policy makers (or implementers) had been. These attempts were, however, largely unsuccessful and only one policy maker was available to be interviewed. Therefore, for the assessment of relevance to policy and practice of the research projects, and for understanding how the research teams engaged in knowledge translation, the evaluators are largely dependent on the opinions of researchers themselves, of members of the programme and steering committee and on available documentation.
3 Programme management

This chapter provides an assessment of various aspects of the management of the programme at the level of NWO-WOTRO. This includes the governance of the programme, its financial management, processes for monitoring and evaluation, and the interaction with other stakeholders.

Consistent with the Terms of Reference issued by NWO-WOTRO for the evaluation of the GHPHSR programme, the evaluation conducted by Technopolis Group has focussed on the programme’s results in terms of effectiveness, relevance and adequacy, and utility but did not include an in-depth assessment of the managerial and administrative processes underlying the programme. These process dimensions are therefore only discussed in this report as they directly and visibly pertain to the achievement of the programme’s results.

3.1 Programme governance

The day-to-day management of the GHPHSR programme was in the hands of a dedicated programme secretariat at NWO-WOTRO. The secretariat was responsible for the interaction with and communication to the researchers, for the programme administration and for coordinating the work of the programme’s other governance structures: the Steering Committee (SC) and the Programme Committee (PC).

The Steering Committee was created to ensure that the activities undertaken by the GHPHSR programme were in line with the programme’s mission, objectives, and general framework and generally provide oversight to the programme. The SC was made up of six members, selected by NWO-WOTRO, and was supported by the GHPHSR programme secretariat. Its mandate included decisions regarding or approvals of:

- the composition of the Programme Committee
- the overall financial framework and annual budget plans
- final decisions on funding of proposals, based on advice by the Programme Committee.

In turn, the SC established a Programme Committee (PC), that was given a mandate to assess the research proposals and provide the SC with advice on funding. The PC was composed of six independent, international senior experts from the African and European academic and non-academic (NGO) community. It was chaired by an independent Dutch expert. The mandate of the PC included:

- assessing submitted research proposals (both preliminary proposals and full proposals) and providing the SC with recommendations on funding
- formulation of the second and third Calls for Proposals, including evaluation and selection criteria
- monitoring of funded activities and, where necessary, development of measures to ensure compliance with the approved proposal and contract
- proposing additional activities required to reach the GHPHSR programme goals to the SC
- advising the SC on the GHPHSR programme framework and policy.

The Programme Committee had no decisive power regarding GHPHSR funded activities.

Members of the PC were instrumental in selecting projects based on their relevance, scientific quality, quality of collaboration – using inputs by external reviewers – and in providing the research teams important
feedback on how to revise or refine their projects at various points in time. The final decisions on which projects to fund were taken by members of the SC, following the recommendations by the PC. Between successive funding calls, the SC and PC members played an important role in collecting input from the national and international GHPHSR community on how best to formulate the specific call texts. In combination with their own observations on progress in ongoing projects, this led to further refinement of the calls.

Various members of the PC were also part of the teams that conducted the mid-term reviews of the programme. These reviews involved field visits to the project sites, enabling the PC members to discuss the projects not only with the researchers involved but also with local stakeholders, such as policy makers and managers. This experience enabled them to provide concrete and actionable recommendations for adjustments to the project for the remaining period. This frequently included suggestions on how to better link the research to policy and practice. The mid-term reviews thus were not a simple administrative formality, but directly influenced the outcomes and impacts of the research projects. In general, throughout the entire programme, the SC and PC members have formed a useful connector not only between researchers across individual projects, but also between the between the researchers and the broader fields of academia and practice. Their close involvement in the programme is further exemplified by their active participation in many of the high-level events where the programme and the projects were presented.

3.2 Financial management

3.2.1 Income and expenditures

In line with the previously outlined scope of the evaluation, Technopolis Group did not conduct a financial audit of the programme as a whole, nor of the activities funded by it. All budgets and annual reports (including financial reporting) have been approved by the programme’s external funder, the Ministry of Foreign Affairs.

The financial reporting shows that throughout the programme, there have been only two sources of funding: a contribution of the Ministry of Foreign Affairs and a contribution of NWO-WOTRO. The NWO-WOTRO Board approved the programme proposal in June 2008 and made €2.5m available, provided the Ministry of Foreign Affairs would approve it as well and make €6m available for the first call. The total budget awarded in the first call was €4.2m. The total budget awarded in the second call was €2.1m. In the third and final call, €0.96m was awarded. Overall, this means that €7.3m was allocated.

Several of the projects included co-financing from other parties as well, including some of the Dutch host institutions. Others received co-funding from NGOs or local stakeholders. However, it also happened that co-financing that had been anticipated fell through and therefore some interventions had to be adapted or even dropped.

3.2.2 Grant management

Under NWO’s rules, only Dutch institutions can be the direct recipients of grant funds, unless the main funder of a programme requests otherwise. As in the case of the GPHSR programme no such request was made, funds could not be directly transferred from WOTRO to the African partner institutions. The financial management and administration were thus in the hands of the Dutch institutions leading the projects. How
and when funds were disbursed from the Dutch institution to the African partners, and how these were subsequently managed, was left to the partners to agree among themselves. This arrangement had some implications for both the efficient implementation of the project and for the relationship between Dutch and African institutes, as discussed further in section 7.2. Per the second funding call, project leadership could also reside with an African institution, though the grant could still only be disbursed to the Dutch institution. The project awarded in the third call (KT-Net) was led by the University of Makerere, without a Dutch partner. As the project was led by a non-Dutch institution, NWO-WOTRO required an external financial audit of the final financial account. As of 2013 most NWO-WOTRO programmes allow for non-Dutch (and non-academic) institutions to lead projects, with full responsibilities for financial and administrative management. However, this change was made only after the last of the GPHSR projects had been awarded.

Although NWO-WOTRO proved reasonably flexible in applying (financial) rules and regulations, in some cases project partners still felt frustrated by the inability to modify activities and re-allocate budget. For example, in one case project implementers unsuccessfully requested reallocation of funds from a budget line for communication to finalisation of research activities, in their eyes a more urgent matter but one that conflicted with the programme’s emphasis on knowledge translation and dissemination.

3.3 Monitoring and evaluation

Monitoring and evaluation (M&E) for the GPHSR programme has been done at two levels: the project level and the programme level. At the onset of the programme a relatively light-touch approach to monitoring and evaluation (M&E) was applied at the project level. Applicants in both the first and second call were required to include their own plans for communication and M&E into the proposals. Beyond this, it was foreseen that projects would be monitored by the programme secretariat (and programme committee) in terms of input, progress, outputs, outcomes and impacts around two years after the start of the programme, during a mid-term review (MTR), and again at a final external evaluation. There were no formal requirements for annual review or supervision by the programme’s oversight committees. At the instigation of members of the SC and PC, a revised and more stringent M&E plan was put in place. Subsequently, monitoring of project progress and results was done by the secretariat through annual progress reports and through formal and informal contacts with investigators. Furthermore, in preparation for the MTRs, research teams had to submit self-assessment progress reports. Site visits were conducted by an MTR committee made up of members of the Programme Committee and external reviewers. A summarising MTR report was submitted to the GPHSR Programme Committee.

The ramped-up intensity of monitoring and evaluation and the increased interaction between the research teams and the programme secretariat, as well as the close involvement of the Steering Committee and Programme Committee, has proven highly valuable. It allowed for the relatively timely identification of emerging issues and delays at the project level and for the development of corrective actions.

At programme level, annual monitoring was done. Initially, an interim assessment was planned to assess the relevance, efficiency and effectiveness of the GPHSR programme implementation, but this was replaced by the results/lessons learnt booklet that was launched at the HSG Symposium in Vancouver in 2016.

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3.4 Interaction between the programme and other GPHSR stakeholders

3.4.1 Connection to stakeholders in the Netherlands

The initial driver behind the programme had been the Netherlands Platform for Global Health Systems and Health Policy Research (as discussed in section 1.2). In 2011, members of this Platform informally met with members of the SC and PC to reflect on the text of the second call for proposals. In 2012, a similar discussion took place to discuss the text of the third call. As the Platform formally ceased operations in 2012, no further collective interactions with members of the Platform were organised. Nonetheless, individual members of the Platform continued to interact with members of the SC and PC and with researchers, among others by attendance of the Global Health Systems Research Conferences in Montreux, Beijing, Cape Town and Vancouver.

As stated, the Ministry of Foreign Affairs was the sole external funder of the GPHSR programme. A representative of the ministry was frequently present as an observer during meetings of the SC.

3.4.2 Connection to the international GPHSR community

Both the SC and PC are substantially composed of members of the international GPHSR community. They include representatives of institutions from both Europe and the Global South, and bring academic as well as operational expertise to the programme. Several members are key opinion leaders in global health and health policy and systems research. For instance, in addition to their roles in the PC, dr. Bocar Kouyaté and prof. Göran Tomson are members of the scientific and technical advisory committee of the WHO’s Alliance for Health Policy and Systems Research; dr. Alex Ezeh was the first executive director of the African Population and Health Research Centre, dr. Lola Dare is the founder of the Centre for Health Sciences, Training, Research and Development (Chestrad), in Africa, prof. Stephen Matlin was the Executive Director of the Global Forum for Health Research, prof. Rose Leke (immunology and parasitology) is among the most internationally recognised and awarded African women scientists, and dr. Ok Pannenborg was the World Bank’s Chief Health Advisor/Director and its Chief Health Scientist for over a decade. Through their individual expertise and networks, each of these members has provided guidance to the programme.

In several of the projects NGOs were involved. However, all communication from the side of NWO-WOTRO has been directed at the principal investigators leading the research; no forum was offered to comprehensively involve this broader set of participants in the programme.

3.5 Main findings

Whilst no comprehensive assessment was done of the efficiency and effectiveness of the management of the programme, it appears that the structures that were put in place to management the programme administratively and financially, and to monitor the implementation of the projects were appropriate. Sufficient flexibility was provided to allow adjustments in the design and implementation of the programme along the way. This flexibility has been important to the relevance and effectiveness of the projects and the programme as a whole. The programme’s relevance was further promoted by ensuring linkages to the international GPHSR community, via the composition of the SC and PC and by high-level participation in international meetings and conferences.
During the implementation of the GPHSR programme, some important changes were made to the rules and regulations as applied by NWO-WOTRO. Whilst some of these changes came too late for the GPHSR funded projects, they are likely to make a positive contribution to future programming of research for development.
This chapter contains a description of the outputs generated by the programme. It distinguishes between outputs at the level of the programme as a whole, and outputs at project level. The first refers to the actions undertaken by the programme to translate the overarching objectives into actions, through the issuing of calls for proposals and the subsequent selection and awarding of research projects. At the project level, the term outputs, refers to the translation of research findings into, for instance, scientific articles or presentations. These outputs are by themselves neither results (outcomes), nor impacts but they enable the scientific and wider stakeholder community to take note of the research findings.

4.1 Programme outputs

4.1.1 Calls for proposal

The previously discussed programme objectives were translated into action through three open competitive funding calls. The first call for proposals under the GHPHSR programme was issued in 2010. The call aimed at enhancing cooperation of Dutch research groups with partner organisations in LICs and at contributing to cohesion in the Dutch research field. It prioritised research that “could demonstrate how health systems can be improved, and how improved health systems can contribute to reaching the Millennium Development Goals” (Table 1).

The second call was issued the following year. The overarching strategic theme and the key themes within it remained unchanged. The call, however, differed from the first in that it sought out proposals that focussed on ‘systems thinking’ and synergy between the six WHO health system building blocks, and encouraged applicants to incorporate issues such as global influences, leadership and governance, linkages between practice and policy, evidence-informed policy, or health information systems, into their proposal. This call was also open to non-scientific applicants. Moreover, the LIC partner could now act as the main applicant. The explicit inclusion of global influences, leadership and governance came at the suggestion of members of the Netherlands Platform for GHPHSR.

In both the first and second call, proposals were required to be transdisciplinary in nature, wherein transdisciplinary was to be understood as research that “not only crosses disciplinary boundaries (and thus is interdisciplinary) but also involves knowledge from beyond the scientific community.” Furthermore, any application had to involve research groups from at least two Dutch institutions and from one or more low-income countries.

Eligible countries were those that in 2008 were classified as ‘least developed countries’ and those that were partner countries for Dutch development cooperation. Whilst eligibility was not limited to Africa, priority was given to applications involving countries in Sub-Saharan Africa. The focus on Sub-Saharan Africa was supported by the fact that this is where the greatest needs for health systems strengthening were (and continue to be) and where progress against the MDGs had been slowest. There was no intention on the part of NWO-WOTRO to further cluster projects geographically.

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1 NWO WOTRO (2010) Global Health Policy and Health Systems Call for full proposals

2 According to the OECD/DAC list of recipients of Official Development Assistance
The third call 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 included activities to prepare for this were preferred. From the onset of the programme, the intent had been to focus the third call on knowledge translation. However, the exact nature of that call was transformed in response to observations by the SC that knowledge translation efforts in the projects funded in the first and second were lagging. It was felt that the third call thus needed to be more embedded into the rest of the programme and take on a pro-active role, engaging with and supporting researchers in the other projects.

<table>
<thead>
<tr>
<th>Call (year)</th>
<th>Funding Available</th>
<th>Funding Awarded</th>
<th>Focus</th>
</tr>
</thead>
</table>
| Round 1 (2010) | €4.0m | €4.23m | Strategic research theme: equitable access to quality health systems  
- Key theme 1: organisation and delivery of essential and quality health services  
- Key theme 2: financial and human resources  
- Key theme 3: governance, stewardship and decision-making  
- Key theme 4: global influences and their impact on local health systems  
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. |
| Round 2 (2011) | €2.2m | €2.13m | Strategic themes: as above  
This second call prioritised research that demonstrated how health policy and/or health systems could be improved, and how improved health policy and health systems could 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 was preferred in this call. |
| Round 3 (2012) | €1.0m | €0.96m | The GPHS research programme intends to facilitate a network of the eight research coalitions currently conducting the research programmes funded via the GPHS programme. The network is envisaged to be a platform for exchange of knowledge concerning health policy and health system research methods, how health systems can be strengthened, and how this knowledge is best translated into policy and practice. The network is intended to stimulate the application of the joint knowledge generated to improve health systems at country level, across countries, the African continent, and on a global scale. |
4.1.2 Proposals received

The granting process comprised two phases. In the first phase, preliminary applications (‘preproposals’) were assessed by the Programme Committee, based on criteria of scientific quality, relevance and quality of collaboration. Next, selected applicants were invited to elaborate their application into a full proposal. The full proposals were subsequently assessed by (anonymous) international peers, whilst applicants were given opportunity to respond to the reviews.

In the first Call for Proposals NWO-WOTRO received 14 pre-proposals. All were deemed administratively admissible and were accepted into the competition. The PC met to assess the pre-proposals based on scientific quality, relevance for development and quality of collaboration. The scientific quality included looking for originality, effectiveness of the research approach and feasibility. Under relevance for development, issues of global and local concern within programme objectives, as well as the extent to which the research questions and intended research results were aimed at, and capable of, providing answers to the identified development or societal problem/opportunity and the potential to get the research into policy or practice were taken into account. It also considered 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 the research; quality of communication, dissemination and implementation plan. Although the PC was generally positive about the proposals, for this first call it also observed that none of the proposals were scored excellent, they all seemed biased towards a Dutch leadership and did not cover health systems aspects beyond health care systems, as had been anticipated. Eight teams were invited to submit a full proposal, out of which five were selected for funding.

For the second call 26 pre-proposals were submitted of which seven were invited to prepare a full proposal. Of these three proposals were selected for funding. For the third call, five proposals were received of which one was selected for funding. The programme committee noted that in this third call the applicants were strong but that the area of knowledge translation was not represented as strongly as was expected. This was attributed to the innovative nature of the call.

4.1.3 Projects supported by the programme

In total, eight research projects were selected. Although the programme did not set thematic priorities a priori, once the final selection of projects across all calls was completed, three main themes could be discerned: 1) Antenatal and maternal health, 2) Health financing, and 3) Community empowerment.

Additionally, a separate initiative was funded in the form of the ‘Knowledge Translation Network (KT-Net)’, coordinated by the Makerere University School of Public Health (Table 2). Aim of this initiative was to provide an overarching platform for health systems related knowledge translation and promote the joint use of evidence for policy making. Together, the nine funded projects involved over 25 universities and research institutes across Africa and the Netherlands, and took place in eight countries.
Table 2 Overview of GHPHSR funded projects

<table>
<thead>
<tr>
<th>Project title</th>
<th>Investigators*</th>
<th>Call</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Antenatal and maternal health</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Accelerating progress towards attainment of MDGs 4 and 5 in <strong>Ghana</strong> by</td>
<td>Prof. dr. ir. J.W.M. van Dijk</td>
<td>1</td>
</tr>
<tr>
<td>strengthening the functioning of basic health systems (Accelerate)</td>
<td>Prof. I.A. Agyepong</td>
<td></td>
</tr>
<tr>
<td>Improving maternal health services through political accountability mechanisms</td>
<td>Prof. T. de Cock Buning</td>
<td>2</td>
</tr>
<tr>
<td>in <strong>Burundi</strong> and <strong>DR Congo</strong></td>
<td>Prof. P. Kayembe</td>
<td></td>
</tr>
<tr>
<td>Mainstreaming a health systems approach to delivery of maternal health</td>
<td>Dr D. Blaauw</td>
<td>2</td>
</tr>
<tr>
<td>services: transdisciplinary research in <strong>Rwanda</strong> and <strong>South Africa</strong></td>
<td>Dr L. Bijlmakers</td>
<td></td>
</tr>
<tr>
<td>(MHSAR)</td>
<td></td>
<td></td>
</tr>
<tr>
<td>Addressing social, cultural and historical factors limiting the contribution</td>
<td>Dr P. Ondoa</td>
<td>2</td>
</tr>
<tr>
<td>of medical laboratory services to antenatal care in <strong>West Africa</strong> (<strong>Socialab</strong>)</td>
<td>Prof. A.I. Sow</td>
<td></td>
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<tr>
<td>(Socialab) (<strong>Senegal</strong>)</td>
<td></td>
<td></td>
</tr>
<tr>
<td><strong>Health Financing</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Community-Based Health Insurance in <strong>Ethiopia</strong> (<strong>CBHI</strong>)</td>
<td>Prof. A.S. Bedi</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dr. G. Alemu</td>
<td></td>
</tr>
<tr>
<td>Towards a client-oriented health insurance system in <strong>Ghana</strong> (<strong>COHEiSION</strong>)</td>
<td>Prof. T.F. Rinke de Wit</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr. D.K. Arhinful</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Prof. dr. I. Hutter</td>
<td></td>
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<tr>
<td><strong>Community engagement</strong></td>
<td></td>
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<tr>
<td>Developing Sustainable Community Health Resources in <strong>Uganda</strong> (<strong>CoHeRe</strong>)</td>
<td>Prof. R. Pool</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dr. D. Mafigiri</td>
<td></td>
</tr>
<tr>
<td>Empowering the community towards malaria elimination in <strong>Rwanda</strong> (<strong>MEPR</strong>)</td>
<td>Dr M. van Vugt</td>
<td>1</td>
</tr>
<tr>
<td></td>
<td>Dr. S. Koenraadt</td>
<td></td>
</tr>
<tr>
<td></td>
<td>Dr L. Mutesa</td>
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<tr>
<td><strong>Knowledge translation</strong></td>
<td></td>
<td></td>
</tr>
<tr>
<td>Knowledge Translation Network (<strong>KT-Net</strong>)</td>
<td>Dr. S. Kiwanuka</td>
<td>3</td>
</tr>
</tbody>
</table>

4.1.4 **MEETINGS AND CONFERENCES ORGANISED**

The GHPHSR Programme convened various meetings during the span of the programme. Both the PC and SC met a minimum of two times a year. For the programme committee, the discussions centred on the advice to be provided to the SC on the awards of proposals, while the SC met to take the final decisions and decide on the proposals to be awarded.

