



# Future Health Systems Innovations for equity

## Future Health Systems: DFID Inception Phase Report

<b>Title of research programme:</b>	Health Services for the Future: Delivering effective health services
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<b>Name of lead institution and Director</b>	Johns Hopkins Bloomberg School of Public Health, Professor David Peters and Dr Abbas Bhuiya
<b>Name of CEO</b>	Dr Sara Bennett
<b>Key Partners:</b>	<ul style="list-style-type: none"><li>- ICDDR,B, Dhaka, Bangladesh</li><li>- China National Health Development Research Center (CNHDRC), Beijing, China</li><li>- Indian Institute for Health Management Research (IIHMR), Jaipur, India</li><li>- School of Public Health (SPH), Makerere University College of Health Sciences, Kampala, Uganda</li><li>- Institute of Development Studies (IDS), University of Sussex, Brighton, UK</li></ul>
<b>Countries to be covered by research:</b>	Afghanistan, Bangladesh, China, Democratic Republic of Congo, Ethiopia, India, Kenya, Nigeria, Rwanda, Tanzania, Uganda

### 1 Summary of Research in Lay Terms

The Future Health Systems (FHS) research program consortium (RPC) will provide high quality knowledge about how health systems can improve quality of and access to basic health services for the poor. We will focus on how to improve services that benefit the poor and socially marginalized groups, and how to strengthen service delivery in complex contexts where there is conflict, unstable social and environmental conditions, and/or gender discrimination.

To do this we will conduct scientifically rigorous research in Afghanistan, Bangladesh, China, India and Uganda. The main research questions for the consortium are:

1. **Unlocking Community Capabilities:** How can the wide range of resources available at the community be systematically identified and used to improve the quality and impact of health services, particularly for disadvantaged groups, in all their diversity?
2. **Stimulating Innovations:** How can new technologies and organizational innovations be introduced and sustained to improve the quality, coverage and affordability of healthcare in resource-poor settings?
3. **Learning by Doing:** How can models for systematic learning-by-doing be best used by providers, beneficiaries, officials and key local actors to improve the delivery of health services, particularly for poor and marginalized populations?

Our consortium will invest in ensuring that our learning is widely disseminated to policymakers and practitioners, and that uptake and use are encouraged. We will also seek to develop capacity among the developing country partners with whom we work.

The main products of our work during the first year include:

- Publication of at least three academic papers that summarize our thinking about the core research questions and review appropriate research approaches.
- Effective engagement of key stakeholders in FHS focal countries with our research through policy roundtables, media engagement and other appropriate mechanisms to ensure that FHS research better informs policy decisions.
- Beginning to implement interventions to strengthen health service delivery in all five core study countries.
- Production of a strategy and plan to strengthen health services research capacity across seven schools of public health in East Africa, including several in fragile states.

## **2 Detailed Research Framework**

### **2.1 Approach to developing research**

During the inception phase, the research plans and protocols were developed through an iterative process of team- and consortium-wide activities. Beginning at the First Global Symposium on Health Systems Research in Montreux in November, 2010, where FHS presenting findings from our work in the first DFID RPC grant, the FHS consortium met to map out the inception phase work. Three thematic groups were formed comprised of members from each of the partners, and the groups outlined a plan of work for the inception period. In each case, this involved preparing a literature review and concept notes concerning knowledge gaps and methodological best practices to guide the research plans for the country-based teams and the cross-consortium theme work. We also identified a fourth thematic area of conceptual and methodological concern, Complex Adaptive Systems (CAS), which was described in the FHS proposal as providing theoretical models for understanding how health systems function and is particularly relevant for addressing the problems of improving implementation and scaling up effective health services.

In April 2011, the consortium met in Brighton, UK, to further develop the research plans and initiate work on theories of change (TOC) for each country's research (see Annex 9). Each of the thematic teams presented their findings and recommendations about the application of the theme to the FHS RPC. Each of the thematic teams was tasked with further work to develop their conceptual models and bring forward specific methods and instruments for consideration by the consortium. The country teams presented their main research questions and broad designs, and interacted with each of the thematic teams to discuss how to improve the research designs and best apply the thematic work in each country. After the meeting, each of the country teams also initiated stakeholder analyses as a means of identifying the main stakeholders in the health system relevant to their research proposal, and specifically those with interests in the intervention strategy being developed in each country, based on the guidance and set of tools developed by the consortium (Annex 7).

In consultation with the thematic group leaders, the research directors developed a detailed protocol to review and facilitate the design of strong research proposals (Annex 6). When the country research concept notes, theories of change, and research instruments were completed, each of the thematic and country teams contributed to the review of the country research notes.

In July 2011 in Toronto, the FHS RPC held another meeting in conjunction with the International Health Economics Association meeting, where a number of FHS members were presenting their research.

Research plans for each of the country and thematic teams were discussed in detail, along with a set of research instruments that would be prepared for each of the consortium members.

