Governance for Equity in Health Systems
Program overview 2011–2016
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Note: This is a shortened version of the Governance for Equity in Health Systems prospectus approved by the IDRC Board of Governors in June 2011.
## List of Acronyms

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<th>Full Form</th>
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<tbody>
<tr>
<td>CIDA</td>
<td>Canadian International Development Agency</td>
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<tr>
<td>CIII2</td>
<td>Canadian International Immunization Initiative Phase 2 Operational Research Grants</td>
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<tr>
<td>GEH</td>
<td>Governance, Equity and Health (previous program name)</td>
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<td>GEHS</td>
<td>Governance for Equity in Health Systems</td>
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<tr>
<td>ICTs</td>
<td>Information and Communication Technologies</td>
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<td>ICT4D</td>
<td>Information and Communication Technologies for Development</td>
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<tr>
<td>IDRC</td>
<td>International Development Research Centre</td>
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<td>LMICs</td>
<td>Low and Middle Income Countries</td>
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<td>MDGs</td>
<td>Millennium Development Goals</td>
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<td>NEHSI</td>
<td>Nigeria Evidence-based Health System Initiative</td>
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<td>SDC</td>
<td>Swiss Agency for Development and Cooperation</td>
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<td>SID</td>
<td>Special Initiatives Division</td>
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<td>UNAIDS</td>
<td>Joint United Nations Programme on HIV/AIDS</td>
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<td>WARO</td>
<td>Regional Office for West and Central Africa</td>
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<tr>
<td>WHO</td>
<td>World Health Organization</td>
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Executive Summary

Improving health outcomes in low and middle income countries (LMICs) requires a coherent effort to address the multiple root problems of ill health. Central to this challenge is the need for strong and equitable health systems to ensure the promotion of good health, and the prevention and treatment of illness at the primary level of care. Recognizing the multiple interconnections between health and development, the Governance for Equity in Health Systems (GEHS) program is leading the way in strengthening governance for equitable health systems to improve health outcomes in LMICs.

Building on a strong foundation and demonstrated results, GEHS in this third programming phase (2011-2016) will apply a sharper governance and equity analysis to understand the interconnections within health systems. By systematically applying the three central effective principles of its programming – governance, equity, and systems integration – GEHS will ensure that the core challenges of decision-making, resource allocation, and power distribution in health systems are addressed to improve health outcomes. The programming emphasis on primary health care will be done in consideration of the overall governance and functioning of health systems. It will also include examination of the interface of supply and demand necessary to improve access to health and redress inequities.

The Program’s strategy revolves around four main outcomes that are closely interconnected and will mutually and constantly be reinforced to achieve the ultimate outcome of strengthened equitable health systems thereby contributing to improved health outcomes. The outcomes include:

- development of capacities to form a critical mass of LMIC researchers and institutions
- development of a knowledge base on innovative and rigorous research methodologies
- generation of a body of knowledge and evidence-base of research findings
- influencing of policies, practices, agendas and funding priorities to strengthen health systems.

In order to translate these outcomes to real change on the ground, GEHS will consistently apply through its various program activities an integrative and learning-based framework. This will help mitigate the risk of supporting activities and projects in silos, and it will create the time and space to enable systematic synthesis and reflection, ensuring that cross-cutting issues of gender, information and communication technologies and global governance are maintained. Consistent with a systems approach, there will be sharper programming in the continuing areas of health financing, health information systems, and eHealth with a primary health care focus. GEHS’ collaborative approach is key to building the field of governance for equity in health systems research through forging coherence in methodologies, practice and action. Only then, with a critical mass of LMIC researchers, institutions and decision-makers, can the Governance for Equity in Health Systems program strengthen equitable health systems and contribute to improved health outcomes.
1. Context and Background

   a. Development Challenge and Situational Analysis

Health and development are intertwined. The “arrangements” that society makes for supporting better health, as noted by Amartya Sen (1999), are among the social opportunities - one of five interconnected freedoms\(^1\) - that are critical for development. These ‘arrangements’ are the policies, activities and institutions in place which constitute a health system that enable the promotion of good health and prevention and treatment of illness. Rooted in people and their interrelationships these arrangements make health systems by definition dynamic, complex and adaptive systems (Gilson, 2010; van Olmen et al., 2010). The aspirations of health systems to ensure good health stems from the critical foundation laid by the Universal Declaration of Human Rights (1948) and the Alma Ata Declaration (1978). The former sets health as a fundamental human right and the latter reaffirms the essential nature of primary health care and state responsibility in strengthening health systems.

While the advancement of medical science and the technological revolution is increasing the potential for a healthier global society, health inequities between industrialized and developing countries, and also within countries themselves are growing. It is critical to address inequities in health and health systems as they represent systematic, avoidable and unfair differences in health outcomes and access to health promoting conditions and services. Linked to these challenges is the issue of governance – the institutions and processes which determine where and how resources are allocated.

A case in point is vaccine-preventable deaths such as polio, where despite technological and development advances the disease still persists in low and middle income countries (LMICs). It can be argued that the focus on the disease rather than addressing the health systems in which it persists has hindered progress. This challenge persists for other vaccine preventable diseases. While global immunization coverage for some routine vaccines is reported to be approximately 80%, examination at the country level and within countries reveals rates far below those required\(^2\).