The GHPHSR programme was well represented at the first Global Symposium on Health Systems Research in Montreux, by almost all SC and PC members as well as by the secretariat. This meeting was used as an opportunity to discuss the draft text of the second call for proposals, which was officially announced at the symposium. The GHPHSR programme also organised an afternoon session at the symposium, together with the Swedish International Development Cooperation Agency (SIDA), on equal partnerships and knowledge sharing between high-income countries and LMIC institutions.

The GHPHSR programme also actively participated in the 2012 second Global Symposium on Health Systems Research in Beijing, by organising a parallel session on health systems research and knowledge translation. They also used the opportunity to hold a joint meeting of the SC and PC members.

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*Investigators include the principal investigator, representing a Dutch institution, and the co-investigator. In several cases, the principal investigator involved in the initial application was, during the implementation of the project, replaced. Listed here is the most recent principal investigator.
The programme was also present at other international meetings, such as the Global Forum on Health Research (organised by the COHRED Group) in Cape Town. It organised an internal programme learning session around the results and lessons in The Hague. A final programme meeting, focussing on the relevance and uptake of results, was held in Kampala, Uganda in 2016. A satellite panel session was organised in the fourth Health Systems Global symposium in Vancouver, Canada of the same year, where a non-technical final publication, highlighting results, impact and lessons learned, was launched. Another satellite session was organised by KT-Net with six of the research teams around innovative health systems and power dynamics in health care. The GHPHSR programme contributed to the conference both at programme and at project level. The programme itself was represented during a panel discussion on funding strategies for health systems research.

Lastly, there were various meetings organised by KT-Net, such as the Africa annual meetings which offered an opportunity for networking under this collaboration to present the progress made by the projects on KT activities and to share learning with other partners. KT-Net was also involved in hosting the final programme meeting in Uganda and in preparing the teams for the Vancouver Symposium.

4.2 Project outputs

4.2.1 Scientific publications

The eight research based projects and one knowledge translation project contributed to over 78 articles published in peer reviewed scientific journals, with a further four articles under review and over 50 articles still in preparation at the time of final reporting. The amount of publications varied among the projects, ranging from 25 to just one. Although no bibliometric analysis was done on the scientific outputs of the projects, there are around a dozen publications in renowned journals such as The Lancet, Implementation Science, Plos One, Globalization and Health, BMJ Open and Health Policy and Planning.8

4.2.2 Posters, presentations and conferences

Numerous posters, presentations were presented at international English and French speaking conferences such as the Global Symposium on Health Systems Research in Vancouver and Cape Town, and the African Society for Laboratory Medicine conference in Cape Town. Presentations were also shared at national conferences, both orally and in the form of posters. Over 72 presentations in various forms were delivered at these conferences. Funding from KT-NET supported three joint session presentations in three different global conferences. These sessions included partners who were working on community resources for health (Rwanda, Uganda), presentations for partners working on health financing (Ghana) and presentations on knowledge translation experiences (Ghana, Senegal, Rwanda, Uganda).9

4.2.3 Non-scientific publications and knowledge translation products

KT-Net provided tailored capacity development to each research group, based on identified capacity gaps. It then also supported the researchers with knowledge translation activities. This support resulted in the researchers being able to develop engagement strategies, write policy briefs, blogs and produce videos and

8 2016 Journal Impact Factors for these journals were: The Lancet (47.831), Implementation Science (3.354), Plos One (2.806), Globalization and Health (2.536), BMJ Open (2.369) and Health Policy and Planning (2.368).

9 KT-NET final report.
press releases of their evidence. Over 25 policy briefs, six videos and more than 100 popular communication products such as blogs, newspaper articles, and TV news bulletins were produced and disseminated. Over 25 dissemination workshops and policy dialogues were held. Collaborations across the project partner countries enabled the writing of a book on health financing with lessons from five African countries.

4.3 Main findings

Overall, the programme has taken a clear and decisive path to translate the overarching strategic objectives into a set of actions and outputs.

At the programme level, the objectives were translated into three separate funding calls, each of which had a distinct character, designed to align it with the then perceived research priorities. The eight research projects could be clustered into three thematic areas. In the research coalitions, significant numbers of Dutch and African institutions were involved, bringing together a wide range of scientific disciplines and stakeholders. The projects were further supported in their engagement with policy makers and other stakeholders by the innovative KT-Net project. Significant efforts were undertaken to bring the programme – and the funded research projects – to the attention of the international GPHSR community.

Overall, the GPHSR programme has generated a commendable output for a programme of its relatively small size. Whilst some projects have been more successful than others, with an average of 10 published peer-review articles per project (and further publications still in preparation) the scientific output has been substantial. This includes various publications in high-impact journals. The programme has also been remarkable in its emphasis on non-scientific but policy relevant outputs.
5 **Project outcomes**

In November 2016 NWO-WOTRO published a final publication entitled ‘Global Health Policy and Health Systems Research programme: impact and lessons learned’. It contains a summary of the project evaluations, presenting the key results for each project. Its focus is on the projects’ contribution to the overarching programme objectives, considering their contributions to knowledge generation, capacity strengthening and collaboration, and on (short-term) knowledge translation and uptake of research outcomes.

Although this evaluation did not seek to exhaustively repeat the work already done in the individual project evaluations, it provides a programme-level synthesis, based on review of project documentation and on interviews, to arrive at a set of higher-order conclusions on the programme’s effectiveness. In the following sections these results are grouped around the three overarching programme objectives detailed in section 4.1.3.

The first section thus considers the contributions the projects have made in terms of the knowledge they have generated to contribute to strengthening of health systems in LICs. The next section assesses the contributions made to strengthening the research capacity in LICs through the individual projects and at the level of the programme as a whole. This is followed by a review of the contributions made through the projects on strengthening collaboration in the Dutch research and knowledge community for GHPHSR.

5.1 **Contribution to knowledge generation to support health systems strengthening in LICs**

Individual project results are summarised in tables included in Appendix A. This section offers a higher-level synthesis, cutting across projects, and clustered around the three thematic areas to which the projects were mapped.

5.1.1 **Antenatal and maternal health**

Four of the funded projects were centred on aspects of antenatal and maternal health care. Each of these took place in a different country or set of countries (Ghana, Burundi & DR Congo, Rwanda & South Africa, Senegal) and took a different approach. Yet, they all offer some potentially very useful insights into how the quality of care, and uptake of essential services for antenatal and maternal health could be improved, not just in these countries but more generally. In this section, some of the main insights that – to some degree – can be connected across the studies are presented.

The ACCELERATE study in Ghana looked at the interplay between broader health system factors and maternal and neonatal health services. It showed that the quality of care is not just dependent on the interaction between the service providers and their clients, but that other health system functions at all levels are important determinants as well. For instance, the motivation of health workers at the facility level is impacted by factors at regional and national levels, such as policies and management. Furthermore, quality of care was negatively impacted when managers at the facility and district level were not given sufficient decision-making space to directly address inefficiencies. It was shown that intervention measures such as creating more open-door policies, involving frontline workers in decision making, recognising their needs and challenges and working together to address them are critical.
The MHSAR project also considered the role of various health system 'building blocks' in the organisation and effectiveness of maternal health service delivery. In Rwanda, health system factors – such as poor infrastructures and lack of training – were shown to be important contributors to sub-standard care. On the other hand, it also showed that the quality of care was positively affected by engagement of community health workers (CHWs), by expanded coverage of the community health insurance and by strong leadership. Furthermore, accountability was improved by the introduction of results-based financing.

The role of CHWs and accountability for improving the quality of maternal care, similarly, was the focus of the study set in Burundi and DR Congo. Here, in particular the importance of mechanisms for social and political accountability was explored. The assumption is that, to improve and sustain the quality of care of maternal health services, women need to be able to hold their service providers to account. However, in certain contexts, for instance in rural fragile areas, there may be no trusted mechanisms for women to express their concerns and dissatisfaction. The study showed in such circumstances, community health workers present a viable alternative channel for accountability, by acting as a go-between and giving voice to women.

Akin to what was found in the ACCELERATE study, the SOCIALAB study in Senegal highlighted that lack of agency for district health managers posed a barrier for the effective delivery of essential services, in this case diagnostic services for antenatal testing.

Jointly, these four studies show that – whilst technical expertise and resources are essential – the delivery of good quality antenatal and maternal health services is intricately linked to factors in the health systems in which they are embedded. Interventions narrowly focussed on technical improvements, e.g. by training of frontline health workers, may thus not achieve their potential unless these factors are sufficiently paid attention to in a systemic manner in the context of policy change and health system reform.

5.1.2 Health Financing

A second theme within the project portfolio was that of health financing, and in particular the role of health insurance. This was the central theme in two of the funded projects: the CBHI project in Ethiopia and the COHEiSION project in Ghana.

Purpose of the CBHI project was to understand how households deal with unexpected health expenditures and to assess how community-based health insurance (CBHI) affected health care utilisation and out-of-pocket spending. Health insurance plays an important role in protecting people from the potentially devastating impacts of unexpected health costs, and increasing their uptake of necessary services. The project found that, in general, households tended to cope with unexpected health expenditures by cutting back on their other expenditures and by borrowing money or selling off assets. The main reason people opted to not seek health care are because of the high costs and perceptions of poor quality of services, rather than a lack of awareness or inability to recognise health problems. The CBHI project has supported the scale-up of the Ethiopian CBHI scheme by looking at underlying mechanisms for, among others, risk pooling and reimbursement.

Whilst the project in Ethiopia looked mainly at barriers to uptake of health care, and the modulating role played therein by health insurance, the COHEiSION project in Ghana also looked at the barriers to uptake of health insurance itself and how to overcome these. Similar to the Ethiopian study, it found that perceptions of (poor) quality of care are an important barrier to uptake of services, but also found that these perceptions differed with insurance status. Whilst insured patients perceive a poorer quality of care, health providers
consider the delayed reimbursement a disincentive to provide services to insured clients. The introduction of health insurance also resulted in an increased workload for health providers. The project emphasises that interventions to stimulate client engagement in healthcare provision should be simple but cost-effective to ensure scalability and sustainability.

Taken together, these two studies show not only the potential benefits that can be derived from the introduction of a health insurance system, but also that the system can produce unwanted side-effects – such as decreased quality of care, overburdening of health providers and delayed payments – that need to be carefully considered and managed.

5.1.3 Community Engagement

The third theme that emerged from the selected proposals was that of community engagement. This formed the guiding thread in two projects: the MEPR project in Rwanda and the CoHeRe project in Uganda.

Aim of the first had been to contribute to the elimination of malaria by connecting social mobilisation to the national and district malaria control program and (inter)national expert knowledge bases. Together with the community, an approach was designed to directly involve the community in efforts to promote awareness of malaria and to implement malaria prevention strategies. This was done via the creation of Community Malaria Action Teams (CMATS). The study found that, by putting the communities in control, there was a notable increase in community acceptance of preventive measures, such as the use of mosquito nets. The project also showed that involving local leaders who are perceived as influential at the community level strengthens the delivery of health messages to the population. The project contributed to a substantial reduction in malaria incidence (from 68% in 2013 to 21% in 2014) in the region.

The importance of enabling communities to develop and implement strategies based on their own priorities was also demonstrated in the CoHeRe project. Here, the initial project set-up in which the study team was expected to design an intervention, was abandoned when the community in the intended intervention site took initiative to develop the intervention in line with their own stated priorities. The community decided to focus on addressing problems with poor sanitation and basic hygiene. The study showed that local ownership of an intervention, implemented with local resources, is an important condition for its sustainability. It stresses that policymakers and NGOs should avoid intervening prescriptively or injecting excessive resources into communities, because this results in dependence and helplessness.

These two projects show that community engagement and ownership are essential for the success and sustainability of an intervention. This requires that communities are not only involved as the passive subjects of an intervention, or that they are involved only in the implementation phase, but that they are in charge of the prioritisation of their needs and in the design of the interventions to address these. If they are, outcomes from the interventions can be dramatically more effective. Inclusion of this recognition into policy development and subsequent health care reform would then be needed to render this sustainable.

5.2 Contribution to capacity development for GPHSR in LICs

In addition to contributing to the knowledge base for global health systems and health policies, the GPHSR programme sought to “strengthen the health-related research capacity between African and Dutch research institutions and universities” by developing capacity at several levels; individual, institutional and stakeholder
or policy maker level. However, it was recognised early on that institutional capacity development at a significant scale would be beyond the reach of a programme of this nature. In practice, therefore, the emphasis was on an individual level. Nonetheless, some effects can also be observed at an institutional level. This section thus looks at capacity developed in various ways and at different levels.

5.2.1 **INDIVIDUAL RESEARCH CAPACITY**

Individual capacity to conduct GPHSR was developed primarily by funding PhD and post-doc positions and by providing MSc scholarships. In total the programme supported 22 PhD students of African origin, of whom 15 had completed their theses at the time of final reporting. Additionally, 4 post-doc researchers and 2 MSc students were funded. The PhD researchers were part of PhD schools in the Netherlands. Both through these schools and through their participation in the research projects, the researchers received training in relevant research methods, such as systematic reviews, participatory action research, realist reviews, near-miss audits. PhD and post-doc researchers also received training in scientific writing and were enabled to develop their skills in, for instance, English or French and working with software packages such as Epi-Info. In the context of the COHEISSION project, it was noted that students who had been involved in field work as data collectors also gained valuable experience in conducting research that they were able to apply in their Master studies.

The individual level capacity development benefitted not only junior researchers, but also the more senior researchers involved. The transdisciplinary nature of the projects meant that researchers at all levels were exposed to disciplines and research techniques with which they had not previously been familiar. Furthermore, the complexity of the funded projects meant that senior staff gained experience with managing large collaborative, and at times multi-country, projects.

Through the support of KT-Net, many researchers – both from LICs and in the Netherlands – also gained experience with methods for knowledge translation and communication. Prior to this, many academics had limited to no prior experience in engaging directly with policy and decision-makers.

Of the 22 supported PhD researchers, nine (40%) are so-far continuing in academic institutions in Africa. Five (23%) are currently pursuing careers in government positions in Africa, mainly in their home countries. The remainder were still completing their research, or are working for NGOs or in the private sector at the time of the final project reporting.

5.2.2 **INSTITUTIONAL RESEARCH CAPACITY**

None of the projects applied an explicit institutional approach to capacity development. This was a deliberate choice on behalf of the programme, as a research funding programme is generally not a well-suited instrument for such institutional capacity development which requires a longer time horizon and greater commitment of resources. Institutional capacity development was therefore mostly indirect, through ‘ripple effects’ from individual level efforts. For one, the programme has contributed to the creation of a ‘pool’ of relevant research capacity in the countries where the research was conducted from which institutions will be able to draw in future. As stated previously, at the final reporting, several African based PhD students were already working in academic positions from which they will be able to contribute to the further strengthening of their institutions.

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10 Based on information available from the final project reports for all except one project; for the MHSAR project no such data could be found.
Projects also have contributed to institutional level changes in other ways. In one project, the involvement of researchers from both the social sciences and medical departments was said to have resulted in increased capacity to conduct interdisciplinary research between these two, previously disconnected, parts of the institute. In Ethiopia, the CBHI project resulted in institutional capacity development in two more important ways. First, a training and capacity development programme was developed and given for 15-20 Ethiopian researchers. Second, members of the team were asked to provide teaching inputs for the development of a PhD programme in Economics at the Bahir Dar University. In another example of effects beyond the immediate members of the research team, the results of the SOCIALAB project will be used to revisit the curricula for training human resources for health within the RESAOLAB Network, the West African Network of Biomedical Analysis Laboratories.

Although in many cases, the research collaboration between the Dutch and African institutions predated the GPHHSR funded projects, the projects have helped to strengthen these partnerships. Continued collaboration will depend on the availability of research funding, but many researchers have expressed an intent to work together again in future.

### 5.2.3 Capacity of Health Policy Makers and Other Stakeholders

Beyond the capacity to conduct GPHHSR research, the projects have also had varying degrees of impact on health policy makers and implementers. Cooperation between the research teams and NGOs and public authorities was a prerequisite for funding, and is therefore present in all projects. Whilst in most projects the capacity impacts on these sets of stakeholders were not made explicit, one notable example of this kind of capacity development can be found in the project on social accountability in Burundi and DR Congo. Here, NGOs were key players in the implementation of the project. In the context of the project, several workshops were conducted with national and provincial policy makers, healthcare managers, and NGO staff. These workshops included learning and exchange sessions with policy makers and researchers on the social accountability concept and Theory of Change. The NGO staff also received support in scientific writing. Similar impacts likely occurred in other projects. However, in the absence of data obtained from discussions with these stakeholders, it cannot be ascertained how this capacity development was experienced by parties other than the researchers.

### 5.3 Contribution to Strengthening Collaboration in Dutch GPHHSR Community

In the text of the first call for proposals, it was explicitly stated that the programme aimed at contributing to cohesion in the Dutch research field by strengthening collaboration within the Dutch research and knowledge community. The programme intended to enhance the establishment of a limited number of research hubs in the Netherlands, with at least two collaborating Dutch research groups from different organisations.

Across the eight funded projects a total of 11 knowledge institutions were involved (Figure 3). The Amsterdam Institute for Global Health & Development, perhaps unsurprisingly, emerges as the dominant centre of expertise for GPHHSR, having been involved in some capacity or another in half of the funded research projects. Different departments of the University of Amsterdam have also substantively contributed. Strikingly, four of the involved institutions are based in Amsterdam (AIGHD, KIT, UvA and VU) and some of the researchers have connections to more than one of these institutions (e.g. one senior researcher who works
at KIT also holds a position at the VU). This clearly demonstrates a degree of interconnectedness between these institutions.

The project involving the greatest number of Dutch knowledge institutions was the MEPR project. This project brought together a coalition of researchers from a wide range of disciplines, including biological sciences, behavioural sciences, entomology, and health economics. Six out of the eight research projects involved no more than two Dutch knowledge institutions, although some included other Dutch organisations such as PharmAccess and Healthnet-TPO. In the MHSAR project the intended cooperation between Dutch institutions did not materialise, as the PI from the UvA took up a post abroad early in the project and no suitable replacement could be found. In two projects PhD theses were defended at more than one Dutch university. In the other projects (senior) researchers from other universities participated as team member in the projects.