## 2.2 Hypotheses

Each of the country teams has identified an intervention strategy to improve the delivery of health services in their country (see Annex 9 for each country’s theories of change, and Annex 12 for full country proposals). In the case of India and one of the two Uganda projects, the teams identified processes (as opposed to interventions) that will enable communities and other key stakeholders to develop an intervention strategy. In keeping with our understanding of CAS, the teams are planning for the strategies to evolve over time as implementers, users, and other key stakeholders interact in the health system, and as other events influence how the health system operates. In each case, the teams hypothesize that the intervention strategy can improve the delivery of health services. The main research questions, intervention strategies, and health services outcomes are identified in Table 1.

**Table 1: Summary of Country Research Questions, Intervention Strategy, and Health Services Outcomes**

Country	Main Research Question	Intervention Strategy	Primary Health Services Outcomes
<b>Afghanistan:</b> Enhancing Community Capacity for Health Service Delivery in Afghanistan	In a post-conflict society, how can trust be built in public institutions that provide health care through the use of community scorecards on health services?	Facilitation of community development, including the use of scorecards on health service delivery by local providers	Scorecard measures of quality and utilization of primary health care services (currently 25 facility-based indicators at provincial and national level)
<b>Bangladesh:</b> Does an integrated system of health services, linking informal and formal healthcare providers by information technology and mobile phones, strengthen health services in rural Bangladesh?	Can an innovative and locally relevant network of providers supported by technology systems be supported to improve quality, utilization, and equity of health services?	Application of mobile technology and computer-assisted guidance with network of informal and public health providers	Population and facility-based measures of utilization and quality of health care (e.g. outpatient utilization rates; percent of patients of village doctors receiving an antibiotic; percent of patients having one of 20 common conditions whose treatment follows standard guidelines)
<b>China:</b> Effective Drug Delivery at Rural Grass-Root Health Facilities	Can the Chinese health reforms be implemented in a way that improves the quality of and access to health services delivery at an affordable cost?	Multiple levels of intervention including mandated case-based financing reforms and the introduction of an essential drugs systems to promote rationale use of drugs, with scope for wide variation in financing, organization, and oversight at the county level	Facility-based and population based measures: Quality of care (e.g. Proportion of prescriptions with: (i) antibiotic; (ii) intravenous injection; (iii) vitamin) Utilization of care (Outpatient visits per capita) Cost of care (total cost to government and out-of-pocket payments) Patient satisfaction (index to be developed)
<b>India Phase 1:</b> Decoding Healthcare Access under Climate Crisis: A Case Study of Sundarbans	Can the health and livelihoods of a climatically fragile population be	New model of health care to be developed from phase 1 research and interactions with	Descriptive measures on health, health services, livelihoods, risks, coping strategies, functioning of health-related markets

Country	Main Research Question	Intervention Strategy	Primary Health Services Outcomes
	understood in a way to feasibly design a new model of care that takes advantage of local resources and is resilient to environmental shocks?	DOHFW, community members, and other stakeholders	
<b>India Phase 2:</b> Healthcare Access under Climate Crisis: A Case Study of Sundarbans	Can a new model of service delivery provide effective health services for children in an environmentally fragile setting?	New model of health care delivery based on phase 1 work that links formal and informal providers and holds key stakeholders accountable for effective service delivery	Increase in coverage and quality of child health care for nutrition-related and common diseases such as diarrhea and ARI in six vulnerable blocks of Sundarbans.
<b>Uganda 1:</b> Innovations for increasing access to integrated safe delivery, PMTCT and newborn care in rural Uganda	Can an integrated system for maternal-newborn care be implemented in a way to increase utilization, quality, and impact of maternal-newborn health care?	Community mobilization through CHWs, supply and demand vouchers, integration and quality improvements of clinical services for maternal and newborn care	Population and facility-based: Rates of ANC, Institutional delivery, PNC, and Neonatal mortality (projected by LiST)
<b>Uganda 2:</b> Mobilizing Community Resources for Maternal Health	Can existing community resources be mobilized to support a successful voucher scheme that has increased access to institutional deliveries and post-natal care?	Community mobilization to develop financing scheme to maintain system to finance maternal and newborn care	Development of tools for community capacity and demonstration of community capacity through sustainability of voucher scheme

## 2.3 Methodologies

The FHS consortium is planning to conduct its research in way that builds on the work of the previous RPC, including the development of conceptual frameworks and research methods (Table 2). We have incorporated the health markets systems framework developed previously, which provides a way of thinking about sets of players, institutions, incentives, and behaviors in a health market system (Bloom et al. 2011; Bloom et al. 2008). We've also developed a model for understanding changes in the delivery of health systems through a complex adaptive systems (CAS) lens (Paina & Peters 2011), and will be further developing CAS models during the grant period.

We have reviewed and adapted frameworks for using participatory research methods in communities, for studying community capabilities, and how they influence health services. We also intend to develop a framework to understand and improve decisions concerning the ethics of participatory research, particularly when the researcher is embedded in local institutions for policy and program decision-making. In the area of stimulating innovation, the theme group will be focusing on the organizational, institutional, and technological arrangements that have the potential to substantially increase access by the poor to safe

## Future Health Systems

and effective health-related goods and services. We will develop frameworks for understanding and intervening in health knowledge economies.

