HEALTH SERVICES FOR THE FUTURE: DELIVERING EFFECTIVE HEALTH SERVICES

FUTURE HEALTH SYSTEMS: YEAR 2 ANNUAL REPORT

PO 5467


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1. Program Description

The goal of Future Health Systems (FHS) is to improve access, affordability and quality of health services for the poor. We are a partnership of leading research institutes from across the globe working in a variety of contexts: in low-income countries (Bangladesh, Uganda), middle-income countries (China, India) and fragile states (Afghanistan). In order to build resilient health systems for the future, we generate high quality scientific knowledge about how health systems can better deliver basic health services to the world’s poor.

FHS supports its country research teams to identify and respond to health system challenges identified by local stakeholders. FHS focuses on three principle themes:

- **Unlocking community capabilities** - how can the range of resources available to communities be systematically identified and used to improve the quality and impact of health services, particularly for disadvantaged groups? We are setting up systems to transmit information collected at the community level to health workers and decision-makers and thus enhance local-level accountability. We are also using participatory research approaches with communities to explore new strategies to channel community resources to help improve health.

- **Stimulating innovations** - how can new technologies and organisational innovations be introduced and sustained to improve the quality and coverage of health care in resource-poor settings? Building on a partnership with an established e-health business in Bangladesh and engaging international networks (involving mobile phone and internet technologies), FHS is testing new models of service delivery with government and non-governmental organisations (NGOs) interested in improving the quality, coverage and affordability of health services to disadvantaged populations.

- **Learning by Doing** - recognising that health interventions take place in complex adaptive systems, we are undertaking systematic learning processes that bring together key actors involved in service delivery, particularly for marginalised populations. These include service providers, communities of service users, government and outside facilitators.

In each case we seek to weave these themes into country-driven research initiatives. In addition to the three themes above, work conducted under FHS 1 on **health markets** continues.
2. Overview of the Year

2.1 Progress and achievements

Table 1 below provides a country-by-country update on the status of FHS research. By and large the research has progressed well. Our field-based work in Afghanistan is now complete, and the Ministry of Public Health there continues to explore means to roll out the community-based scorecards. Both India and Uganda have moved from the initial preparatory stage of their work towards full implementation. In China the first round of data collection is complete and analysis advanced. The China team continues to feed into and advise the national government based upon its work in the three case study countries. Progress in Bangladesh in terms of implementing the intervention has been slower, for the reasons described below, but findings from baseline and exploratory studies are now being written up for publication.

Table 1 – Country-by-country status of research

<table>
<thead>
<tr>
<th>Country</th>
<th>Main Research Question</th>
<th>Key Achievements</th>
<th>Changes</th>
</tr>
</thead>
<tbody>
<tr>
<td>Afghanistan</td>
<td>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?</td>
<td>The team completed the research on community-based scorecards in Afghanistan and have been supporting the Afghan Ministry of Public Health to expand the initiative to other areas through providing training and collaboration with an NGO.</td>
<td>The research as originally conceived is complete, but we have realised that we have a substantial amount of quantitative data from Afghanistan over many years. We are currently planning new research based on this existing data that will allow us to analyse changes in health services through a complex adaptive systems lens.</td>
</tr>
<tr>
<td>Bangladesh</td>
<td>How does the application of telemedicine services, linking village doctors to medical call centres affect the quality and utilisation of services?</td>
<td>The Bangladesh team made significant contributions to the <a href="#">Lancet series on Bangladesh</a>. Progress on the implementation research regarding m-health in Bangladesh has been slower, for reasons explained in more depth below, but the team completed a profiling of e- and m-health services in Chakaria, Bangladesh.</td>
<td>In late 2011 the team launched an m-health service in collaboration with a private for-profit provider TRCL, however the service provided by the TRCL call centre has been poor, undermining the intervention, and the team have finally decided to launch their own service, rather than work through the call centre.</td>
</tr>
<tr>
<td>Country</td>
<td>Main Research Question</td>
<td>Key Achievements</td>
<td>Changes</td>
</tr>
<tr>
<td>------------</td>
<td>-----------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------------</td>
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</tr>
<tr>
<td>China</td>
<td>How have rural grass-roots facilities adapted government-initiated provider payment reforms and what appears to have been the impact of the adoption of these reforms?</td>
<td>The China team completed a first round of data collection in their study counties and analysis and write up is on-going. The team continue to feed emerging findings into policy debates in China.</td>
<td>No changes during the current year, though progress is slightly slower than expected.</td>
</tr>
<tr>
<td>India Phase 1</td>
<td>What are feasible and sustainable strategies to reach excluded children with quality and appropriate basic health care strategies, in a climatically marginal and vulnerable community?</td>
<td>The India team completed their Phase 1 work, which culminated in the publication of the Sundarbans Health Watch, as well as multiple presentations of findings within India, particularly in the West Bengal region.</td>
<td>No major changes – the India team is currently discussing the opportunity for interventions to address child health with the West Bengal government, and with local NGOs, but no conclusion has yet been reached.</td>
</tr>
<tr>
<td>Uganda 1</td>
<td>Can an integrated system for maternal-new born care be implemented in a way to increase utilisation, quality, and impact of maternal and newborn health care?</td>
<td>All baseline data collection and analysis has been completed, and the project is now in its implementation phase with both CHWs and health workers trained and vouchers for maternal and newborn services being distributed.</td>
<td>None</td>
</tr>
<tr>
<td>Uganda 2</td>
<td>How can existing community social and leaderships structures, as well as community financing be used to improve birth preparedness, and the utilisation and quality of maternal health services?</td>
<td>Most of the preparatory phase of the work has been completed, including data collection and analysis, mobilisation of local stakeholders, development of training materials for Village Health teams and sensitisation of community through radio slots. Actual implementation phase is just starting.</td>
<td>Marginal changes to the proposal, reflecting emerging learnings from work within the community, and the action research approach adopted.</td>
</tr>
</tbody>
</table>
Linking this country-level work to the three core themes of FHS: considerable progress has been made on the theme of unlocking community capabilities (UCC). JHU is undertaking a systematic review of the UCC literature in health encompassing over 500 articles, which should be available during the coming year. Interesting findings from Afghanistan, India and Uganda, all cast light on appropriate processes for working with communities, as well as lending weight to the arguments that engaging communities is key to promoting ownership and sustainability of maternal and neonatal health interventions. Recipients of FHS young researcher awards have been particular active in this field conducting social network analysis of the resources mothers can draw upon for child health in Sundarbans and conducting a PhotoVoice project in Uganda that involved youth in identifying maternal health issues in their communities and opportunities to engage in their improvement. The photos from the PhotoVoice project were displayed during a November 2013 symposium on teenage pregnancy in Uganda, co-hosted by FHS and the Ugandan Ministry of Health.