![Figure 3 Knowledge institutions from the Netherlands involved in funded GPHSRR projects](image)

<table>
<thead>
<tr>
<th>Institution</th>
<th>Project (role)</th>
</tr>
</thead>
<tbody>
<tr>
<td>African Studies Centre Leiden</td>
<td>CBHI (research)</td>
</tr>
<tr>
<td>Amsterdam Institute for Global Health &amp; Development (AIGHD)</td>
<td>SOCIALAB (PI) MEPR (PI) COHEI (PI) CoHeRe (research)</td>
</tr>
<tr>
<td>Erasmus University Rotterdam</td>
<td>CBHI (PI)</td>
</tr>
<tr>
<td>KIT Royal Tropical Institute</td>
<td>MEPR (research) Social accountability (research)</td>
</tr>
<tr>
<td>Radboud UMC &amp; Radboud University Nijmegen</td>
<td>MHSAR (Co-PI) MEPR (research)</td>
</tr>
<tr>
<td>University of Maastricht (UM)</td>
<td>MEPR (research)</td>
</tr>
<tr>
<td>Utrecht UMC</td>
<td>ACCELERATE (research)</td>
</tr>
<tr>
<td>University of Groningen</td>
<td>COHEI (research)</td>
</tr>
<tr>
<td>University of Amsterdam</td>
<td>CoHeRe (PI) Socialab (research) ACCELERATE (research)</td>
</tr>
<tr>
<td>VU Amsterdam</td>
<td>Social accountability (PI)</td>
</tr>
<tr>
<td>Wageningen University &amp; Research (WUR)</td>
<td>ACCELERATE (PI) MEPR (PI)</td>
</tr>
</tbody>
</table>

Within the frame of this evaluation it was not explicitly traced whether the cooperation between the Dutch participants was new or whether the projects were prolongations of already existing relations. However, based on the number of institutions involved and the nature of the coalitions formed, one can reasonably conclude the programme did indeed contribute to greater cohesion in the Dutch GPHSRR community. Whilst some of the involved institutions are reasonably established centres for global health and health policy research, such as Radboud University /Radboud UMC or the UvA, others like the University of Groningen are relative newcomers to the field. The programme thus has succeeded in expanding the field and bringing in new actors, whilst anchoring them to an established base.
Nonetheless, some marginal notes are in order. First, the GHPHSR programme was launched around the same time that AIGHD was created. This institution was established as a collaboration between the Academic Medical Center (AMC), the UvA and the VU and – analogous to the GHPHSR programme – sought to bring together researchers from different disciplines relevant to global health and development. The predominance of Amsterdam-based institutions in the GHPHSR programme and their collaboration thus is an indication that other forces, alongside the GHPHSR, had an impact on fostering collaboration among Dutch institutions as well.

Furthermore, several interviewees, indicated that the involvement of multiple institutions did not always guarantee strong collaboration and transdisciplinary working. This issue was repeatedly flagged in some of the project-level mid-term reviews. Also across projects, it was not felt that researchers were actively reaching out to other groups to share knowledge and expertise, outside of the meetings organised by the GHPHSR programme. Members of the SC and PC in particular, but also some PIs expressed disappointment with the degree of collaboration between different institutions. Some attempts were made to boost this, by organisation of meetings between the Dutch institutions, but these did not generate much traction. Among survey respondents, a third (6 out of 18) felt that the programme had somewhat, but insufficiently contributed to strengthening collaboration within the Dutch GHPHSR community, a considerably less favourable score than for perceived impact on the other programme objectives (Figure 4).

Figure 4 Survey responses to "To what extent has the GHPHSR programme (and the projects funded by it) contributed to..." (N=18)

<table>
<thead>
<tr>
<th></th>
<th>Highly</th>
<th>Sufficiently</th>
<th>Somewhat, but not sufficiently</th>
<th>No opinion</th>
</tr>
</thead>
<tbody>
<tr>
<td>Strengthening NL/NL collaboration</td>
<td>5</td>
<td>6</td>
<td>6</td>
<td>1</td>
</tr>
<tr>
<td>Strengthening NL/LIC collaboration</td>
<td>10</td>
<td>6</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Strengthening research capacity in LICs</td>
<td>13</td>
<td>3</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Training programmes</td>
<td>10</td>
<td>5</td>
<td>1</td>
<td>2</td>
</tr>
</tbody>
</table>

No satisfactory explanation could be found for why this collaboration did not materialise to a greater extent and why the GHPHSR community appears to be less self-organising than researchers in some other areas, such as research for sexual and reproductive health. It is worth recalling that prior to the programme, there had been some momentum within the community, which had resulted in the creation of the Netherlands Platform for GHPHSR. However, in the absence of external funding, the Platform effectively ceased to exist and currently there is no clear organising centre to connect the community at a national level.

Within the funded projects, all knowledge institutions involved were either based in the Netherlands or in Africa. No other Northern universities were substantially involved. Indeed, the programme’s Calls for Proposals required only collaboration between Dutch institutions and those in LICs; no mention was made of,

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11 In one project the PI who had led the proposal development subsequently moved from a Dutch university to one in the UK. She was intended to thereafter continue as a collaborator, though the project reporting does not indicate whether this in practice was the case. In another project, one of the African researchers had an appointment at the University of Göttingen, Germany. However, neither case is indicative of a deliberate attempt to internationally position the Dutch institutions.
for instance, wider European networking or collaboration. Interviews with Dutch researchers did not provide sufficient data on the degree to which the researchers and research groups involved in the programme are part of such international research collaborations.

5.4 Synergies and trade-offs

Although in the preceding sections achievements against the individual objectives were discussed as if these were the result of unconnected efforts, in practice they are very much interlinked. They can both reinforce each other and counteract each other. For instance, development of local capacity may help the generation of knowledge, as local researchers have a better understanding of the relevant context. Alternatively, having to substantially invest limited resources, both financially and in terms of time, may take away from a project’s ability to generate results within the project duration. Interviewed project leaders did not perceive a great tension in this area. Involvement of local researchers was seen as a strength to the projects rather than as a challenge.

More tension was observed in balancing the needs to conduct good quality research and to engage with policy makers. PhD students and their supervisors were primarily concerned with completion of the research and preparation of their theses and papers and did not consider this type of engagement a priority. Members of the SC and PC noted that their focus was not strongly on knowledge transfer. The lack of communication and coordination between the different projects also did not help in getting knowledge and research results flowing from one institution to another. The addition of KT-Net helped in bridging these gaps, as will be discussed further in Chapter 6.

5.5 Main Findings

In each of the main objectives of the programme some measure of success has been achieved. In terms of contributing to the generation of knowledge to support strengthening of health systems in LIC, the three different thematic areas have all produced insights that can be taken forward in their respective fields of policy and practice. Here, the programme has helped to underline the interconnectedness of different parts of a health system and emphasised the need for demand-led priority setting and community ownership of interventions.

Development of capacity for conducting research for GHPHS has been particularly successful at the individual level, where the programme has benefitted both junior and senior-level researchers from LICs. By participating in collaborative and transdisciplinary research, researchers at all levels have gained skills in novel research techniques. They have also been able to add skills in knowledge translation and dissemination to their toolset. These skills they will be able to bring to bear within their further careers, either in academic positions or within other, oftentimes governmental, positions from which they can influence health policy and practice. In this way, individual capacity development is benefitting capacity at the institutional level as well.

Whilst the GPHHSR programme has succeeded in attracting new institutions and researchers to the Dutch GPHHSR community and improving collaboration, this has not materialised to the extent that was hoped for.

For the most part, the different objectives of the programme supported and reinforced each other rather than that significant compromises had to be made.
Project Impacts

Whereas the GHPHSR programme is, in essence, a research funding programme, from the onset it was made clear that research projects had to have clear policy relevance and that research should contribute to the increased use of high-quality knowledge. Submitted proposals also had to include a communication plan that set out how the researchers intended to promote the uptake, translation and application of their findings and how they would work with local stakeholders to encourage the application of research findings in policy and practice.

Examples of such impact could include, for instance, new or changed health policies, health system reforms, systems for health care delivery, and, ultimately, health outcomes. These effects are often hard to observe and attribute as they are influenced by an enormous variety of external factors and because of the lengthy time lag between conclusion of research and changes at the system or policy level. In the following sections, an overview is presented of how the research projects have contributed, or have the potential to contribute, to changes in health policy and practice. This is preceded by a discussion of how the projects engaged in knowledge translation and of the role played therein by the KT-Net project.

6.1 Knowledge Translation

At the onset of the programme, it was hoped that the research coalitions formed would be able to actively take on the task of knowledge translation themselves. However, by the time of the mid-term review, the Steering Committee became concerned that, although projects were beginning to show technical progress, they were unlikely to achieve actual policy impact as the projects were not sufficiently connecting to relevant local stakeholders. Researchers often did not know how to connect or communicate with policy makers, for lack of experience in doing so. In the opinion of the Steering Committee some researchers also did not appear sufficiently interested in engaging policy makers during the conduct of the research. Researchers were often reluctant to do so whilst the research projects were still ongoing, considering it premature and preferring to wait with knowledge translation until conclusions had been fully formed. The committee thus concluded that an ‘interlocutor’ would be required to encourage cross-learning by organising symposia to discuss intermediate results and to support the research teams in dissemination of findings to wider audiences. A third Call for Proposals was issued which resulted in the creation in 2013 of the KT-Net project, led by Makerere University in Uganda.

KT-Net project was primarily focused on enhancing translation and utilisation of knowledge generated by the eight GHPHSR-funded research coalitions. It had five main objectives:

1. Hosting a shared platform for KT (Knowledge Translation)
2. Building KT capacity among the eight coalitions and relevant stakeholders
3. Supporting KT activities across the network by providing technical support and small grants
4. Assessing/evaluating the KT effects across the network
5. Promoting collaborations and sharing KT ‘best practices’ across the GPHRS network and other global partners.
Initially, the role of KT-Net was fairly limited. The plan was for the platform to host annual meetings, designed to bring together representatives of each of the projects to discuss progress and offer training in knowledge translation. This, however, did not yield sufficient effect, also as many projects delegated relatively junior researchers to the meetings. The programme then asked KT-Net to more actively liaise between the projects and help foster linkages. The mission was gradually expanded to also include meetings with, for instance, policy makers and local NGOs. Throughout, the efforts of KT-Net have been concentrated foremost on African researchers and stakeholders, rather than on researchers from the Dutch knowledge institutions.

The final assessment report of KT-Net provides a positive impression of the contribution KT-Net has made to the other eight projects. It has generated over 25 policy briefs and put out numerous other forms of publications, such as press releases, articles, blogs and videos. It also helped organise numerous dialogues between researchers, policy makers and other stakeholders. Indeed, interviewed members of the Steering and Programme Committees hold a favourable view of the project and credit it with having made a commendable contribution to knowledge translation. The methods of knowledge translation and dissemination used by KT-Net generated increased attention for the programme results. It has even been advocated that any future programme of this kind should start from the creation of a shared knowledge translation platform rather than impose this post hoc.

Researchers have a somewhat mixed perception of the contribution KT-Net has made to their knowledge translation activities. Many were appreciative of the support they received in packaging their message, recognising their own shortcomings in this respect, and welcomed the learning opportunities that KT-Net offered. This was particularly the case among African researchers, as they were most involved with KT-Net. They met on several occasions with other coalitions and some were stimulated to think about future collaborations beyond the duration of the programme with implementing institutions from other countries. Others, however, perceived KT-Net mostly as running interference in their projects, especially in the early stages of KT-Net when it was not well understood how KT-Net related to the projects. However, much of this reluctance to work with KT-Net gradually dissipated, as researchers began to see the added value KT-Net could bring them. The extent to which KT-Net was involved with individual projects also varied somewhat, based on both the stage of the research and on the availability of local researchers.

Despite the misgivings of some researchers, the overall impact of KT-Net appears to have been very positive. The nature of KT-Net, as a short-term funded project, however means that there are no provisions to ensure its sustainability or to further support activities still emanating from the projects after their formal completion. Already, for projects that have run over time and for students who are still in the final stages of their PhD research, there is no additional support for publications and dissemination activities anymore. The often substantial delay between completion of research projects – or rather, the funding of projects – and the publication of papers implies that sufficient funds would need to have been set aside to accommodate this, which generally has not been the case as funds needed to be spent within the agreed timelines of the projects (including budget neutral extensions).
6.2 Contributions to policy and practice

6.2.1 Stakeholder engagement

A project’s ability to have impact hinges on the extent to which researchers have been able to communicate with and involve health policy makers, implementers and other important stakeholders. Across the project portfolio, there are examples where researchers have managed to do so. In some cases, this has been done through the organisation of and participation in policy dialogues, often with the assistance of KT-Net. In others, health policy makers were directly involved in aspects of the research, for instance where co-investigators also held positions in the ministry of health. Some researchers have pointed out the inherent tensions that come with working with policy makers in this fashion, as policy makers sometimes have an immediate interest in addressing questions that are not the intended focus of the research. Several of the African researchers are currently holding positions from which they can exert influence on the uptake of research findings into policy and practice, for instance with (regional) ministries of health or with national disease control programmes. For instance, one researcher went on to serve as the provincial Minister of Health in the Bas-Congo region (DR Congo).

Activities aimed at the research-policy interface included:

- Consultations with key stakeholders and community participation (Burundi and DR Congo, COHEISION).
- Dialogue meetings with health committees (Burundi and DR Congo)
- Policy discussions between the Directorate of Laboratories and the Directorate of Reproductive Health on how to increase the uptake of maternal ANC testing (Socialab).
- Findings dissemination meetings (among policy makers and beneficiaries) and a policy brief (MEPR).
- Network at district level to share research and experiences (Burundi and DR Congo).
- Training of policy makers, health workers’ and health managers (ACCELERATE, Burundi and DR Congo).
- An open, searchable resource to assist in identifying the most policy-relevant topics for reducing health inequalities in maternal health in LMICs (MHSAR).
- Targeted interactions at international health policy and systems research conferences between participating policy makers and researchers from the GPHSR countries concerned (all projects)

Among health policy makers interviewed, there is also some evidence of increased engagement with the issues raised by the projects specifically, but also with health systems thinking in general. One policy maker, for instance, has since gone on to take additional courses on health policy and health systems research and indicated that there is now increased emphasis on taking stock of, and using research results in health policy making.

Whereas the engagement with stakeholders can be relatively easily traced, measuring impact of the programme on health systems, policies and practice is far more challenging. The causal chain between research and impact is long and complex and impacts often cannot be clearly attributed. No measurable indicators have been formulated to trace the programme’s impact. Furthermore, some of the funded projects have only relatively recently been completed and not all research findings have been published yet. It is
therefore not possible to provide a complete assessment of the programme’s realised or likely impact. Nonetheless, there are some early indications of contributions to policy and practice.

### 6.2.2 Policy impacts

There are several examples of policy impact emanating from the funded projects. These differ in the nature of the impacts, as well as in their scope and scale (e.g. community level or national).

The MHSAR project, for instance, led to increased focus on strengthening health systems in maternal health programmes in Rwanda and South Africa, by recognising the linkages between health systems and maternal health services. As a result, an early warning system was developed to detect health system failures that could compromise maternal health services. Additionally, a workshop was held with local key stakeholders in the region wherein the participants developed concrete action plans related to each of their individual areas of work, and strategies for holding each other accountable for these plans.

The ACCELERATE project contributed to the development of a clinical decision making tool to identify high risk pregnancies and to assist front line health care workers in the provision of essential maternal and neonatal health care. Whether the implementation of this tool will result in improved maternal outcomes is, as yet, unknown. Other insights gained from the project on factors determining non-adherence to guidelines were not yet taken forward for implementation.

The SOCIOLAB project resulted in recommendations for an improved ANC-laboratory interface in the studied facilities, based on the identified barriers to ANC test uptake. These recommendations were taken up directly by the Directorate of Laboratory in Senegal and are being examined by Mali and Burkina Faso in the context of the RESAOLAB network.

As a consequence of the CBHI project in Ethiopia, a risk pooling system has been integrated with different tiers of the government (regional and federal) in order to allocate the risk at a higher level and to mitigate financial risks. At the federal level, reservations are made to ensure institutional sustainability and provide protection against any form of financial embezzlement, theft or other crisis.

The COHEiSION project in Ghana had indirect, but possibly major policy impact. Some research team members of this project participated in the National Health Insurance Review 2016. Based on this, a new National Health Board and a Patient Protection Council will be installed, aimed at building an actively informed and involved membership to prevent the scheme from being abused and protect members’ interests.

Whilst the above shows that various projects have already had an impact on policy and decision-making, the step from research results to policy remains large. Effective implementation at systems level was often frustrated by more generic policy conditions that are not easily changed within the context of a research project, but that require large efforts. This includes leadership (at policy level, but also in hospital management), governance (including coherence in financing and managerial mandates), accountability (that refers to the culture of performance at the facility level, including the attitude and work ethic of health workers), and ownership (meaning that people with the authority and resources to take action consider themselves the right people to take an issue further).
6.2.3 **Contributions to Practice**

In addition to the above contributions to policy, many projects report contributions to practice. Often these are in the improvement of community involvement, such as in the project on political and social accountability in Burundi and DR Congo, and the CoHeRe and MEPR projects in Ghana and Rwanda respectively. The latter contributed to the creation of Community Malaria Action Teams that are expected to remain active.

The care related projects also led to improvement of the management in the healthcare system (Burundi and DR Congo, MHSAR) and improved communication within the healthcare sector (SOCIOLAB). The SOCIOLAB project resulted in the production of guidelines for midwives and lab personnel on how to conduct maternal HIV testing during antenatal care. These guidelines have been implemented nationally in Senegal.

The COHEiSION and CBHI projects in the health financing area delivered many concrete results, resulting in, among others, increased enrolment in the National Health Insurance Scheme in Ghana, and both client oriented improvements and organisational improvements.

6.3 **Main findings**

The GPHSR programme has clearly underlined that, even when researchers are demonstrably committed to policy-relevant research, knowledge translation and engagement with stakeholders often remains challenging, either for lack of know-how or for different perceptions on the importance of this. The programme has successfully addressed this challenge by putting in place a mediating support platform, in the form of KT-Net. During the programme implementation, the role of KT-Net was gradually expanded to further bridge the divide between researchers and policy makers. Consequently, the programme has overall succeeded to a remarkable degree in getting stakeholders from policy and practice to take note of the programme results. Various examples, albeit at a modest scale, were already found of impact on policy and practice. Whether these impacts will be sustainable or whether they can be scaled-up is largely dependent on factors beyond the direct control of the programme.

Whilst the experience with KT-Net has been largely positive, it appears that for a structure of this kind to be optimally effective, it should be in place before the onset of the research projects and that adequate clarity is provided upfront on the respective roles and responsibilities of the platform vis-à-vis the research teams.
Research Fairness

As explained in Section 2.4, special consideration was given in this evaluation to dimensions associated with fairness in research. In this chapter, each of these dimensions is discussed. The dimensions are each discussed from two perspectives. First, it is considered what activities were undertaken by NWO-WOTRO (that is, at the programme level) and the research teams (at the project level) to promote research fairness in that particular area, at least in theory. Next, it is discussed what effect these activities resorted in practice and what other issues emerged.

7.1 Fairness of opportunity

The RFI methodology refers to fairness of opportunity as providing stakeholders “the opportunity to influence studies or research programmes at the stage or stages where it most impacts on their own ability to learn, contribute or participate, thereby providing a sound foundation for respect in the current and future research partnerships”.

Fairness of opportunity is considered a prerequisite for the design of research that will be relevant and efficient, and that can have lasting impacts. Within this dimension, three topics were examined. Each of these is summarised in the following sections.

7.1.1 Relevance to local communities

Purpose of inclusion of ‘relevance to local communities’ in the RFI methodology is to promote research that is sensitive to the risks and benefits of research to the communities in which research is conducted and takes into account local research system capacities. The intent is, furthermore, to foster collaborative research that enables countries or communities to “further their own research system, competitiveness and contributions to national development plans”.

Indicators within this topic emphasise alignment of research priorities with locally or nationally articulated priorities.

The RFI’s emphasis on ensuring that research conducted is based on locally perceived needs and priorities agrees well with the importance that the GPHS R programme has placed on relevance for development. In its Calls for Proposals for the programme, NWO-WOTRO made this explicit by setting ‘relevance for development’ as one of the selection criteria. Although the calls provided an overarching strategic theme and some key thematic areas – aligned with the health-related MDGs – (section 4.1.3), these were formulated broadly. Within that overarching agenda, it was left up to the research consortia to develop their own research questions, derived from local needs and priorities. In their proposals, applicants had to describe how their research would address problems and opportunities for issues of global and local concern. There was, however, no explicit requirement to structure proposals around local or national health research agenda’s (or similar ‘official’ health and research priorities).