In addition to the conceptual frameworks that are used to guide our research enquiring, in each of these areas thematic areas (see Annex 11 for detailed cross-cutting proposals), the consortium has developed or is adapting more specific methods and tools to be used by the country teams in their empiric work. These tools include data collection instruments we've developed for assessing quality of care at health facilities, modules for household surveys, and guidelines for participatory research and evaluating innovation and complexity.

**Table 2: Conceptual Frameworks, Methods and Tools Used According to Research Theme**

<b>Thematic Area</b>	<b>Conceptual Frameworks</b>	<b>Methods and Tools</b>
Consortium-wide	A. Health Markets Systems  B. Framework for evaluating scale-up of health services and outcomes	A. Market systems <ul style="list-style-type: none"> <li>• Develop-distort dilemma (sustainability and growth analysis)</li> <li>• Market player analysis</li> </ul> B. Health evaluation measurement <ul style="list-style-type: none"> <li>• Health facilities assessment tools to assess structure, process, and outcomes of care, including patient satisfaction and provider motivation and satisfaction instruments</li> <li>• Scorecards for multi-dimensional assessment of health services</li> <li>• Household survey modules</li> </ul>
Complex Adaptive Systems	CAS Pathways for Health Service Delivery (to be developed further)	<ul style="list-style-type: none"> <li>• Evaluation guideline for assessing complexity in health systems</li> <li>• Agent-based modeling tools (Netlogo)</li> </ul>
Unlocking Community Capabilities	Participatory research framework Community capability framework Ethics of embedded participatory research (to be developed)	<ul style="list-style-type: none"> <li>• Participatory research guidelines</li> <li>• Qualitative research guidelines</li> <li>• Stakeholder analysis guidelines</li> <li>• Household survey instrument for assessing community capability</li> </ul>
Stimulating Innovation	Regulatory interventions in the health system (to be developed)	<ul style="list-style-type: none"> <li>• Evaluation guideline for understanding innovation</li> </ul>

Note: The thematic group on Learning by Doing is incorporating its research into the Complex Adaptive Systems (CAS) framework that examines emergent behavior and learning, in addition to playing a role in the Policy Influence and Research Uptake (PIRU) strategy and the capacity building work of the consortium.

The FHS consortium uses a broad mix of quantitative and qualitative research methods in our research. Table 3 outlines the research design for assessing a policy or program intervention in each country. The quantitative components include pragmatic randomized cluster trials and quasi-experimental designs to assess changes in health services and related independent variables in intervention and comparison sites over time, in each case using strategies that are expected to evolve over time. The qualitative research component in each country plays the role of formative research, evaluative (explanatory research), or as action research (in the case of India and Uganda 2) where participants design, implement, monitor and evaluate interventions during the course of the project.

**Table 3: Country-Specific Research Designs: Intervention and Qualitative Research**

Country	Health systems intervention research design	Qualitative research design
Afghanistan	Trial of community scorecards on health services and community development initiatives in eight intervention and comparison communities	<ul style="list-style-type: none"> <li>Formative research to design community scorecards and data collection instruments</li> <li>Evaluative research to explain or validate results on health services delivery from the community's perspective, and explain how governance in the health sector is changing and how trust is built in public institutions related to the delivery of basic services</li> </ul>
Bangladesh	Pragmatic cluster randomized trial of mobile phone and computer-assisted clinical support to a network of informal and public providers in nine intervention unions and comparison unions	<ul style="list-style-type: none"> <li>Formative research to design data collection instruments and design interventions with providers and patients</li> <li>Explanatory research to assess how intervention effects are spread (e.g. communication channels)</li> </ul>
China	Quasi-experiment: random selection of 67 counties from across China comprising early adopters of health reforms, middle and later adopters, compared over time. Reforms involve requirement to use case-based payment and application of essential drugs list, with large scope for variation in financing, organization, and oversight of care.	Explanatory research with key informants in each county to identify specific content of reforms actually implemented, reasons for selection, how reforms work in practice, and unintended consequences
India (Phase 1)	Process and outcome evaluations to emerge from community-based action research	Formative and explanatory research informing and assessing the action research that will involve representative community members, local providers, and officials, to describe better current health conditions and coping strategies, and to design, implement and monitor a new model of health service delivery in a fragile environment (Sundarbans)
Uganda 1: Integrated maternal-newborn care	Pragmatic cluster randomized trial of integrated package of maternal-newborn care in six intervention and six comparison health sub-districts.	<ul style="list-style-type: none"> <li>Formative research to design data collection instruments and design interventions with providers and patients</li> <li>Explanatory research to assess how implementation actually proceeded</li> </ul>
Uganda 2: Community Resources	Process and outcome evaluations to emerge from community-based action research	Formative and explanatory research informing and assessing the action research, that will involve representative community members, local providers, and officials to design, implement and monitor financing scheme for maternal childcare

In each country that human subjects research is involved, institutional ethical review clearance is required and has already been initiated during the inception phase.