The other two consortium themes, stimulating innovation and learning are also making good progress, and are expected to crystallise in this programme year. Bangladesh is the site where there is a most obvious fit with the stimulating innovation theme, and work there has been frustrated due to the challenges with the intervention (although lessons have also been learnt from this process). Despite this, work has gone forward and additional funding has been leveraged to support this work. With regard to the learning by doing theme, during the past year FHS has focused mainly on putting in place mechanisms that will allow us to capture learning in each of the countries, as work unfolds and adaptations to service delivery systems and processes are made. This will be drawn together for a forthcoming workshop in Baltimore in June 2014, which is expected to herald a number of programme outputs.

In addition to progress on the core theme of the consortium, FHS members continue to be engaged in work on health markets, which was an important theme of the first round of FHS. This included organising a meeting in Bellagio in December 2012 on the Future of Health Markets, which led to the Bellagio Statement on the Future of Health Markets, a subsequent webinar and a forthcoming mini-special issue in Globalization and Health. FHS team members (Dr David Bishai and Dr Gerry Bloom) also co-organised the Private Sector in Health Symposium (www.pshealth.org) that took place in Sydney in 2013 in conjunction with the International Health Economics Association world congress.

### 2.2 Challenges and Disappointments

There have been relatively few challenges or disappointments this year. Perhaps the most significant set back has come in the m-health work in Bangladesh where an m-health call centre for village doctors that was launched by FHS in 2011 was eventually closed. The initiative was launched in collaboration with a private, for-profit firm that provided the call centre services (for a small fee), while FHS provided relevant training to village health doctors and helped evaluate the initiative. However six months into the initiative (December 2011) the call centre became quite unresponsive, failing to answer calls, or return messages, and despite efforts to reinvigorate the partnership the initiative slowly died. This experience has been documented by FHS, and icddr,b is now launching its own call centre, building on lessons from this experience.
2.3 Context
We continue to believe that the focus of FHS work is still very much in alignment with priorities identified by senior national and international policy makers: interest is high in how best to scale up implementation of interventions known to be effective. Further, many of the methods that FHS is seeking to employ, including implementation science and complex adaptive systems science, are currently receiving a lot of attention from the global health community. For example, Dr David Peters produced the first implementation research handbook for health research (http://who.int/alliance-hpsr/alliancehpsr_irpguide.pdf), and Jim Kim at the World Bank is increasingly arguing for development of a science of delivery (e.g. http://www.worldbank.org/en/news/speech/2013/05/21/world-bank-group-president-jim-yong-kim-speech-at-world-health-assembly). We believe that FHS is very well positioned to inform these dialogues about the use of research and evidence to inform improvements in health services, and indeed members of FHS are already actively participating in such debates (for example: http://www.ncbi.nlm.nih.gov/pmc/articles/PMC3308928/)

At the national level, the FHS team is relieved that its research work in Afghanistan was completed without event, as the situation there became increasingly insecure and difficult to operate in. Interestingly FHS country teams in Uganda and India have both drawn attention to the importance of local politics for their work, and how changes in political leadership at the local level can challenge progress. Both the India and Uganda teams have had to re-educate local leadership and seek to re-secure their support after local elections led to changes in critical personnel.

Overall, however, the expected results of FHS are in line with those articulated in the log frame and in the inception phase report.

3. Logframe Outputs

OUTPUT 1: High quality and relevant research is carried out and published

Progress to-date
Output 1.1 - Number of peer-reviewed articles produced (including either secondary analyses, such as literature reviews or primary data collection research)

During the period October 2012-December 2013 FHS produced 23 peer-reviewed articles, in addition to 24 articles previously published, FHS has produced 47 articles under the current contract, compared to a target of 8 by December 31st, 2013.
Highlights of this body of work include a number of methodological articles addressing applications of complex adaptive systems to health services (Xiao et al 2013), the used of mixed methods in health systems research (Ozawa and Pongpirul 2013) and the use of information technology to conduct real time monitoring of vulnerable groups (Lucas et al 2013). In addition FHS members played a key role in the recent Lancet series on Bangladesh with multiple different FHS co-authors on five of the papers. It is relatively early in the life of the consortium for research findings to be published, but FHS is publishing papers based on some of the preparatory work conducted, for example the stakeholder analysis conducted in Uganda was published (and other stakeholder analyses have been submitted for publication), and a study of the effect of climatic shocks on child health in the Sundarbans, India, was also published.

**Output 1.2 Number of research or policy briefs that seek to guide decision-making at local, national or international levels regarding health service delivery**

FHS produced three policy briefs since October 2012, in comparison to a target of 2 by December 2013.

Two of these were produced in association with policy maker meetings. One, was the outcome of a Bellagio meeting on the Future of Health Markets, and the brief took the form of a meeting statement, considering long term trends in health markets, and what actions different stakeholders should undertake to ensure that health markets worked better for the poor. Another, based on findings from the series of baseline studies undertaken in the Sundarbans, India, examined the status of child health in the Sundarbans, and what could be done to improve it. Finally the FHS team in Bangladesh developed a policy brief on the experience of developing an m-health scheme in Chakaria, identifying implementation challenges and what could be done to address them.

It should be noted that in addition to the three briefing documents, FHS has also produced 20 blogs since October 2012. While some of these blogs have been short updates on conferences, others have taken the form of more substantive explorations of policy relevant issues. For example in October 2013 FHS ran a series of blogs on new technologies and the self-management of illness, exploring factors such as the ethics of new technologies, ICTs and self-management. The blogs are also targeted at informing policy and decision-making, at different levels.

**Other Research Outputs**

Besides the products noted above, FHS is also wrapping up its field-based work in Afghanistan. The FHS Afghanistan team undertook operational research to pilot a community-based scorecard to improve health services, trust and accountability. Results indicated impressive abilities of communities – working with providers and others – to improve health services. They were able to improve facilities (e.g. by designating a women’s waiting area, or repairing a water pump or roof), and to improve cleanliness and provider performance. The FHS team presented findings from this study to the Consultative Group on Health and Nutrition at an MOPH meeting. This has led to government interest in scaling-up the intervention. The FHS
Afghanistan team has managed to save a little money to continue to help support the government on this work. They are also in the process of drafting research papers.

In brief, other notable developments on the research side include:

- FHS has led a process, together with other RPCs, to spearhead work on gender and health systems that seeks to add a stronger gender dimension to on-going research within the consortia. We are hopeful that this grant agreement with DFID will be finalised shortly.
- FHS initiated research during 2012 on the ethics of health systems research, this was followed-up in 2013 with a meeting in Baltimore co-hosted by FHS, the Berman Institute of Ethics, and the Bloomberg School of Public Health that brought together ethicists and researchers from across the world to discuss ethical challenges in conducting health systems research and whether a distinct approach to the ethics of health systems research (as opposed to other types of research) was needed. This is not one of our core themes, but does speak to concerns raised by FHS researchers in terms of managing their interactions with communities.
- FHS faculty are playing an active role within the new Health Systems Global Society: Bennett is Vice Chair of the Society; Peters is one of the coordinators of the Thematic Working Group (TWG) on Teaching and Learning Health Systems Research; Bloom is a coordinator of the Private Sector in Health TWG; and Hyder of the Ethics of Health Systems Research TWG. George, has been a key player in the TWG on Social Science approaches for research and engagement in Health Policy and Systems.