Challenges of governance and equity are also evident in addressing maternal deaths and HIV/AIDS. Approximately 358,000 women still die every year as a result of pregnancy or childbirth. Almost 90% of these deaths occur in sub-Saharan Africa and South Asia (WHO, 2010a). Despite progress in fighting the HIV/AIDS epidemic, the gap between people needing treatment and available resources is vast. This is especially evident in sub-Saharan Africa which bears 68% of the global HIV burden and where women in particular are affected. Inadequate prevention programs are resulting in increasing rates of new infections and the 2010 Joint United Nations Program on HIV/AIDS (UNAIDS) Global Report calls for addressing gender and social inequities as

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\(^1\) Amartya Sen (1999) conceptualized five distinct freedoms: 1) political freedoms, 2) economic facilities, 3) social opportunities, 4) transparency guarantees and 5) protective security. Each of these rights and opportunities helps to advance the general capability of a person.

\(^2\) For example the 2008 Nigeria Demographic Health Survey (2009) showed that overall only 23% of Nigerian children ages 12-23 months are fully vaccinated. At state level it is even lower with one North-East state having a rate of 1%. This includes BCG, measles and three doses each of DPT and polio vaccine (excluding polio vaccine given at birth).
part of the “new” vision of zero new infections (The Lancet, 2010). In addition, non-communicable diseases such as cancers, cardiovascular disease, and diabetes, also threaten development, with women again bearing a disproportionate burden.

The governance issues at the heart of this poor state of health manifest themselves in fragmented health systems, ineffective health reform policies, corruption, inefficient and uncoordinated donor investment and flow of aid, and an under and inappropriately resourced health sector (Sanders et al., 2005). In addition the absence of established social protection and pre-payment financial schemes and continued reliance on direct payments for health services often results in household impoverishment – over 100 million people fall into poverty every year due to catastrophic health expenditures (WHO, 2010b).

Nevertheless, progress – although uneven - has been made as measured by the Millennium Development Goals (MDGs). There is also an increasing recognition by governments, funders and global institutions of the need to prioritize the strengthening of health systems rather than addressing single diseases.

One of the continuing challenges and debates is about the elements that constitute a health system, their functional and structural relationships amongst each other and within the system, and about the optimal strategies needed to strengthen equitable health systems. The focus on the individual components of health services, diseases, and technologies has resulted in the implementation of vertical programming (focusing on combatting single diseases such as diarrhoea, or addressing single issues with immunization programs), and the fragmentation of the overall system. For example, interventions such as delivering and making effective use of bed nets to reduce malaria, or providing emergency obstetrics care cannot be successfully implemented in isolation – they occur within political, economic, social, and technical contexts. Links between education and health are also critical, especially between girls’ education and maternal and child health outcomes.

This gap is further compounded by a lack of analysis of the distribution of power and interests within the health systems environment. However, a health systems approach focused on governance to promote equity ensures that the whole is greater than the sum of its parts. This allows analyses of root problems and addresses the multiple levels and their interrelationships at which these problems operate. It gets the system back into health systems research. Finding solutions to address these root problems is challenging, takes time, and is contextually grounded. It is only through this comprehensive approach that sustainable health systems can be built. These gaps and debates underline the need to foster coherence amongst researchers, institutions and other stakeholders – in terms of developing methodologies, creating a relevant knowledge and evidence-base of research findings and influencing policy and practice to strengthen equitable health systems.

Governance processes play a strong role in how and whether decentralization, devolution and privatization mechanisms actually improve the quality, quantity and equity of health services. The determinants of fair service delivery include variables such as financing, design, and implementation; levels and structures of decision-
making; and the wider socio-economic and political environments. Understanding these variables and their interrelationships – the interface of supply with demand – together with a synthesis of what has worked and not worked in the past, is vital to reduce inequities and strengthen health systems. It is also important to understand how international donor funding and agendas impact upon in-country processes and the sustainability of health systems.

A cornerstone of strong equitable health systems is primary health care – the first level of contact for individuals, families and communities with a national health system for preventing illness and promoting health. Primary health care is not just a level of care but a strategy and philosophy that encompasses socio-political, economic and biomedical understandings of health. One knowledge gap is around effective strategies to strengthen local level institutional, community and individual capacities such that the skills and the confidence exist to influence priorities and generate resources from state and national levels. Given that the majority of health systems are decentralized, supporting research at the local level is critical, while at the same time recognising the connections with upper levels of decision-making structures. For example, while one may be able to improve preventive services such as immunization, at the local level, sustainability is partly dependent on resource allocation decisions at state and national levels.

Strengthening services and capacities at the local level is linked to improved health financing mechanisms to redistribute resources towards poorer groups with greater health needs. There is little evidence and lack of consensus on the best ways to move quickly towards universal health coverage. Generating new knowledge on how to mobilise resources for health care in countries struggling with limited resources and lacking an integrated national approach is critical. Specific questions include how best to collect and use funds to pool risk so that all people have access to quality health services and do not suffer financial hardship paying for them, and; how to regulate private financing mechanisms or combine them with state financing mechanisms to ensure equity. Another area of inquiry relates to strategies to sustain and coordinate external and national funding to strengthen health systems and ensure optimum use of available resources. Exploring these questions can support countries to achieve universal health coverage.