### 3 Overview of Research Management and Governance

#### 3.1 Inception phase processes

The current DFID grant builds upon a prior five-year grant held by the same consortium partners, and in many cases upon longer standing relationships among the partner institutions. Accordingly, during the inception phase the consortium has focused on updating and further clarifying its methods for doing business, rather than building these from scratch.

The series of consortium meetings described above were used progressively to refine the vision of the consortium in its new phase of work, assist the development of country-led research protocols, identify and develop cross-cutting themes and protocols, as well as develop the policy influence and research uptake (PIRU) strategy and capacity development plans. All partners have participated in the series of consortium-wide meetings, frequently sending both senior and more junior researchers as well as PIRU officers, and these meetings were also supplemented by regular teleconferences across all partners.

A survey of all consortium participants conducted in August 2011, showed that most consortium members found the consortium processes to have been inclusive and participatory. On a scale of 1-10 (where 10 is high), consortium members gave the consortium an average rating of 7.91 on the overall inclusivity of the inception phase process, and we also received an average rating of 7.70 of respondents indicating that their ideas were represented in the inception report. The consortium also asked questions in line with the Keystone Accountability Survey for partnerships in order to compare with their baseline<sup>1</sup> of other partnerships. We scored broadly in line with the Keystone baseline on questions like ‘How much does Future Health Systems understand your priorities and constraints?’ (FHS: average of 7.22 vs baseline average of 6.86); and ‘How much of an influence do you have on FHS's plans and strategies?’ (FHS: 6.48 vs baseline of 6.26). We also scored well on the question: ‘How much does FHS feel like a partnership of equals?’ with an average of 7.61.

We have also used the inception phase to review our Memorandum of Understanding (MOU) and have taken the opportunity to update the MOU in several respects. The MOU now identifies the HEALTH Alliance (Higher Education Alliance for Leadership in Health – see section on capacity development for more details) as a core partner (although it continues to receive its funding through Makerere University), and more clearly defines a role for consortium affiliates. The revised MOU is now circulating among partner institutions for signature.

#### 3.2 Organization and Structure

Figure 1 provides an updated version of the organizational structure of the consortium. While key personnel have remained the same as in the proposal, the consortium has hired a new Policy Influence and Research Uptake Manager (Jeff Knezovich) and a Research Manager (Daniela Lewy). Dr Elizabeth Ekirapa-Kiracho has replaced Dr George Pariyo as head of the Uganda team.

The structures originally described in the proposal are now fully functional. The Management team meets regularly by teleconference, as well as individual members interacting on a regular informal basis. The management team handles all aspects of the day-to-day functioning of the consortium, including ensuring

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<sup>1</sup> Owing to data restrictions, it is impossible to check the significance of our score compared with the baseline, but can rather be used as a broad gauge.

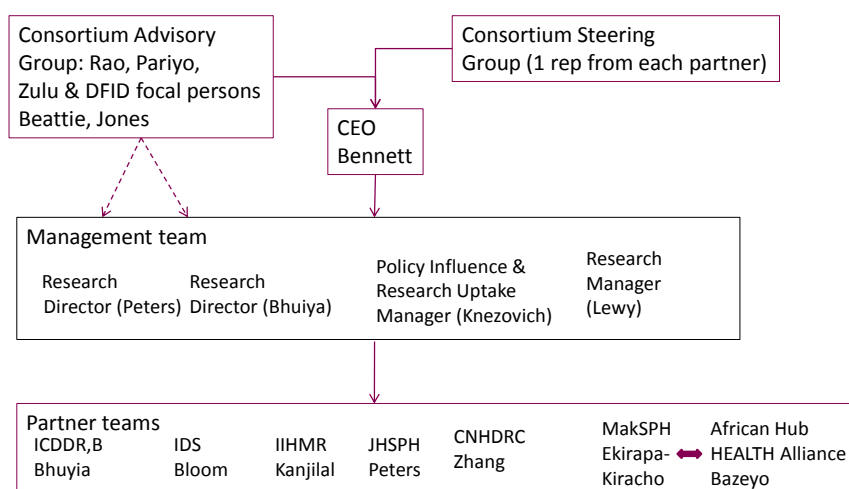
regular monitoring and reporting of consortium activities, the implementation of quality assurance processes and appropriate budgeting and financial reporting. The Consortium Steering Group, made up of a representative of each partner, guides the overall direction of the consortium. To-date, Steering Group meetings have taken place during the face-to-face meetings of partners and have discussed issues such as the MOU, approaches to budgeting and relationships with affiliates. However, as a further full consortium meeting is not planned until May/June 2012, we anticipate that the next steering group meeting will take place by teleconference in November 2011.

Consortium Advisory Group (CAG) members have been identified and each has been individually briefed on the consortium and its activities. Members of the CAG include:

- Ms Sujata Rao – former Health Secretary of India, representing a policymaker’s perspective
- Dr George Pariyo – currently head of research at the Global Health Workforce Alliance, WHO, representing a research perspective
- Dr Eliya Zulu – Executive Director of the African Institute for Development Policy representing a policy influence and research uptake perspective.