**Strengths and Challenges**

As the publication record demonstrates, FHS team members are productive: the RPC members have been working together for some time, and maintain effective collaborations. While in some cases (such as Bangladesh and China) there has been implementation delays against original time frames these have not been overly severe. Further, sometimes such delays represent important parts of the learning process, as has been the case for example with the m-health experiment in Bangladesh.

FHS had hoped that the Bellagio meeting on Future Health Markets might stimulate greater interest on the part of HANSHEP in operational research regarding health markets. However FHS efforts to engage the HANSHEP secretariat in follow-on work were largely unsuccessful.

**Lessons Learned**

- We are learning from our failures (such as the collapse of the m-health scheme in Bangladesh). In this case it would seem that despite good intentions at the start, and a promising beginning, the limited revenue stream from the m-health call centre, ultimately dimmed the interest of the private for-profit company involved in this initiative.
**FUTURE PLANS**

A number of the country teams actively move into the intervention implementation stage during the coming year (this is the case for Bangladesh, India and Uganda), at this point we wish to ramp up our efforts to track the development of the interventions, and document how they evolve and diffuse through the implementation process. Country-teams are starting by revisiting the theories of change they developed at the beginning of the project, and the Hopkins and IDS teams have developed a menu of tools that they can use to help country teams with this process.

We are also planning a workshop, in collaboration with the ESRC STEPS Centre, on complex adaptive systems and health systems in Baltimore in June 2014. We hope that this will enable consortium members to achieve a new level of sophistication in the application of complex adaptive sciences concepts and analytical techniques.

**OUTPUT 2: PUBLICATIONS ARE RELEVANT, ACCESSIBLE AND TIMELY**

**PROGRESS TO DATE**

The second year of implementation has posed an interesting challenge for the FHS policy influence and research uptake (PIRU) activities. Many of the new country research projects took quite some time to pass through ethical review, which has meant a limited availability of new country-level primary research findings in this year (though as the previous section makes clear, the FHS team has remained productive). This is natural during the research cycle. This year PIRU activities focused very much on convening activities at both international and national levels to build greater audiences for our on-going work.

At the international level, this meant engagement at the Health Systems Research Symposium in Beijing in November 2012 (see box 1 for FHS panels), as well as high-level engagement with Health Systems Global, the society in charge of organising the biennial Symposium. There was also collaboration with the Alliance for Health Policy and Systems Research in the writing and launch of *Implementation Research in Health: A Practical Guide*. It also meant on-going work on health markets, including the FHS-coordinated organisation of the Private Sector in Health Symposium in advance of the iHEA World Congress in Sydney in July 2013. This period also saw the launch of the ResUp MeetUp Symposium and Training Exchange, led by FHS in partnership with AFIDEP and to take place in late June/early July 2014.
Box 1 – FHS panel sessions at the Beijing Symposium on Health Systems Research, November 2012

- Teaching health policy and systems research: Current approaches and Challenges (co-organised with other RPCs)
- Complex adaptive systems: Recent applications in health systems research – FHS panel
- Stakeholder analysis as a tool for health systems research: Findings from the Future Health Systems Consortium
- Health system development in complex and dynamic contexts: Learning from Brazil and China

In addition to the FHS-organised panels, many FHS members presented their research in other sessions.

At the national level, India had several meetings of a learning platform in West Bengal, especially to launch the Sundarbans Health Watch Report, which was particularly well received. The Uganda team convened a symposium with the Ministry of Public Health surrounding Safe Motherhood Week. The Bangladesh team played a significant role in conceptualising and writing the Lancet papers on Bangladesh, and were also key players in the launch of the Lancet series. The China team had a number of meetings at the county-level in their study areas to introduce the study and secure buy in from local participants. And in Afghanistan, there was a series of meetings with local NGOs and officials from the Ministry of Public Health and the national Coordinating Group on Health and Nutrition regarding findings from the feasibility study on community based scorecards that took place there.

Indicator 2.1 Average number of unique web visitors per month across FHS’s family of websites during past six months

Table 2 gives an indication of how the family of FHS websites have performed during the reporting period in terms of unique visits.
**Table 2 – Unique visitors to FHS family of websites**

<table>
<thead>
<tr>
<th>Website</th>
<th>6 month average unique visits*</th>
<th>Reporting period average unique visits</th>
</tr>
</thead>
<tbody>
<tr>
<td>FHS (<a href="http://www.futurehealthsystems.org">www.futurehealthsystems.org</a>)</td>
<td>879</td>
<td>942</td>
</tr>
<tr>
<td>HSB (<a href="http://www.dchsb.net">www.dchsb.net</a>)</td>
<td>12</td>
<td>42</td>
</tr>
<tr>
<td>PSinHealth (<a href="http://www.pshealth.org">www.pshealth.org</a>)</td>
<td>243</td>
<td>329</td>
</tr>
<tr>
<td>ResUp (<a href="http://www.resupmeetup.net">www.resupmeetup.net</a>)</td>
<td>122</td>
<td>70</td>
</tr>
<tr>
<td>TOTAL</td>
<td>1156</td>
<td>1390</td>
</tr>
</tbody>
</table>

* December 2013 has been included in these figures, but this tends to skew the six-month rolling average downwards as the last two weeks of December are usually quite a dead period because of the holiday season. Also note that targets were put in place with September as the end of that six-month rolling period (which would have been 1448 unique visits)

Considering the entire family of websites, we have slightly exceeded Indicator 2.1, Milestone 1. The target was 1100 unique visitors on a six-month rolling average by the end of December 2013, and we are currently at 1156. Looking at the overall period, we are even higher with 1390 average monthly unique visitors across all of the websites.

**Indicator 2.2 Number of e-newsletter subscribers (Please note that individuals need to request to be added to the FHS contact list)**

We have considerably exceeded Indicators 2.2, Milestone 1. The milestone was to have 250 subscribers to our email list. Currently we have 442 (that’s for FHS alone – our family of lists have considerably more subscribers – PSinHealth currently has 877, DC HSB has 302, and ResUp has 81). This success is very much down to the substantial outreach efforts mentioned above. See the chart below for growth in subscribers to the FHS mailing list.

**Growth in FHS e-newsletter subscribers**
Indicator 2.3 - Expert panel assess FHS products to be relevant, accessible and timely for policy makers

We have delayed the measurement of Outcome 2.3 pending further discussions with DFID about quite how this indicator should be framed and measured, and whether it makes sense to establish this panel just for FHS or for several RPCs.