Health policy making and programming require timely, reliable and relevant evidence which should be and can be provided by public-sector managed health information systems. Focusing on the singular health information systems component has often resulted in the creation of parallel systems rather than strengthening existing health information systems that can be linked to state financing and planning systems. For example, with HIV/AIDS, the funding has created, among other things, separate information systems. While it provides funders with the needed data, it also fragments the health system, dividing patients and health providers along artificial disease lines. If high income countries do not support such parallel systems, why is there a different approach for LMICs? In fact, given resource scarcity, there is a need to understand the political contexts in which information is (or is not) generated, the sources from which information stems, the capacities to produce and use relevant and accurate data, and the dynamics between users and producers of health information. For example, the
rapid growth of networks supporting the low-cost transmission of data and voice communications, even in resource-constrained contexts that rely on mobile phones, creates both opportunities and challenges to the flow and analysis of health information. Harnessing this growth and linking it with development processes can ensure that evidence is available, reliable, relevant, and used to inform practices and policies.

Governance and equity issues are key to examining and understanding the interrelationships and root problems of poor health outcomes and dysfunctional health systems. In the context of global economic integration, the current financial and economic crisis demonstrates both the risks and opportunities provided by turmoil. On the one hand, the foreign aid budgets of and outward investment by the rich Western countries are under considerable strain. On the other hand, many LMICs continue to display healthy growth rates and have considerable budgetary space (and domestic will) to invest in social sectors such as health. The challenge for research and policy alike is to translate the changing health financing landscape into desirable health outcomes.

Since its beginning in 2002, the Governance for Equity in Health Systems (GEHS) Program has demonstrated that a systems approach with governance and equity as key analytical principles can and does strengthen health systems. This is supported by the external evaluation which concluded that this approach is IDRC’s niche amongst the growing number of funders in the area of health systems research (Brown, Habte, & Singh, 2010). This strong foundation and the focus for the next programming cycle is consistent with IDRC Strategic Framework 2010 – 2015 that articulates a commitment to equitable development, and the need to address the underlying reasons for poor health using a holistic and systems approach.

b. About the Program

An exploratory phase (2002-2006), was followed by a second phase (2006-2011) in which the GEHS program supported research that applied a governance and equity lens to strengthen health systems. In that second phase, the program-level outcomes focused on: 1) reflection of Southern voice and power in local, national, regional and global health policy debates; 2) capacity development for generating, exchanging, and applying policy-relevant knowledge; and 3) changes in practice and action to improve health service delivery practices, inform policy at local and national levels, and modify donor practices.

Those outcomes were reflected in research that resulted in more efficient antiretroviral drug roll-outs and effective nursing practices in the context of the HIV/AIDS crisis in South Africa and increased immunisation coverage. Investment was also made in the area of maternal health because of its importance in flagging the failure of health systems to deal with preventable causes of mortality and morbidity. In West and East Africa the collection and use of better quality information informed better care for mothers through the introduction of referral criteria and improved health promotion.

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3 Evidence from the following research projects supported by GEHS: Community Views of Antiretroviral Therapy in Southern Africa; The Public Sector Anti-retroviral Treatment in Free State – Phase II; and Impact of HIV/AIDS on Health Service Capacity at the Primary Care Level (South Africa).

4 Evidence from the Canadian International Immunization Initiative operational research grants (CII2). The project is a collaborative effort on the part of the partners in the Global Health Research Initiative (see Box 1).
services. Governance issues around maternal health were also explored through support for projects in India and Ethiopia, which increased the prominence of this issue among decision-makers. Initiatives to empower communities to become more involved in local decision-making in Latin America have also influenced and strengthened overall governance in the countries.

In the area of health financing, the Program’s efforts have targeted equity gaps that impede universal health coverage. This has included establishing evidence for policy change to remove user fees in Latin America, the Caribbean and Africa. Supported researchers have also provided input at the global level, specifically for the 2010 WHO report on universal health coverage (WHO, 2010b).

In other global fora, such as the Ministerial Forum on Research for Health in Bamako (2008), the Commission on Social Determinants of Health, and the First Global Symposium on Health Systems Research (2010), the Program has supported LMIC researchers and institutions to engage and influence by sharing their research findings. In part this has been achieved by supporting capacity development of individuals, networks and institutions. It has also involved the development of technical tools and frameworks and the convening of multi-stakeholder dialogues.

The second phase gave rise to a number of large donor partnerships. For example, the Nigeria Evidence-based Health System Initiative (NEHSI) built on the experiences and lessons of the

Box 1. Research is the intervention: Improving child health through health systems strengthening research: the story of the fallacy of coverage

An essential component of health systems is primary health care. One critical service of primary health care is immunization to protect children from vaccine-preventable diseases. While immunization can and does save lives, the availability of vaccines does not necessarily translate into every child being vaccinated. This is one of the main conclusions of a series of findings uncovered by the Canadian International Immunization Initiative operational research grants (CIII2) and which has been termed “the fallacy of coverage”. The same grants also identified locally relevant solutions to address this fallacy.

