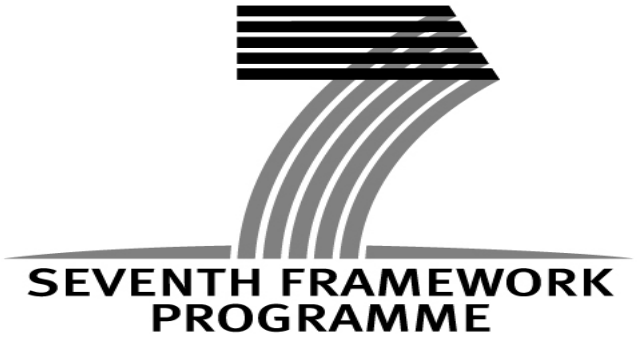

Cooperation

HEALTH

Theme

Call identifier: FP7-HEALTH-2010

COLLABORATIVE PROJECT

Part B: Description of work

Proposal full title: Assessing the impact of fee exemption on maternal health in West Africa and Morocco: new tools, new knowledge

Proposal acronym: FEMHealth

General Information (version date): 2013-12-18

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List of Acronyms

BOC	Basic Obstetric Care
CAREF	Centre d'Appui à la Recherche et à la Formation (Mali)
CERRHUD	Centre de Recherche en Reproduction Humaine et en Démographie
CFA	West African Franc
CHR	Centre Hospitalier Régional (Regional Hospital Centre)
CHU	Centre Hospitalier Universitaire (University Hospital Centre)
CMA	Centre Médical avec Antenne chirurgicale (District Hospital)
CoP	Community of Practice
CSCOM	Centre de Santé Communautaire (Community Health Centre)
CSPS	Centre de Santé et de Promotion Sociale (First line Health Centre)
CSREF	Centre de Santé de Référence (Referral Health Centre)
DALY	Disability Adjusted Life Year
DHS	Demographic and Health Survey
DSF	Direction de la Santé de la Famille (Family Health Department)
EmOC	Emergency Obstetric Care
GRIPP	Getting Research into Policy and Practice
IMMPACT	Initiative for Maternal Mortality Programme Assessment
INAS	Institut National d'Administration Sanitaire (Morocco)
IRSS	Institut de Recherche en Sciences de la Sante (Burkina Faso)
ITM	Institute of Tropical Medicine, Antwerp
LHSTM	London School of Hygiene and Tropical Medicine
LHS	Local Health System
MDG	Millennium Development Goal
MICS	Multiple Indicator Cluster Survey (UNICEF)
MMR	Maternal Mortality Ratio
MOH	Ministry of Health
MRC	Medical Research Council
NGO	Non-Governmental Organisation
NHS QIS	National Health Service – Quality Improvement Scotland
POEM	Policy effects Mapping
RCT	Randomised Control Trial
RE	Realist Evaluation
SAMM	Severe Acute Maternal Morbidity
UoA	University of Aberdeen
WAHO	West African Health Organisation
WP	Work Package

B1. Concept and objectives, progress beyond state-of-the-art, S/T methodology and work plan

B 1.1 Concept and project objective(s)

There is a growing consensus that maternal health outcomes can only be improved through policies and programmes that combine interventions to address the different causes of ill health and target multiple groups. Such policies and programmes are complex in nature as they involve coordination between different tiers in the health system and multiple actors including communities, health workers and managers. User fee exemption for delivery and emergency obstetric care (EmOC) is one such policy that has been introduced by several African countries with the aim of improving access to care and thus improving maternal and neonatal outcomes. However, the current evidence base regarding the impact of this policy is not well developed, in part because of evaluation designs that are not able to capture all the necessary information for policy-makers to make informed decisions. This proposal aims to reduce this gap by developing research methodologies and tools that will lead to enhanced research on policy implementation, stronger evidence and improved dissemination.

The overall aims of the project are (1) to develop new methodological approaches for the evaluation of complex interventions in low income countries, (2) to improve the health of mothers and their newborns by performing comprehensive evaluations of the impact, cost and effectiveness of the removal of user fees for delivery care EmOC on maternal and neonatal health outcomes and service quality, and (3) to improve the communication of this evidence to policy-makers and other stakeholders. Specific objectives include:

1. To develop enhanced methods for the evaluation of complex interventions involving various levels of the health system and carried out on a large scale. Innovation will relate to the following areas:

    a. developing a policy implementation measurement tool that describes interventions in terms of their adherence to original objectives, their eventual scope and penetration;
    b. developing innovative methodologies for health policy analysis, focusing on what drives policy change and how policy is transferred, both from international to national level (and back), but also regionally;
    c. developing a Policy Effects Mapping tool (POEM) and a comparative case study design, based on realist evaluation that focuses on adequacy and plausibility of effect of intervention rather than on probability and provides policy relevant information;
    d. using critical events (near miss) as an entry point for the evaluation of health outcomes and quality of care;

    Tools will be developed in year one, tested in year two and finalised for external use in year three.

2. To apply these enhanced research methods to evaluate the impact, cost-effectiveness and mechanisms of fee exemptions for delivery care, especially emergency delivery care, in Benin, Mali, Morocco and Burkina Faso.
    The evaluation results will be generated by the start of year three. These will be synthesised regionally and disseminated within that year.

3. To pilot a new way of synthesising and disseminating results to policy-makers using a network beyond the four countries - a 'community of practice' which encourages cross-learning between policy-makers, international organisations and researchers and between countries in the region.
    The CoP will be established from the start of the project, and will continue after the project's end, if it is positively evaluated, both internally and externally.

These objectives will be delivered by 9 work packages (WPs). The detailed objectives of each work package are listed in Part A, but general objectives for each WP are:

- to coordinate the work of the consortium and synthesise the findings across other WPs (WP 1);

- to establish a research framework for evaluating complex interventions; develop innovative methodologies for health policy analysis and health finance research; and measure changes to service costs and household expenditure (WP 2);
- to evaluate the impact of selective free health care policies on local health systems and to analyse the conditions and mechanisms of success or failure of policy implementation (WP 3)
- to determine the impact and effectiveness of user fee removal on maternal and neonatal morbidity and quality and uptake of emergency obstetric care, using a generic approach that it is easily adaptable to other programmes aimed at improving timely access to emergency care. This generic approach will be centred on the concept of near-miss events and will use hospital-based information (WP 4);
- to disseminate findings of all WPs in a policy-relevant way and establish an active regional community of practice on selective removal of user fees in the health sector (WP 5)
- to develop in-country methodologies and evaluate the impact of selective free health care policies on local health systems, health outcomes and quality of care (WP 6, 7, 8 and 9). The latter WPs are based in the focal countries.

These general objectives are mapped onto a set of activities for each WP (see section 1.3), as well as onto the outputs which have been defined for each WP (see Part A), and the general milestones and deliverables for the project. All of these have specified deadlines within the lifetime of the project. The consortium will also monitor wider impacts, as laid out in section B.3.

B 1.2 Progress beyond the state of the art

FEMHealth will develop research and evaluation methodologies that allow assessment of policy interventions in complex situations. Our methods are innovative in a number of ways. First, FEMHealth will explore the process of policy success in terms of policy transfer and implementation by examining the interfaces between three levels of the healthcare system. Second, we will conduct comparative realist case studies (Pawson & Tilley 1997*),* a promising but yet little applied approach to evaluation of interventions in complex situations, such as local health systems. Third, we will use critical events (near miss) as an entry point for the evaluation of health outcomes and quality of care. Lastly, we will pilot a new way of synthesising and disseminating results to policy-makers using a network beyond the four countries - a 'community of practice' which encourages cross-learning between policy-makers, international organisations and researchers and between countries in the region.

A1. Addressing challenges in analysis of policy processes

There is considerable scope for theoretical and empirical innovation in studies of *policy transfer*, especially pertaining to low- and middle-income countries (Gilson & Raphaely 2008; Walt et al. 2008). In contrast to the attention that has been paid to policy transfer between high-income countries*,* there has been relatively little research into policies transferred between high-, middle- and low-income countries (Dolowitz & March 1996). Notably there is very little research into how middle- and low-income countries transfer policies and actively draw lessons from each other. Moreover, the role of international organisations in changing, reviewing and promoting policies and programmes as global 'best practice,' or recommendations to specific countries, has not been extensively studied (Walt et al. 2004). How systematic research and global-level 'best practice' recommendations impact on these process remains debated within various public health sub-fields, including in maternal health, and requires further study of the kind proposed within FEMHealth (Béhague & Storeng 2008; Béhague et al. 2009).

The proposed health policy research will therefore address: 1) the diffusion of policy from international to national level in the focal countries; 2) whether and how policy transfer takes place between the focal countries; and 3) how to build insights about the policy transfer process into evaluations of complex interventions.