Other achievements in research uptake

We have been expanding our online engagement across the board. As of mid-December 2013, @futurehealthsys has 1503 followers on Twitter (more than double our last report) – and @PSinHealth has 694 followers. FHS currently has 23 presentations on Slideshare, 6 of which have over 1000 views (the one with the lowest views still has over 250 while the one with the most views has over 2000). PSinHealth has five presentations on Slideshare, each with roughly 200 views. FHS has 21 videos on YouTube with 1,139 total views; PSinHealth has a further 9 videos with 580 total views.

The most viewed content produced this year on the FHS website was the Meeting Statement from Bellagio on Future Health Markets. We see this as a particularly relevant and timely publication, and suggest that the accompanying dissemination work – e.g. the webinar in the run up to the Private Sector in Health Symposium – contributed to its high number of views and downloads.

Lessons learned

- In the run up to the Private Sector in Health Symposium we were able to facilitate a number of webinars. This format has proved to be a useful mechanism for engaging in content across borders. We have been learning and documenting lessons for running webinars and applying them to an internal FHS webinar series.

Future plans

As indicated above, as part of our research into the ‘learning by doing’ strand of work, the teams will be reviewing their country-level theories of change and making plans accordingly. The focus at the country-level this year will be the continued capacity development of the PIRU Officers via the ResUp MeetUp Symposium and Training Exchange. We will also be jointly convening a workshop on Complex Adaptive Systems in Baltimore, USA in June 2014.

At an international engagement level, much of our influencing activities will progress through participation in Health Systems Global Thematic Working Groups (Private Sector in Health, Teaching and Learning Health Policy and Systems Research, Social Science Approaches to Health Systems Research and Ethics in Health Systems Research) and through significant engagement with the Society’s biennial symposium, which will take place this year in Cape Town, South Africa, in late September 2014.

The expectation is that, given where the consortium is in the research cycle, research findings will start becoming more available toward the second half of this year and into the following programme year.
OUTPUT 3: CAPACITY FOR HIGH QUALITY, POLICY-RELEVANT, HEALTH SERVICES AND SYSTEMS RESEARCH STRENGTHENED IN FOCAL AND AFRICAN HUB COUNTRIES

PROGRESS DURING YEAR 2

During the second year of the project we have continued with the three primary strategies to support capacity development as we had during the first year of the project. However FHS has sought to innovate in terms of the mechanism for delivering training and capacity development, and in particular we have began to run a series of consortium-wide webinars, that have proved to be an efficient way in which to provide training in specific research methodologies. The webinar series is described in more detail under the training workshops heading below. The three primary strategies (and related indicators) are listed below.

**Indicator 3.1 Proportion of respondents in Schools of Public Health in the African hub who agree or strongly agree with positive statements about institutional capacity for health systems research**

Not measured this period

FHS continues to engage in an intensive program of work, which has a strong focus on capacity, with the HEALTH Alliance, a network of seven Schools of Public Health in East and Central Africa.

During the first year of the project all seven schools of public health conducted analyses of their own health systems research capacity. Four papers based upon these analyses have now been submitted to the journal Health Research Policy and Systems for a mini ‘special issue’. The papers that are currently under review address (1) curricula for teaching health systems research across the Schools (2) facilities (e.g. libraries), infrastructure and organisational capacity to support health systems research (3) capacity for translating evidence to policy and (4) reflections on the capacity assessment tool and its use. In addition the Africa Hub has submitted a funding proposal to IDRC for their consideration that focuses on capacity development across the Schools. The team is currently addressing comments from IDRC and plans to re-submit the proposal shortly.

In February 2013, JHU and Makerere ran a five-day training session at Jimma University, Ethiopia on HSR methods. Participants in the course included 16 faculty members from Jimma University as well as three regional participants (from DRC, Rwanda and Uganda). Subsequent to this training workshop, the African Hub agreed that it would like to institutionalise its own regional health systems research short course. A curriculum development meeting was held in August in Kampala, and a curriculum has been developed and has gone through one round of peer review. The idea is to develop a three-month regional training course that would mix face-to-face teaching sessions with mentored practical work involving the design and implementation of small-scale health systems research studies. Tuition fees would cover the cost of the course.
Indicator 3.2. Cumulative number of faculty receiving capacity development support through FHS from (i) training workshops (ii) formal mentoring arrangements or (iii) small grant opportunities

Table 3 - FHS support to faculty development*

<table>
<thead>
<tr>
<th></th>
<th>Male</th>
<th>Female</th>
</tr>
</thead>
<tbody>
<tr>
<td></td>
<td>Reporting period</td>
<td>Cumulative</td>
</tr>
<tr>
<td>Participants in traditional training workshops</td>
<td>17</td>
<td>103</td>
</tr>
<tr>
<td>Recipients of formal mentoring</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Recipients of FHS small grants</td>
<td>1</td>
<td>1</td>
</tr>
<tr>
<td>Milestone December 2013</td>
<td>15</td>
<td>15</td>
</tr>
</tbody>
</table>

* excludes participation in webinars

The targets set for this indicator were exceeded even during year 1 when FHS ran some very large workshops (e.g. for 50 people in China), as a consequence it would probably be advisable to raise the targets.

This year FHS has continued the traditional face-to-face training workshops (as described below), but has added to this a series of training webinars open to all researchers affiliated with FHS. The webinars are intended to provide more focussed support on particular research methods, relevant to the research being undertaken by the consortium. To-date four such webinars have taken place and have addressed (1) quantitative methods for scale development on community capabilities (2) social network analysis and its application to health systems research questions, (3) social media for research and research uptake, and (4) process documentation in complex adaptive systems. Although we have clear ideas of both the number of registrants and the number of computers logged in to the webinars, the number of attendees of any given webinar is difficult to track because, in some instances, more than one person participates in a webinar from a given computer/log in. Additionally, the webinar on social media was produced in front of a live audience at IDS as well as an online audience. Finally, many of those webinars were recorded and made available via YouTube to FHS members. Having said that, the webinar software recorded a range of 10-24 online participants in the webinars.
In terms of country specific workshops, the following training workshops have been conducted by FHS during year 2:

- Analysing qualitative data (July 30 2013), and systems mapping and causal loop analysis (July 31 2013) in Beijing China (10 participants – 6 female, 4 male) training conducted by Sara Bennett, JHU
- Methods for Health Systems Research (February 2013) in Jimma Ethiopia 19 participants, 11 male, 8 female), training conducted by Asha George & Ligia Paina, JHU and Freddie Sengooba, Makerere.
- Participatory rapid appraisal techniques December 2012, to IIHMR, Kolkata, 5 participants, 3 female, 2 male by Alex Shankland, IDS.

We have also noted that our teams, particularly in China and India are increasingly able to find local, relevant training opportunities, for example team members from these countries have used FHS support to participate in workshops on topics such as Social network analysis, use of GIS data for decision making, Cochrane Collaboration systematic reviews, and climate change.