Six CIII2-supported research teams – from South Asia to West Africa – demonstrated how research can be a powerful intervention to increase immunization coverage (Mhatre & Schryer-Roy, 2009). Researchers working with health workers, decision-makers and communities introduced innovative approaches to improving immunization uptake among hard-to-reach groups. These included introducing structured series of community discussions on the cost-benefits of immunization to increase demand, supporting quality supervision to improve efficacy rates of supply, and recognizing the role of strong leadership to create the conditions for good systems performance. While it can be said that many of the barriers to increasing coverage are known, it is only through a systematic research process that we can break through these barriers. Specifically, this process involves working at the interface of supply (health services and decision-makers) and demand (communities) within the health system, and providing the impetus and evidence to tailor programs and practice. Support of such operations research offers one solution to saving children’s lives in the developing world and builds sustainable in-country capacities.

Evidence from the following GEH-supported project: Public Policy and Protection from Exclusion Phase III.

Evidence from the following GEH-supported projects: Negotiating Rights – Building Coalitions for Improving Maternal Health Services in Uttar Pradesh, India, Governance, Maternal Mortality and Health Systems in Ethiopia – INCLEN pilot study

Results from the following projects: Governance Analytical Framework: an Approach to Health Systems Research; and Strengthening Governance through Improvements in Equity and Accountability in Health Systems of Latin American Countries.

Researchers from the following projects: Extending Social Protection in Health in Latin America and Caribbean; The Southern African Regional Network on Equity in Health (EQUINET)-Reclaiming the Resources for Health (#105675); and Health Insurance to address Health Inequities in Ghana, South Africa and Tanzania.

This is a CAS$19 million initiative involving the Government of Nigeria, IDRC and the Canadian International Development Agency (CIDA) (July 2008-December 2015).
Tanzania Essential Health Interventions Project, is demonstrating how a research and capacity strengthening approach can foster a culture of evidence-based planning for improving primary health care. Partnership with the Swiss Agency for Development and Cooperation (SDC) enabled the Program to take research findings to a wider level of policy and implementation (Barnett et al., 2010).

Similar to other IDRC programs, Program staff played a significant facilitation and convening role. This “grants plus” model was noted by the external reviewers as being appreciated by recipients and important in ensuring resonance with the realities on the ground.

**Lessons learned**

The second phase of programming deepened the understanding about the dynamics of governance and equity and examined in detail the various components of health systems (e.g. financing, health information systems, and service delivery). Key insights highlighted and reinforced by the supported research include:

- **Capacity development is core to all the projects supported by the Program and is directed at multiple levels (individuals, networks and institutions).** Some of the challenges include: enabling capacity development at the institutional level, reducing the North-South gap, and building a critical mass to influence global policies and practice.

- **Equity and governance in practice are useful concepts to help prove, redress and manage systematic exclusion.** This also includes examination of the barriers to access by vulnerable populations and inequitable implementation of various programs, policies and allocation of resources. For example, understanding and targeting equity gaps to overcome barriers to achieve universal coverage and social protection. This sets the foundation for further supporting the development of research methodologies focused on governance and equity.

- **Importance of unpacking and linking the failure in health services delivery, such as immunization (Box 1) and maternal health services to the governance, capacities and the context in which they operate to improve quality and coverage of services.** This lesson calls for further supporting research that is placed within the context of health systems to build a larger body of knowledge and evidence-based research findings to improve health and health services.

- **Importance of understanding the complex interconnected root problems that contribute to poor health (Box 2).** Focusing only at the service level does not recognize the reality that maternal and child health is related to the intersection of poverty and status of women. The same can be said of the HIV/AIDS epidemic, where supported research surfaced concepts such as “choice disablement”, challenging the assumption that all groups of people have the choice to use conventional prevention strategies (Andersson, 2006). This primary health care approach of prevention and addressing underlying problems will be more strongly emphasized in the third phase.
Overall, supporting reflection and synthesis at the program level and the strengthening convergence and coherence in programming are clearly important. These lessons and the recommendations from the review of the second phase, along with a number of stakeholder consultations, have informed this prospectus for the third phase of programming in 2011-2016.

**Going forward**

Building on this strong foundation and demonstrated results, the GEHS program, will lead the way in strengthening governance for equitable health systems in LMICs. It will continue to contribute to the **ultimate outcome of strengthened equitable health systems contributing to improved health outcomes.**

While the second phase articulated the application of a governance and equity lens as the “GEH approach”, this third phase will take this approach one step further. Experience from the second phase and current debates point to the need to make explicit and systematic the application of the concepts of governance, equity and an integrated systems approach through a recognized mechanism known as ‘effective principles’\(^\text{10}\). This application also puts front and centre a health systems approach rather than a traditional thematic entry point approach. Thus governance, equity and integrated systems will be the explicit principles guiding the type of research the Program will fund to achieve its outcomes.