One of FEMHealth's innovations will be to use analyses of the policy process as one component of a multi-method evaluation of the implementation of complex policies in a number of countries. Despite the recent growth of interest in health policy analysis, incorporating such analysis into broader evaluation frameworks is novel. While it is increasingly recognised that health systems and policy research are important complements to more traditional epidemiological study designs within public health research, how such policy analysis can be integrated with other

knowledge input in the evaluation of complex health system recommendations (such as financing reform involving the removal of user fees) is not well understood. The consortium will contribute to examining this issue.

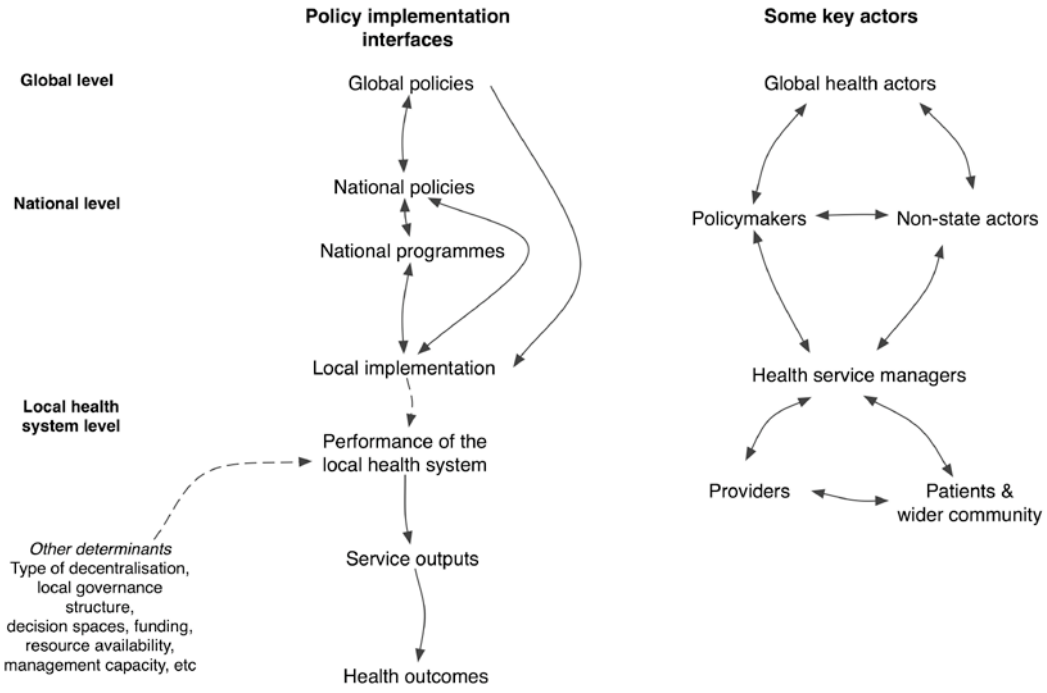
When seen in conjunction with analysis of health policy implementation and outcomes at sub-national levels (WP 3), a focus on the policy process and policy transfer in particular can help to evaluate the effectiveness of policies to remove user fees for maternity care, and in particular to understand why policy change is successful and the differential success of similar policy measures in different places. The focal countries are particularly interesting for considering questions relating to policy transfer because it seems, from anecdotal reports, that there has been strong national-level leadership in initiating policy change. It will be particularly instructive to consider how lessons are shared between countries and also what impact 'bottom-up' learning from countries have on global-level debates about evaluating the effectiveness of user fee policies for other settings.

A.2. Development of the realist case study approach

In the policy-implementation gap research, the analysis of the underlying processes of policy success/failure is poorly developed. Policy implementation failure can be explained by a number of factors. Ineffective policies, even when well implemented, will not attain results. Strong evidence-based policies will obviously not be effective if not implemented, or unsuccessfully implemented (Hunter & Marks 2002). However, not much progress has been made in developing comprehensive frameworks for analysis of the effects of national level-policies on the operational health services and of the mechanisms through which policies are implemented (Hunter & Marks 2002). FEMHealth addresses this issue from the point of view of the providers and health service managers who are supposed to carry out policies and programmes through an innovative method. It will explore conditions of success and failure of a national policy from the perspective of the operational health services as well as answering that question from the policymakers' or knowledge producers' perspective.

The starting assumption is that the implementation phase provides clues that help explain policy success or failure. A number of factors will determine how managers of local health systems (defined as health districts, networks of hospitals and health centres, or NGO facility networks) react to a national policy. From this perspective, a national health policy directive is an external influence on the local health system that brings new responsibilities, activities, (possibly) resources and thus the need to allocate time and set priorities **(**see Figure 1**).** A financing policy is indeed just one of many directives that health service managers need to take into account. Furthermore, decentralisation has introduced many new actors in the decision-making process at LHS level: elected political authorities, board members, etc. New policies can become the subject of debate or a stake in conflict of interests or power games. Finally, in today's landscape, (global) non state actors play an increasingly important role, not only in the national policymaking processes, but also directly at LHS level.

Figure 1. Pathways of influence of global and national policies on local health system performance



FEMHealth will analyse the policy-implementation gap by developing a methodological approach that will contribute to better research tools for this issue. We will take a two-step approach. First, the effects of policy on operational health services will be mapped. Second, in-depth realist case (RE) studies will explore how and why policies have effects, or not.

There are few documented frameworks and methods to assess policy implementation at operational level in the domain of public health and health service organisation. These cover very disparate issues. For example, in their paper on health system constraints to reaching the Millennium Development Goals, Travis et al. (2004) mention 4 negative effects of vertical programmes on operational health services: duplication, distortion, disruption, and distraction. McKinsey & Company (2005) focus on the effects of Global Health Initiatives at national level and identified 5 potential risks of GHI: swamping the low absorption capacity at national level; skewing national priorities; duplication of processes; excessive burdening of districts with tasks beyond their routine activities; and facilitating the internal brain drain out of horizontal services by offering better remuneration rates and other benefits. Other authors similarly describe system-wide effects of global programmes. Another perspective is offered by the work on health systems strengthening under impulse of WHO. These frameworks establish the key functions and outcomes of a national-level health system. The six building blocks are service delivery, human resources, governance, financing, medical products and information systems (WHO, 2007).

Useful as these approaches are to better understand the effects of global policies at national and operational level, they have their limits. In order to identify effective approaches to increase the success of policy implementation at the *operational* level, a better analytical tool is required. In response, we will develop the Policy Effects Mapping tool (POEM). We will adapt the 6 building blocks model for analysis at the operational
health service level, stressing the governance function and the dynamic linkages between the operational level on one hand, and the influences exerted by policies, programmes and external actors on the other hand. With the resulting tool, we will assess the effects of the fee exemption policy on these key functions of a local health system.

In a second step, realist evaluation case studies will be carried out at district level. These aim at understanding the determinants of the gap between policy and implementation, or in other words what makes that particular policies are implemented and others not. At the same time, we aim at working on a methodological issue. Realist evaluation indeed may offer an approach to increase the external validity of traditional case studies. It does so by

analysing not only whether change in outcomes occurred, but also why, or why not, and in which conditions. This provides information that allows decision-makers to judge whether the lessons learnt could be applied elsewhere (Pawson 2006). Repeated case studies lead to more refined hypotheses ('middle range theories') that offer increasingly refined information of underlying mechanisms and essential context conditions, thereby not only increasing generalisability of such case studies (Murphy 2001), but also clarifying the attribution of effect to the configuration of intervention-context-mechanism. It should be noted that Pawson does not claim that realist evaluations will provide fail-proof evidence. Instead, he argues that it will offer plausible explanation that provides more useful information than traditional evaluations, which focus only on effectiveness evaluation.

Realist evaluation is not without its problems. Pawson & Tilley (2006) offer an attractive methodological approach but little practical guidance. FEMHealth will therefore also contribute to filling this gap by developing practical applications of realist evaluation and by documenting its use, limitations and possibilities.

In summary, FemHealth will develop and disseminate the POEM tool, as well as case reports of its application in the focus countries. It will also develop methodological papers on realist evaluation and disseminate case reports on the realist evaluation of the abolition of user fees in selected districts in each focus country.

A.3. The concept of "near-miss" and its role in safety improvement

Experience with the use of near-miss has increased in poor and middle-income countries, but there is very little experience with its use as an outcome indicator to assess the success of safe motherhood programmes at the population level. The met need for life-saving surgery has been estimated in a variety of settings (Belghiti et al. 1998, Van Damme et al. 1998, Criel et al. 1999, Ronsmans et al. 1999, Jahn et al. 2000, Odero et al. 2001, Prytherch et al. 2007, Hunger et al. 2007, De Brouwere et al. 2002), but this indicator does not cover all cases of near-miss and the validity of the absolute target against which performance is assessed has not been verified.