**Awards for junior faculty and post-graduate student research** – at the end of program year 1 we made 4 small awards for junior faculty and post-graduate student research. Three of these awards were to colleagues in India (all women) and one to a Ugandan colleague (male). Mentors, largely from inside FHS, were assigned to each junior faculty member. All four awardees have made good progress in their work, and three were able to present their work at the annual Consortium meeting held in Brighton in June 2013. The FHS management team were particularly impressed by the innovation and rigor of the work conducted. For example, David Musoke, run a photo-voice project with youth in Uganda, asking them to document the barriers that they perceived for women seeking to access maternal health services in Uganda. This photos from this project were exhibited during the policy discussion on teenage pregnancy in Uganda co-hosted by the FHS Makerere team and the Ministry of Health. David is now writing up the findings from the study, that draws upon both the photos and semi-structured interviews with participants. David was also recently selected for a TDR African region small grantee award.

**Indicator 3.3 - Number of papers accepted by peer review journals in which junior researchers in the FHS team have been (i) lead authors (ii) co-authors**

Table 4 shows the number of FHS peer review journal authors that had lead authors or co-authors who were junior faculty (meaning that they were not fully tenured and/or their title indicated relative lack of seniority – such as assistant scientists, research fellows, research assistants, doctoral students etc.).
Table 4 – Proportion of FHS publication with junior faculty.

<table>
<thead>
<tr>
<th></th>
<th>Reporting period</th>
<th>Cumulative</th>
<th>Milestone</th>
</tr>
</thead>
<tbody>
<tr>
<td>Junior lead author</td>
<td>6</td>
<td>8</td>
<td>1</td>
</tr>
<tr>
<td>Junior co-author</td>
<td>8</td>
<td>15</td>
<td>6</td>
</tr>
<tr>
<td>Total number of articles (including those without junior authors)</td>
<td>23</td>
<td>47</td>
<td></td>
</tr>
</tbody>
</table>

**Lessons Learned**

- The consortium webinars have proven to be an effective way to provide training and technical support on specific research methods at relatively low cost. They have allowed us to tap into specialised expertise (notably at JHU) that are not a core part of FHS and whom we would not be able to get to visit countries.

- Initially significant management effort was invested in developing appropriate organisational and governance structures around the African Hub. This effort started during the inception phase and continued during Years 1 and 2. A new African Hub coordinator was appointed during Year 2. Overall we feel much more confident that the African Hub activities are now moving forward in a very productive fashion, and that there is true ownership of the agenda across the seven Schools of Public Health. Accordingly the initial time spent on getting management structures right appears to have been a good investment. While Hub activities have moved relatively slowly, we think it is important that decision-making remained in the hands of the African Hub participants, without too strong an external push from the FHS management team.

- The young grantee awards have been highly successful, and we plan to issue another round shortly.

**Future Plans**

- Continue and expand the webinar series
- Provide support as need be to the African Hub for (i) development of the regional training (ii) resubmission of the grant proposal to IDRC (iii) workshop on grant writing
- Compete and issue another round of young researcher awards
**ENGAGEMENT WITH BENEFICIARIES**

FHS has a multitude of beneficiary relationships throughout the ten countries in which we work. A few of the beneficiaries include the community, policy and decision-makers, broader academia and junior faculty from the partner institutions. As Output 3 above discussed capacity development beneficiaries, here we focus on the earlier categories (namely community, and policy and decision-makers).

**COMMUNITY BENEFICIARIES**

At the community level, the Afghanistan team piloted community-based score cards in several rural communities throughout Afghanistan (in Bamayan and Takhar provinces). Through facilitating these scorecards, communities became more aware of both their rights and responsibilities in contributing to the local health situation. For example, the scorecard process in Siadara, Bamyan, mobilised the community health *shura* to repair the water pump and petition the Provincial Rehabilitation Team (PRT) to repair the electricity supply to the local clinic. On the other hand, in Sarqol, Bamyan, the community was informed as to their entitlements under the Basic Package of Health Services (BPHS) that the community was too small to have its own ambulance. They subsequently dropped the request and focussed on other areas for improvement, like securing additional patient beds and repairing a broken wall.

In Uganda, direct engagement with community health workers as well as community savings groups has been undertaken. Local ‘youth’ were also engaged through a PhotoVoice research project to identify community-level maternal health issues and opportunities for them to help improve those situations. In Bangladesh, given the difficult political climate, much engagement has focused at the community-level. One of the problems identified with the initial pilot project was a lack of knowledge from the trained doctors operating the call centre of the local dialect in Chakaria. As icddr,b has taken over implementation of the intervention directly, they are now receiving calls to their own mHealth line from the village doctors, as they are well known to the community.

The FHS India team has repeatedly engaged relevant decision makers around the findings from its preliminary work in the Sundarbans with a view to informing the development of initiatives there that will contribute to child health. Although these discussions have yet to come to fruition, to-date the India team have engaged with health officials at the district and state level, NGOs working in the region and the media.

**POLICY AND DECISION MAKERS**

In terms of policy engagement, the Afghanistan team participated in significant national-level dissemination of findings from the implementation research into the scorecards. This involved meetings with the NGOs that are contracted to provide health services as well as meetings of the Coordinating Group on Health and Nutrition, which is chaired by the Minister for Public Health. These presentations garnered much interest for further scale up of the approach. In China, the teams have engaged with policy makers in each of the pilot counties to discuss payment reform and to introduce their research. In India, the team met with a range of policy makers and NGOs operating at a state level in West Bengal to launch the first Sundarbans Health Watch. And the
Uganda team had a number of discussions with the Ministry of Health as well as parliamentarians regarding their work. For example, in conjunction with Safe Motherhood Week, the Uganda team co-hosted a one-day symposium with the ministry.

At the international level the FHS team organised a consultation in Bellagio, Italy, on the future of health markets, which resulted in the most viewed document from FHS this year – the Bellagio Statement on the Future of Health Markets. The FHS team also organise a policy discussion forum in Washington DC, known as the Health Systems Board (http://www.dchsb.net). While this policy forum is designed to promote exchange between a broad range of health systems stakeholders, including academics, policy makers, staff of international agencies and students, it also serves as a means to engage policy makers in dialogue around issues that FHS is concerned with. For example, a recent session organised by JHU focussed on the effects of government crowd out by NGOs in contexts such as Afghanistan.

Finally, Bennett and Peters are leading the development of a new World Health Organisation strategy on people-centred and integrated health services. While this work is being funded directly by WHO, the draft strategy has drawn heavily upon the research and thinking done within FHS and upcoming meetings and presentations regarding the strategy provide an excellent forum to engage with key global and national stakeholders in health services.

6. Outcomes and Impacts

Outcome Indicator 1: X number of examples of policy/practice outcomes (which may include Attitudinal change; Discursive commitments; Procedural change; Policy content; Behaviour change)

To date FHS can identify two specific areas in which FHS research has affected policy or practice outcomes. The milestone for December 2013 was zero.