The call text recognised that, for some researchers, ensuring relevance for development in the proposals would mean they would have to step outside of their comfort zones and draw upon the knowledge and experience of local stakeholders. The calls therefore required that, prior to the final funding allocation decision, all applicants of successful pre-proposals would conduct multi-stakeholder workshops in the countries where the research was to take place. Purpose of these workshops was to enhance collaboration.

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12 Research Fairness Initiative COHRED (2017) RFI Reporting guide series:2
with, and obtain input of research partners and other local stakeholders to further develop the proposal (see also section 7.1.2).

The emphasis on ensuring relevance to local communities, policy and practice was maintained throughout the project implementation. Even though the proposals had to describe the research methodology and intended interventions up front, during implementation the research teams were given space to adapt and better tailor their research to local needs.

What was observed in practice was that projects varied in the ways in which the research objectives and questions were developed. Projects usually started out as an idea from the principal (co-)investigator or a senior member of the team. Some projects, such as the ACCELERATE and CBHI projects, were conceived as a direct result of interactions with policy makers in local ministries of health. Others were essentially an extension of prior research (proposals) or a roll-out to another setting (e.g. the MEPR, SOCIOLAB and CBHI projects). Although in many cases the formation of the research partnership was driven by the PI from a Dutch university, in at least one project the research idea originated with the African (co-)PI who initiated the collaboration. None of the PIs indicated that their institutions required them to abide by officially stated local health priorities or research agenda’s. Nonetheless, there was a general sense of moral obligation to ensure that the research is relevant to the communities in which it is conducted.

Even in the absence of a formal requirement, research questions appear to have been sufficiently aligned with local health (research) priorities in the country where the projects were conducted. In Ghana, for instance, the issue of maternal mortality was high on the political agenda at the time. This, together with the fact that the PI had previously been responsible for several projects related to maternal mortality in Ghana, led the ACCELERATE project to focus on maternal health. In the MHSAR project too, the research focus on the relationship between health system factors and maternal health was motivated by efforts by the Rwandan and South African governments to combat maternal mortality. In some other projects, the linkage to national priorities or research agenda’s was less explicit. For instance, in the SOCIOLAB project, the focus on maternal health was introduced to better align with the GPHSR programme objectives but was initially not considered a priority by the research team in Senegal. However, this may well reflect the local research team’s own focus rather than a lack of alignment with health (system) needs. Moreover, the project was initially intended to be set in Mali but, because of political instability there at the time, the fieldwork for the project was moved to Senegal. This entailed a change in the co-PI as well. Consequently, local researchers in this project did not have the same degree of involvement in the design of the research as had been the case in most other projects.

Whereas this evaluation did not explicitly seek out opinions of representatives of local communities or policy-makers on their perceptions of the relevance of the research projects, the project documentation and researcher interviews provide numerous indications that projects were considered relevant and resonated with local stakeholders. Much of this has been captured already in our discussion of contributions to policy and practice (sections 6.2) and therefore is not repeated here.

### 7.1.2 Early engagement of partners

The Calls for Proposals for Rounds 1 and 2 emphasised that “relevant stakeholders in health policy and systems development and implementation from outside the scientific community (e.g. government agencies, NGOs etc) are expected to be engaged in all phases of the programme: from its inception to sharing emerging results.” As part of this
requirement, and to ensure that research projects would properly take into consideration local context and actively engage local stakeholders, NWO-WOTRO mandated all research teams to organise stakeholder workshops in the countries where the research would be conducted. These workshops took place before final selection of the projects, such that the workshop outcomes could be fed back into the project design (e.g. in the formulation of research questions) and methodology.

The mandatory workshops mainly took the form of either a stakeholder presentation, where stakeholders could provide input on the relevance and feasibility of the proposed project, a methodology workshop to refine or define the scope of the proposal, or an ‘open space’ meeting to solicit community input. Consequently, local stakeholders were involved in the design of all projects, although that involvement appears to have been more substantial in some projects than in others, depending also on the maturity of the pre-proposals.

One example where local communities were extensively involved, not only at the onset of the project but throughout its implementation, was the MEPR project in Rwanda. Here, the project was designed bottom-up, by allocating funds to first allowing communities to organise, and then let them identify weaknesses in local malaria control before interventions were developed. The National Malaria Control Programme and Rwandan Ministry of Health were also involved in the proposal development. In Ethiopia, a methodology workshop was organised with, among others, the Ethiopian government, the Ethiopian Health Insurance Agency, bilateral donors, the Dutch embassy and local research institutions, and to refine and define the scope of the research for the CBHI project. The CoHeRe project in Uganda, focused on developing sustainable community health resources in poor settings, took an even more open and community-led approach by deviating from the original intention of developing an intervention, in favour of allowing local communities to develop their own solutions to identified problems. The fact that the programme allowed such flexibility in the design and implementation of the selected projects can be considered a true strength.

Generally, researchers considered the stakeholder workshops very useful. The perception among researchers and other interviewees, based on their interactions with local stakeholders, is that this early engagement contributed to the appreciation of the research and the uptake of findings.

### 7.1.3 Fair Research Contracting

Fairness in contracting between research partners refers not only to fairness in the legal and technical aspects of the contract, but also to balance of power between the contracting academic institutions and their ability to negotiate the terms of the contract on more or less equal terms. In other words, even when contracts are fair, this does not necessarily mean that the contracting process was inherently fair and equal. The latter depends on whether both parties possess sufficient expertise in drafting and understanding the terms of the contract to discuss potential points of contention and arrive at a mutually acceptable outcome.

From the perspective of NWO-WOTRO the contracting party had to formally be the Dutch institution of the PI (or, from the second round, the Dutch co-PI if the PI was from an African institution). This contracting party then was responsible for the financial management of the grant and for arranging the agreements or contracts with third parties. NWO-WOTRO did not further stipulate the contents of these third-party agreements, including those with the African research partners, leaving this responsibility to the Dutch institutions.
The project documentation provided to the evaluators did not contain records of any third-party agreements between the grant recipients and other parties involved in the research. Only in one case was a Memorandum of Understanding (MoU) explicitly referred to: in the MEPR project the signing of the MoU with the Rwandan Ministry of Health – one of the implementing partners and co-funders – and the subsequent processing of administrative financial documents took longer than expected resulting on some delays to the project. However, here too the MoU was not part of the project dossier held by NWO-WOTRO and shared with the evaluators. It was thus not possible to independently confirm whether formal agreements existed in all projects or what their contents were. Instead, this assessment relies on the account of interviewees.

Many researchers indicated that in the formational stages of the partnership the interactions were predominantly informal and based on trust, often emanating from previous collaborations. Nonetheless, various researchers indicated that, once the grant was awarded, formal MoUs and contracts were signed between the lead institution in the Netherlands and the African research partners (e.g. in the MHSAR, CBHI, COHEiSION and CoHeRe projects). The agreements made therein seem to vary across projects. In some projects, more detailed agreements were made, not only on the administration of the grant, but also on, for instance, data ownership or salaries. Furthermore, whereas in some instances agreements were signed with all implementation partners, in others this was done only between the Dutch and African institutions leading the project. In one case, it was remarked that, in retrospect, it would have been beneficial to have also had an MoU outlining the scope of respective partners.

The capacity to negotiate the terms of the contract similarly varied. Institutions like the Noguchi Memorial Institute in Ghana are experienced in managing research grants, whereas this capacity was not always as strongly developed in some of the involved ministries. In at least one case, a language barrier existed between the two contracting parties that complicated the interactions. Whereas one researcher remarked that the project had helped local staff develop skills for grant management, another noted that “managers were not taught in a workshop how to deal with things. Things were ironed out because [one of the PIs] was there, not because they were allowed to make their mistakes and have their capacity built.”

One particular challenge to fairness of opportunity at the programme level, emanated from the requirement in the first funding call that a Dutch principal investigator had to lead the project. Consequently, the initiative to conduct the research and the formation of the consortium was led by the institutions from the Netherlands. In its assessment of the received proposals, the Steering Committee remarked that all projects involved already had existing collaborations and that several of the relatively strong institutions from Sub-Saharan Africa were not included in any of the applications that were received. They therefore advocated for also allowing PIs from African institutions to lead. Consequently, in the second call, it was agreed that the principal investigator could also come from an African institution if they had the necessary knowhow and resources to lead the project, but with the requirement that they would need to have a Dutch partner. As a result of this revision the top two proposals that were funded in the second call were led from Africa.

### 7.2 Fairness of process

Within the RFI framework, fairness of process aims at making explicit the expectations of all partners involved, to provide clarity and reduce negative consequences of miscommunications or misunderstandings. It also aims to encourage partners to live up to the expectations that others may have of them. For this
evaluation, two main topics were considered: fairness in local hiring, training and sourcing, and fairness in collaboration, data ownership, access and usage.

7.2.1 Fairness in local hiring, training and sourcing

Fair local hiring, training and sourcing looks at whether the research appropriately draws on locally available resources, as doing so will have beneficial effects in the country where the research is conducted, beyond the immediate effects of the research itself. It also considers whether local staff are remunerated fairly.

As part of the programme’s objective to support local research capacity development, all proposals were required to involve a minimum of two post-doc or PhD researchers originating from LICs. Furthermore, in the Calls for Proposals, NWO-WOTRO indicated that all applicants had to adhere to national remuneration guidelines in the LICs. Researchers from LICs could be provided with either a salary or a net monthly living allowance. It was, furthermore, specified that:

- an overhead budget is available (max 8% of the budget), which may be used in LICs to help cover expenses related to, for example, office space, secretarial assistance, training and external advisors in the LICs.
- At least 50% of the budget needs to be spent in LICs (infrastructure, activities and/or researchers from developing countries).

Consistent with the programme’s requirements, each of the projects involved LIC researchers from junior, as well as senior levels. Some PhD students had dual appointments at both a Dutch and an African institution. As the evaluation did not look into budget allocations or expenditures, either at the programme level or at the project level, it did not independently confirm whether the projects complied with the requirement that at least half the budget be spent in the African countries. However, it is assumed that any substantial deviation from this would have been mentioned in the MTR and final assessment reports and have been discussed at the board level.

Although one researcher objected to the fact that, for the money that was used to hire one post-doc in the Netherlands, two could have been hired from Africa to work on the same project, for the most part, interviewees did not perceive major issues with fairness in local hiring, training or sourcing. However, there was one major challenge that resulted from the programme’s requirement (in line with NWO policy) that only Dutch institutions could receive the funding, and be responsible for grant management. Consequently, the funds were usually held in a Dutch account and only released to the African institutions in tranches or as reimbursements. As not all Dutch institutions were properly set up to handle this in an expedient manner, this arrangement hindered the ability of the African institutions to effectively manage the work on the ground, where most of the research took place. Many deemed the procedure inefficient and unfair. It also meant that African institutions could not benefit from capacity development in terms of capacity needed to manage projects. This arrangement also meant that certain aspects of the project were more expensive than if this had been done by the African institutions. Some interviewees even indicated that, as more money stayed in the Netherlands for project management, fewer interventions could be implemented in Africa. Whilst this statement appears plausible to a degree, it could not be corroborated by the evaluators for lack of comparative costing data.

13 The SOCIOLAB was the only one that did not involve PhD students hired to work on the project.
7.2.2 Fairness in collaboration, data ownership, access and usage

A commonly heard complaint among LIC researchers in global health and development – as in other fields – is that there has long been a tendency by Western researchers to use local researchers only to collect data, but that these researchers are then excluded from the subsequent analysis and publication steps (sometimes referred to as “parachute” research). It is therefore increasingly recognized that fair collaboration should include clear agreements about data ownership, access and usage that do justice to the involvement of the respective parties.

Whilst it is worth noting that NWO-WOTRO was a co-funder (through the NACCAP programme) of the COHRED publication on fair research contracting, within the text of the Calls for Proposals no expectations were raised concerning fair ownership and use of research data. Neither was this mentioned in the NWO General Terms and Conditions of 2007. The revised terms and conditions of 2011 (applicable to the grants awarded in Rounds 2 and 3) stipulated only that “Research results that have been produced with the aid of NWO funds should be made accessible to the general public and for further research as much and as soon as possible”, and that “Publications supported by NWO funds should therefore, irrespective of other publication possibilities, be made accessible to the general public as quickly as possible via Open Access”. These conditions, however, refer to outputs emanating from the results synthesis, but not to the underlying data sets and do not govern the relationship between research partners. This was therefore left to the parties involved to arrange among themselves. In 2015, NWO-WOTRO introduced new regulations and funding conditions, in which it made consortium agreements that include a stipulation of intellectual property rights to the project data mandatory. Because the regulations were introduced after granting of the final GHPHSR project, however, these conditions did not yet apply.

Interviewed researchers indicated that most often expectations and agreements were clarified verbally, but in at least two projects (CBHI and MEPR) a formal Memorandum of Understanding (MoU) was signed that contained detailed agreements outlining the access to data and authorship. It was established that the parties would have full joint ownership and that all researchers involved would be authors on all papers. In other projects researchers had similar expectations, even when these were not formally laid down.

Indeed, scientific articles linked to the projects all involved researchers from both the Dutch and African institutions. In many of these articles African authors were listed as first and/or last (corresponding) authors. The capacity of African researchers to analyse data and be actively involved in preparation of scientific manuscripts, however, was reported as somewhat variable across projects. Likewise, local researchers at times were said to have been less interested to partake in these processes than the Dutch PIs. This may reflect the fact that not all the African (co-)PIs were full-time engaged in research, whereas the Dutch PIs were all senior researchers at universities. Furthermore, because the PhD students all were registered with Dutch universities, the strong involvement of Dutch senior researchers is to be expected.

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14 NWO-WOTRO (2013) WOTRO Newsflash. When there is no lawyer: guidance for fair research contracting. http://publicatie.nwo.nl/preview?eDGJFY*IP8hDj1A1s1Ak26MXNOp.fp8wK3ZCvJy8F2S*3HEezjy7HQI_3Qxoro

7.3 **FAIR SHARING OF BENEFITS, COSTS AND OUTCOMES**

The third dimension pertaining to fairness in research involves the ways in which costs, benefits and outcomes of individual studies and collaborations are shared between partners. Fair sharing of benefits enables partners to develop their ability to conduct research and be competitive. It also means that the benefits of research flow back into the communities where the research was conducted.

7.3.1 **FAIRNESS IN DEVELOPING RESEARCH SYSTEM CAPACITIES**

Development of the capacity in LIC institutions to conduct GPHHS research was one of the key objectives of the programme, as discussed in detail in section 5.2. As highlighted there, the programme’s emphasis has been on building individual level capacities, with some spill-over effects on the institutional level. As many of the researchers that benefitted from capacity development have remained within academia, or otherwise maintain a link to GPHHSR, the programme has successfully contributed to increasing the research capacity in LIC, at least in the short-term, albeit at a modest scale. Whether this will have a lasting impact is dependent on numerous factors that are largely beyond the control of the GPHHSR programme, NWO-WOTRO or even the researchers themselves. For instance, for the development of their academic careers, researchers rely on the availability of funding and on the ability to obtain tenure at their institutions. In the absence of this, researchers may opt to leave academia. In this light, it is worth considering the observation made by one researcher that, because the PhD degrees were awarded by Dutch institutions, the African supervisors did not get the same recognition for their contributions. Dutch universities also receive a so-called ‘promotiebonus’, a financial reward, for every PhD student who completes his or her thesis at the university. As these bonuses are awarded to the universities rather than to the individual thesis supervisors or the research groups, it is unlikely that the African institutions will have shared in these bonuses.

Within the context of the GPHHSR programme, no explicit efforts were made to stimulate longer-term and institutional level research capacity development. The evaluators are not aware of any cases wherein (junior) researchers were contractually required to stay within their host institutions or elsewhere within the public sector for any substantial period beyond the project duration (so-called ‘bonding’, a practice more commonly applied in the training and retention of health workers). Rather, several institutions were unable to guarantee the positions of the researchers after their promotions for lack of funding.

As a funder for relatively short-term research projects, the GPHHSR programme also was not designed to support longer-term relations between the Dutch and African institutions within the research coalitions. In general, this type of support falls outside of the purview of NWO-WOTRO as it primarily a science funding institution. It would be more within the mandate of Nuffic, the Dutch organisation for internationalisation in education, for instance via its ‘Netherlands Initiative for Capacity development in Higher Education’ (NICHE) (operational until 2022) programme or its successor the ‘Orange Knowledge Programme’.16

7.4 **MAIN FINDINGS**

Significant steps were taken at the level of the programme and the projects to promote fairness of opportunity, particularly by ensuring relevance to local communities and engagement of local stakeholders in the design and subsequent implementation of the projects. This was done mostly through meetings and

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workshops (e.g. the proposal development workshops) with communities and stakeholders rather than by relying on formally stated local health (research) priorities.

In the relationship between Dutch and local research partners, NWO-WOTRO mostly left responsibility for the terms of the collaboration to the parties involved. Most of the partners, on both ends, perceived the North-South collaboration as fair: issues were discussed and the respective roles and responsibilities were jointly decided upon. Even in projects that did not take off very smoothly and that required time to understand and establish relationships, the collaborations were still perceived as fundamentally positive. However, naturally some difficulties were encountered as well. Not all Dutch institutions had substantive experience with North-South collaborations, which posed challenges to both sides of the partnership. This inexperience manifested, for instance, in one partner bringing in a researcher from another African country rather than seeking (or developing) capacity locally, thereby creating tension in the partnership. In another project, the researcher from the African institution considered its Dutch partner to have exhibited somewhat controlling behaviour by wanting to control the local activities, even though they were not on site.

Other challenges included problems with communication, the political environment, cultural differences in working styles (e.g. greater expectations of formality and deference to hierarchy by African researchers), and perceived lack of engagement by local researchers as a result of them holding jobs in addition to their research tasks, or having to participate in field activities outside the scope of the project. Notwithstanding some of these challenges, researchers across the various consortia indicate that they would welcome further collaboration with these partners, provided funds are available to do so. Several partnerships have already gone on to apply for further funding to continue their collaboration.
Whereas the preceding sections have looked at the GHPHSR programme primarily through the lens of its effectiveness, it is also important to consider the programme from the perspective of relevance and utility. **Relevance** herein refers to the relation between the programme’s objectives and the needs and gaps the programme sought to address. **Utility** takes an even broader scope, in that it considers the programme against the backdrop of the global health and development agenda. This chapter considers each of these dimensions respectively and looks at the programme in its global context.

### 8.1 Relevance

To better understand the relevance of the GHPHSR programme, one needs to consider developments in the broader global health research community, as well as in the Netherlands at the time the programme was created.

First, as elaborated in section 1.2, in the first decade of the 21st century, much of the research in the field of global health was rather mono-disciplinary. For instance, epidemiologists would be focussed on disease prevalence, medical anthropologists would be looking at how communities interact with healthcare providers, and health economists would look at the effectiveness of health insurance. However, it was uncommon for these disciplines to come together and look at health, health interventions and health systems in a holistic way.

The realisation that there was a need for a different approach to conducting global health research came hand in hand with a shift from more vertical approaches to delivery of health services, to one that stressed the importance of integrated health systems. Against the backdrop of insufficient progress against the MDGs, strengthening of health systems came to be recognised as a necessity, but the evidence base for how to achieve this was weak. This, in turn, required a deeper understanding of the complex interplay between different elements or building blocks of a health system through research. Such a ‘health systems thinking’ approach called for researchers from different disciplines to put together their expertise.