Ronsmans and colleagues (2009) have suggested a more comprehensive approach to arrive at the incidence of near-miss in populations with very low access to professional delivery care. By defining complications at the very extreme end of the severity spectrum they postulate that their count in hospitals can be used to represent the incidence in the general population. They define complications that are "absolutely" life-threatening - using concepts of organ failure and life-saving surgery - such that women who experience these problems are unlikely to survive if they do not receive care in a hospital. Using this approach, population estimates of near-miss can be obtained from hospital data, assuming that women with such complications either make it to the hospital and survive, or do not reach the hospital and die. Evidence from poor countries has shown that the large majority of near miss arrive in hospital very late (Filippi et al. 2005; Filippi et al. 2009). Since the intended effect of user fee removal is to increase timely and equitable access to care for all, we anticipate that a successful policy will increase uptake of care for women with complications whilst reducing the number of women who arrive in a critical life-threatening state (such as, for example, uterine rupture, hypovolaemic or septic shock). In other words, hospitals will see an increasing case load for obstetric complications – and the need for obstetric care will be increasingly met - , but the incidence of near-miss-upon-arrival will decrease across all socio-economic groups.

While there is extensive experience with the development and definition of maternal near miss, including in low resource settings, much less is known about neonatal near miss. Many systems that score neonatal morbidity exist, but most are too complicated for use in developing country hospitals (Avenant 2009). Mukwevo et al. (2007) used organ system based criteria similar to those used for maternal near-miss to classify neonatal near miss in one hospital in South Africa. The rate of neonatal near miss was 25/1000 live births and was approximately four times that of the neonatal death rate. The near miss approach identified many more cases of intrapartum asphyxia, trauma and ante partum haemorrhage. Since these problems are modifiable, a focus on neonatal near miss is potentially promising to complement the investigation of maternal near miss.

Health care near-miss has been defined as "a situation in which an event or omission, or a sequence of events or omissions, arising during clinical care fails to develop further, whether or not as the result of compensating action, thus preventing injury to a patient." (Department of Health 2000). This is an increasingly popular concept in western countries, where serious adverse outcomes (such as death or obstetric near-miss) are much rarer than in low income countries. Data capture systems have been developed for staff to report health care near-miss

events voluntarily in the UK, Australia or the USA (National Health Services QIS 2006). We will adapt this concept, relying on a small number of health care near-miss indicators or "snapshots" which can be collected routinely. For each of these indicators, sufficient data will be collected to understand the direct cause and the root causes, by documenting the health care context, so that the project can also propose mitigating measures (Jones et al. 1999). This small but enlightening set of indicators of health care near-miss will be developed during a methodological workshop but may include, for example, delay in receiving emergency treatment, non-use of partographs in normal deliveries or incomplete medical records for mothers and newborns. The development of a combined health outcome and health care near-miss tool will be an innovative output of this project and adaptable to other health problems, in particular those for which timely access to emergency care is critical (such as cardio-vascular diseases, injuries or life threatening infectious diseases).

A.4 Community of practice

Our analysis is that there is a need for innovative models of knowledge management in low-income countries. These innovations should take into account that the knowledge that policy makers of low-income countries need is much broader than what is published in international scientific journals. They certainly need knowledge on implementation issues, such as: how should the policy be implemented in their context? Why has a policy worked in one setting and not in another?

Our view is that because of their working environment and their distance from operations, many scientists have not much to share in these domains of knowledge. One of the main knowledge holders are probably other practitioners developing and implementing similar strategies with a similar set of constraints; these people may be other policy makers in another country, experts working for an aid agency or even consultants.

The recognition that knowledge is not held by only one group has many implications. A major implication is that the interface putting knowledge holders together and allowing them to share knowledge must be much more open than thought usually. It must be more open in contents recognised as valuable to be shared and in terms of contributors and users of the pooled knowledge.

Our progress beyond the state of the art in terms of GRIPP will be to move from the classical model of distant and discontinuous interactions between researchers and policy makers to a model of continuous and open interactions between a larger set of knowledge holders. Our approach will be to launch a community of practice.

The concept of community of practice was introduced by cognitive anthropologists who studied the learning process that occurs in apprenticeship situations. The term refers to formal and informal groups of practitioners into which newcomers enter to acquire the socio-cultural practices of the community. More recently, community of practice has become associated with knowledge management. The model is particularly powerful in strengthening professional connections between members of the community. These interactions within the community are conducive to nurturing new knowledge, stimulating innovation, and sharing existing tacit knowledge within the group.

A community of practice has three structural elements: a *domain* of knowledge, a *community* of people who care about this domain; and the shared *practice* that they are developing to be effective in their domain (Wenger, McDermott, & Snyder 2002).

The domain creates common ground and a sense of common identity and purpose. A well-identified domain legitimizes the community by affirming its purpose and the related value for participants. It inspires members to contribute and guides their learning process. Our own proposition of domain (to be later validated by the participants of the first community meeting) is "selective free health care policies, with a focus on strategies targeting pregnant women and children".

The community is the social fabric of the learning experience. Regular interaction must be favored. The community model encourages a willingness to share ideas, ask difficult questions and listen carefully. Our community will try to gather practitioners involved in the formulation, implementation or evaluation of innovative selective free health care strategies. Our community will be open to national policy makers (e.g. a

"Directrice Santé de la Famille", other ministries), staff of international agencies, of civil society organizations (e.g. national and international NGOs) and of academic and training institutions in Francophone Western Africa, Maghreb and Europe.

The practice can be defined as the set of frameworks, ideas, tools, information, styles, language, stories, and documents that the community members share (Wenger, McDermott, & Snyder 2002). The practice is the specific knowledge that the community develops, shares and maintains. Our main practices of focus will be: how to design a free health care policy to the greatest benefit of pregnant women and children without undermining other objectives of the health system; how to implement such policy reforms in the most effective way; what are the appropriate approaches and measurement techniques to monitor and evaluate such reforms; how to consolidate political support for the reform.

We believe that the community of practice is particularly appropriate to international health knowledge for the following reasons:

- The model recognizes that policy is a complex process and not a linear one; knowledge must be fed in a continuous way, especially in countries that are moving fast in their reform process or willing to do so.
- By its large involvement of key stakeholders, our community fully acknowledges that research and policy should be a process of collective construction by researchers, policy makers and practitioners.
- The community addresses the problem of the 'missing interface'. Instead of putting forward a view of specialized intermediaries between researchers and policy makers, the community is a real organizational model of knowledge production and sharing.
- The community model recognizes that individuals have strong intrinsic motivation to share ideas. Its communitarian approach builds on co-ownership and common vision. It values knowledge already present at regional level.

Our community will not only be our main strategy to close the gap between researchers, policy makers and practitioners; it will also be one of the main research questions for our consortium. Noteworthy, such a self-study and documentation of how researchers engage with policy makers seems to be an emerging 'good practice' for international research consortia (Hyder et al. 2007).

While the community of practice is a model currently being adopted by several leading developmental agencies such as the World Bank and UNICEF, our project will innovate in the fact that the community is initiated by researchers; while recognizing the value of practical knowledge, we will also insist on the importance of evidence and conceptual thinking.

A review has confirmed that there is today no literature on community of practice in international health. This implies that research questions on the strategy abound. Our own focus will be on the following questions:

- Is it an appropriate model for knowledge *production* in international health?
- Is it an appropriate model for knowledge *sharing* in international health?
- Is it an effective approach for researchers to engage with national policy makers and aid agencies?
- Is it a good strategy to overcome the many barriers for basing policies on evidence?
- What are the challenges and strategies to steward a community of practice in international health at a regional level?

The 3-year experience of the community will be extensively documented. Documentation will cover:

- The objectives assigned to the community by its members.
- The life of the community (processes, positive and negative external shocks, internal tensions, adaptations and correcting measures)
- The success of the community as a contributor to knowledge in the domain of expertise (e.g. recognition by external actors, international agencies, other scientific consortia).
- The success of the community to produce value for its members (surveys).

The documentation will be organized according to state of the art techniques in this domain (Wenger, McDermott, & Snyder 2002): it will combine quantitative indicators with qualitative narratives, including anecdotes showing how the community is contributing to produce value for its individual members and the governments removing user fees in a selected way.

General indicators for assessing research performance in relation to methodological innovations are given in Table 1 below.