This third phase of programming will strengthen health systems with an even **sharper pursuit on governance and equity strategies.** The Program will work to improve the **interconnections** among the components of the health system and address the **upstream intersections** of social and economic disparities. This is in contrast to the approach of other funders who frequently emphasize silver-bullet solutions and disease-specific interventions. The focus on governance for equity in health systems ensures that the core challenges of decision-making, resource allocation, and power distribution in health systems are addressed to contribute to improved health outcomes. As discussed in the next section, the mechanism for ensuring this focus and coherence will be the systematic application of a set of three effective principles.

Consistent with this approach, the research focus will be on groups that have limited or no access to health services thus requiring a **primary health care approach.** A primary health care approach ensures the provision of care at the point of people’s lives to prevent illness, promote health and reduce barriers to access. The focus on strengthening primary health carer will be done in consideration of the overall governance and functioning of health systems – examining the interface of supply and demand in order to change the current inequity of access. An emphasis on primary health care will include prevention initiatives to protect those most vulnerable, for example from HIV/AIDS, maternal morbidity and death, and vaccine-preventable deaths. It will also require addressing the complex interactions along the spectrum of care and the social, gender, racial, and cultural constructs operating behind inequities.

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\(^{10}\) Effective principles is the term used by Patton (2011) as a mechanism to provide guidance that must be interpreted, applied and adapted to contexts. They are not meant to be prescriptive.
This can potentially catalyse changes in fiscal and governance policies and mechanisms, in addition to strengthening institutional capacity.

In pursuit of governance for equity in health systems the Program will make a concerted effort to promote and synthesize research methodologies that strengthen health systems. This will include innovation in the use of mixed methods (quantitative and qualitative), transdisciplinary research\(^1\), methods that directly address the interface between demand and supply to increase access to health and health services, and the development of strategies for sustainable capacity development. In addition, GEHS programming will benefit from a new focus on eHealth research using methodologies and networks established under IDRC’s former Information and Communication Technologies for Development (ICT4D) Program Area.

A select group of LMIC researchers are clearly leading the way in developing methods for and approaches to strengthening health systems. For this programming cycle, GEHS will build on this strength. It will actively support and facilitate collaboration among LMIC institutions and researchers structured to shape and influence national, regional and global policies and practices. This strategy will aim to improve the influence of LMIC researchers on policy and practice, capacity development, and changed practice and action to increase access to services. Such collaboration will initiate the process of field building which is explained further in the next section.

As recommended by the external review, GEHS will explicitly engage with relevant global stakeholders to use the body of knowledge generated to inform and influence policies, practices, agendas and funding priorities.

2. Approach to Programming

a. Program Goal

The overall goal of the GEHS Program is to strengthen LMIC research teams and institutions to collaborate, facilitate and catalyse rigorous and relevant research methodologies generating a body of knowledge and evidence-based research findings. This body of research will be used to

\[^1\] Transdisciplinary research calls for teams to work together using a shared conceptual framework, drawing together discipline-specific theories, concepts, and approaches to address a common problem (Choi & Pak, 2006).
inform and influence local, national, regional and global policies, practices, agendas and funding priorities to strengthen equitable health systems in LMICs, thereby contributing to improved health outcomes.

b. Program Outcomes

The GEHS Program envisages four interconnected outcomes that will contribute to the program goal. These four outcomes focus on:

1. development of capacities
2. development of a knowledge base of research methodologies
3. generation of a body of knowledge and evidence-base of research findings
4. influencing of policies and practices through a critical mass of researchers and institutions.

Capacity development is the first program outcome. It is the foundation for developing a critical mass of LMIC researchers and institutions with the capacity to contribute to the field of health systems research that informs policies and practices to strengthen equitable health systems.

The second outcome is the development of a knowledge base on research methodologies by researchers and research communities who will innovate, use and promote appropriate and rigorous methodologies for a stronger governance and equity analysis to strengthen health systems.

A strong methodological base leads to the third outcome which will support quality research that builds a body of knowledge and evidence-base of research findings on governance for equity in health systems. Researchers, institutions and relevant stakeholders grounded in Southern realities will examine, analyse and seek solutions that address the multiple levels and dimensions in which governance and equity operate to hinder access to health and health services. The synthesis of the body of research will generate knowledge that addresses the core challenges of decision-making, resource allocation and power distribution in health systems. The body of knowledge will be used to address root problems and enable health systems to focus on prevention and health promotion strategies.

A critical mass of researchers and institutions promoting and innovating rigorous methodologies which generate credible quality research, particularly a synthesis of a body of knowledge, leads to the fourth outcome of influencing policies, practices, agendas and funding priorities to strengthen equitable health systems, thereby contributing to improved health outcomes.

Figure 1 conceptually maps the progress of the third phase of the GEHS Program in strengthening equitable health systems to address the inequities confronting women, children, families and marginalized populations. It is based on an S-shaped curve of innovation (Slater & Mohr, 2006)\textsuperscript{12}. In a systems context, progression to the ultimate

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\textsuperscript{12} The S-curve theory was developed in the field of technology management to explain the evolution of radical innovations which through adoption of various strategies, overcome resistance to become the mainstream market.
outcome is not linear rather it is a process of constant feedback and adaptation of strategies. At the beginning GEHS will work with the early adopters (point A), who already have the vision and are conducting credible research. Supporting this group and involving other innovators, strategies will be introduced (point B) to overcome the expected resistance (top part of the S-curve). Over time this will result in the formation of a critical mass of researchers, institutions, and knowledge (point C) needed to influence change and achieve better health.