The need for more multi- and transdisciplinary research for global health and development was also felt in the Netherlands (see also section 1.2). Here too, the research community was substantially divided along disciplinary lines. A key aspect of the relevance of the GHPHSR programme therefore lies in it having encouraged members from different disciplines of the research community to come together in research projects that were structured around complex questions. At the time the programme was created there were few other funding opportunities for such multidisciplinary health systems-based research. This observation is underscored by the fact that several PIs and some with close familiarity with the programme indicated they were not aware of significant alternative funding options. Whereas open funding programmes would, in theory, have been accessible as well, these were not considered supportive of the complex type of projects that were conducted under the GHPHSR programme.

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The consensus among interviewees and survey respondents therefore is that the GPHSR programme was both necessary and timely. The focus on funding research with relevance for strengthening of health systems was in keeping with the identified priorities for global health and development, set both globally and in the Netherlands. Within this overarching objective, also the thematic areas addressed by the funded projects were considered appropriate by those with broad and good familiarity with the programme (Figure 5). The fact that the programme took a demand-driven approach to programming, rather than imposing priorities top-down, was generally considered positive. The mid-term reviews confirmed that most of the projects were relevant for the local context.

Figure 5 Perceived appropriateness of the programme’s priority areas in relation to the global health and development agenda among respondents broadly and well aware with the programme (N=18)

In the preparations for the second Call for Proposals, members of the Steering Committee met with members of the Netherlands Platform for GPHSR. Here, the platform members expressed enthusiasm for the programme’s increased focus on governance and accountability, issues that are of great importance to the proper functioning of health systems but were not well studied. Interviewed members of the programme and steering committee, all of whom can be considered experts in the field, felt that overall the projects addressed relevant research questions. The programme’s preparedness to fund complex and, at times, high-risk projects created substantial added value beyond existing funding opportunities.

The programme had some further distinctive features that added to its relevance, such as the emphasis on bilateral research collaboration, engagement with policy-makers, and community-based approaches. These features are particularly important in relation to the programme’s objective to support research capacity development in LICs. The need for development of such capacity is widely acknowledged, as locally-led health research in LMICs is considered critical to overcoming health challenges and achieving universal health coverage. However, there is uncertainty about how best to tackle this challenge.

A recent meta-analysis by Franzen et al. looked at various methods commonly used for health research capacity development (HRCD) to consider their relative effectiveness and merits. The paper reflects on

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different modalities for HRCD: vertical research projects, centres of excellence, North-South partnership (project-specific), and networks and consortia. It identifies various ‘good practices’ but observes that these are not always enacted. For instance, North-South collaborations between HIC and LIC research institutions are considered to have the potential for more sustainable HRCD impact than vertical projects, but in practice such collaborations cannot always be considered equal partnerships, due to uneven power relations. The authors also emphasise the importance of research being led by local investigators rather than by investigators from the HIC countries that provide the research funding, a practice they observe remains pervasive. They conclude that “the persistence of flawed development strategies is driven by approaching capacity development within the context of a dedicated research model. This creates a trade-off between doing good research and doing good capacity development. Projects prioritising good research place research outputs as the primary goal and assume capacity will be developed through limited LMIC involvement in research activities. This means that specific development strategies designed to improve capacity are not used. This ‘implicit’ capacity development is known to be largely ineffective, yet is it regularly used.”

Whereas researchers in the GHPHSR programme did not perceive such a strong trade-off, and most commonly felt that the attention for capacity development went hand-in-hand with conducting policy-relevant research, the question can still be asked whether – from the perspective of capacity development for health research – a programme such as GHPHSR is the optimal modality.

8.2 Utility

At the time the GHPHSR programme was created, the global health and development agendas were largely shaped around the Millennium Development Goals. The three relevant goals to consider in this regard were:

- MDG4: Reduce child mortality
- MDG5: Improve maternal health
- MDG6: Combat HIV/AIDS, malaria and other diseases

As highlighted throughout this report, the Calls for Proposals in Rounds 1 and 2 were relatively open but among the final selection of projects, three main themes could be discerned: antenatal and maternal health, health financing and community empowerment. The first of these clearly aligns with the emphasis on MDGs 4 and 5. The second theme ‘health financing’ corresponds with one of the WHO health system ‘building blocks’. This framework, published in 2007, provides the basic framework for health systems thinking. In that regard, both themes were very much in line with the thinking of the time. Survey respondents with ‘broad’ and ‘good’ familiarity with the programme agree that the programme’s higher-order objectives, including the emphasis on supporting research for strengthening of health systems, aligned well to very well with the global health and development agendas at the time. (Figure 6).
The MDGs ended in 2015 and have since been succeeded by the Sustainable Development Goals (SDGs). Whereas under the MDGs health took a prime position, with three separate goals, under the SDGs health has been brought under a single goal. SDG 3 aims to “ensure healthy lives and promote wellbeing for all at all ages”. This overarching goal has been broken down further into ten targets. Compared to the health-related MDGs, SDG3 takes a more holistic approach by including targets on achieving universal health coverage (target 3.8), non-communicable disease (target 3.4) and considering health in the context of environmental challenges (target 3.9). Other SDGs have a connection to SDG3 as well, as they relate to determinants of (ill) health. These include, but are not limited to, poverty (SDG1), nutrition (SDG2), gender equality (SDG5), sanitation (SDG6) and the effects of climate change (SDG13). Whilst the priorities that were set in the era of the MDGs remain relevant under the SDGs – maternal and child health, and communicable diseases continue to have explicit targets, the SDGs call for a recalibration of priorities also in the agenda for GPHSR (see also section 10.5). Already at the level of NWO-WOTRO the SDGs are used as the general strategic framework for research programming; moreover, NWO-WOTRO leads the SDG knowledge agenda for the Netherlands.

8.3 Main findings

Against the backdrop of developments in both the global and Dutch community for research for health and development, most notably the MDGs, the GPHSR programme was a highly relevant and timely addition to the Dutch research landscape. The programme offered a relatively unique funding opportunity for complex, transdisciplinary health-research projects. Care was taken to ensure, or at least encourage, that the research conducted under the programme would be relevant to local communities and stakeholders. The focus of the programme remains highly relevant in the era of the SDGs, where the emphasis on holistic system-based approaches is arguably even stronger.

Although the programme has admirably attempted to marry support for research with support for research capacity development, and to a degree has succeeded in this attempt, from the perspective of capacity development other modalities may hold greater potential for long-term and meaningful impact.
Cross-cutting observations

Beyond the observed effects of the projects (outputs, outcomes and impacts), and the relevance and utility of the programme as a whole, a number of cross-cutting observations were made. These observations should be considered as the ‘benefits of hindsight’ rather than as a programme critique, and are intended to feed into recommendations for future research programming in this field.

9.1 Complexity

The research funded by the GPHSR programme is characterised by a large degree of complexity. For one, projects were conducted by consortia of a minimum of three, but sometimes as many as five institutions – frequently involving implementation partners as well. These partners were spread over multiple locations, both in the North and in the South. Second, the projects brought together researchers from various scientific disciplines who were not always used to interacting with each other. Third, they commonly were constructed around several separate PhD or post-doc projects. This complexity is reflected in the fact that in the programme documentation, the projects are usually referred to as “programmes” in their own right rather than as projects. Whereas one can argue the distinction is semantic, the chosen terminology is testament to the unusual nature of the projects.

The complexity of the projects is to a large extent driven by the objectives of the programme: health systems, by definition, are complex systems and research in this field thus requires a multi- or transdisciplinary approach. This, in turn, calls for the involvement of a coalition of researchers. Moreover, policy-relevant research depends on the meaningful engagement of local stakeholders. The third element of complexity, however, can be linked – at least in part – to the way in which the calls were structured, as applicants were required to provide separate descriptions, including research questions and methodologies, for each of the PhD or post-doc projects. Breaking down the projects this way allowed the research teams to focus at, for instance, different levels of the health system (e.g. at the facility, managerial and national levels in the ACCELERATE project) or different study settings (e.g. in Rwanda and South Africa, in the MHSAR project).

Whilst from the perspective of relevance of the projects, and thus the programme, the focus on this kind of complex research is highly commendable, in practice it also posed certain challenges. Even though the research coalitions were mostly based around prior collaborations between senior researchers, the interactions between the research teams were not always very smooth. Interviews with researchers and members of the programme and steering committees revealed that, in some coalitions, there were tensions that negatively impacted the progress within the projects. Expectations on respective roles and responsibilities were not always immediately clear. The geographic spread posed challenges as well. Dutch researchers, especially senior investigators, not always were sufficiently aware of realities in the field, as they did not frequently visit the research sites. Research that was spread over multiple countries faced particular challenges, as it was costly for researchers from the LICs to travel between them. This limited the flow of information between different project sites.

In general, many projects appear to have struggled with integrating the different research components. In half of all the mid-term reviews, the reviewers expressed serious concerns about the level of disconnect between parts of the research. By the time of the final assessments, this integration appears to have improved somewhat, although various projects fell short of the expectations of the assessors (and the researchers).
9.2 Ambitions and scope

For a programme of relatively modest means, the GHPHSR programme had set itself a rather ambitious agenda. Not only did it link objectives for supporting research to capacity development and fostering collaboration, it also emphasised on complex and risky projects whilst leaving a relatively broad scope. Indeed, early in the development of the calls, the programme was cautioned by members of the Netherlands Platform for GHPHSR against becoming too ambitious. It was recommended that the programme should narrow its scope, for instance thematically or geographically. This would create greater synergy between the projects and make the management of the programme more efficient. Whilst the programme did set thematic and geographic priorities, it kept a fairly wide-ranging scope. Whilst the projects have produced some interesting results, and the programme has made some contributions in each of its objectives, the overall impacts are relatively small scale and their longer-term sustainability is unclear.

In hindsight, one could conclude that the ambitions perhaps were somewhat too high, not only at the level of the programme but also, and possibly even more so, within individual projects. During the mid-term reviews it was flagged that many projects were behind schedule or had encountered difficulties in the start-up and implementation. Several of the final assessments explicitly stated that the ambition levels for the projects had been too high and that objectives were not fully met, despite many interesting and relevant results. A certain degree of overreaching is always to be expected, especially in the context of a competitive funding call. The Programme Committee also recognised this and opted to accommodate it by allowing a degree of flexibility in the work plans, but supporting the coalitions in aiming high. It could be argued that in its choices the programme favoured potentially overly ambitious research at the expense of more modest, yet more realistic proposals. Nonetheless, the evaluators feel that overall the choices were deliberate risks well taken.

9.3 Monitoring, evaluation & risk mitigation

From the previous discussions on complexity and ambitions, a further observation arises. That is, whilst the GHPHSR funded projects were in several ways unusual research projects, they were initially monitored the same way as most other NWO-WOTRO research projects at the time. This meant that, beyond the mid-term reviews and final assessment, there would be no regular monitoring of progress. Whilst the projects were at the core research projects, their greater proximity to policy and practice made them particularly sensitive to contextual factors that could constrain their progress, such as political pressures to refocus aspects of the research and reliance on external stakeholders for, for instance, funding, data access or implementation of study interventions. Combined with their inherent complexity, this meant that many projects encountered challenges that caused delays and in some cases led to deviations from the original work plans that were not properly communicated to NWO-WOTRO.

At the urging of the SC more regular monitoring was introduced. It is clear, both from the project documentation and from discussions with the members of the steering committee, that this resulted effect. The mid-term reviews were particularly valuable in identifying weaknesses in the programme implementation. The corrective measures suggested in these reviews were mostly well taken up by the research teams and contributed to the final results.

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21 The evaluators did not review the assessment of unsuccessful proposals and therefore does not have insight into the ambition level of those proposals. The observation, however, extends to hypothetical (or adjusted) proposals that could have been developed by the same researchers in which the expectations were lower.
It is also worth noting that proposals did not include a risk identification and mitigation plans. In one case, the mid-term review urged a risk identification would be done, in relation to developing political instability in the study country (Burundi), though this was not done. This part of the project was subsequently suspended as the situation became too unsafe to continue operating. In other cases, the lack of contingency planning for encountered problems, such as loss of external funding or of key stakeholders from the project, had strong negative impacts on the projects. Whilst risk identification and mitigation planning is not commonly done in basic research projects, and indeed risks often come from unexpected corners, there can be some benefit in encouraging researchers to consider alternative approaches and scenario’s in the design of their research. This is especially true when (parts of the) research is set in fragile contexts or is reliant on the involvement (financial or otherwise) of external parties.

9.4 **Main findings**

In retrospect, various issues have emerged that have challenged or constrained the overall success of the programme. These relate primarily to the complex nature of the research itself and to the design of the projects in relation to this complexity. Whilst some complexity is arguably both necessary and unavoidable in the field of GPHSR, the programme offers some insights into how the resulting risks can be mitigated. It is shown that a combination of careful progress monitoring on the one hand, and adaptability – both by the researchers and by the funder – on the other is a key success factor. In addition, mechanisms to promote knowledge exchange within and across the research teams are necessary to ensure true transdisciplinarity and learning.
**Conclusions and recommendations**

In this final chapter, the main observations of the preceding chapters and their implications are brought together. These have been grouped around the evaluation dimensions of effectiveness and relevance, with separate attention being paid to issues of sustainability and fairness. The final section of this chapter offers a set of recommendations. Since at present it is not known whether there will be a continuation of the programme and, if so, what form such a programme would take, these recommendations are mostly strategic in nature. Where more operational recommendations are offered, these should be seen as having relevance not only for future GPHSR programming but more generally for programming for complex and systems-based research.

### 10.1 Programme effectiveness

Through three successive Calls for Proposals, a total of nine coalitions and projects were funded. Eight of these were research projects, and one was the cross-cutting KT-Net project that focussed on assisting the other coalitions with knowledge translation and communication.

On the primary programme objective of contributing to knowledge generation to support health systems strengthening in LICs, this evaluation finds that the programme has had substantial success. There has been a substantial scientific output with numerous publications in high-impact journals, in addition to a strong output of non-scientific publications, such as policy briefs and articles in the popular press. Results of the funded projects yielded various insights that can be, and in some cases already are being, taken forward in their respective fields of policy and practice. This include a better understanding of the interconnectedness of different parts of a health system, for instance the influence of governance and decision-making structures or health financing systems (insurance) on quality of health care, as well as of the importance of community empowerment.

Although some of the funded projects fell short of their own stated ambitions, relevant findings were obtained that have impacted, or have the potential to impact, policy and practice. These have been discussed in detail in Chapters 5 and 6, but are summarised in Table 3. Stakeholders from policy and practice appear to have taken note of the programme results, even if in many cases it remains to be seen whether this will ultimately translate into impact. Moreover, whether such impacts will be sustainable or whether they can be scaled-up is largely dependent on factors beyond the direct control of the programme.

**Table 3 Main scientific insights of the GPHSR programme**

<table>
<thead>
<tr>
<th>Lessons learned: scientific insights</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Poor outcomes of new-born and maternal care are often not simply the result of poor technical quality of services provided. The client-provider interface is strongly affected by broader contextual and health systems factors at all levels of the health system. This includes, among others, the agency and decision-making space of healthcare providers and health facility managers.</td>
</tr>
<tr>
<td>• Community Health Workers can form an important linkage between the community and the formal health system. They contribute directly to the quality of services provided, but also act as a conduit for accountability, by presenting women with a trusted channel of communication.</td>
</tr>
<tr>
<td>• Health seeking behaviour is strongly correlated with the costs of healthcare and ability to afford it.</td>
</tr>
</tbody>
</table>
By enabling households to absorb financial shocks from unexpected ill health, health insurance encourages uptake of essential health services. Design of health insurance schemes, however, should carefully take account of the impacts on patients, as well as health care providers to avoid negative impacts on quality of care and workload.

- Successful and sustainable health interventions require meaningful community engagement, not only during implementation but also in planning and design. Interventions should be structured by, and based on the needs and priorities of the community in which they are set.

Beyond supporting knowledge generation for health systems strengthening, the programme had two further objectives, namely contributing to capacity development for research in LICs and contributing to strengthening collaboration in the Dutch GPHSR knowledge community. In respect to the former, the programme has emphasised on individual capacity development, through supporting junior and senior researchers, with spill-over effects at the institutional level. The significant involvement of researchers from LICs at all levels in the projects has certainly made a positive contribution. Junior researchers have been given the opportunity to start their academic careers, by supporting them in PhD and post-doc projects where they learned many valuable research skills. Senior researchers likewise benefitted from capacity development, by exposure to new research methods and working across scientific disciplines. It is encouraging to note that the majority of newly trained researchers remain in positions, either in academia or in the public sector, from which they will be able to contribute to strengthening their local health systems. Within the scope of a, by international standards, relatively small scale research programme, capacity development however is bound to remain small in scale. The programme also does not have the means to ensure the sustainability of these efforts in the long-term.

The contribution to strengthening collaboration in the Dutch GPHSR community has not been as strong as was hoped. Whilst the programme has successfully attracted a number of new researchers to the field, at least for the duration of the programme, overall the field remains fairly fragmented. After the external funding for the Netherlands Platform for GPHSR ended, the community did not self-organise in any other way to jointly discuss priorities and agenda’s. At the level of the coalitions formed under the programme, some coalitions appear to be more lasting than others. This most often depends on individual researchers – who for instance have dual appointments – or on the availability of funding for further collaborative research.

These results and impacts, as achieved through the individual projects, reveal several critical factors for the success of research such as that funded by the GPHSR programme. These have been summarised in Table 4.

Table 4 Critical success factors

Lessons learned: conditions for successful GPHSR

- Knowledge translation and direct engagement with policy makers and practitioners – not just by dissemination of research findings but during design and implementation of the research – is outside of the ‘comfort zone’ for many researchers. Policy-relevant research requires academics to become more familiar with effective stakeholder engagement and communication. Support for knowledge translation has the most potential for being effective if it comes at an early stage of the research and if there is sufficient clarity among researchers and the platform on mutual roles and responsibilities.
Large, complex research with multiple stakeholders requires clear leadership and coordination, with sufficient commitment from senior researchers. Regular reporting and monitoring of progress is important to make timely adjustments to protocols and work plans, and to mitigate emerging risks. In addition, sufficient flexibility is needed to adjust projects during implementation.

Transdisciplinary research projects need a clear plan for the integration of different elements and disciplines to provide 'connective tissue' for the project. This involves regular communication, preferably including face-to-face, between researchers working on different projects or in different project sites.

Proper understanding of local contexts, conditions and expectations, both in the field and in LIC-based institutions, requires good communication and presence in the countries where the research takes place.

Meaningful, efficient North-South collaboration is essential for policy-relevant research and impact. This should include enabling South-initiated and -led research, and support for projects designed by stakeholders in the South.

Platforms to organise and promote collaboration, knowledge sharing and mutual learning in research require sustainable funding and institutional ownership.

10.2 Programme relevance

The programme placed appropriate emphasis on relevance a priori by seeking the input of national and international experts in the field of GPHSR, including via the selected members of the SC and PC. Their contributions helped design a programme whose objectives and strategic focus were based on high-level priorities in the global health and development agenda’s. The programme also filled a gap in the Dutch research funding landscape.

The programme’s approach for bottom-up programming and involving local stakeholders in the project design certainly made a positive contribution to the relevance of the projects. Nonetheless, the evaluators note that, with some notable exceptions, the research appears to have been driven more by the research coalitions, soliciting inputs from local stakeholders only for fine-tuning proposals, than that it was truly led by demand from the field (e.g. requested by local policy makers or communities). This does of course not necessarily mean that the research that was conducted was not relevant, though it underlines the risk of imposing Northern-led research agenda’s on LICs.