Allison Beattie and Iain Jones, consortium link persons at DFID, constitute the remaining members of the CAG. The consortium sought to hold an initial CAG teleconference in July 2011, but unfortunately several CAG members were unable to join at the last minute and the meeting had to be postponed to early September 2011.

**Figure 1: FHS Organizational Structure**



### 3.3 Quality Assurance

Given the decentralized approach to research development, strong quality assurance and quality support processes are key. The consortium has developed a technical review protocol (see Annex 6) which was used to review both country and cross-cutting research protocols during the inception phase. While the research directors take overall responsibility for quality assurance, standard principles of peer review are used. Each protocol is reviewed by two reviewers from inside the consortium using the technical review templates. These reviewers are selected by the research directors based upon their knowledge and expertise, and the research directors are also responsible for discussing the reviews with relevant teams and agreeing on amendments to be made. The review process is intended to be a supportive one, enabling both capacity



## Future Health Systems

development and quality assurance. The section 6 below describes the key M&E approaches that will be used to ensure that research is implemented in a timely and efficient fashion. Peer review processes will continue to be used to review new proposals and research products.

### 4 Overview of Capacity Development

The FHS consortium understands capacity and capacity development strategies to exist at three interdependent levels: the individual, the organizational and the institutional or network level. In building our capacity development strategy we have encouraged partners to think at all three of these levels. However, based on the capacity assessments made by our core partners, and given the relatively modest resources within the consortium for capacity development work, many of the strategies agreed by partners focus on the individual level.

Our strongest efforts towards capacity development are through the African Hub which is working with the HEALTH Alliance, an established consortium of Schools of Public Health in East Africa<sup>2</sup>. This consortium includes several schools working in post-conflict or fragile contexts which currently have rather limited capacity for health systems research. We present our capacity development plans in two parts: one detailing plans for the Africa Hub, the other focusing on core partners.

#### 4.1 African Hub

**Process** - FHS presented its work and opportunities for collaboration to the deans of seven East African schools of public health in Kigali in February 2011, and the prospect of a collaborative approach to capacity development for health systems research was met with much enthusiasm. The deans also emphasized the need to reach out to policymakers within their respective countries to promote capacity for evidence use and production. A detailed tool was designed to help the schools self-assess their capacity for health services and systems research and build a capacity development plan. This involved: data collection on funding, publications, faculty and other institutional arrangements; a Likert-scale instrument to understand faculty perspectives within the schools on strengths and weaknesses; and internal discussions to reach collective agreement on strengths and build a capacity development plan. Focal persons were appointed by the deans in all seven schools, and Makerere School of Public Health hosted a workshop to help refine the self-assessment tool and train focal persons in its use. The capacity assessment is ongoing, with a further workshop to discuss findings planned for November in Kenya. Plans identified here are indicative.

**Strategy** – Each School will produce its own capacity development strategy, however we anticipate that there will be cross-cutting strategies that the network will engage in collectively. These will be organized through the FHS Hub (located at the Makerere School of Public Health) with support from other consortium members as needed. Cross-cutting activities are likely to include:

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<sup>2</sup> The Health Alliance includes the School of Public Health, University of Kinshasa, DRC; College of Public Health and Medical Sciences Jimma University, Ethiopia; School of Public Health Moi University, Kenya; School of Public Health Nairobi University, Kenya; School of Public Health, National University of Rwanda, Rwanda; School of Public Health and Social Sciences, Muhimbili University of Health and Allied Sciences, Dar es salaam, Tanzania and Makerere University School of Public Health, Kampala, Uganda

- Curriculum development – sharing of curricula across schools and workshops to help strengthen teaching on health systems and health systems research
- A program of targeted skill development for faculty, probably starting in June 2011 with a workshop on proposal writing
- Mentoring networks across partners
- Small capacity development grants to address institutionally-specific capacity barriers, e.g. Internet access or advice on financial management systems
- Small research grants linked to the core FHS themes
- Cross-country exchange of ideas and research through a regional learning platform

The full plan for the African Hub is in Annex 10. Please note that the HEALTH Alliance together with FHS is actively seeking additional funding (from the Rockefeller Foundation and the International Development Research Center, Canada) to support this work.

## 4.2 Consortium Partners

Each core consortium partner conducted a self-assessment of capacity (based on a streamlined version of the tool used by the African Hub) and developed its own capacity development plan (see Annex 2). Table 4 summarizes the key features of each individual partner's plan.