Table 1. Research performance indicators (methodological innovation)

Baseline state	**Expected progress**	**Indicator(s)**
Health policy		
Inadequate analytical frameworks for analysing global-local and South-South policy transfer and development	Ethnographically-informed policy analysis carried out and methodological lessons identified	Methodological report on studying policy transfer and dissemination of policy analysis
Realist evaluation		
Inadequate analytical frameworks and tools to assess the effects of national policies and programmes on operational health services	POEM tool developed	POEM tool published Country-level findings published
Few documented applications of realist evaluation in public health research in low and middle-income countries. Little knowledge of why health policies are implemented or not at operational level	Realist case studies carried out and methodological lessons identified	Methodological paper on application of realist evaluation Country-level case reports disseminated Cross-country analysis disseminated
Near miss		
Lack of comprehensive tools and approaches to assess the impact of financing policies on maternal and neonatal health outcomes, timely access to care, and quality of care	A comprehensive multi-disciplinary understanding of the positive or negative impact of the policies on health outcomes for mothers and babies, quality of care, and access to emergency care Comparison across countries is available to understand trends and equity issues. This will enable the project to make recommendations on how to improve policies to remove user fees	Number of open-access research papers written on the research tools, impact of policies on health outcomes, quality of care and timely use of emergency obstetric care Number of policy recommendations made on the basis of findings on impact of policies on maternal and neonatal health outcomes and quality of care
Community of practice		
Poor formulation and implementation of selective free health care policies in sub-Saharan African countries Lack of face-to-face events,	A vibrant regional community of practice is in place; it is identified by major stakeholders, including those who are not contractual members of FEMHealth, as a key platform to	Number of experts registered in the community of practice Proportion of participants in the community of practice activities

networks and virtual platforms for policy makers, practitioners, experts and scholars to share knowledge on these policies at regional level	learn about selective free health care	(face-to-face events and e-discussion groups) who are not FEMHealth researchers

General performance indicators for the project as a whole will include, for example, the following:

- Number of research protocols submitted for ethical review
- Number of new tools (e.g. definitions of neonatal near miss etc) and research technologies developed
- Number of policy makers involved in community of practices
- Number of policies revised as a result of research and community of practice activities
- Number of papers published in peer-reviewed journals
- Impact factors of those journals and number of 'hits' for open access articles
- Number of projects using our tools for other evaluation topics
- Number of deliverables accomplished within time frame
- Number of policy briefs written
- Number of hits on our website per month

B 1.3 S/T Methodology and associated work plan

(i) Overall strategy for research

The overall aims of the project are to develop new methodological approaches for the evaluation of complex interventions in low income countries, to improve the health of mothers and their newborns by performing comprehensive evaluations of the impact, cost and effectiveness of the removal of user fees for delivery care EmOC on maternal and neonatal health outcomes and service quality, and to pilot a new way of sharing knowledge between policy-makers and other stakeholders. In order to do these three things, we have organised ourselves into 9 work packages. Two of these have 'overview' functions: WP1, which provides the **management** and coordination of the programme, and WP5, which focuses on **dissemination of knowledge**.

The core research is undertaken by three thematic WPs and four country WPs. The first is focussed on **health policy, health financing and health economics (WP2)**. These are particularly important elements in this proposal, as the intervention is a health financing one, which involves the shifting of costs (in theory) from patients to governments (and donors). Its impact will be heavily linked to the effectiveness of the financing channels. In addition, the analysis of the equity effects of the policy will be critical to understanding its success or failure. This WP will therefore develop the overall causal framework for the analysis and will help to synthesise the end findings on cost-effectiveness of interventions, in particular by collecting cost data, which will be combined with results from other WPs to derive cost effectiveness (understood here in the broadest sense, to include wider health system impacts as well as narrow ones). The health policy component will analyse the way in which policy is driven, and also assist in evaluating the internal innovation of the community of practice component. The second thematic WP is the **local health systems (WP3)** one. This takes a two-way analysis, considering both what enables successful implementation of the policies at the district level, but also what the effects of the policy are on the health system itself. This will be key to understanding the dynamics of reform (not just the effects, but the processes which contribute to them and which will need to be taken into consideration in generalising from evaluation results). The final thematic WP looks at **quality of care and health outcomes (WP4)**. Neither are easy to measure in the maternal health field, which is why tools will be adapted and piloted which have potential to track quality of care and changes to outcomes without major (and expensive) maternal mortality surveys.

Four focal countries will be involved in research in all three of these thematic areas (though the exact combination of tools varies according to the local needs and the timing of reform – some have had some degree of documentation already; others very little or none). Three are in francophone West Africa – **Benin, Burkina Faso and Mali** – and one in the Maghreb (**Morocco**). They are participating in this proposal because they have all introduced policies to remove fees for deliveries and caesareans in the past few years, and have all expressed a strong commitment to evaluating their reforms. None of them has as yet had a full evaluation of their policies. They will work in close collaboration with researchers based in the thematic WPs to develop the tools, conduct the research, disseminate findings, and adapt the tools for other contexts.

The final WP is the dissemination one. This has two parts. The first is a '**community of practice'**, which will set up a regional network of policy-makers, researchers and health partners, to learn lessons from one another during this period of reform (most countries in the region having introduced some version of this targeted cost reduction policy in recent years). The CoP itself is an innovation which we will be evaluating. In addition, more conventional dissemination at the international level will also be supported by this WP, working with all other partners.

Risks and contingency planning

One of the main risks in any research programme is that the government in the country in question has limited interest in its outputs. In the case of FEM Health, this has been mitigated in two ways in particular:

1. All of the Ministries of Health have been approached during the design phase in order to inform them, assess their interest and gain their consent. All countries which are participating have expressed their interest in the research (and those which did not have been excluded).

2. The Community of Practice is expressly designed to develop more policy-oriented knowledge and tools, which should increase the interest of policy-makers, and keep the issue at the agenda during the gap between the beginning of the project and the preliminary results.

A second risk is of overlapping with and duplicating other research efforts in the region. The consortium has attempted to mitigate this by making contact with other research groups in advance, to foster cooperation and explore complementary areas.

In general, the range of countries and range of tools reduce risk of failure on any particular front, as constraints in one country can lead to the tool development being focussed in another.

Clearly, if we encounter political impediments or restrictions on access to data in some of the contexts, that will require us to downscale or adapt our objectives.

A final anticipated risk is of problems with capacity in any of the research teams. This will be managed by continuous monitoring and communication, so that difficulties in delivering agreed outputs are identified early on and remedial action taken. Remedial actions will include (as appropriate) more external support, additional training, and changes to roles, where necessary.

(ii) Timing of work packages

All work packages will run for three years, which is the minimum period necessary to complete the programme of research (involving preparation, tools development, field work, analysis, dissemination and validation/adaptation of tools). All WPs are linked, with thematic WP staff supporting the country programmes in all four countries, and country WPs participating in developing the research in all thematic areas, according to their local priorities.

The initial period will involve a rapid assessment of the reforms in each country, to establish the government priorities, to update on available secondary data and to identify high and low performing areas in which to conduct the research. This will be led by WPs 2, 3, 6, 7, 8 and 9. The aim is to focus many of the tools in 6 focal districts per country. During this initial period WP2 will develop and circulate a causal framework for the evaluations in each country.

During the first two months, each WP will update their literature reviews in their topic areas and draw up more detailed plans. These will be finalised at a workshop in the third month. After that, the WPs will focus on developing and testing their tools. Research protocols will be prepared in focal countries and submitted for ethical review. In the case of the CoP, this will be the periods of establishing their network of practitioners in the region.

All tools will be reviewed at the next major meeting at the start of year 2. After that the intensive fieldwork will begin, from months 12-18 broadly, but longer in the case of some WPs. During the remainder of the year, field work will be written up and collated, and the experience of using the tools will also be documented. This leads to some dissemination products during the second half of year 2.

In the final year, after a meeting to share findings and plan for synthesis and dissemination, the focus will be on analysis, and integration of findings across WPs and across countries. These findings will be reviewed and finalized at a meeting in Ouagadougou in the last week of November 2013. A range of dissemination products will be produced, including reports, articles, briefing papers, website materials, conference presentations, possibly books and materials for local and international media. The community of practice, which throughout will be producing materials focussing on implementation issues, will in this last phase also be evaluated itself.

	Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	39
WP1	**Management**																																				
1	Development of the project website																																				
2	Organization of first project workshop (planning work)																																				
3	Harmonised WP plans produced																																				
4	Integrated work and dissemination plan for programme																																				
5	Communication with WPL on progress																																				
6	Organization of 2nd project worksho[(reviewing tools)																																				
7	Financial and scientific report first periodic review																																				
8	Communication with WPL on progress																																				
9	Organization of 3rd project workshop (sharing findings and planing dissemination)																																				
10	Final reports																																				

LEGEND

International meeting

Deliverables

Results

	Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
WP3	**Local Health Systems**																																				
1	Development & application of tool for rapid assessment of policy implementation in focal countries (with WP2)																																				
2	Rapid assessment report																																				
3	Finalised WP plan																																				
4	Development of POlicy Effects Mapping tool (POEM)																																				
5	Scientific guidance for data collection for POEM																																				
6	Scientific guidance for data analysis & reporting of national POEM study																																				
7	Comparative analysis of the 4 POEM studies and writing of the international POEM report																																				
8	Development of the Comparative case study design																																				
9	Scientific guidance for the field research for realist case studies																																				
10	Scientific guidance for data analysis of realist case studies.																																				
11	Comparative case analysis & synthesis																																				
12	Report on the lessons learned on conducting realist case studies																																				
13	Guideline for using POEM																																				
14	Publication of articles, policy briefings, bok chapters, conference papers etc.																																				

	Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
WP4	**Health outcomes and Quality of care**																																				
1	Litereature review on neonatal and health care near miss																																				
2	Workshop to define near miss criteria																																				
3	Finalised WP plan																																				
4	Development of data collection instruments and field training for near miss incidence and quality of care																																				
5	Development of interview guides for in-depth interviews and protocols for participant observation																																				
7	Data analysis (secondary data)																																				
8	In-delth fieldwork for all tools																																				
9	Data analysis (primary data)																																				
10	Comparative analysis of near miss incidence and quality of care across 4 countries																																				
11	Comparative analysis of uptake of obstetric care across 4 countries																																				
12	Comparative analysis of women's perceptions																																				
13	Guideline for using near miss as an entry point for the evaluation of health outcomes and quality of care																																				
14	Generic tool for the evaluation of timely access to EmOC adaptable to other fields																																				
15	Publication of articles, policy briefings, bok chapters, conference papers etc.																																				

	Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
WP5	**Dissemination and Community of Practice (CoP)**																																				
1	Coordination of the CoP																																				
2	Preparatory work and consultantion, recruitment																																				
3	Organization of 1st CoP meeting, minutes approved																																				
4	A case for action is developed and disseminated																																				
5	Research protocol is developed																																				
6	Production of newsletters																																				
7	Development of the CoP website, it is kept up to date																																				
8	Discussion group forum launched																																				
9	Work on synthesis papers for each main tool and for results of poicy implementation in each country																																				
10	Development of the web-based resource guide, accessible online																																				
11	Organization of 2nd CoP meeting, minutes approved																																				
12	Work on synthesis pepers for results of each WP and for each country																																				
14	Production of policy briefs jointly with other WP on main policy implication																																				
15	Report on the lessons learned from developing a regional CoP																																				
16	Organization of 3rd CoP meeting, minutes approved																																				
17	Organisation of national and regional dissemination workshopd																																				
18	Support to academic outputs, including peer-reviewed articles and possibly a book.																																				

	Months	1	2	3	4	5	6	7	8	9	10	11	12	13	14	15	16	17	18	19	20	21	22	23	24	25	26	27	28	29	30	31	32	33	34	35	36
WP6, 7, 8, 9 Country Workpackages																																					
1	Collaboration with WP2&3 on rapid assessment of state of policy implementation																																				
2	Contribution to International scientific meeting and to CoP meeting 1																																				
3	Country WP finalised																																				
4	Development of data collection tools in colaboration with WP2,3,4, field testing																																				
5	Data collection tools adapted to the national context																																				
	Contribution to International scientific meeting and to CoP meeting 2																																				
6	Data analysis (secondary data)																																				
7	In-depth fieldwork for all tools																																				
8	Data analysis (primary data)																																				
9	Intermediary technical country research report																																				
10	Contribution to International scientific meeting and to CoP meeting 3																																				
11	Final evaluation report on national policy																																				
12	Production of a leaflet with the main findings of the research																																				
13	National dissemination activities: workshops, press conference																																				
14	Publication of articles, conference papers etc.																																				

B2. Implementation

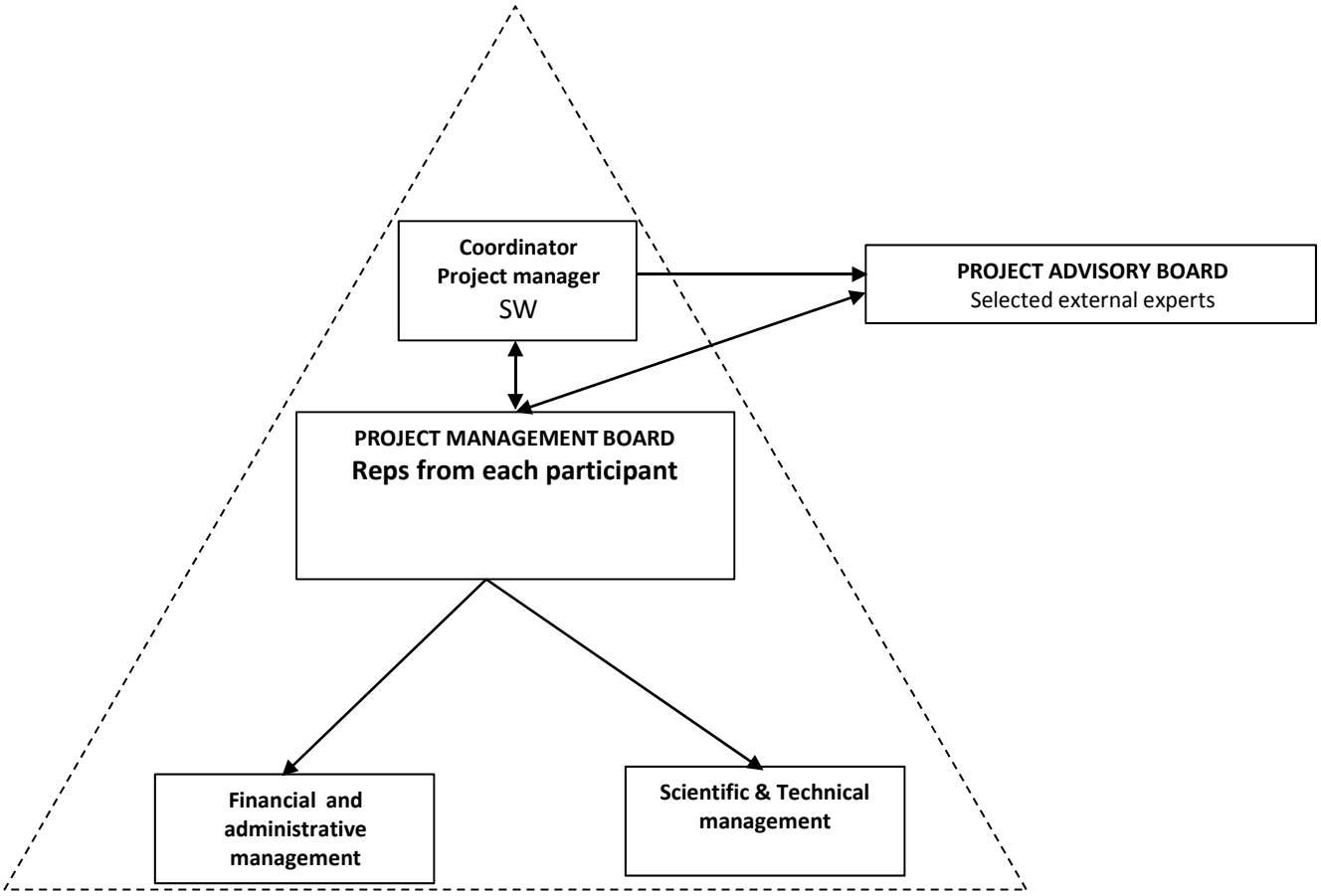
B 2.1 Management structure and procedures

Project management

The management structure of the project is shown in Figure 3. There will be a Project Management Board that will provide a permanent link between the different work packages and ensure consistency to the overall objectives.

A Project Advisory Board will be established in order to provide external comments and recommendations on the project progress and quality to the Management Board.

Figure 3: Framing of the project management



The project management will be oriented towards an efficient use of human and financial resources, which also guarantees the quality of the results. Some key considerations will be taken into account:

- The diversity and networks of the partners shall be used for knowledge and efficiency improvement;
- The task assignment shall correspond to each participant's skills and resources within the framework of the project;
- The fitness to the project objectives and smooth communication shall ensure a good quality of results.

A consortium agreement which will go into the specifics of the framework to be signed among partners at the beginning of the project to define and formalise responsibilities, roles, relationships, conflict resolution procedures, and intellectual property rights. This agreement will be produced by the University of Aberdeen's European contracts officer and will follow the DESCA contract model.

Scientific Coordinator
The consortium has agreed that the University of Aberdeen will coordinate the project with Dr Sophie Witter as Scientific Coordinator. Dr Witter takes overall responsibility for managing the project, and will be responsible for the smooth and timely execution of the planned activities, and of the transmission of the contractual deliverables to the Commission and to all the partners. Dr Witter, with support from the Project Manager will also be responsible for all the administrative follow-up.

Project Manager/ coordinator
Alec Cumming will be the project manager and financial and administrative coordinator. He will be responsible for the monitoring of progress with respect to milestones and expected outputs. In addition he will have responsibilities for progress reports submitted to the EU and liaison with the Commission and stimulation of proper/optimal interaction between partners. He will inform the coordinator in case of problems and report to the Project Management Board.

As project manager, Mr Cumming's tasks will include:

- Contract and financial administration activities;
- Coordination and organisation of the progress meetings;
- Relation with the European Commission services: preparation and submission of periodic and final reports, payments and general communication;
- Decision with the partners on possible modification in the project planning (to be also submitted to the European Commission services);
- Transmission of the payments to each partner, in function of their involvement;
- Processing of the deliverables before submission to the EC, in compliance with the Guidelines for reporting (http://cordis.europa.eu/fp7/project-management.htm).