Despite this reservation, the evaluators recognise that the GPHSR programme’s general relevance is demonstrated by the fact that several projects have had tangible impacts on policy and practice. At the earliest point of the knowledge translation pathway, the programme has contributed to improved communication with, and engagement of, local policy makers and implementers in research. Researchers, both in the Netherlands and LIC, have developed a capacity for knowledge translation that they have been able to use in the development of policy-relevant outputs (e.g. policy briefs and dialogues) or outputs relevant for clinical practice (e.g. recommendations for the improvement of maternal healthcare). KT-Net has been a valuable catalyst in this process. Further down the pathway, some of the projects have also resulted in policy impacts such as a review of the design and implementation of the health insurance schemes in Ethiopia and Ghana. Overall, the evaluation finds that the programme can be considered to have been highly relevant to
the priorities and needs of the time. With shifting international and national priorities, such as the SDGs and a greater focus on sexual and reproductive health and rights by the Dutch government, some reassessment of the priorities for future GHPHSR seems warranted, although the systems approach taken in the programme already has clear relevance to the SDGs as well.

10.3 Scale-up and sustainability of contributions

The GHPHSR programme throughout has been driven by an intent to get researchers, in the Netherlands as well as in the South, to take notice of the importance of GHPHSR and its relevance to policy and practice. In this light, the projects funded were intended as a demonstration of “proof of principle”. The programme, however, did not aim for large scale and sustainable impacts of the projects on health systems and policies. Projects were not required to develop a plan for roll-out and scale up the results and no funds are available to support this. At the programme level, some effort has been undertaken (through the involvement of KT-Net and at the urging of the Steering Committee) to promote synergy between projects. For instance, researchers from the projects on health insurance in Ghana and Ethiopia respectively were urged to share experiences. Such interactions may provide greater applicability to research findings and contribute to the potential for scale-up.

Overall, expectations for impact at the far end of the policy and practice spectrum should be inherently modest for a programme of this kind; having funded just eight research projects, each with an average budget of just under €800k, and spread over eight countries. Whilst it is positive that policy relevance has been an important focus of the programme, in reality, research is sufficiently far removed from the policy making process that one can often not hope for impact beyond having engaged policy makers and having made them aware of findings. In that regards, the programme has made commendable efforts.

Also in terms of capacity development, the sustainability of the programme’s contributions deserves some consideration. Whilst the programme has clearly contributed – albeit on a modest scale – to local research capacities, whether this will translate also into meaningful capacity in the mid-to long-term in uncertain. This depends on how the careers of the researchers involved will progress and how they use the knowledge they have obtained for the better of African research and health policy.

Whether capacity development is sustainable at the institutional level depends on various factors. First, the issue is whether the institute can retain these researchers in the face of competing demands for their expertise, for instance from international NGOs and donor organisations. This includes whether researchers have sufficient opportunities to attract funding for further research and whether their institutions provide space to continue these lines of research. Some African researchers have already indicated that they have concerns about the lack of career possibilities for their junior researchers in the face of budget constraints in the public sector, including academia. Additionally, critical mass needs to be achieved such that the institute is no longer reliant on individual capacities. Generation of additional capacity may require longer-term commitment both on the part of the Dutch institutions and in the African institutions themselves. Encouragingly, Dutch PIs in several projects expressed an interest in continuing their collaboration with their African colleagues in future projects, if funding is available.

Only during the final years of the GHPHSR Programme discussions took place to explore longer-term sustainability of the health policy and systems research agenda between and among African research
institutions and Dutch universities or research institutes, notably during a special session on this at the 2016 Kampala Conference. Among the more prominent recommendations from these, the importance was noted to ensure specific demand from the African research community, as opposed to the dominant current supply-driven initiatives that originate in Northern academic institutions or research funders. As such, proactive research initiatives by African constituencies would need to approach Dutch institutions for funding, rather than waiting for and responding to Dutch calls-for-proposals. In this light, one example worth mentioning is that recently the health research unit of the Ghana Health Service was said to have sought input from district health managers on future research priorities and that the GPHHSR programme has helped to bring greater awareness among some local decision-makers of the important of being involved in this process.

10.4 Fairness in research

Although ‘fairness in research’ was not an explicit aim of the GPHHSR programme, the general principle of fairness underpins the work of NWO-WOTRO and is apparent in many aspects of the programme design, even if not always rendered explicit. Furthermore, during the implementation of the GPHHSR programme – partly inspired by the challenges encountered therein – NWO-WOTRO has made some welcome policy changes that likely will further promote fairness in research. In particular, enabling research projects to be led and managed by non-Dutch institutions has the potential to result in better South-led research.

Whilst the North-South collaboration in the GPHHSR-supported projects was not always without its challenges, these appear to have been mostly the result of cultural differences or logistical and administrative challenges rather than that they are indicative of serious inequities in the partnership. Nonetheless, fairness in research deserves continued attention within the research community itself, as well as at the level of research funders such as NWO-WOTRO.

10.5 Recommendations

At present, it is not known what the intentions are within the Ministry of Foreign Affairs or NWO-WOTRO to continue funding research with relevance to global health systems and policies. The here presented recommendations thus take a broad perspective on what factors to consider in the design of any research programme in this field, without focussing at issues specific to the GPHHSR programme.

10.5.1 Recommendations for GPHHSR programming

- Complex research involving a wide-ranging set of stakeholders requires a more hands-on approach to monitoring project progress to timely identify and respond to challenges. This is particularly the case in high-risk research settings.

- Because of the inherent complexity of GPHHSR projects, sufficient room needs to be given to adapt the research in line with emerged challenges or insights. This requires a flexibility on the part of the funder to allow changes to the project plan and corresponding reallocation of resources. On their part, researchers have a responsibility to adequately communicate challenges early on and flag potential implications for the project.

- Priority setting for future GPHHSR programme should be more clearly demand driven, led by researchers and other stakeholders from the South. Where available, national (health) research agendas of LICs should be prioritised.
The transition from the MDGs to the Sustainable Development Goals marks a further shift towards integrated health systems and thinking beyond the traditional confines of healthcare systems, e.g. social determinants of health (e.g. inequality and life style), migration and security, and climate change. This broader thinking should be taken into account in further programming for GPHSR in the Netherlands. Universal Health Coverage in particular will be a key priority area within GPHSR for the next 10 to 15 years. In a recent report, the Clingendael institute has identified five paradigms through which global health can be viewed, namely: 1) Health & Security (e.g. migration, pandemic preparedness, climate change), 2) Health & Development (e.g. poverty & inequity, access to healthcare), 3) Health & Trade (e.g. access to medicine), 4) Health & Global Public Goods (e.g. market failures, R&D), 5) Health & Human Rights. These paradigms offer a useful starting point for broad stakeholder discussion on the GPHSR agenda.

At the level of the Netherlands Ministry of Foreign Affairs, the focus has in recent years shifted towards sexual and reproductive health and rights. The emphasis on maternal and child health remains important within this agenda. Of particular interest from the perspective of the ministry would be research around issues affecting adolescents, and on health security in fragile contexts.

**10.5.2 Recommendations for health research capacity development**

- Sustainable and institutional capacity development for GPHSR in LICs requires a more dedicated modality, such as programmes for ‘training of trainers’, support for South-South research collaborations and networks, or institutional twinning. This also calls for a longer time-horizon for funding and support.
- Individual level research capacity development through participation in research should remain a component of funding programmes.

**10.5.3 Recommendations for collaboration and cohesion in the Dutch GPHSR community**

- The continued fragmentation of the Dutch GPHSR community suggests a central point of organisation and coordination, to regularly bring together researchers from different disciplines and foster communication, is needed. The model of the Dutch Knowledge Platforms for global development could serve as inspiration. AIGHD potentially could also take on this role.

**10.5.4 General recommendations**

- Fairness in research should be a central tenet of any funding programme for research for development. Guidance on how to achieve this and adhere to good practices, whilst avoiding bad ones, can be extremely valuable. NWO-WOTRO could encourage (voluntary) reporting by funded researchers on the indicators formulated by the Research Fairness Initiative. It could also endorse the RFI and seek certification itself.

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23 The evaluators have not conducted an assessment of the respective advantages and disadvantages of different modalities for capacity development and therefore are not recommending a particular model. The here mentioned modalities should be seen merely as an illustration of possibilities, to be explored further on the basis of the specific objectives.
### Appendix A List of Interviewees

<table>
<thead>
<tr>
<th>Name</th>
<th>Role within GPHSR programme</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. O. Pannenborg</td>
<td>SC</td>
</tr>
<tr>
<td>Prof.dr. S. Matlin</td>
<td>SC</td>
</tr>
<tr>
<td>I. Huijts</td>
<td>SC</td>
</tr>
<tr>
<td>Prof.dr. R. Leke</td>
<td>SC</td>
</tr>
<tr>
<td>Dr. H. Wildschut</td>
<td>PC</td>
</tr>
<tr>
<td>Prof.dr. G. Tomson</td>
<td>PC</td>
</tr>
<tr>
<td>Dr. L. Dare</td>
<td>PC</td>
</tr>
<tr>
<td>Dr. M. van Vugt</td>
<td>PI 07.45.101</td>
</tr>
<tr>
<td>Dr. S. Koenraadt</td>
<td>PI 07.45.101</td>
</tr>
<tr>
<td>Dr. L. Mutesa</td>
<td>PI 07.45.101</td>
</tr>
<tr>
<td>Prof. J. van Dijk</td>
<td>PI 07.45.102</td>
</tr>
<tr>
<td>Prof.dr. I. Agyepong</td>
<td>PI 07.45.102</td>
</tr>
<tr>
<td>Prof.dr. A. Bedi</td>
<td>PI 07.45.103</td>
</tr>
<tr>
<td>Dr. G. Alemu</td>
<td>PI 07.45.103</td>
</tr>
<tr>
<td>Dr. D. Arhinful</td>
<td>PI 07.45.104</td>
</tr>
<tr>
<td>Prof.dr. R. Pool</td>
<td>PI 07.45.105</td>
</tr>
<tr>
<td>Dr. M. Dieleman</td>
<td>Co-PI 07.45.201</td>
</tr>
<tr>
<td>Prof. D. Blaauw</td>
<td>PI 07.45.202</td>
</tr>
<tr>
<td>Dr. L. Bijlmakers</td>
<td>PI 07.45.202</td>
</tr>
<tr>
<td>Dr. P. Ondoa</td>
<td>PI 07.45.203</td>
</tr>
<tr>
<td>Dr. S. Kiwanuka</td>
<td>PI 07.45.301</td>
</tr>
<tr>
<td>Dr. D. Walugembe</td>
<td>PI 07.45.301</td>
</tr>
<tr>
<td>Dr. A. Rulisa</td>
<td>Health policy maker Rwanda</td>
</tr>
<tr>
<td>Dr. Gifty Ofori Ansah</td>
<td>Health policy maker Ghana</td>
</tr>
</tbody>
</table>
## APPENDIX B MEMBERS OF GPHSR GOVERNANCE STRUCTURES

### B.1 NWO-WOTRO SECRETARIAT

<table>
<thead>
<tr>
<th>Name</th>
<th>Period</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Eva Rijkers</td>
<td>2009-2014</td>
</tr>
<tr>
<td>Dr Martijn Wienia</td>
<td>2014 -</td>
</tr>
</tbody>
</table>

### B.2 STEERING COMMITTEE

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Ok Pannenborg (Chair)</td>
<td>Senior advisor Health, World Bank</td>
</tr>
<tr>
<td>Dr Alex Ezeh</td>
<td>Exec.Dir. African Population &amp; Health Research Center</td>
</tr>
<tr>
<td>Prof. Stephen Matlin</td>
<td>Director, Global Forum for Health Research</td>
</tr>
<tr>
<td>Dr Mit Philips</td>
<td>Director of Operations, Analysis &amp; Advocacy Unit, MSF Belgium</td>
</tr>
<tr>
<td>Prof. Rose Leke (from 2010)</td>
<td>Head of Dept. of Microbiology, Immunology and Haematology, University of Yaounde I, Cameroon</td>
</tr>
</tbody>
</table>

#### Observers

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Piet-Hein van Kessel (until 2011)</td>
<td>Chair Programme Committee</td>
</tr>
<tr>
<td>Dr Hajo Wildschut (from 2011)</td>
<td></td>
</tr>
<tr>
<td>Anno Galema (until 2010)</td>
<td></td>
</tr>
<tr>
<td>Renate Pors (2010-2011)</td>
<td></td>
</tr>
<tr>
<td>Annie Vestjens ((2011-2012)</td>
<td></td>
</tr>
<tr>
<td>Marco Gerritsen (2015-2016)</td>
<td></td>
</tr>
<tr>
<td>Ini Huijts (2017-)</td>
<td></td>
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<tr>
<td>On behalf of Ministry of Foreign Affairs</td>
<td></td>
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</tbody>
</table>

### B.3 PROGRAMME COMMITTEE

<table>
<thead>
<tr>
<th>Name</th>
<th>Function</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr Piet-Hein van Kessel (chair, until 2011)</td>
<td>Specialist Obstetrics &amp; Gynaecology</td>
</tr>
<tr>
<td>Dr Hajo Wildschut (chair, from 2011)</td>
<td>Senior obstetrician-perinatologist at Westfries Gasthuis Hospital, Netherlands</td>
</tr>
<tr>
<td>Dr Lola Dare</td>
<td>Exec.Secr. Centre for Health Sciences Training, Research and Development, Nigeria</td>
</tr>
<tr>
<td>Dr Dela Dovlo (until 2012)</td>
<td>Health Systems Advisor, HDS, WHO</td>
</tr>
<tr>
<td>Dr Bocar Kouyaté</td>
<td>Adviser to the Minister of Health, Burkina Faso</td>
</tr>
<tr>
<td>Dr Syed Masud Ahmed (until 2013)</td>
<td>Research Coordinator, BRAC, Bangladesh</td>
</tr>
<tr>
<td>Dr Bruno Marchal (from 2012)</td>
<td>Research Fellow, Institute of Tropical Medicine Antwerp, Belgium</td>
</tr>
<tr>
<td>Dr Osman Sankoh</td>
<td>Executive Director INDEPTH Network, Ghana</td>
</tr>
<tr>
<td>Prof. Göran Tomson</td>
<td>Professor, Karolinska Institute, Sweden</td>
</tr>
</tbody>
</table>
APPENDIX C PROJECT SUMMARIES

C.1 ROUND 1

**EMPOWERING THE COMMUNITY TOWARDS MALARIA ELIMINATION (MEPR)**

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Community empowerment</th>
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<tbody>
<tr>
<td>07.45.101</td>
<td>€1,100,000</td>
<td></td>
</tr>
</tbody>
</table>

**Study setting**
Rwanda

**PARTNERSHIP**

**PI, Netherlands**
Dr M. Van Vught (Academic Medical Centre / Amsterdam Institute for Global Health and Development)
Dr. S. Koenraadt (Wageningen University, the Netherlands)

**Co-PI / Local PI**
Dr. Leon Mutesa (School of Public Health, University of Rwanda)
Dr Claude Muvunyi (Centre Hospitalier Universitaire de Kigali, Rwanda)

**Other Dutch institutions**
University of Maastricht, University of Nijmegen, KIT Netherlands

**Other local institutions**
School of Public Health, University of Rwanda, Institute for Biomedical Sciences, Rwanda Biomedical Centre, NMCP (Malaria), SPIU (financial arm of govt.)

**Non-research organisations**
100th Village

**DESIGN**

**Research objectives**
To contribute to the elimination of malaria by connecting social mobilisation to the national and district malaria control program and (inter)national expert knowledge bases.

**Capacity development objectives**
Training of 4 PhD students and 2 MSc students. The project includes a "Training of trainers" in hosting workshops

**Project organisation (proposed)**
4 sub-projects:
1. Application of a Community-Based Participatory Approach towards Malaria Elimination in the Eastern Province of Rwanda to study group dynamics, self-organisation, ownership and commitment.
2. Study to determine a) which demand side indicators are associated with a higher malaria prevalence or incidence per household, and b) how and when the provided health service can be improved and/or adapted to the population’s needs.
3. Study of how Integrated Vector Management (IVM) strategies can be implemented within existing (vertical) malaria control programmes to empower the community towards malaria elimination in Ruhuha, Rwanda.
4. Study looking at Willingness-to-Pay (WTP) for different strategies for improving the management of malaria, exploring innovative ways of financing the interventions and measurement of the economic and behavioural impact of the malaria interventions.
## Major changes

- The original (Co-)Principal Investigators left the project and were replaced.
- One PhD student stopped after the first year and was replaced with another candidate.
- The project was prolonged and budget changed.
- The focus of the surveys was changed from the health centre level to the household level.

## OUTPUTS

### PhDs, postdocs, students

2 PhD graduated, 2 more expected. 1 Master student paper submitted for publication

### Scientific output

14 peer reviewed publications, 11 more expected. 14 conference presentations

### KT products

- The project hosted a second workshop entitled MEPR Training and Research Findings Dissemination in July 2015.
- Policy briefs, policy dialogues, blog articles, documentary videos were produced by KT-Net.

## RESULTS & IMPACTS

### Main scientific findings

Together with the community an approach was designed for community involvement via community malaria action teams (CMAT), aimed at sensitisation of the community and at identifying weaknesses and strengths in local malaria control.

The efforts of the CMATs resulted in a notable increase of community awareness on malaria transmission, treatment and prevention. Communities were educated on recognising mosquito larvae and on the link between these larvae and malaria. There was also an increase in community acceptance of preventive measures, such as the use of mosquito nets.

During the project implementation, a reduction of malaria incidence from 68% in 2013 to 21% in 2014 was established in the intervention area.

### Capacity developed

2 PhDs trained.

1 PhD student is now responsible for the mosquito control programme for Rwanda; 1 works at a national health insurance organisation.

### Policy & practice

The results of the programme are translated to the relevant policy and practice circles, e.g. the National Malaria Control Programme, Ministry of health, and community leaders. There has been good interaction with stakeholders and the community: there is a high turnout of the various stakeholders and the programme is presented under the umbrella of the Ministry of Health.

### Other key observations

- Involvement of local leaders strengthened the delivery of health messages to the population.
- The CMATs required continued incentives to facilitate their work.
ACCELERATING PROGRESS TOWARDS ATTAINMENT OF MDG 4 AND 5 IN GHANA THROUGH BASIC HEALTH SYSTEMS FUNCTION STRENGTHENING (ACCELERATE)

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Antenatal and maternal health</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.102</td>
<td>€776,400</td>
<td></td>
</tr>
</tbody>
</table>

**Study setting**
Ghana (Greater Accra Region. A second site in Northern region was proposed but could not be implemented due to funding constraints)

**PARTNERSHIP**

<table>
<thead>
<tr>
<th>PI, Netherlands</th>
<th>Co-PI / Local PI</th>
<th>Other Dutch institutions</th>
<th>Other local institutions</th>
<th>Non-research organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof.dr.ir.J.W.M. van Dijk (Wageningen University &amp; Research)</td>
<td>Prof. I.A. Agyepong (Ghana Health Service)</td>
<td>UMC Utrecht, University of Amsterdam, PharmAccess, Royal Embassy of the Netherlands</td>
<td>University of Cape Town, South Africa University of Ghana, Noguchi Memorial Institute for Medical Research</td>
<td>UNICEF Ghana (cancelled), FOCUS (USAID), BCS (USAID)</td>
</tr>
</tbody>
</table>

**DESIGN**

<table>
<thead>
<tr>
<th>Research objectives</th>
<th>Capacity development objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>To strengthen basic health system functions of organisation and the delivery of essential and quality health services, human resource management, and governance and clinical decision making related to maternal and neonatal health.</td>
<td>Training of 6 PhD students in epidemiology (2), medical anthropology (1), organisational anthropology (1), health policy and administration (1), policy analysis (1). 1 more PhD student was added to the project later.</td>
</tr>
</tbody>
</table>

**Project organisation (proposed)**

3 interrelated sub-projects, each addressing a different level of organisation (district, regional and national level). Within these, there were 7 detailed studies:

1. Clinical decision-making level
   a. Epidemiological study clinical decision making in relations to maternal health care (MHC)
   b. Epidemiological study of environmental and clinical factors associated with newborn mortality
   c. Clinical controlled trial of an m-Health intervention to improve clinical decision-making of frontline health workers
   d. Ethnographic study of clinical decision-making in a hospital context.