Afghanistan – as described above, the FHS Afghanistan team has had significant engagement with the Ministry of Public Health around the development of the Community Based Scorecard scheme, as a consequence of this engagement the CBHC unit in the Ministry has become strong advocates for the expansion of the community scorecard, and have been working to encourage the USAID Leadership Management and Governance Project to take forward this initiative.

Uganda – other development partners in Uganda have become interested in the idea of transport vouchers, specifically the Baylor College of Medicine Children’s Foundation, Uganda, is implementing a transport voucher project in the districts of Kabarole, Kamwenge, Kibaale and Kyenjojo to transport pregnant women to the health centres. CUAMM Uganda is designing a transport voucher scheme for MCH to serve 7 districts in Karamoja region. Learning from the FHS team have informed the designs used for the voucher projects for both of the above programs. Meetings were held with the program design teams for the new projects and FHS shared its experiences with them.
These changes in Uganda are in addition to the two practice and one programmatic change reported in last year’s annual report.

**Outcome Indicator 2: X number of evidence-informed debates (online or in-person) including policy or practice decision makers which make use of FHS research evidence**

Under this outcome indicator we point to two key debates. One was the Bellagio meeting on Future Health Markets, organised by FHS, that resulted in a Bellagio statement and a follow-up webinar that disseminated key findings. The Bellagio meeting itself involved national policy makers (such as a Ministerial advisor from the MOH Nigeria), private sector entrepreneurs and officials from international agencies such as the Gates Foundation and DfID. The FHS team drew upon its work under FHS 1, as well as more recent thinking concerning innovation, complex adaptive systems and learning to develop background papers for the meeting that guided discussion. This also served as a strong foundation for FHS to lead the Private Sector in Health working group and one-day symposium in Sydney, Australia, which particularly furthered the debate on the role of the private sector in health among practitioners.

Second, the FHS Uganda team has invested heavily during the past year in building relationships with the Ministry of Health as a means both to inform its own research, but also ensure open channels for disseminating findings. In October 2013 the Makerere FHS team and the MOH co-hosted a symposium on teenage pregnancy to commemorate Safe Motherhood Month. This was co-sponsored by UNFPA, WHO and Marie Stopes. The FHS team called for greater attention to the cost-effectiveness of interventions to prevent teenage pregnancy and the PhotoVoice project (described above was also exhibited at the symposium).

The December 2013 milestone for this indicator was also zero.

**Broader outcomes and impacts of the RPC**

In broad terms the main impacts of FHS include advancing thinking about private markets, particularly the informal nature of private health care markets and the types of approaches that may be taken to shape such markets; enhancing understanding about and intervening in health systems and policy as a complex adaptive system; raising attention and developing thinking around community capabilities; and advancing the practice and science of implementation research. The outputs described above, are all intended to build towards this broader impact. Clearly at this point in the RPC it is not feasible yet to identify outcomes or impacts in all of these significant areas.

In addition there are some more specific outcomes from during the reporting period that we flag here. One of the unexpected effects of the research in Bangladesh has been the decision by icddr,b to open its own m-health call centre. The call centre that was previously being operated by the private firm aimed to provide advice to village doctors for a modest fee. However, as described above, it did not function well due to a combination of factors encompassing a lack of call centre doctors with appropriate language skills, and most likely insufficient financial incentives to supply services to this segment of the market. icddr,b is now seeking to step into
this gap, building both upon its own experience in running hospitals and field sites, as well as what the team have learnt from the private sector company in terms of operating a call centre. It should also be noted that this intervention laid the groundwork for two FHS-related studies, one on ICTs for health-seeking behaviour funded by the UK’s ESRC and another from IDRC on the social implications of mHealth technology in Bangladesh.

The FHS team also proposed a package of activities to HANSHEP that built upon the discussions at the Bellagio meeting. This proposal encompassed (i) development of a HANSHEP Knowledge Priorities group to identify key research questions and leverage research funding (ii) the development of a data platform on health markets (iii) a regulatory challenge fund designed to stimulate innovation in regulation and (iv) a health markets learning lab that would seek to identify and promote the diffusion of good innovations. Unfortunately none of these ideas were directly picked up by HANSHEP but it would appear that the thinking has influenced some HANSHEP activities, for example HANSHEP is currently supporting the piloting of a self-regulatory body in Nigeria, and HANSHEP also hired a knowledge and learning consultant.

**Future Plans**

Most of the main research of the consortium is currently in progress, so research findings are still only emerging intermittently. At this point in the project, the primary focus of the FHS team in terms of ensuring ultimate outcomes and impact is through building relationships with key constituencies at both national and global levels. All FHS teams are actively engaged in this so as to build firm foundations for future efforts to use evidence to influence policy and practice.

In addition, FHS teams are currently in the process of revisiting their theories of change. Two and half years into the main phase of the project, it is clear that much learning has accumulated, and the FHS team collectively felt the need to reflect on the learning so far, and adapt theories of change as necessary, in order to ensure final outcomes.

### 7. Costs, Value for Money and Management

**Expenditure Report**

The full financial report is presented in Annex B. Table 1 presents expenditure reports against the original RPC budget presented in the inception phase report. Table 2 presents the same data by DFID Financial year. In order to manage funding, the project has adapted future year budgets once annual expenditure reports are available. Tables 3 and 4 present current budgets by both program year and DFID financial year, and compare them to original budgets.

The program expenditure is largely on track against budgets. For the Programme Year 2 (October 2012 – September 2013) the original budget was £1,380,306 and estimated expenditure for the programme year is £1,378,869. However the RPC had significant carry over (particularly from the inception phase period), and did not ramp up expenditure sufficiently to absorb additional funding (we had projected spending of £1,449,112 which would have fully absorbed carry over). So, to-date (by programme year), total expenses of £3,678,749 are about
£88,877 less than cumulative budget. Projections to the end of the DFID fiscal year also suggest that the RPC is likely to have carry over into next financial year of the order of about £120,000.

The slightly lower than expected levels of spending during Year 2 are related to a few factors. Both JHU and IDS have had gaps in staffing as some staff have left and it has taken longer than expected to replace them with new staff. There is also an under-expenditure on travel, which may be related to the increasing use of internet-based means of communications including the employment of webinars for training and quarterly steering committee meetings.

Last year’s annual report described how both the Uganda and Afghanistan teams had purposely underspent during the Year 1 period. In Uganda this had been due to the delay in receiving complementary funds to support the implementation of the intervention. In Afghanistan additional funds had been reserved to support travel for the endline assessment, as increasing insecurity had meant that it was no longer feasible to use road travel to study sites. At this point, end of Year 2, we close out our Afghanistan program with some cash in hand, however Uganda has now began implementation of the intervention and is on track financially.