Figure 1: Conceptual map of GEHS strategies to contribute to ultimate outcome

Note: Points A, B, and C show points in time as GEHS progresses during its programming cycle. Point A is in year 1 where GEHS continues its work with researchers and institutions, considered the early adopters. As GEHS goes into its subsequent years of programming, going up the S curve of innovation, there is more collaboration (Point B) to the point of C where there is a critical mass of researchers, institutions and decision-makers, to influence policies, practices, agendas and funding priorities to contribute to GEHS’ ultimate outcome.

There is an assumption that strong health systems have a positive impact on health outcomes. The contribution to improved health outcomes is not always direct and is context specific. For example, support for projects on health financing focusing on preventing catastrophic expenditures, lend themselves to contributing to improving both poverty and health related outcomes through increasing access to services. Primary health care projects have the potential to contribute to improved child health outcomes such as decreased mortality and morbidity through improved immunisation rates. (See Box 1)
Table 1 illustrates the minimum, medium and maximum levels of progressive impact of each of the four outcomes. The minimum outcomes reflect and build on current programming, initiating the systematic application of the effective principles. The medium outcomes reflect the expected progression at the local and national levels. The maximum outcomes are more ambitious and visionary, engaging at the global level and field building. The four outcomes below focus on selected areas of work that build on investments and gains of the first and second phases of GEHS.

Table 1. Summary of expected program outcomes

<table>
<thead>
<tr>
<th>Current trend</th>
<th>Minimum</th>
<th>Medium</th>
<th>Maximum</th>
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<tbody>
<tr>
<td></td>
<td>Strengthening capacities to undertake and use research</td>
<td>Influencing at national and regional level</td>
<td>A critical mass aligned for maximum influence</td>
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<td></td>
<td>Fund curriculum development, training and mentoring programs</td>
<td>Increased coordination and cooperation among researchers, relevant stakeholders</td>
<td>Vibrant collaborations of LMIC researchers and institutions aligned around the effective principles influencing global policies and practices</td>
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<td></td>
<td>Capacity strengthening to undertake research on governance for equity in health systems strengthening</td>
<td>Publications and engagement in relevant national and global fora to influence national and regional policies and practices</td>
<td>Building the field of governance for equity in health systems strengthening</td>
</tr>
<tr>
<td>1. Developing a critical mass of LMIC researchers and institutions</td>
<td>Exposure and dialogue</td>
<td>Innovation, application, and consolidation</td>
<td>Recognition of credible body of research methods</td>
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<td></td>
<td>Researchers from various disciplines discuss research methods to deepen and consolidate their understanding of appropriate methods</td>
<td>Researchers and institutions are systematically applying, innovating and creating new methods</td>
<td>Recognition and use of a rigorous and appropriate body of research methodologies to influence and be the ‘mainstream’ approach</td>
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<tr>
<td>2. Enabling the innovation, use and promotion of appropriate and rigorous methodologies</td>
<td>GEHS supported researchers have developed a growing body of methods that use effective principles of governance, equity and integration to strengthen health systems.</td>
<td>The challenge lies in the internalization and widespread adoption of these methods and their translation into funding decisions and practices to strengthen health systems.</td>
<td>The four outcomes below focus on selected areas of work that build on investments and gains of the first and second phases of GEHS.</td>
</tr>
<tr>
<td>Current trend</td>
<td>Minimum</td>
<td>Medium</td>
<td>Maximum</td>
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<tr>
<td><strong>3. Building a body of knowledge and evidence-base of research findings on governance for equity in health systems</strong></td>
<td><strong>Building GEHS knowledge base and research findings</strong></td>
<td><strong>Opening and deepening the GEHS knowledge base</strong></td>
<td><strong>Affecting research paradigms and their influence</strong></td>
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<td>Strong research findings exist, but there are differing understandings of the methods and concepts. This fragments the knowledge base, divides the research community, and sends conflicting messages to decision makers and practitioners. The challenge lies in synthesizing research findings into a coherent body of knowledge that can have greater influence.</td>
<td>GEHS supported research is applying and confirming the effective principles and addressing local health systems priorities and influencing local health policies and practices. Coordination with the methods dialogue (above)</td>
<td>GEHS supported research is growing and consolidating with a deepened application of the effective principles, integrating social and gender analysis, and innovative ICTs. Influencing national and regional policies, practices/priorities</td>
<td>Coherent and recognized body of knowledge applying the effective principles. Critical mass of researchers and institutions are influencing global policies, practices, research agendas and funding priorities</td>
</tr>
<tr>
<td><strong>4. Influencing policies, practices, agendas and funding priorities</strong></td>
<td><strong>Influencing local and national changes</strong></td>
<td><strong>Affecting regional changes</strong></td>
<td><strong>Taking leadership for global changes</strong></td>
</tr>
<tr>
<td>GEHS supported research has had varying influence on policies and practices at local, national, regional and global levels. There is a need for more coherence and collaboration among and with LMIC researchers, relevant stakeholders and institutions to have a more significant influence not only on policies and practices but also on research agendas and funding priorities.</td>
<td>GEHS supported research conducted by skilled researchers is influencing and informing local and national policies and practices</td>
<td>A growing critical mass is producing a relevant body of knowledge and evidence-base. Informing and influencing regional policies, practices, and priorities</td>
<td>A critical mass of researchers and institutions leads the body of knowledge, research findings and research methodologies. Informing and influencing policies, practices, agendas and funding priorities at global level, including at the WHO and Northern agencies</td>
</tr>
</tbody>
</table>