2. Managerial level
   a. Study of motivational and organisational issues in a hospital context
   b. Study of district level management and decision-making with respect to maternal...
and new-born health focusing on leadership.

3. National level

Study in understanding national agenda setting in policy making for maternal and new-born health.

<table>
<thead>
<tr>
<th>Major changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Because expected co-funding from USAID and UNICEF for the intervention study was not released, there were substantial changes in the setup of the programme. The envisaged study cum intervention in Northern Ghana had to be cancelled and the team decided to concentrate efforts on the Greater Accra region. The other PhD-projects were refocused to investigate constraints at multiple levels in the health system, resulting in a multi-level diagnosis of some of the challenges on attaining MDG 4 &amp; 5 in Ghana.</td>
</tr>
<tr>
<td>• With additional investment of UMC Utrecht and remaining funds a cluster-randomized controlled trial was designed to test a mobile health intervention to support clinical decision-making to improve maternal and neonatal health outcomes in Ghana’s Eastern region, making up for a 7th PhD project.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>OUTPUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PhDs, postdocs, students</strong></td>
</tr>
<tr>
<td>5 PhDs graduated, 2 more are expected.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scientific output</th>
</tr>
</thead>
<tbody>
<tr>
<td>25 peer-reviewed papers to date, another 15 expected</td>
</tr>
<tr>
<td>Presentations at international conferences, such as the Global Symposium on Health Systems Research in Vancouver (2016).</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>KT products</th>
</tr>
</thead>
<tbody>
<tr>
<td>• 2 videos were produced, summarizing a key message from the project.</td>
</tr>
<tr>
<td>• 6 Policy briefs were compiled and shared by use of the Accelerate Website and fora such as the Ghanaian Health summit.</td>
</tr>
<tr>
<td>• 3 separate dissemination meetings were organised with different themes for different audiences over 2016.</td>
</tr>
<tr>
<td>• The closing conference attracted over 60 participants from government, research organisations, non-governmental organisations and the private sector in Ghana and West Africa.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>RESULTS &amp; IMPACTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Main scientific findings</strong></td>
</tr>
<tr>
<td>• Underlying causes of high maternal and newborn mortality ratios are multifarious and complex and cannot just be reduced to non-adherence to guidelines and failing leadership of managers.</td>
</tr>
<tr>
<td>• Epidemiological evidence shows that low birth weight is related to a range of community-based and individual factors, putting women and children at risk.</td>
</tr>
<tr>
<td>• Most vulnerable women are least likely to receive adequate care. Among other factors, this was shown to be due to challenges frontline workers encounter in their communication with clients and a range of organisational factors, such as the infrastructure and the availability of the rights materials for treatment and lack of sufficient numbers of staff.</td>
</tr>
<tr>
<td>• M-health interventions improve access to the right information of health</td>
</tr>
</tbody>
</table>
workers.

- Organisational factors have a huge influence on health workers motivation. These relate to the lack of decision making space of managers at hospital and district level and the high uncertainty about the availability of adequate human and material resources.
- Policies at national level show an inherent path-dependency towards certain interventions and are not always in congruence with realities on the ground and the allocation of sufficient means for implementation.
- Improving maternal and newborn health care will require interventions at all levels to remove constraints on health worker ability to deliver the right care at the right place at the right time.

<table>
<thead>
<tr>
<th>Capacity developed</th>
<th>5 PhDs graduated, 2 more expected.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Four have been able to secure research positions and one a position at policy making level. There are concerns about the lack of possibility of follow-up to establish them as independent postdoctoral researchers developing and furthering their own research, practice and policy research agenda and working group. Due to budgetary constraint of the Ghanaian government to implement changes in GHS, the position of the PhDs and post-doctoral fellows is not guaranteed after completion of the research capacity building programme. Likewise career pathways within the GHS or academic setting remain uncertain.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Policy &amp; practice</th>
<th>Clinical decision making tools have been developed to identify high risk pregnancies and to assist front line health care workers in the provision of essential maternal and neonatal health care.</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>It is too early to conclude whether the intervention study will have an impact on mortality figures.</td>
</tr>
<tr>
<td></td>
<td>In-depth insight has been obtained on factors determining non-adherence to guidelines, which have yet to be taken to a different organisational level to be translated into policy and practice.</td>
</tr>
<tr>
<td></td>
<td>Findings on the sustainability of the LDP programme, and on a range of causes of underperformance of health workers have yet to be translated into policy and practice.</td>
</tr>
<tr>
<td></td>
<td>Through the dissemination meetings and the closing workshop, stakeholder engagement and dialogue has been facilitated allowing to further address key health system challenges in maternal and neonatal health in Ghana.</td>
</tr>
</tbody>
</table>

<p>| Other key observations | The funding-related shift in focus from an intervention-based project to a series of studies assessing health systems and policy constraints allowed for more room to conduct in detail diagnostic research into processes affecting clinical decision-making and organisational issues at health facility and district level. These efforts opened up a new perspective not only to look at the aspect of clinical decision-making but also at the decision-making space of district-level health managers, hospital managers and policy makers in general. |</p>
<table>
<thead>
<tr>
<th>COMMUNITY-BASED HEALTH INSURANCE (CBHI) IN ETHIOPIA</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Project no.</strong></td>
</tr>
<tr>
<td><strong>Budget</strong></td>
</tr>
<tr>
<td><strong>Health financing</strong></td>
</tr>
<tr>
<td><strong>Study setting</strong></td>
</tr>
<tr>
<td><strong>PARTNERSHIP</strong></td>
</tr>
<tr>
<td><strong>PI, Netherlands</strong></td>
</tr>
<tr>
<td><strong>Co-PI / Local PI</strong></td>
</tr>
<tr>
<td><strong>Other Dutch institutions</strong></td>
</tr>
<tr>
<td><strong>Other local institutions</strong></td>
</tr>
<tr>
<td><strong>Other and non-research organisations</strong></td>
</tr>
<tr>
<td><strong>DESIGN</strong></td>
</tr>
</tbody>
</table>
| **Research objectives** | • To identify the conduits through which health shocks affect household welfare, for instance, in terms of increased expenditures, foregone health care or greater use of child labour.  
• To examine how health care utilisation, out-of-pocket health spending and poverty are affected by CBHI. |
| **Capacity development objectives** | * Development and delivery of a training module on health equity and financing, and methods of impact evaluation for academic staff at Ethiopian universities and research institutes.  
* 2 PhD students |
| **Project organisation (proposed)** | 3 sub-projects:  
1. Analysis of the distribution, determinants and welfare implications of health and other economic/social shocks.  
2. Assessment of the effectiveness of a pilot Community Based Health Insurance project in Ethiopia  
3. Training module on (i) health insurance and financing (ii) economics of public health spending (iii) measuring health equity and (iv) methods for impact evaluation. |
| **Major changes** | None reported |
| **OUTPUTS** |  |
| **PhDs, postdocs, students** | 2 PhDs (Erasmus University) |
| **Scientific output** | 9 peer-reviewed papers, 4 in preparation  
Over 30 presentations |
### KT products
- 4 policy briefs
- A video which highlights the achievements and challenges of the CBHI scheme was developed.
- Mid-term and final workshop. Researchers working on health insurance related projects in Ghana, Rwanda and Kenya were invited to the final project workshop. Researchers from Abt Associates and EHIA were also present. Interactions during the final workshop and post-workshop discussions have led to greater understanding of the specific challenges facing the health insurance scheme in each of these countries.
- Several meetings took place between the PIs and the EHIA to discuss policy-relevant issues. Within Ethiopia itself the project has featured in some newspaper reports and on TV news bulletins. Through the various policy interactions the results of the research have fed into the scaling up of the CBHI project.

### RESULTS & IMPACTS

#### Main scientific findings
- Households in Ethiopia tend not to rely on social networks to cope with health and economic shocks but resort to reducing consumption, drawing down savings or borrowing. There are clear differences in terms of coping strategies across shock types. Economic and natural shocks are more likely to trigger reductions in savings and in food consumption while health shocks are more likely to trigger asset sales and especially, a far greater reliance on borrowing.
- Despite considerable investment in health care infrastructure, health care utilisation in Ethiopia remains low. Study findings suggest that low utilisation rates are not due to lack of disease awareness or a low-perceived need for health care but due to the quality and cost of available care.
- CHBI scheme uptake is about 50 percent of eligible households. The CBHI scheme reduces the incidence of borrowing to finance health care needs by 8-13% and leads to a 30-41% increase in utilisation of outpatient care at public facilities, a 45-64% increase in the frequency of outpatient visits to public facilities, and a 56-87% decline in the cost per outpatient visit to public facilities.

#### Capacity developed
- 2 PhD projects completed.
  One of the PhDs students trained through the project has returned to Ethiopia and is currently employed as a consultant and as a researcher at Addis Ababa University. The second is currently working at the World Bank.
  A project on training and capacity building of 15-20 Ethiopian researchers was successfully completed. The training module was very highly evaluated and there is demand for continuous training.
  A spin-off of the training was a meeting and interaction between researchers from Bahir Dar University and members of the research team which has led to the development of a PhD programme in Economics at the University to which researchers from the CBHI
programme have contributed in terms of teaching inputs.

<table>
<thead>
<tr>
<th>Policy &amp; practice</th>
</tr>
</thead>
<tbody>
<tr>
<td>• Several steps have been taken to highlight the main insights yielded by the research to relevant policy actors, in particular the Ethiopian health insurance agency (EHIA). While some of the messages/insights yielded by the research have been used to justify and inform the scaling up of the pilot, others have been ignored.</td>
</tr>
<tr>
<td>• Research team members have been invited to work together with the government on a research project dealing with the introduction of social health insurance in Ethiopia.</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other key observations</th>
</tr>
</thead>
<tbody>
<tr>
<td>Initially the government was not keen on the evaluation of the CBHI pilot scheme and was not willing to provide permission for data collections. Timely involvement of the relevant stakeholders is crucial for the successful implementation of recommendations that are based on the research findings.</td>
</tr>
</tbody>
</table>
## TOWARDS A CLIENT-ORIENTED HEALTH INSURANCE SYSTEM IN GHANA COHEISION

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Health Financing</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.104</td>
<td>€849,568</td>
<td></td>
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</tbody>
</table>

### Study setting
Ghana

### PARTNERSHIP

<table>
<thead>
<tr>
<th>PI, Netherlands</th>
<th>Co-PI / Local PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Prof. Dr. T. Rinke de Wit, Academic Medical Center</td>
<td>Dr. D. Arhinful, Noguchi Memorial Institute for medical Research at the University of Ghana</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Other Dutch institutions</th>
<th>Other local institutions</th>
</tr>
</thead>
<tbody>
<tr>
<td>University of Groningen, Royal Embassy of the Netherlands in Ghana</td>
<td>Business School University of Ghana, Ministry of Health (Ghana), National Health Insurance Authority, Ghana Health Service, Christian Health Association Ghana, SNV</td>
</tr>
</tbody>
</table>

### DESIGN

#### Research objectives
To enhance and sustain health insurance participation in the National Health Insurance Scheme (NHIS) of Ghana through improved client oriented quality of care. To achieve this, the project aimed to identify: (1) what are the main perceived barriers of health care clients to enrol in the National Health Insurance Scheme (NHIS) and (2) which are the most effective interventions that address these barriers.

#### Capacity development objectives
Training of 3 PhD students

#### Project organisation (proposed)
3 connected sub-projects:

1. Study to understand clients’ perception on health and, quality of services related to health care providers and health insurances, based on their expectations and experiences, their cultural background and their needs.

2. Study to assess the service provider’s data on medical-technical quality and the relation between these data and client perceived quality.

3. Study to assess the relation between the quality of National Health Insurance Authority (NHIA) provided services to clients and the quality of NHIA services as perceived by clients and enrolment.

#### Major changes
- A budget neutral extension was requested, as two of the three PhD candidates who were not able to finalise their PhD theses before the project end date.
- Changes were also made to the budget and allocation of funds. The original design of the study was to embark on full scale intervention in half of the facilities but this decision had to change due to inadequate funds.

### OUTPUTS

<table>
<thead>
<tr>
<th>PhDs, postdocs, students</th>
<th>Scientific output</th>
</tr>
</thead>
<tbody>
<tr>
<td>1 PhD student has graduated, 2 are working towards completing</td>
<td>9 papers in peer reviewed journals</td>
</tr>
</tbody>
</table>
### KT products
- 7 policy briefs were disseminated among the stakeholders.
- A video project on the key findings was prepared in collaboration with KTNET.

### RESULTS & IMPACTS

| Main scientific findings | Disparities exist in socio-cultural beliefs and values regarding illness, health seeking, quality of care and the control of the services between clients, healthcare providers and the insurer, leading to misconceptions. These disparities contribute to reduced trust and interest in accessing healthcare services. Insured clients believe that they receive poorer quality care than the uninsured. Clients further expressed dissatisfaction with delays in NHIS card production and distribution. Clients perceive that health facilities are not delivering the NHIS benefits package as promised. Community cohesion and solidarity was found to promote enrolment in the NHIS. Health care providers attribute client complaints of poor quality standards to lack of adequate logistics and human resource constraints. The persistent problem of delayed provider reimbursement to accredited health facilities is identified by providers as a disincentive to remain and provide services for NHIS clients. The introduction of the NHIS has contributed to increased workload on providers. From the insurance side, the NHIS premium exemption policy for older people has led to an increase in insurance coverage and utilization of healthcare services for the aged. Interestingly however, the uninsured were associated with better quality care than the insured. Based on study findings, several improvements have been suggested, including: enhance effectiveness of information and communication by considering the different perspectives of clients and health care providers about the concepts of illness, health seeking and quality of care; strengthen institutional management and control to provide services that put the client at the centre; and institutionalise the monitoring of client perspectives of services. |
| Capacity developed | Two out of the three PhD students were from Ghana, while one PhD student was from the Netherlands. Of the 4 PhD projects planned, three have been, or are expected to be completed successfully. The fourth project had not sufficiently advanced at the completion of the project. |
| Policy & practice | Feedback received from stakeholders during the final dissemination meeting was incorporated into 4 policy briefs. At this meeting stakeholders, including the NHIA, indicated that findings pertaining to their respective institutions would be seriously considered for policy implementation. Dr. D. Arhinful, the Co-PI of the COHEISION project and Dr. E. Nketiah-Amponsah, the post-doc on the project were invited to serve on the NHIS M&E and Research Sub-Committee Meeting of the NHIS Review Committee commissioned by the president of the Republic of Ghana. |
| Other key observations | Care should be taken to use data for research purposes which are derived from data collected by the health insurers. |
DEVELOPING SUSTAINABLE COMMUNITY HEALTH RESOURCES IN POOR SETTINGS IN UGANDA (COHERE)

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Community empowerment</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.105</td>
<td>€842,103</td>
<td></td>
</tr>
</tbody>
</table>

**Study setting**
Uganda

**PARTNERSHIP**

**PI, Netherlands**
Prof. R. Pool (University of Amsterdam)

**Co-PI / Local PI**
Dr. D. Kaawa-Mafigiri (Makerere University)

**Other Dutch institutions**
AMC / AIGHD

**Other local institutions**
Kabale University, Uganda, Ministry of Health Uganda

**DESIGN**

**Research objectives**
To identify and use existing community resources in poor communities in Uganda to spread health information, encourage health promoting behaviours and bring vulnerable community members into better contact with existing health services.

**Capacity development objectives**
3 PhD students, 2 postdocs, MSc students

**Project organisation (proposed)**
4 connected sub-projects:
1. To explore and map social groups, networks and roles to identify those that could be used to transfer health-related knowledge and influence health-related behaviour in a poor rural setting
2. As sub-project 1, in a poor urban setting
3. Explore the nature, distribution and flow of information and behaviours related to the "social" health issues in the selected two sites
4. Develop and evaluate an intervention based on the findings of the aforementioned sub-projects

**Major changes to project**
- There were 2 changes in field sites. First, the rural site was shifted from Rakai to Luweero, because the latter district better qualified for the project focus. Second, the original plan to compare a rural to an urban (sub-project 2) setting was dropped, because it was felt that a focus on one field site would provide richer data given the interlinked foci of the three PhD projects.
- During the first project phase, the community started to reflect on their situation and to develop themselves ‘solutions’ with their own means. Therefore, rather than develop and implement an intervention, this aspect of the project was abandoned. Instead, attention was focused on analysing how and why such local, internal processes emerged.

**OUTPUTS**
<table>
<thead>
<tr>
<th><strong>PhDs, postdocs, students</strong></th>
<th>2 PhDs graduated, 1 more expected. 1 MSc student graduated.</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>Scientific output</strong></td>
<td>• 8 Peer-reviewed publications, 8 manuscripts in preparation.</td>
</tr>
<tr>
<td></td>
<td>• 16 conference presentations</td>
</tr>
<tr>
<td><strong>KT products</strong></td>
<td>• 2 newspaper articles</td>
</tr>
<tr>
<td><strong>RESULTS &amp; IMPACTS</strong></td>
<td></td>
</tr>
<tr>
<td><strong>Main scientific findings</strong></td>
<td>• Community members identified poverty as their major priority problem. The most important health-related problems that people felt were within their capacity to solve themselves were poor sanitation and related basic hygiene problems, and sexually transmitted infections. Barriers to dealing with these problems were mainly related to relationships and conflicts in the village, local social dynamics and the general lack of a specific stimulus, as well as poor communication between community and the local health care sector.</td>
</tr>
<tr>
<td></td>
<td>• Various social groups offered much potential for grounding social and health-improvement activities, as did informal information transfer processes. The basis for such activities is to be found in the specific mechanisms of reciprocity and natural helping that are embedded in communities. One finding that was particularly relevant was that once such processes of reciprocity and natural helping are (perceived as being) co-opted by outside parties (NGOs, the government) and turned into more formal 'interventions' they cease to function spontaneously and need to be maintained by external (financial) support.</td>
</tr>
<tr>
<td><strong>Capacity developed</strong></td>
<td>Two of the three CoHeRe PhDs have been given a permanent contract as lecturer at Makerere University. The third PhD has been appointed as senior researcher with a national research organisation. The Ugandan postdoc is about to be promoted to senior lecturer at Makerere and the Dutch postdoc has been appointed as a tenured lecturer at UvA. One of the Ugandan PhDs has also received a postdoc in an UvA led VIDI project. The project also led to consolidating the collaboration and a further joint project in Uganda.</td>
</tr>
<tr>
<td><strong>Policy &amp; practice</strong></td>
<td>CoHeRe Activities have resulted in improved sanitation and hygiene in the study community (new communal latrine, hand-washing facilities and campaign, improvement of rubbish disposal, improvement of cooking facilities), and improved Sexual and Reproductive Health interventions (community education campaigns, outreach clinics, increased counselling and testing for HIV and STIs, male circumcision).</td>
</tr>
</tbody>
</table>
## C.2 Round 2

### IMPROVING MATERNAL HEALTH SERVICES THROUGH POLITICAL ACCOUNTABILITY SYSTEMS IN BURUNDI AND DR CONGO

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Antenatal and maternal health</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.201</td>
<td>€785,182</td>
<td></td>
</tr>
</tbody>
</table>

**Study setting**

Burundi & DR Congo (Activities in Burundi were suspended)

### PARTNERSHIP

**PI, Netherlands**

Prof. dr. T. de Cock Buning (Athena Institute, VU University, Amsterdam)

**Co-PI / Local PI**

Prof. P. Kayembe (University of Kinshasa School of Public Health)

**Other Dutch institutions**

Royal Tropical Institute (KIT)

**Other local institutions**

Institut National de Santé Publique (INSP) Burundi, Women’s rights defense association (ADDF) Burundi, l’ Association de bien-être familiale (ABEF) DR Congo, Health, Development & Performance (HDP) Rwanda

**Non-research organisations**

Cordaid and Medicus Mundus in DR Congo, Cordaid and Care International in Burundi, Foundation for Children’s Rights Malawi

### DESIGN

**Research objectives**

To assess whether and how political accountability mechanisms increase responsiveness and performance of maternal health services in Burundi and DR Congo. It further assessed in which contexts these mechanisms are successful and why. Purpose of this was to advise policy-makers, development actors and civil society organisations in fragile states on how to engage with citizens to improve maternal health services.