Project management board
The project management board will consist of one representative of each consortium partner. These members will also represent the WPs, as each institution takes the lead role in at least one WP. It is chaired by the Scientific Coordinator. The management board will make decisions on the overall project strategy, progress, major revisions (if needed), financial matters, and establish continuous internal and external exchanges and information dissemination.

The Project Management Board will be essential in the definition of technical quality standards, and will react to the recommendations of the Advisory Board. An important effort will be devoted at the beginning of the project in order to reach a good understanding of the project objectives and tasks from the very beginning.

Project Advisory Board
A selection of external experts from the policy and scientific communities will constitute an Advisory Board for the FEMHealth project. The objective of this board will be to give an external point of view on the project advancement and quality.

The Advisory Board will:	**Date of reception or event**
Comment on all major deliverables (Concise written comments expected within 15 days after reception of the deliverable)	All as in project plan
Will be involved in the consultation process (and invited to some of the project workshops)	M4, M12, M24
Advise the project team at key steps of the project	Milestones as identified in project plan
Will be involved at the end of project dissemination events as speakers or chairs	M34
Will support the dissemination of the results	By giving the project results access to their own networks.

The Advisory Board members will receive all the FEMHealth project deliverables and may give their comments on all of them. Their comments and recommendations will be duly taken into consideration and discussed during the Management board meetings.

Advisory board members will mainly work as single contributors but their regular exchanges between members on the deliverables' quality and the project advancement will be fostered. Teleconference meetings of the Advisory Board will be arranged as necessary, but as a minimum at the beginning of the project (M1) and annually (M12, M24) and as part of the dissemination function (M34)

The Advisory board can potentially be composed of:

- Senior academic researchers with expertise in maternal health
- Academics with expertise in the evaluation of complex policy implementation and policy analysis
- Representatives from relevant international organisations and networks
- Representatives of focal countries

The Project Advisory Board members will be nominated at the beginning of the Project.

Work package management

Each work package will have a WP leader who will be responsible to the management for:

- The delivery of work package milestones within time and financial restraints;
- The production of deliverables as planned in the work packages;
- Supporting the coordinator with the preparation of the WP reports.

Frequent and high quality communication between the WP leaders and the coordinator will be essential to the appropriate WP work and thus to the overall project success.

Project meetings

Regular meetings will allow the assessment of the progress within each WP and to link the WPs to each other, following a presentation of the key results by the WP leaders. Monitoring will be primarily focused on progress towards agreed objectives and deliverables especially in terms of their relevance for policy development within developing countries. The final meeting in Ouagadougou, Burkina Faso, is a key point in the project enabling synthesis of tools and findings into the final reports and deliverables, alongside dissemination of project outcomes.

The Management Board meetings will be held at least every 6 months, from M1 (kick-off meeting) to M36. It is anticipated that these meetings should be no longer than one full working day. To minimise the costs of these meetings, the Management Board meetings will take place back-to-back to workshops planned in the project, or by teleconference.

Communication

Day-to-day communication among partners will be ensured by electronic mail and telephone conversation. E-mail messages including important decisions on the WP outcome will be copied to the coordinator to ensure continuity of project management.

From previous multi-disciplinary and international project management experiences, the coordinator and project partners are very aware that good communications among members of the Project Management Board are of prime importance and that regular project meetings (see time-table above) are essential if project objectives and deliverables are to be met on time and strongly linked to policy and scientific communities.

Project advancement control

For each deliverable, a list of intermediary outputs and milestones, for each partner, will be prepared by the WP leaders, in consultation with WP 1. The submission of these outputs and the achievement of the milestones will be considered as indicators to control the project advancement. Both will be a tool for the project team to have a clear view on the common understanding of the project outcomes and for Dr Witter to monitor the work progress as planned in the WPs' description.

In addition, regular communication and meetings among WP members and the coordinator will enable a clear vision on the work progress achieved and will help to apply necessary corrective actions when the indicators and milestones are not achieved. The Project Manager will provide a template for the outputs and deliverables to ensure a homogenous and well structured layout of the reports.

The Scientific Coordinator, with support from the Project Manager, will also prepare the periodic and final reports for the Commission (M18, M36). These reports will be prepared and submitted following the Reporting Guidance notes available at http://cordis.europa.eu/fp7/project-management.htm.

Project follow-up

A knowledge management system will be developed to improve the information and documents sharing among the partners. This system will allow:

a) to share documents through the Internet (documents will be uploaded and downloaded in a remote archive)

b) a workflow system to be adopted in order to make possible a better coordination of planning and partners work. Every partner will be aware of the overall work to be executed and the one carried out at any time.

The knowledge management system is an internal web site (Private Intranet). Only partners, EC representatives and Advisory Board members will be permitted to enter the site. The following information and functions will be provided:

- Presentation of the general progress
- Information for the Commission and the management board
- Financial progress
- Technical and administrative progress
- Information dedicated to the partners

Quality management

The Scientific Coordinator and the project manager will pay particular attention to the quality of the work performed. An important effort will be devoted to the preparation of the kick-off meeting in order to reach a good understanding of the project objectives and task from the very beginning. Dr Witter will elaborate the format of each deliverable. At each management meeting, a review of the quality level of the work delivered by each partner will be performed, and the Advisory board comments will be studied. If quality of work is judged insufficient by the Scientific Coordinator, the Management board or the Advisory board, corrective actions will be implemented.

Financial management

The project manager will provide the overall financial management of the project, supported by an accountant. The project manager will ensure, on behalf of the scientific coordinator, the timely and comprehensive reporting to the European Commission. All accounts within FEMHealth will be open to internal and external audits.

To ensure homogenous and precise financial reporting, the project manager will provide the partners with a table on the planned and used manpower and resources to control work time and budget consumption on each WP. For each financial period (18-months), the management report will include, according to the EC Reporting Guidance notes, a detailed justification of the costs incurred and of the resources deployed by each contractor, compared to the initial budget and work plan.

Involvement of decision-makers from research countries

We will seek representation of the focal research countries on the advisory board. In addition, guidelines will be produced for in-country engagement with policy-makers, so that their priorities are reflected in the research, and so that they are also involved in its conduct and outputs. The third arm to our engagement with local stakeholders will be through the Community of Practice, which plans a continuous dialogue on technical and practical issues relating to these policies in the region.

Interaction with European Commission Services/Agencies

In the context of the policy relevance of the research being carried out, the consortium will use or set an appropriate mechanism to ensure dialogue with Commission policy-makers and to guarantee regular and appropriate contacts with relevant Commission services/agencies. This may include, inter alia, meetings in Brussels, regular briefings and informal contacts between the consortium and relevant Commission services. Any such contacts should involve the Project Officer.

Addition of partners during project lifetime

It is not anticipated that there will be additional partners joining during the project's lifetime. The addition of partners would imply the need for additional resources. If opportunities arise to bring in additional resources and/or partners, these will be discussed in advance with the project desk officer.

Following internal issues with Partner 6, CAREF, a new partner from Mali was introduced to the project – partner 9, Marikani. CAREFs input to FEMHealth ended in month 13, with Marikani continuing the Mali based activity on work packages 5 and 8 from month 14. All of the staff employed on FEMHealth from Marikani were former CAREF employees, so were fully informed and engaged from the onset of Marikanis involvement.

B 2.2 Beneficiaries

Participant 1. University of Aberdeen, UK

The University of Aberdeen will be responsible for leading WP 1 (Management and Coordination) and WP 2 (Health Policy, Finance and Economics).

The UoA has an outstanding history of pioneering discoveries which have changed thinking and practice in medicine, science, arts and humanities over five centuries. Aberdeen performed outstandingly in the UK's most recent Research Assessment Exercise (RAE2008) with 89% of research activity assessed as international quality and 55% is 'world-leading' *or* 'internationally excellent'. Its health services research was recently rated as the equal first of all UK institutions.

The staff participating within this bid are based within IMMPACT - the Initiative for Maternal Mortality Programme Assessment (http://www.immpact-international.org/). Immpact is a global research initiative whose aim is to promote better health for mothers to be in developing countries. It has recently been involved in evaluating national strategies to reduce maternal mortality in a number of countries, including Burkina Faso, Ghana and Indonesia. IMMPACT is based within the Institute of Applied Health Sciences. There are currently over 350 members of the IAHS, working on areas such as public health, child health, obstetrics and gynaecology, health economics and health services research.

Previous relevant experience

Dr Sophie Witter is a health economist with 20 years of experience in developing and transitional countries. For the last four years she has contributed to the Immpact project at the University of Aberdeen, an international research initiative strengthening the evidence base for reducing maternal mortality. As a research fellow, her specialist area is health policy, finance and systems. Her particular area of responsibility has been the evaluation of the impact of removal of user fees on access to maternity care. Focal countries for this work were Ghana and Senegal. She recently completed a PhD on exemptions policies for delivery care, and edited a book on obstetric financing. She is currently involved in a range of activities relevant for this proposal, including leading a multi-disciplinary team evaluating a pilot free care project in the Democratic Republic of Congo and working with the Supporting Safe Motherhood Programme in Nepal to monitor the impact of the free delivery policy which was recently introduced there. Sophie has previously done a number of studies of household ability to pay for health and coping strategies, including in Burundi in 2003 and in Sudan in 2005. She is francophone.