The interconnection and the dynamism of the outcomes and moving these outcomes from the abstract to real change on the ground will require systematic and continuous risk management. The main risk lies not in the subject matter but at the program level. For successful achievement of the outcomes, GEHS must avoid supporting activities and projects in silos. This includes an explicit effort to apply the effective principles in GEHS’s day-to-day work of proposal review, monitoring and project completion reports. It will also require ensuring continuous information sharing to facilitate existing and new linkages.

Successes in achieving the outcome of influencing policies, practices, agendas and priorities may be intermittent rather than incremental. The risk lies in the fact that this outcome depends on the actions of a wide variety of stakeholders at all levels, many of whom are guided by differing paradigms and incentives. Mitigation strategies are
supported by the approach of improved coherence of methodologies, evidence, and actors that have the force to influence change. As a program, GEHS will focus more on identifying policy gaps and taking leadership to address strategic policy windows.

3. Program Strategy

The primary strategy to achieve the program outcomes is to consistently apply, through the various program activities, an integrative framework that ensures adherence to the effective principles of governance for equity in health systems. This strategy requires continuous review and synthesis to realign the ‘arrangements’ of activities and outputs within the expected outcomes to strengthen health systems research. Thus, the emphasis is not on individual projects, but rather on how each activity contributes to the program goal.

a) Programming Activities

Building on the strengths of selected researchers and institutions, GEHS will begin to engage and catalyse a process of consolidating and innovating appropriate research methodologies. This will be in parallel to supporting capacity development initiatives and health systems research that applies the effective principles. Existing and new actors will be involved in this process. Capacity development activities include post-doctoral fellowships, practitioner sabbatical programs, and research-mentorship programs. Institutional strengthening activities will also be considered in light of the need to strengthen South-South collaborations.

Existing LMIC researchers and institutions are the core around which to build the field of governance for equity in health systems research to articulate and apply the effective principles. In the initial stage, projects that link past and current researchers and institutions will be supported to explore, innovate, and link with emerging actors. These projects will cross geographic and thematic areas.

As the Program evolves, attention will be paid to synthesis and appropriate engagement to facilitate increasing coherence and the development of a critical mass of researchers and institutions to influence change. At the same time GEHS will engage with relevant stakeholders – government officials, international organisations and funding agencies – to develop new donor partnerships and facilitate dialogue at multiple levels on LMICs’ priority health issues and emerging evidence to influence change. In practice, this calls for GEHS to be proactive and engage in donor debates and development of funding agendas at both the country and global levels. It also means establishing a governance structure for selected projects in key areas of maternal health, health financing and health information systems, so that these inform global and national policies and programs, and at the same time provide recognition to and mainstream the methods and evidence of LMIC research (for example see Box 3). Note that the multiple activities of researchers, institutions and GEHS and their combined effect are instrumental in mediating the expected resistance for the Program. This will then enable the Program and its collaborators to influence and inform policies and practices that strengthen health systems and improve health outcomes (see Figure 1 – resistance usually is seen between point C and ultimate outcomes).
b) Modalities of Programming

Building on IDRC’s grants plus model, GEHS’ approach will be one of collaboration at the team level, across IDRC, among researchers, decision-makers, practitioners and institutions in LMICs, at the regional and global levels. In practice, the team will develop, review, and implement projects and activities to integrate the effective principles and achieve the outcomes and their interconnections. This ensures a coherent GEHS program rather than discrete portfolios of projects.

Collaborative engagement with stakeholders outside IDRC explicitly calls for respectful and iterative interaction to maximize synergies and build the field of governance for equity in health systems methods and knowledge. Field building is not developing a separate or new discipline; rather it is establishing coherence in methodologies, practice and action for strengthening health systems. Field building also recognises that strengthening capacity has to go hand-in-hand with reshaping the system to change development processes (Hay, 2011).

Box 3. Research, capacity and policy response for greater equity in health and health financing: The Network of Networks

Building on investments and research in three distinct regional networks on health financing for equity (see Annex 1), this project is developing a global network of networks to build South-South collaborations in health financing. The new inter-institutional space is facilitating cross-regional comparative and collaborative work in three areas: 1) scientific research based on improved methodologies, 2) capacity building for research on health equity, and 3) dissemination and policy dialogues. For each area detailed plans and strategies were developed in consultation with members of the three networks and key national and international stakeholders to ensure the broad buy-in and relevance of the research agenda at all levels.