**Table 4: Summary of partners' capacity development plans**

Institution	Key element of capacity development plan
ICDDR,B, Bangladesh	Key capacity challenges concern lack of specific relevant skills within the Bangladesh team, particularly in the areas of health economics and policy influence and research uptake. These will be addressed through a program of hiring and training. The Bangladesh team will also invest in community capacity development particularly training of village doctors.
CNHDR, China	Among junior researchers key needs focus around research design, methods and theories, as well as paper writing. For senior researchers while there are still needs for additional training in advanced theories and methods a key concern is research management. Various training workshops are planned using both Chinese and consortium resources. One workshop on complex adaptive systems was conducted in July 2011 in Beijing.
IHMR, India	The Indian team is a relatively new multi-disciplinary team. Key challenges are to ensure that they are able to work together effectively and in strengthening skills in implementation and evaluation research. This will be addressed through local resources and also through pairing with ICDDR,B. Training in drafting of journal articles is also needed.
MakSPH, Uganda	MakSPH has relatively few senior staff and there are relatively limited mentoring systems. Grant-writing tends to fall upon a few faculty members. Capacity development plans seek to develop north-south mentoring networks, use workshops to develop grant- and paper-writing skills and build capacity in research-to-policy activities.
IDS, UK	IDS would like to ensure that FHS provides opportunities to further faculty engagement in post-conflict states and thinking about health systems capacity development in such situations. IDS is also seeking opportunities to extend skills in the production of high quality on-line resources.

## Future Health Systems

JHSPH, USA	JHSPH has a number of faculty working in health systems, but sometimes the field lacks a clear identity within the School. FHS provides an opportunity for collaborative work and the establishment of a clearer identify for health systems work. JHSPH also looks to FHS to provide fieldwork opportunities for graduate students, particularly doctoral students.
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We also plan to pursue the following cross-cutting strategies:

- **Skill-development workshops** – Trainings for junior to mid-level faculty will focus on specific needs or steps in the research. Several specific skills or techniques were identified by more than one research team, including: higher level qualitative research methods, paper writing, and advanced economic modeling. We will take advantage of consortium annual meetings to piggy-back skill development workshops. To the extent possible, these will also involve African hub members so as to allow cross-pollination of ideas between all parts of the consortium.
- **Small grants program** – We want to provide opportunities for promising young researchers and graduate students across the consortium to undertake health systems research, and thus propose offering a program of small grants both for research and for paper writing. This would be a competitive program, open only to junior faculty and graduate students. The amount of funds provided would be small (typically around US\$2,000-5,000), and funding would be supplemented by mentoring by more experienced faculty from across the consortium.
- **Mentoring** – While there is a lot of interest in mentoring, effective mentoring requires recognition of specific needs of mentees and support for mentors to clarify mentee needs and reward their mentoring. We are exploring ways in which to start small, more focused mentoring initiatives. One option might be to establish a mentoring network focused on developing more women leaders within the consortium.

### 5 Overview of Research Uptake

The Future Health Systems RPC recognizes that the research we undertake is relevant to policy and practice at both the national level within the countries where we operate but will also have broader implications for the way developing countries approach health systems development. Simply making research available is not sufficient to generate uptake. During the inception phase, we have developed a broad framework for our policy influence and research uptake (PIRU) activities that is founded upon the following principles:

- **Country driven:** Echoing the organization of the overall RPC, the PIRU Strategy is designed at the country level with emergent international or global engagement focused mainly around cross-cutting themes.
- **Two-way process:** Although policy influence and research uptake implies an outward push of information, this consortium views this as a two-way process of engagement designed to stimulate both demand for our research but also research that is more responsive to end-users' needs.
- **Objective led:** Instead of starting from an output and looking to disseminate it, PIRU activities and outputs will follow from strategic objectives, which may mean using a variety of appropriate channels and approaches for the objective and the target audience. These objectives will tie into the broader 'theory of change' for each of the countries and for international/cross-cutting engagement.
- **Embedded in the research process:** PIRU processes are not standalone. PIRU processes must work hand-in-hand during the research design to agree objectives and ensure appropriate research and research outputs to meet them.

- **Being there:** Where possible, instead of creating new communication channels and activities, the consortium will employ a 'being there' approach of accessing and using existing channels.
- **Accessible:** Where possible the consortium will pursue communication routes that are as accessible to as many people as possible. This includes targeting open access publishing options that break down financial barriers to access as well as using technology to reduce geographic barriers to access.
- **Operating in complex environments:** Policymaking itself is a complex process, and trying to influence those processes require complex – not simple or even complicated – solutions. We will adopt an iterative scoping, testing and learning approach guided by core objectives.
- **Reflective and adaptive:** PIRU activities in each country and at an international scale will adopt a 'learning by doing' approach that relies on systematic monitoring to adapt approaches to context.
- **Internal and external:** In order to engage external audiences, there must first be strong internal communication, especially as it is a consortium comprised of many partners. The PIRU strategy will therefore look to ensure effective knowledge management and sharing.

Overall, the PIRU team is working towards six core objectives over the next five years:

1. Key stakeholders in focal countries are engaged in FHS research and findings from FHS inform their 'policy' decisions.
2. International and regional, policy- and decision-makers engage with FHS research through appropriate mechanisms and use FHS findings to inform their decision-making process.
3. High quality FHS outputs and activities inform academic debates on health service delivery issues and the poor.
4. Internal communications among consortium partners is strengthened to allow for a better flow of information from internal to external audiences, and from the country to international levels (and vice versa).
5. Effective monitoring, evaluation and learning processes are established to help consortium members adapt to dynamic and complex systems and to support learning-by-doing processes to improve interventions.
6. Sustainable capacity for knowledge translation, internal communication and policy engagement is strengthened in focal countries.