Value for Money
As reported in last year’s annual report FHS has been striving to ensure value for money by focusing on the main cost centers, i.e. labour and travel, as well as by maximizing the amount spent in low- and middle-income countries where costs tend to be lower. In Year 2 about 41.5% of the budget was spent in the UK and US. We have not succeeded in reducing the proportion of labour costs spent in high income countries, but have seen some reduction in travel costs (from about 11.5% to 9.5% of total costs) – perhaps associated with increased use of the internet for training and work, and facilitated by improved internet connectivity across our work sites. We have also continued to try to piggy-back trips onto other planned travel where feasible.

We have also initiated a process, this year, of revision of country-level theories of change and engagement strategies to ensure that the proposed activities remain relevant in shifting contexts.

Management
The RPC continues to be managed by a small management team comprising the two research directors (Dr David Peters and Dr Abbas Bhuyia), the CEO (Dr Sara Bennett), and the PIRU Manager (Mr Jeff Knezovich). The research manager Ms Daniela Lewy who had ably managed many of the day-to-day aspects of the RPC since its start, left in August 2013 to pursue a doctoral degree. We are in the process of replacing her position with a junior, technical team member (Ligia Paina) and an administrative person (Marcinda Fast). Dr Abbas Bhuyia was made acting Executive Director of icddr,b in June 2012, and in the last annual report the RPC expressed concerned about how this would affect his ability to contribute to FHS work. This was indeed something of a problem during the second half of 2012 and early 2013, but a new director was appointed in April 2013, and Dr Bhuyia has since had more time to devote to FHS. In addition to the small management team, there is a steering committee comprised of the heads of individual country teams that meets approximately every quarter by phone.
The RPC continues to seek to ensure quality of research products through internal management meetings to monitor progress against plans and a system of peer review for FHS products. The monitoring system used by the project is described in more detail below, but in brief, monthly management team meetings review routine reports received from countries and are used to identify problems with the implementation of work plans, or unexpected shifts in strategy. The management team then follows up with respective teams by email, phone or if necessary through country visits so as to address the problems that have arisen.

During Year 2 we held the first face-to-face meeting of our CAG members comprising Dr Phyllida Travis, WHO, Geneva; Dr Allison Beattie, DFID and Dr Eliya Zulu, the African Institute for Development Policy. The CAG participated in the first two days of the Consortium’s annual meeting in Brighton and provided very useful feedback on consortium progress to-date. In particular the CAG encouraged the RPC to:

• Ensure that all country work contributed in some way to the cross-cutting themes
• Strengthen the focus on program results, the “so what” of the research
• Endeavour to focus capacity development efforts more.

As a consequence of CAG inputs, individual country teams are revising their theories of change (so as to maintain a focus on program results), and we have sought to reinvigorate work around the CAS cross-cutting theme.

As discussed above, there continues to be some delay in implementation of particular projects, for example the Bangladesh team is having to re-conceive their m-health interventions and re-start implementation; the China team has been slow to get the follow-up survey into the field, and despite solid preparatory work in India, it has been difficult to reach agreement with stakeholders on an intervention to be implemented in the Sundarbans. While these were all unexpected delays, they have also added to our understanding of the complexity of the interventions being implemented.

8. Work Plan and Timetable

Each of the six institutions that make up FHS, plus the African Hub, develop their own work plans. Due to lack of space we cannot fully present all of these, but instead focus on select highlights. Routine work such as daily activities related to program implementation, data collection and analysis and faculty mentoring are accordingly omitted from the table below.

Please note that the FHS program year runs from 1st October to 30th September, accordingly teams have not yet produced work plans beyond 30th September 2014.
Table 5 – Highlights of Work Plan: Year 3

<table>
<thead>
<tr>
<th>Date</th>
<th>Activity</th>
<th>Responsible</th>
</tr>
</thead>
<tbody>
<tr>
<td>January 2014</td>
<td>Initiate CAS monitoring/process documentation of FHS projects</td>
<td>JHU and IDS working with country teams</td>
</tr>
<tr>
<td>January 2014–April 2014</td>
<td>Webinars to revisit country teams theory of change</td>
<td>FHS management and country teams</td>
</tr>
<tr>
<td>January 2014</td>
<td>Conclude &amp; Submit IDRC proposal for research capacity funding</td>
<td>Africa Hub</td>
</tr>
<tr>
<td>February 2014</td>
<td>Finalise baseline report on mobilising community resources for maternal health</td>
<td>Uganda team</td>
</tr>
<tr>
<td>February 2014</td>
<td>China team annual meeting</td>
<td>China team</td>
</tr>
<tr>
<td>February 2014</td>
<td>Second workshop on ethical issues in Health Systems Research in Baltimore</td>
<td>JHU</td>
</tr>
<tr>
<td>March 2014</td>
<td>Finalisation of report on first round of research findings from China</td>
<td>China team</td>
</tr>
<tr>
<td>March 2014</td>
<td>Award of round 2 of small grants to faculty and students</td>
<td>FHS Management and Africa Hub (two separate competitions for main consortium and Africa Hub)</td>
</tr>
<tr>
<td>June 2014</td>
<td>Final reports from current four young researchers’ grants due</td>
<td>Four young researchers</td>
</tr>
<tr>
<td>June 2014</td>
<td>Health Watch II in the Sundarbans</td>
<td>India team</td>
</tr>
<tr>
<td>June 2014</td>
<td>Student tour of major health care institutions to generate health system innovations [Rwanda and UON]</td>
<td>Africa Hub: University of Nairobi and Rwanda School of Public Health</td>
</tr>
<tr>
<td>June 16-18th 2014</td>
<td>Symposium on the application of complex adaptive systems science to health systems, Baltimore USA</td>
<td>JHU and IDS teams</td>
</tr>
<tr>
<td>June 19–20th, 2014</td>
<td>FHS consortium meeting</td>
<td>All</td>
</tr>
</tbody>
</table>
June 30th 2014  | Submit manuscripts on (i) community experiences of M-health (ii) effect of m-health initiative on quality of care and (iii) current situation in e – and m-health. | Bangladesh team

30 June – 4 July | ResUp MeetUp Symposium and Training Exchange in Nairobi, Kenya | PIRU team members and relevant researchers

July 2014 | HEALTH Alliance Dean’s meeting – Africa Hub progress reviewed by Deans and policy decisions taken | Africa Hub

September 2014 | Second round of data collection in China | China team

September 2014 | Review of experiences with implementation of major health reforms in China | IDS and China team

September 2014 | India Bangladesh cross visits of two young researchers | India and Bangladesh teams

September 30 – October 3rd 2014 | Global Symposium on Health Systems Research, Cape Town | All teams

9. Risks
Table 6 presents the risks identified in the inception phase report and identifies changes in the nature of risks faced, and changes in risk mitigation measures. All teams are asked to provide an updated risk assessment as part of their monthly reporting. Any substantive changes in risk are reviewed and discussed by the project management team.