The organizational structure of the project also includes a high-level advisory committee to provide an international platform for dialogue on evidence from and by LMICs and to facilitate influence on global policies to support universal coverage. By facilitating synergies and bridging the local, regional and global levels, the project has the potential to significantly strengthen health systems through sustainable and equitable health financing that promotes universal coverage in developing countries.

c) Making Choices

Governance for Equity in Health Systems focuses on the reduction of barriers to improving health and approaches to strengthening primary health care. A cornerstone of strengthening equitable health systems is primary health care – in its focus, approach and philosophy. In practice all projects and activities will have to:

- apply the effective principles (governance, equity and systems integration)
- be contextually rooted
- address root problems
- reflect the primary health care priorities of the promotion of good health and prevention and treatment at the primary level of care
- inform and influence policy and practice to strengthen equitable health systems.
GEHS will continue to work in the area of health financing, health information systems, and maternal health; however, this work will be focused based on the above criteria.

In light of a systems approach, vertical, one-issue and disease specific initiatives will not be supported. In addition agendas and activities must be spearheaded by LMIC researchers, stakeholders and institutions.

d) Cross-Cutting Issues

IDRC’s identified cross-cutting issues of gender and information communication technologies (ICTs) are addressed through the effective principles. Gender is inherent in the equity principle and involves an analytical approach to examine and address both gender and social inequities. Integral to this analysis is a focus on understanding and addressing the interconnected and systemic problems of dysfunctional health systems.

Similar to health financing and health information systems, the use of ICTs is viewed as an area of work that will be reviewed through the programming criteria and effective principles. This will include integrating eHealth and appropriate future technological innovations to strengthen health systems (see Box 4).

Global governance is critical in how states and foreign policy actors prioritise and use health research for effective resource allocation to address issues of brain-drain, epidemics and intellectual property. In developing a critical mass of researchers and institutions, GEHS will have to support capacity strengthening to address these larger global issues. For example, dialogue is already taking place on how to connect the leaders, capacities and interests of regional political bodies (e.g. in Eastern, Central and Southern Africa) so that they can influence global agreements, treaties and frameworks.

e) Assessing Quality and Adapting

Assessing quality will be grounded in the approach of building a coherent program based on integrating the identified effective principles. Focusing at the program level rather than individual projects will require systematic team engagement to assess progress and identify required changes.

A formal monitoring and evaluation process and framework will be established. An explicit learning-based framework will be built in to the GEHS programming to create
the time and space needed for systematic synthesis and reflection by team members and critical friends of GEHS.

4. Regional and Thematic Priorities

Historically, GEHS has been active in Africa, Latin America, the Caribbean and Asia, with priority given to Africa followed by Latin America and the Caribbean. This balance will continue subject to the expertise of staff. In addition, given the recommendations in the external review, efforts will be made to strengthen institutional health research capacity in Francophone West Africa.

Consistent with a systems approach, and recommendations of the external review and IDRC’s Board of Governors, the thematic focus will call for sharper programming in the continuing areas of health financing, health information systems and eHealth with emphasis on primary health care grounded in the effective principles of governance, equity and systems integration.

In practice, large initiatives on maternal health, health information systems and health financing will continue in Africa. Maternal health and health financing programming is evolving across multiple regions. This provides an opportunity for cross-regional comparison and exchange leading to a more coherent body of actors, methodologies, knowledge and evidence-based research findings which can have greater influence.

In Latin America and the Caribbean, GEHS will build on its investment, which has resulted in increased understanding of governance and its impact on fiscal and decentralization policies and practices. This focus can potentially inform health reform policies to increase access to health services at local levels and lead to more effective resource allocation at the national level.

In Asia, although the focus has been more on South Asia, GEHS will determine how to broaden its regional spread to South East Asia and how the primary health care approach and issues of equity and governance can be further explored to strengthen state and national health systems as well as inform global policies.

In the Middle East, programming, while limited, will focus on capacity strengthening and supporting knowledge production.

5. Concluding Comments

Building on a strong foundation and demonstrated results, in this third phase the Governance for Equity in Health Systems Program will lead the way in strengthening equitable health systems. The Program will endeavour to support and strengthen a vibrant collaboration of LMIC researchers and institutions, innovating and developing a rigorous and appropriate body of research methodologies that articulates and applies the effective principles of governance, equity and systems integration. This will generate a coherent body of knowledge and evidence-based research findings to inform and
influence policies, practices, agendas and funding priorities contributing to improved health outcomes for all citizens.

IDRC and GEHS have a unique opportunity and a duty to address the pressing health challenges, and it is within a research, knowledge and health systems paradigm that it will take on this agenda. In the words of Amartya Sen (2004):

*The global health crisis we face today demands fresh reflection and new departures. Central to this encounter is the development and use of social and scientific knowledge. The crisis does, of course, demand dedicated action as well as faith in humankind's ability to overcome monumental adversities. But we need a knowledge-centred approach to make our actions fit the needs...*
6. References

NOTE: The context and background provided throughout this prospectus draws upon research and lessons from a large number of resources and consultations. In order not to encumber the text only select references were used.