The PIRU strategy itself considers a set of core communication activities, outlines specific engagement strategies, sets out internal communication approaches and activities, develops monitoring, evaluation and learning mechanisms and explains how we intend to deliver on the strategy.

**Core communications** activities will ensure value-for-money for the consortium by reducing duplication of effort, providing shared platforms and templates, and will serve as a crucial link between country-level activities and international discourse. A set of core products was determined based on a scoping exercise of existing channels that each partner organization had access to. Policy briefings, web-based communications, open-access journal articles and stories of change will be prioritized as core products for the next phase.

**Engagement strategies** have been established for each of the five country teams. These were developed through first working with each country team to elaborate a theory of change and then conducting preliminary stakeholder analyses to determine their positions, knowledge needs and preferred communication channels. Although the goals, approaches and balance of effort vary across each country, most of the country strategies contain three main elements:

## Future Health Systems

- **Direct support to the implementation of the intervention** (e.g. in Bangladesh supporting one of the program's goals to engage in direct behavior change communication around preventative health measures through SMS and other platforms)
- **Engagement with local/district-level and national-level stakeholders about the focus issue, especially policymakers** (e.g. in India establishing a platform on health in the Sundarbans to promote better coordination among service delivery stakeholders).
- **Engagement at the international level to ensure relevant lessons from these projects inform broader development discussions** (e.g. in Afghanistan feeding into discussions about the utility of community scorecards to improve health and other services in post-conflict settings).

**Internal communications** are critical to the success of the consortium as we are working across a number of partners. Our internal communications approach serves four main functions: community building, updates on activities, knowledge management, and decision-making. The intention is to find an appropriate mix of technological and intra-personal solutions to ensure effective working of the consortium.

**Monitoring and evaluation** of our PIRU activities will feed into our learning-by-doing theme and will combine elements of process monitoring, measurements of uptake, assessments of usefulness, built-in reflection points, and – in the longer term – retrospective assessments of impact pathways. Each country will focus on M&E activities that are most appropriate to their context.

**Delivering the PIRU strategy** will be coordinated by a Policy Influence and Research Uptake Manager based at IDS. Each country partner also has a PIRU Officer embedded within the team. We will also undertake a yearly planning process to monitor progress while allowing for changing circumstances. As different activities are agreed, we will review team capacities and how they will be strengthened in order to deliver on our objectives.

## 6 Overview of monitoring and evaluation (M&E)

M&E is important for the consortium in terms of:

- Tracking progress in research implementation and enabling course corrections if necessary
- Ensuring transparency and accountability to DFID and to the consortium steering committee
- Learning about which research strategies are effective and why.

FHS's overall M&E approach will be driven by the consortium-wide theory of change and log frame (see Annex 1). The log frame identifies the overall purpose of the consortium as generating knowledge that will lead to improvements in the delivery of basic health services for the world's poor. Changes in utilization and quality of health services will be measured in all FHS core countries in order to assess attainment of this goal, with different services being assessed in different countries according to the focus of the research. The goal of the consortium concerns improving policies, programs and practice through new evidence and the effective communication of this evidence. The consortium will track all such shifts in policy and practice in the core countries where it works. Finally, five outputs for the RPC linked to each of the three cross-cutting themes of the consortium, capacity development, and PIRU are identified. Indicators and sources of evidence at each of these levels are identified in the log frame in Annex 1.

### 6.1 Routine monitoring for accountability and course-correction

A system of monthly monitoring has been established. All partners complete a standardized report on a monthly basis that is sent to the research manager, who in turn collates and circulates these. The monthly reports discuss progress against work-plans, unexpected delays, and list all publications and key research

uptake activities, as well as any observed changes in policy or practice as a consequence of the research. The management team review the reports on a regular basis and provide support to teams to resolve any problems that have arisen during the reporting period. These monthly reports also serve as the basis for annual reports to DFID. The system of monthly reports also helps ensure that the FHS website is kept up-to-date and will feed into e-newsletters so that all consortium partners and stakeholders are kept abreast of developments across the consortium.

A mid-term review is planned: we will use this opportunity to reflect internally on progress and challenges, as well as seeking external input. We anticipate that this review may lead to adjustment of strategies.

## 6.2 Evaluation and learning

The third cross-cutting theme of the consortium is learning-by-doing. Much of the research being undertaken has the flavor of action-research, where researchers are active participants in the process of reviewing current practices in service delivery, providing evidence that can inform attempts to strengthen health services, and working with other stakeholders to identify appropriate courses of action. We will seek to document and analyze not only the nature of the intervention (e.g. what training has been provided to rural medical practitioners, or how vouchers schemes operate) but also the context and process through which these interventions came about. Accordingly, the consortium is developing guidance on documentation of the research process and facilitators from JHSPH and IDS will help research teams document on an annual or bi-annual basis the research processes which have occurred and the effects that they have had so that we can learn about effective research strategies. This learning will also feed into the planned mid-term review of the consortium.