**Table 6 – Changes in Risk Assessment**

<table>
<thead>
<tr>
<th>Risk</th>
<th>Probability</th>
<th>Impact</th>
<th>Update</th>
<th>Mitigation strategy</th>
</tr>
</thead>
<tbody>
<tr>
<td>Support for new intervention strategies by policy makers and implementers falters</td>
<td>Low (changed from “high” to “low” at the end of year 1, remains low)</td>
<td>Medium</td>
<td>We continue to believe that policy makers are supportive of the types of intervention strategies being pursued by our teams.</td>
<td>The project continues to seek close engagement with policy and decision makers to ensure that research can occur around the planned interventions.</td>
</tr>
<tr>
<td>Political instability and resurgence of violence undermine RPC efforts to conduct research and develop research capacity in fragile and conflict affected areas.</td>
<td>Low (changed from High last year)</td>
<td>Medium</td>
<td>All fieldwork in Afghanistan is now complete and this was the primary country for concern with respect to violence. Bangladesh has suffered considerable election violence recently that has somewhat slowed project implementation but is not a major problem for the team.</td>
<td>None</td>
</tr>
<tr>
<td>---</td>
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<td>---</td>
<td>---</td>
</tr>
<tr>
<td>Failure to sustain built capacities beyond the life of the consortium</td>
<td>Medium (Unchanged)</td>
<td>Medium (unchanged)</td>
<td>We are slightly less concerned about this than last year as the Africa Hub seems to be developing its own leadership, but acknowledge that it continues to be an issue</td>
<td>Continue to seek other funding to support Africa Hub work, and invest in developing both the individual leadership skills and necessary systems for the Africa Hub to function effectively.</td>
</tr>
<tr>
<td>Close collaboration with substantive private corporations challenges researchers' ability to maintain intellectual independence</td>
<td>Low (changed from medium)</td>
<td>Low (changed from medium)</td>
<td>As noted above, the collaboration in Bangladesh between FHS and a private corporation has been discontinued, and so this risk has virtually disappeared.</td>
<td></td>
</tr>
<tr>
<td>Equivocal research findings undermine attempts to translate knowledge into practice</td>
<td>Low</td>
<td>Medium</td>
<td>Unchanged – research findings not yet produced</td>
<td>Unchanged</td>
</tr>
</tbody>
</table>

Based upon the assessment in the table above we now rate the overall risk of the project as low. This change in status is attributable to two main factors, first the fact that FHS is no longer working in Afghanistan, which was a high risk environment with respect to political unrest and...
violence, second because FHS is no longer collaborating with a private corporation in Bangladesh. It should be noted that initially we had seen the risk of this collaboration as being related to the private corporation wishing to influence research findings in ways that undermined independence, but ultimately the problem arose due to the firm not fulfilling its service delivery commitments.

10. **Monitoring and Evaluation**

FHS continues to require all country teams to submit monthly reports. These reports capture the factors indicated in Table 7 and are used both as an on-going management tool to check progress across research teams, and as a means of collecting evidence to feed into this annual report. FHS is currently seeking to supplement this information through more in-depth process tracking. JHU and IDS are developing a menu of instruments for this, and will support teams through this process.

**Table 7 – Factors reported on by FHS teams**

<table>
<thead>
<tr>
<th>Research process</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe any particular challenges encountered and/or areas where input from others could be useful.</td>
</tr>
<tr>
<td>Please describe any changes in plan or intervention design since you commenced this work. How did these changes come about (consider both internal and external causes as well as the decision-making process involved)?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>Research outputs and activities</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please list all FHS-related papers <strong>submitted</strong> to peer review journals during the past month (Please provide author, title of paper, journal name).</td>
</tr>
<tr>
<td>Please list all FHS-related papers <strong>accepted</strong> by peer review journals during the past month (Please provide author, title of paper, journal name).</td>
</tr>
<tr>
<td>Please list all other (non-peer reviewed) publications related to FHS including (book chapters, presentations at conferences, popular press articles, website publications, proposals, policy briefs, working papers etc.) Please provide full citations.</td>
</tr>
<tr>
<td>Please list any teaching materials that FHS research has contributed to. Include course, subject &amp; note if material is open access and available to be posted on FHS website.</td>
</tr>
</tbody>
</table>
Please list any **events, conferences, meetings, workshops** (closed or open) with key intervention stakeholders (**including policymakers, practitioners, communities and health sector entrepreneurs**) and, when available, where more information can be found about the engagement (i.e. event websites/presentations etc.)

**Policy influence and research uptake impacts and outcomes**

Please describe any new **policies**; or **changes to existing policies**; or **contact with policymakers** who are seeking research-based evidence that reflect FHS research. Please explain why you attribute these changes to FHS research and provide evidence where possible.

Please describe any new **programs and initiatives** or changes to existing programs and initiatives that reflect FHS research. Please explain why you attribute these to FHS research and provide evidence where possible.

Please describe any new **practices** or changes to existing practices that reflect FHS research. Please explain why you attribute these to FHS research and provide evidence where possible.

Briefly describe any **significant** shifts in the social/ political/ cultural context in which the team is working and how the team has responded to these shifts.

**Capacity building - Capacity for high quality, policy-relevant, health services and systems research strengthened in focal and African hub countries**

Number of faculty receiving capacity development support through FHS from **training workshops**. Please list the **name and gender** of the faculty member and the training received.

Number of faculty receiving capacity development support through FHS from **formal mentoring arrangements**. Please list the **name and gender** of each mentored faculty member.

**Program management**

Please list other grants that are co-funding FHS activities, and their current status

Please list any new proposals submitted during the past month that link to FHS activities


Please describe any gender issues in your FHS work (context; challenges/ strategies; needs to be addressed/ resources or learnings to be shared)
Please describe any ‘lessons’ learnt from this month of FHS work (e.g. things that went well, things that should be done differently next time) that could inform future work, especially lessons that could be relevant to other aspects of the consortium.

<table>
<thead>
<tr>
<th>Have there been any shifts the risks associated with your work? If yes, please describe this and what you are doing to address them.</th>
</tr>
</thead>
<tbody>
<tr>
<td>Please describe any collaboration with other RPCs during the past month.</td>
</tr>
<tr>
<td>Please describe at least one key accomplishment that happened this past month:</td>
</tr>
</tbody>
</table>

11. **Further Information**

Please note that in discussion with DFID there have been amendments to our logframe during the last year. The current version of the logframe is presented in Annex A. The main changes have sought to simplify the output structure of the project. There is still one indicator (2.3 Expert panel assess FHS products to be relevant, accessible and timely for policy makers) that is under discussion, as we figure out with DFID how best to implement a measurement strategy for this indicator.

Further, as noted above, while the number of policy briefs produced is relatively small, FHS has invested heavily in blogs. We wonder if it might make sense to incorporate a broader indicator that covers blogs and policy briefs in output indicator 1.2.

Please note that we have chosen not to include a table of publications in this report as R4D uses the FHS website RSS feed to include our publications on their website, and we also submit six-monthly reports on outputs to DFID separately.