**Capacity development objectives**

3 PhD students

**Project organisation (proposed)**

4 sub-projects:

1. Improving responsiveness and performance of maternal health services through political accountability mechanisms in Congo.
2. Improving responsiveness of maternal health services through political accountability mechanisms in Burundi.
3. Improving responsiveness and performance of maternal health services through political accountability mechanisms in fragile states in Sub-Saharan Africa (descriptive case studies in 4 Sub-Saharan African countries).
4. Comparing effectiveness of political accountability mechanisms to improve responsiveness of maternal health services in fragile states.

**Major changes to project**

- Because of political turmoil, following elections, the NGO partners in Burundi stopped their participatory work at the research sites in the country. Due to negative travel advice, no master students were sent to support the projects. As a result, the project could not fully implement the Interactive Learning and Action (ILA) approach as intended.
- In Burundi, Cordaid funding for the project in which the Social Accountability
(SA) intervention was planned, stopped and the researched was refocused on health committees. No joint intervention could be developed. Research on Health Committees in Guinea, Benin and DR Congo was funded by Muskoka and enabled the PhD-students in DR Congo and the Netherlands to jointly conduct research.

- During fieldwork by the Dutch PhD-student a local NGO in Malawi got involved in research on SA-relations.
- Small budget-neutral allocations were made to cope with the expenditures on the research budget and training/writing in Amsterdam.

### OUTPUTS

<table>
<thead>
<tr>
<th>PhDs, postdocs, students</th>
<th>3 PhD students graduated (1 Dutch and 2 African), 1 postdoc trained</th>
</tr>
</thead>
</table>

### Scientific output

- 6 peer reviewed publications, 3 yet to be published
- 8 Posters and conference presentations

### KT products

- Over 8 blog publications
- 4 Policy briefs, 1 PR briefing
- 7 blogs on KTNET website
- 5 videos

### RESULTS & IMPACTS

#### Main scientific findings

The assumption behind social accountability is that citizens express needs and expectations and that health providers respond adequately, thus optimizing health services. However, in rural areas of fragile states, where there are few options for accessing alternative services, citizen expression might be a risky action. Moreover, gender discrimination and abuse against women contribute to low levels of maternal health.

Through focus groups and dialogue meetings, a trusted alternative communication channel that secured the anonymity of the women was found in the form of community health workers (CHW). A comparative study in four other countries in sub-Saharan Africa revealed other alternative routes that worked in these specific rural settings.

- Overall, the project was able to identify and analyse existing mechanisms through which interests of citizens are expressed and integrated into maternal health service standards, in service delivery and in policy and planning. These experiences allowed to further refine the conceptual framework and gain a better understanding of the functioning of social accountability in different contexts.

#### Capacity developed

3 PhD students trained.

Both PhD students and senior researchers gained experience with new research methods including realist reviews and the ILA approach. Senior staff gained experience in managing large collaborative multi-country research projects. Capacity building
Workshops were organized and the PhD students and the senior researchers have received trainings on social accountability and on communication with partners and media.

Workshops were organized with national and provincial policy makers, healthcare managers, CSO and NGO-staff including learning and exchange sessions with policy makers and researchers on the social accountability concept and theory of change.

Joint paper writing with implementing NGO-partners in DR Congo (throughout the project), in Burundi (situational analysis) and in Malawi with NGO Simavi provided a transdisciplinary perspective and supported NGO-staff in scientific writing.

**Policy & practice**

One researcher was asked by the Governor of Bas-Congo to become the new provincial Minister of Health. This enables the integration of research results in discussions on maternal care, especially regarding the role of CHWs as interface. This double role facilitated communication with policy makers at provincial and national level and contributed to the development of a community participation strategy.
# Mainstreaming a Health Systems Approach to Delivery of Maternal Health Services: Transdisciplinary Research in Rwanda and South Africa (MHSAR)

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Antenatal and maternal health</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.202</td>
<td>€785,806</td>
<td></td>
</tr>
</tbody>
</table>

## Study setting
Rwanda, South Africa

## Partnership

<table>
<thead>
<tr>
<th>Role</th>
<th>Name and Institution</th>
</tr>
</thead>
<tbody>
<tr>
<td>PI, Netherlands</td>
<td>Dr. D. Blaauw (Centre for Health Policy at University of the Witwatersrand, South Africa)</td>
</tr>
<tr>
<td>Co-PI / Local PI</td>
<td>Dr. L. Bijlmakers (Institute for Health Sciences, Radboud University Medical Centre)</td>
</tr>
</tbody>
</table>

### Other Dutch institutions
Due to departure of the intended PI before start of the project, the University of Amsterdam dropped out of the project. This project therefore only involved one Dutch institution.

### Other local institutions
University of the Western Cape (South Africa), Ministry of Health (Rwanda)

### Non-research organisations
London School of Hygiene and Tropical Medicine, UNICEF, University of Montreal, EU FP7-funded MASCOT project

## Design

### Research objectives
To identify effective health systems interventions to reduce avoidable maternal deaths in low- and middle-income countries (LMICs), focusing on Rwanda and South Africa.

### Capacity development objectives
2 PhD students, training of LMIC researchers on various research methods, building of research capacity among government and civil society partners in LMIC.

### Project organisation (proposed)

- **2 sub-projects:**
  1. Systematic review of the impact of health system supply and demand interventions on maternal health in LMICs
  2. Realist review impact of health system supply and demand interventions on maternal health in Rwanda and South Africa.
  3. Case studies in Rwanda and South Africa using emergency obstetric care (EmOC) as health probes to investigate linkages between health system components and maternal health
  4. Action research health system interventions to improve organisations and delivery of maternal health services.

### Major changes to project
- The original main applicant and co-applicant left the project at an early stage. In addition, the researchers from UNICEF and University of Montreal left the University of Western Cape and had less involvement in the programme than anticipated originally.
- There were also changes to the institutional partners, with the Rwandan Ministry of Health replacing Project Ubuzima and the Rwandan Biomedical...


<table>
<thead>
<tr>
<th>Centre.</th>
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<tbody>
<tr>
<td>• Sub-project 1b consisted of a realist review delineating the contribution of health system building blocks and demand initiatives to improving maternal health within sub-Saharan Africa. It was to draw more specific, focused results. Three additional countries were to be selected purposefully for this, informed by the findings of sub-project 1a. The realist review proved more complex than anticipated due to limited experience in the research team on realist review and scarce human resources. The team thus decided to focus the review on the governance and accountability health system building block and to not focus on three additional countries.</td>
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<table>
<thead>
<tr>
<th>OUTPUTS</th>
</tr>
</thead>
<tbody>
<tr>
<td><strong>PhDs, postdocs, students</strong></td>
</tr>
<tr>
<td>2 PhD candidates and 1 post doc</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Scientific output</th>
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</thead>
<tbody>
<tr>
<td>• 5 peer-reviewed publications, 4 submitted (under review), 8 in preparation.</td>
</tr>
<tr>
<td>• The MHSAR project had a special session at the 4rd Global Symposium on Health Systems Research Health. This involved 5 academic presentations by the MHSAR research team, policymaker responses from each of the study sites, and a participative fishbowl discussion including session attendees. Further results were presented at the 4th Global Symposium on Health Systems Research Health.</td>
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</table>

<table>
<thead>
<tr>
<th>KT products</th>
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<tbody>
<tr>
<td>• Numerous meetings, discussions and workshops have been held with district and facility level managers in the study districts in both countries. They also participated in feedback and engagement sessions for the case study results in each site.</td>
</tr>
<tr>
<td>• An effective participatory engagement workshop with 62 key stakeholders occurred in 2016 in the Eastern Cape Province. The objectives of the workshop were to facilitate shared learning on the successes and failures of efforts to improve maternal health services in the province and to assist participants in identifying concrete actions they could implement themselves within existing resource constraints. The participants included maternal health managers from all levels of the health system, managers of important support functions, and representatives from various maternal health NGOs active in the province.</td>
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<table>
<thead>
<tr>
<th>RESULTS &amp; IMPACTS</th>
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<tbody>
<tr>
<td><strong>Main scientific findings</strong></td>
</tr>
<tr>
<td>• The systematic review provided a more detailed overview of critical priorities in maternal health in LMICs, including maternity waiting homes, male involvement, birth companions, community transport schemes, and new roles of traditional birth attendants.</td>
</tr>
<tr>
<td>• The case studies in Rwanda revealed a complex relationship between health system factors, maternal health and mortality. Health system factors contributed to sub-standard care in over 60 percent of the cases. District health managers identified the engagement of community health workers and expanded coverage of community health insurance as the most important systemic interventions contributing to improvements in maternal mortality.</td>
</tr>
</tbody>
</table>
They also emphasised improved managerial skills at facility level and the introduction of results-based financing, which has led to improved accountability.

- In South Africa, one case study found that the over-centralisation of emergency obstetric services overwhelms the capacity of hospitals to deliver quality maternity care and of ambulance services for pregnant women. Structural weaknesses in health system building blocks were compounded by a lack of agency among district managers to produce the observed deficiencies in maternal health service provision.

- Another case study in South Africa found significant problems in the functionality of emergency transport and referral systems for pregnant women. Supportive leadership and managerial supervision were found to be key factors explaining variations in maternal health performance between different hospitals with similar resource constraints. A systems dynamics analysis revealed the complex ways in which health system factors were interrelated in contributing to poor maternal health performance, with leadership quality and staff motivation identified as important cross-cutting factors.

- The comparative case-controlled near-miss studies conducted in Rwanda and South Africa as part of the case studies found a high incidence of severe maternal outcomes in both countries. Health system deficiencies contributed to high rates of preventable cases due to direct obstetric causes.

<table>
<thead>
<tr>
<th>Capacity developed</th>
<th>2 PhD students trained.</th>
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</thead>
<tbody>
<tr>
<td></td>
<td>One now serves in a senior research capacity in a South African institution. The PhD student from Rwanda works full time in the Rwandan Ministry of Health. The entire project team has gained expertise in new research methods related to the project particularly systematic reviews, maternal health audits, near-miss investigations, health systems evaluation, and action research.</td>
</tr>
</tbody>
</table>

| Policy & practice | At the end of the effective participatory engagement workshop a commitment planning session was held where representatives developed action plans related to each of their individual areas of work, and developed strategies for holding each other accountable for these plans. Although the programme has contributed to increased research capacity, addressing some of the broader health systems issues is considered a broader and longer term goal. |
## ADDRESSING SOCIAL, CULTURAL AND HISTORICAL FACTORS LIMITING THE CONTRIBUTION OF MEDICAL LABORATORY SERVICES IN WEST AFRICA (SOCIALAB)

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Antenatal and maternal health</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.203</td>
<td>€554,475</td>
<td></td>
</tr>
</tbody>
</table>

### Study setting
Senegal (changed from Mali)

### PARTICIPATION

<table>
<thead>
<tr>
<th>PI, Netherlands</th>
<th>Co-PI / Local PI</th>
</tr>
</thead>
<tbody>
<tr>
<td>Dr. P.L.A. Ondoa (AMC, Amsterdam Institute for Global Health and Development)</td>
<td>Prof. I. Sow (Ministry of Health and Social Action, Senegal)</td>
</tr>
</tbody>
</table>

Other Dutch institutions: University of Amsterdam

Other local institutions: Centre International Charles Mérieux de Bamako (CICM) Mali, Ministry of Health Burkina Faso

### Non-research organisations
Fondation Mérieux

### DESIGN

<table>
<thead>
<tr>
<th>Research objectives</th>
<th>Capacity development objectives</th>
<th>Project organisation (proposed)</th>
</tr>
</thead>
</table>
| To identify barriers to effective laboratory services at different levels (practical, organisational, economic, social-cultural and historical) of the health system, with a specific focus on antenatal care. | Training of 2 post-doc researchers and research assistants | 3 sub-projects:  
1. Biomedical study on the organisational, practical, human resources, and functional factors influencing the laboratory services utilization in ANC.  
2. Socio-anthropological ethnographic study on the historical and sociocultural factors influencing the use of laboratory diagnostics in ANC.  
3. Cross-disciplinary analysis of the results from sub-projects 1 and 2. |

### Major changes to project
- The co-PI was changed
- Re-design of the proposal after some problems with security in Mali so the project was moved from Mali to Senegal.
- Project extended to facilitate dissemination activities

### OUTPUTS

<table>
<thead>
<tr>
<th>PhDs, postdocs, students</th>
<th>2 post-docs</th>
</tr>
</thead>
</table>

| Scientific output       | 1 scientific paper published, 5 more in preparation  
4 conference presentations |

| KT products             | Articles in newspapers and newsletters  
Video on YouTube and website of project’s member’s institutions |
### RESULTS & IMPACTS

#### Main scientific findings
- Three main barriers to uptake of ANC testing were identified: 1) a lack of dedicated programmatic support by national and international stakeholders in the health sector, 2) a barrier at the antenatal care section of the health facilities and the role of midwives as front and back door keeper of laboratory test utilisation, and 3) at the community level, financial barriers.
- Based on the findings 5 areas of interventions were suggested to improve the utilisation of lab tests in ANC for better new-born and maternal health:
  - Implementing clear national guidelines for ANC screening tests
  - Using a quality approach to improve the organisation of clinical and laboratory services at facility level and promote better communication and logistic
  - Promoting research for the development of rapid all-in-one ANC testing solutions feasible at the level of the community (i.e. at peripheral health posts) to increase the uptake of ANC screening among the most vulnerable women
  - Exploring financing options to reduce the price of ANC tests
  - Incorporate the full range of ANC testing into programmatic activities such as Prevention of Mother-to-Child Transmission (PMTCT) of HIV.

#### Capacity developed
- 1 Post-doc was trained to improve her skills in English, writing research proposals, Epi Info and health systems research.
- 1 post-doc followed courses in French and Wolof language.
- The PhD candidates and master students were not part of the research team.
- The results from the project will be used to revisit the curricula for training human resources for health within the RESAOLAB Network

#### Policy & practice
The results led to recommendations for the improvement of medical laboratory services and hence the quality of ANC in Senegal and other settings. The outcomes of the study have been taken up directly by the Directorate of Laboratory in Senegal and are currently being examined by Mali and Burkina Faso in the context of the RESAOLAB network.

Tools developed for ANC and laboratory services, financial aspects and process of ANC test delivery via the ANC users as well as the development of training curricula or laboratory professional in the frame of the RESAOLAB network will benefit from the SOCIALAB project.

#### Other key observations
The scientific capacity to conduct the transdisciplinary analysis and to write up the results of the SOCIALAB programme for high level peer reviewed journal was not sufficient among the local team in Senegal. Various models of mentoring and supervision were tried out but were unsuccessful. The final biomedical data analysis has been fully run by the PI assisted by epidemiologist and statistician at AIGHD. This freed up more time for local data dissemination and engagement with the stakeholders by the team in Senegal.
## KNOWLEDGE TRANSLATION NETWORK FOR AFRICA (KTNET)

<table>
<thead>
<tr>
<th>Project no.</th>
<th>Budget</th>
<th>Knowledge translation</th>
</tr>
</thead>
<tbody>
<tr>
<td>07.45.301</td>
<td>€956,043</td>
<td></td>
</tr>
</tbody>
</table>

### Study setting
All other eight projects (based out of Uganda)

### PARTNERSHIP

<table>
<thead>
<tr>
<th>PI, Netherlands</th>
<th>Co-PI / Local PI</th>
<th>Other Dutch institutions</th>
<th>Other local institutions</th>
<th>Non-research organisations</th>
</tr>
</thead>
<tbody>
<tr>
<td>N/A</td>
<td>Dr. S.N. Kiwanuka (Makerere University School of Public Health (MakSPH))</td>
<td>Prof Michel Wensing (Radboud University Netherlands)</td>
<td>Dr Olico Okui (Uganda)</td>
<td>10 coalition partners from the 8 research groups</td>
</tr>
</tbody>
</table>

### DESIGN

<table>
<thead>
<tr>
<th>Research objectives</th>
<th>Capacity development objectives</th>
</tr>
</thead>
<tbody>
<tr>
<td>The focus of the KT-Net project was on making existing knowledge available and accessible for policy makers and other stakeholders, analysing existing knowledge to benefit policy making, tailor research outputs of the eight coalitions as appropriate for different audiences and stakeholders.</td>
<td>Building KT capacity among all 8 research projects was a key objective of the KT-Net project. The conceptual design of KT-Net project was not intended to meet academic criteria for scientific research. For this reason KT-Net did not contract PhD students.</td>
</tr>
</tbody>
</table>

### Project organisation (proposed)
Specifically, KT-Net aimed to:
1. Host a shared platform for KT (Knowledge Translation) across the eight coalitions.
2. Build KT capacity among the eight coalitions and relevant stakeholders.
3. Support KT activities across the network by providing technical support and small grants.
4. Assess/evaluate the KT effects across the network.
5. Promote collaborations and KT best practices sharing across the GPHFRS network and others global partners.

### Major changes to project
- Project was extended to ensure deliverables for set objectives.
- Project manager left the team in 2016

### OUTPUTS

<table>
<thead>
<tr>
<th>PhDs, postdocs, students</th>
<th>N/A</th>
</tr>
</thead>
</table>
### Scientific output
- 1 publication, outlining the KT-Net protocol and detailing the approach to the assessment of the effect of KT-Net activities on knowledge uptake in and across low and middle income countries (LMICs). Four additional papers are planned.
- A health insurance book capturing lessons on health insurance experiences across five African countries has been drafted as one of the outputs of collaboration across the network.

### KT products
KT products (co-)prepared by KT-Net have been listed throughout the various projects concerned. In total, over 25 policy briefs, 9 videos, and more than 100 popular communication products (blogs, press releases, newspaper articles) were produced and shared.

Over 25 dissemination activities and policy dialogues have been held.

### RESULTS & IMPACTS

<table>
<thead>
<tr>
<th>Main scientific findings</th>
<th>KT situation analyses, stakeholder mapping and capacity assessments were conducted in close cooperation with each of the eight GHPHRS coalitions. A platform for the eight GHPHSR projects was established and actively maintained by Makerere University School of Public Health secretariat.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Capacity developed</td>
<td>Capacity building activities of KT-Net within the network of coalitions included face-to-face training, online guidance of partners in the packaging of research evidence in order to influence sustainable change in health policy, the strengthening of collaboration with relevant networks and stakeholders, and the encouragement of mutual learning</td>
</tr>
<tr>
<td>Policy &amp; practice</td>
<td>See project descriptions</td>
</tr>
</tbody>
</table>