Dr Witter will act as scientific coordinator for the project, as well as leading Work Package 2 on health policy and financing. In addition, the services of a programme manager (Mr Alec Cumming), a communications specialist, an administrator and an accountant will be contributed by the University of Aberdeen. The programme will also benefit from the many maternal health specialists based at Immpact, such as Professor Wendy Graham, who will be able to contribute their knowledge and support to the consortium.

Some recent publications:

Witter, S., Service- and population-based exemptions: are these the way forward for equity and efficiency in health financing in low income countries? *Advances in Health Economics and Health Services Research* (2009**),** vol. 21, p. 249-286. Innovations in health systems finance in developing and transitional economies. Eds. Dov Chernichovsky and Kara Hanson.

Witter, S., Adjei, S., Armar-Klemesu, M. & Graham, W. (2009) Providing free maternal health care: ten lessons from an evaluation of the national delivery exemption policy in Ghana. *Global Health Action*, vol. 2 (http://journals.sfu.ca/coaction/index.php/gha/issue/current*).*

Witter, S, Richard, F, De Brouwere, V. (2008) Learning lessons and moving forward: how to reduce financial barriers to obstetric care in low-income contexts. In 'Reducing financial barriers to access to obstetric care', edited by Richard, F., Witter, S. and De Brouwere, V. *Studies in Health Services Organisation and Policy* series. Antwerp: ITG Press.

Participant 2. Institute of Tropical Medicine (ITM), Belgium

The ***Institute of Tropical Medicine,*** Antwerp, Belgium (ITM) has a long record of research on health service organisation, health sector reform and health care financing in a variety of countries, including in the countries of study. It organises an international Master in Public Health (MPH) focusing on health care systems management and health policy. Participants are mainly health managers and policy makers from Africa, Asia and Latin America. ITM has identified a strong multidisciplinary research team for this project.

Two units of the department of Public Health are involved in this research:
1. Quality and Human Resources Unit (Q&HR), which will be leading the work package on local health systems
The Q&HR Unit aims at contributing to better health care services and systems in LMIC through research, education and services. Q&HR research focuses on the management of health care organisations (HCO), by which we understand any organisation responsible for organisation or provision of health care and services. Currently, research themes include: organisation of the management of chronic diseases, strengthening policies for effective local health systems, health workforce and health service management, safe motherhood and reproductive health policy.

Vincent De Brouwere is a Public Health medical doctor, reader at the Institute of Tropical Medicine, Antwerp (ITM-A), and, from October 07 to September 10, Director of Research based at IRD-INAS, Rabat, Morocco. He has a field experience of 15 years in Developing Countries (7 years in ex-Zaire; then 5 + 3 years in Morocco). His main field of research interest is the health care system, with a particular focus on maternal health and the quality of care, including the management of human resources required for the good functioning of health systems. His role in FEMHealth will be to lead the WP3 and to participate in the overall WP3 development and implementation. He will be a link person for the Moroccan team.

Fabienne Richard is registered midwife who specialised in tropical medicine and public health (MSc). She has 10 years experience as clinical midwife and a field experience of 5 years in developing countries (Kenya, Somalia, Sri Lanka, Afghanistan, Burkina Faso). Her field of research is maternal health, access to health care and quality of care. She recently coordinated the writing of a monograph on financial barriers to obstetric care (see www.itg.be/shsop). She is currently doing a PhD on access to quality C-section in Africa. She will be involved in the implementation of the WP3 (leading the rapid assessment and POEM development, and contributing to the realist studies) and will be a link person for the Malian team.

Bruno Marchal is a medical doctor who specialised in public health (MD, MPH).
He managed a district hospital in Kenya for 4 years and has done research in healthcare management in Ghana, Kenya, Tanzania and Zambia. He is currently doing a PhD study on strategic management and performance of hospitals in Africa, in which he applies realist evaluation as a methodology to deal with complexity. He would lead the development of the WP3 realist case study development and the comparative analysis of the realist evaluation results.

Dominique Dubourg is a general practitioner and demographer. She worked for eight years for Médecins Sans Frontières Belgium, mainly in Guinea-Conakry. She has been working at the Institute of Tropical Medicine since 2000. Her research interests are maternal health, reproductive health, quality and access to obstetric care. She is the international coordinator of the Unmet Obstetric Need Networks which provide support to researchers or national teams for the elaboration of UON adapted protocols, data collection, quality control and analysis.

Some recent publications:

Hounton S, Menten J, Ouédraogo M, Dubourg D, Meda N, Ronsmans C, Byass P, De Brouwere V. 2008. Effects of a Skilled Care Initiative on pregnancy-related mortality in rural Burkina Faso. *Tropical Medicine & International Health* **13**, Suppl.1, 53-60

Hounton S, Newlands D, Meda N, De Brouwere V. 2009. A cost effectiveness study of caesarean-section deliveries by clinical officers, general practitioners and obstetricians in Burkina Faso. *Human Resources for Health*, **7:**34

Koblinsky M, Matthews Z, Hussein J, Mavalankar D, Mridha M, Anwar I, Achadi E, Adjei S, Padmanabhan P, Marchal B, De Brouwere V, van Lerberghe W (2006). Going to scale with professional skilled care. Lancet, 368, 1377-1386.

Marchal, B. & Kegels, G. (2008) Focusing on the software of managing health workers: What can we learn from high commitment management practices? International Journal of Health Planning and Management, 23, 299-311.

Marchal, B., Cavalli, A. & Kegels, G. (2009) Global health actors claim to support health system strengthening - Is this reality of rhetoric? PLoS Medicine, April, e1000059.

Richard F, Ouédraogo C, Compaoré J, Dubourg D, De Brouwere V. 2007. Reducing financial barriers to Emergency Obstetric Care in Burkina Faso: cost sharing mechanisms. *Tropical* Medicine & International Health 12, 972-81.

Richard F, Ouedraogo C, De Brouwere V. 2008. Quality cesarean delivery in Ouagadougou, Burkina Faso. A comprehensive approach. Int J Gynecol Obstet. 103, 283–290

Richard F, Witter S, De Brouwere V. 2008. *Financial barriers to obstetric care in low income countries*. Studies in Health Services Organisation & Policy, **24***,* ISBN 9789076070339 Antwerpen, ITGPress, 304p

2. Health Policy and Financing Unit, which will be leading the Community of Practice

The research, teaching and service provision of the unit are aimed at the development, in a complex globalising world, of high-quality, pluralistic and accessible health care systems. The area of activity of the unit encompasses the broad field of health systems in developing countries, with special emphasis on health policy at national and international level on the one hand, and financing of health care on the other.

Dr Bruno Meessen is a health economist, who has a great deal of practical experience with the design of health sector reforms and their analysis. He frequently provides expertise to governments and international agencies through consultancies, expert meetings or policy technical notes. He was the coordinator of a recent review of user fee removal reforms in sub-Saharan Africa for UNICEF. His research portfolio focuses on new institutional economic analysis applied to public health sector in low-income countries, access to health care, health care financing schemes and performance-based financing.

Catherine Korachais is a member of the research staff in the Unit of Health Economics at ITM

Some recent publications:

Meessen, B. 2009. *Removing user fees in the health sector in low-income countries: A policy guidance note for program managers*. UNICEF, New-York.

Meessen, B., Hercot, D., Noirhomme, M., Ridde, V., Tibouti, A., Bicaba, A., Tashobya, C. K. & Gilson, L. 2009, *Removing user fees in the health sector: a multi-country review*, UNICEF, New-York.

Meessen, B., Van Damme, W., Tashobya, C. K., & Tibouti, A. 2006b, "Poverty and user fees for public health care in low-income countries: lessons from Uganda and Cambodia", *Lancet*, vol. 368, no. 9554, pp. 2253-2257.

CV and publications of the staff involved in this research can be found on:
http://www.uonn.org/uonn/CVunit.htm

Participant 3. The London School of Hygiene & Tropical Medicine (LSHTM), UK

The LSHTM will be primarily responsible for WP 4 (impact of health outcomes and quality of care) and the health policy component of WP 4 (health policy and finance.

The LSHTM is Britain's national school of public health and a leading postgraduate institution worldwide for research and postgraduate education in global health. Part of the University of London, the London School is the largest institution of its kind in Europe with a remarkable depth and breadth of expertise encompassing many disciplines. It is one of the highest-rated research institutions in the UK.

The staff members who will be undertaking the work are based in the Maternal and Neonatal Group within the Department of Epidemiology and Population Health. The Department of Epidemiology and Population Health, with almost 300 staff and over 125 research students, conducts methodologically rigorous and innovative research to inform the understanding of diseases and to provide evidence for decision making in public health. The Maternal and Neonatal Group comprises anthropologists, health economists, statisticians, epidemiologists, and demographers.