All core country partners will be assessing impacts of interventions on indicators of health service utilization and quality. This will be measured through either facility or household surveys during the first year of the research (baseline) and again at the end of the research, and will provide high level indicators of research impact.

## 7 Open access publishing and datasets

The FHS consortium recognizes both the benefits and costs of open access publishing. Given financial constraints we do not think it feasible to ensure that all consortium publications are published as open access papers, however we will ensure that the most significant research findings and particularly those with strong implications for policy and practice are open access. Consortium partners have each budgeted for a small number of open access papers each year.

With respect to making datasets more widely accessible, we recognize the challenges frequently faced in making datasets fully public. Johns Hopkins University participates in the Data Sharing for Demographic Research consortium (DSDR). DSDR is an initiative of the [Demographic and Behavioral Sciences Branch](#) of the National Institutes of Health to develop standards and methods for safe and effective data sharing. The Hopkins Population Center participates in this consortium and has staff who can offer consultation on data archiving and sharing policies for both restricted use and the public use files. Collaboration with the DSDR will enable consortium members to take advantage of state-of-the-art techniques in data sharing while maintaining protection of human subjects. Where the consortium has made major investments in data collection (for example in the planned work in Uganda, which is being supported by multiple partners) we

## Future Health Systems

will seek to make resulting data sets publicly available. However, in the majority of cases, our efforts will be directed to ensuring that datasets are formatted and available for use by students across the consortium partners, thus maximizing the analysis which can be done from one data set, and the opportunities for capacity development.

### **8 Gender mainstreaming**

Gender mainstreaming will be supported at three levels: 1) among key stakeholders and beneficiaries of country intervention and research processes, 2) within country intervention and research processes, 3) among consortium members. At levels 1 and 2, indicators for gender equity in research and intervention participation and impact, will be tracked on an annual basis. At level 3, gender representation in core functions of the RPC will be monitored and measures developed to address any issues. The need for further attention to gender dynamics will be assessed in the context of formative and explanatory evaluations specific to each country intervention research plan. The main forum for reviewing gender mainstreaming will be the annual meeting. The RPC will have a dedicated team member (Asha George) taking responsibility for this.

### **9 Working with other RPCs**

Future Health Systems (FHS) is committed to collaborating with other DFID-funded RPCs in an effort to maximize potential synergies, prevent duplication of efforts, strengthen relationships among local and international researchers working within the same region, and learn from other partnerships' best practices. Already in the Inception Phase, FHS has had direct communications with the COMDIS-HSD consortium, the ReBUILD consortium, RESYST, the Secure Livelihoods Research Consortium (SLRC), and the IDS/DFID Human Development Resource Center. Through face-to-face meetings in Montreux in November 2010, as well as email and phone communication, the RPCs have shared information about contracts and reporting guidelines, as well as discussed opportunities for joint research uptake activities with DFID both at the country and national levels. As both IDS and ICDDR,B are partners in the Transform Nutrition RPC, we are also exploring opportunities to share PIRU resources and staff. There are plans to create a map of RPC activities throughout the globe that outlines research overlaps and extended networks. After the Inception Phase, a follow-up conference call or meeting is planned to share our work plans and delineate concrete shared activities. We are particularly concerned about coordinating activities in countries such as Uganda, where multiple DFID research consortiums are active to avoid fragmentation of capacity. FHS is also collaborating with other major grants working on strengthening health services research, including the EU-funded ARCADE program, which is seeking to develop open access curricula for health services research in sub-Saharan Africa and in Asia.

## List of Annexes

<b>1. Logframe and consortium-wide theory of change</b>	<b>pg. 17</b>
<b>2. Capacity development strategy</b>	<b>pg. 26</b>
<b>3. Policy influence and research uptake strategy</b>	<b>pg. 35</b>
<b>4. Overview of Year 1 workplan</b>	<b>pg. 65</b>
<b>5. Financial plan</b>	<b>pg. 69</b>
<b>6. Technical review protocol</b>	<b>pg. 76</b>
<b>7. Stakeholder analysis tools</b>	<b>pg. 85</b>
<b>8. Risk Assessment and risk mitigation strategy</b>	<b>pg. 102</b>
<b>9. Country-specific theories of change</b>	<b>pg. 107</b>
<b>10. African Hub implementation plan</b>	<b>pg. 113</b>
<b>11. Cross-cutting research theme concept notes</b>	<b>pg. 127</b>
a. Unlocking community capabilities	pg. 128
b. Stimulating innovation	pg. 132
c. Complex adaptive systems	pg. 141
d. African Hub Learning Platform	pg. 147
e. Health Systems Board Learning Platform	pg. 149
f. South Asia Learning Platform	pg. 150
g. Exploring the Ethics of Long-term Research Engagement	pg. 151
<b>12. Country research protocols</b>	<b>pg. 161</b>
a. Afghanistan	pg. 162
b. Bangladesh	pg. 180
c. China	pg. 205
d. India	pg. 221
e. Uganda	pg. 249