Previous relevant experience

The Maternal and Neonatal Group has extensive relevant experience carrying out research to contribute to, and inform, international debate on key policy issues related to the health of young children and their mothers. This includes epidemiological research of maternal and newborn health and research on specific interventions and service content to improve maternal and neonatal care and development of methods for monitoring and evaluation of maternal and neonatal health programmes. The group also has experience conducting social scientific research on health policy and health system issues. The group has established partnerships in Benin and Burkina Faso (as well as in many other countries). The group's principal funders include the UK Department for International Development (DfID), European Union, Wellcome Trust, Economic and Social Research Council (ESRC) and Immpact.

Carine Ronsmans is professor of epidemiology with degrees in medicine, demography and epidemiology and has been working on maternal health within the LSHTM since 1993. She has relevant expertise in the methodological and conceptual aspects of the evaluation of maternal and perinatal health programmes and the measurement of maternal morbidity and mortality. She has experience working in Benin and Morocco, as well as other countries. Professor Ronsmans has received EU funding before. She was the principal investigator for a feasibility project on near-miss audits to improve the quality of obstetric care in referral hospitals in Morocco, Benin and Cote d'Ivoire financed by the INCO DC funding programme of the EU. She is also collaborating on a trial of audits funded by the EU FP6 (please see http://www.lshtm.ac.uk/ideu/mp/audobem/). Her details and publications can be found at: http://www.lshtm.acuk/people/ronsmans.carine.

Veronique Filippi is senior lecturer with degrees in demography and epidemiology and is deputy director for the DFID funded Research Programme Consortium 'Towards 4+5' on maternal and neonatal health. She has relevant experience in the measurement of reproductive and maternal morbidity and its consequences in developing countries; learning from near-miss events in health services; and improving quality of obstetric care through audit. She has extensive research experience in Burkina Faso and Benin. Her details and publications can be found at: http://www.lshtm.ac.uk/people/filippi.veronique

Carine Ronsmans and Veronique Filippi will lead WP4 together. Veronique will act as link person for one or two African partners.

Isabelle Lange is a Research Fellow in Social Anthropology whose research interests lie in the choices surrounding health care and well being; the framing, understanding and transfer of health policy; personal and institutional responses to change; and the interplay between different beliefs and health systems

Jenny Cresswell is an epidemiologist with research interest in reducing unintended pregnancies, the measurement of maternal morbidities, and methods for evaluating complex interventions.

Participant 4. AFRICSanté, Burkina Faso

AFRICSanté (ex- GREFSaD) is an association working in technical advice, research, and training in health. It offers a multidisciplinary team qualified in: demography, sociology, anthropology, public health, health economics, epidemiology, statistics, data bases management, research outcomes and evaluation, communication and management. AFRICSanté is member of the network of Immpact, as well as of its consulting wing, IPACT, and partner of Towards4+5, financed by the DFID. Among others institutions AFRICSanté has collaborated with LSHTM, University of Aberdeen, Macro International, WHO AFRO, Handicap International, and WAHO/OOAS.

AFRICSanté will lead the research in Burkina Faso, while also contributing to the development and use of economic tools in the other focal countries, and to dissemination of findings.

Nicolas MEDA, MD, PhD, HDR, is President of the organisation **and** Medical Doctor. He has a PhD in epidemiology, and is Director of the Department of Epidemiology and Public Health of the Centre MURAZ. He will lead the team in this WP.

Rasmané GANABA, DvM, PhD, is Executive Director of AFRICSante. He is an epidemiologist, and graduate of the University of Dakar (Senegal) and of the University of Montreal (Canada). He will be leading the quality of care and health outcomes component of the work.

Maurice YAOGO, PhD is a Socio-Anthropologist**.** He graduated from the University of Ouagadougou, the University of Nancy II and of the School of High studies in Social sciences of Marseilles in Social anthropology. He will lead the health policy and the household qualitative components of the programme.

Patrick Ilboudo is a health economist who studied in France for a DESS (MPhil). He is currently working on two projects: one funded by the EU on cost-effectiveness, the other funded by Hewlett/ESRC on the consequences of obstetric complications. In this consortium he will be leading the household cost and facility costing components within WP2, as well as leading health financing research in WP 6.

Cheick Omar Diallo is a public health physician, in charge of collecting WP3 quantitative data and supervising WP4 data collection by hospital staff.

Moctar Ouédraogo is a demographer and social scientist, involved in conducting HWIS interviews.

Henri Somé is a IT manager, in charge of programming templates for data entry, supervising data entry, cleaning data bases.

Brahima Diallo is a social scientist, involved in coding qualitative interviews with Nvivo and analyzing and reporting for WP3 tool.

Examples of key references include:

1. Graham W.J., Conombo S.G., Zombre D.S., Meda N., Byass P. and De Brouwere V. Undertaking a complex evaluation of safe motherhood in rural Burkina Faso. *Tropical Medicine and International Health* 2008 volume 13 suppl. 1 pp 1–5.

2. Meda N., Hounton S., De Brouwere V., Sombie I., Byass P., on behalf of the IMMPACT Burkina Evaluation Study Group. From evaluating a Skilled Care Initiative in rural Burkina Faso to policy implications for safe motherhood in Africa. *Tropical Medicine and International Health* 2008 volume 13 suppl. 1 pp 68–72.

3. Storeng K.T., Baggaley R.F., Ganaba R., Ouattara F., Akoum M.S., Filippi V. Paying the price: the cost of emergency obstetric care in Burkina Faso. *Social Science & Medicine* 2008; 66: 545-557.

4. Filippi V., Ganaba R., Baggaley R.F., Marshall T., Sombié I., Ouattara F., Ouédraogo T., Akoum M., Meda N. Health of women after severe obstetric complications in Burkina Faso: a longitudinal study. *The Lancet* 2007; 370: 1329-1337.

Participant 5. CERRHUD, Benin

CERRHUD was founded in 1987 with funding from the Human Reproduction Programme at the World Health Organization. The centre has participated in several international studies including an INSERM-coordinated multi-country study on complications of the first trimester of pregnancy and risk factors for unsafe abortion and a study coordinated by the Institute of Tropical Medicine (Antwerp) on the heterogeneity of HIV in four African cities. CERRHUD was a partner in an earlier project field testing near-miss audits in North and West Africa funded by FP5 INCO DEV and has since participated in scaling up activities towards the routine implementation of audits in hospital practice. At the moment, CERRHUD is involved in a very large RCT of near-miss and criterion based audits, which involves 16 hospitals in Benin (finishing end of 2010) and funded by FP6 INCO DEV.

CERRHUD will lead the research and dissemination in Benin.

The staff involved in this project will include:

- Dr Sourou GOUFODJI: she is a field epidemiologist/reproductive health specialist. She has several years experience in running projects. She will assume the managerial responsibilities for the project in Benin and oversee the collection of data on near-miss events and quality of care indicators.
- Lydie KANHONOU: she is a senior social scientist who has worked on several international projects. Her main areas of responsibilities will include the preparation and management of the implementation of interviews and participant observations, training of interviewers, supervision of collection of qualitative data and analysis of qualitative data on health policy.
- Schadrac C. Agbla is a statistician at CERRHUD since March 2010. He has some years of experience in the field of Biostatistics and Epidemiology and is involved in research in maternal and newborn health. He currently performs statistical analyses of data on the AUDOBEM and FEMHEALTH projects. Since April 2010, Shadrach assists with the Econometrics Qualitative Variables course at the National School of Applied Economics and Management in Cotonou and teaches the practice of econometrics qualitative variables in STATA.
- Adébayo G.Oscar TONOUHEOUA is a Medical Doctor and member of the research team at CERRHUD. His role is Clinical Data Monitor on the FEMHealth project.
- Jean Paul DOSSOU is a Medical Doctor and member of the research team at CERRHUD. He followed the European Course in Tropical Epidemiology in Berlin in 2011, the course on Qualitative and Mixed Methods Research in International Health in Antwerp and intensive training of Emerging Voices of Health Research in Beijing in 2012. He was assigned to the project AudObEm (Audits of Obstetric Emergencies) as Clinical Data Monitor and the FEMHealth (Fees Exemption in Maternal Health) project as a maintainer of activity devoted to assessing the effects of policy of free caesarean section in the local health system in Benin. He is also a member of the Global Health System organisation since September 2012 and is currently a student of Master in Public Health at the Institute of Tropical Medicine in Antwerp.
- Charles Patrick MAKOUTODE is a Health economist and specialist in Public Health research at the Regional Institute of Public Health (Benin) and the African University of Cooperative Development. Charles is responsible for the quantitative part of WP2 FEMHealth since 2011. He has particular expertise in: economic evaluation of health interventions, micro health insurance, health financing and planning of health interventions.

Examples of key references include:

1. Filippi V, Brugha R, Browne E, Gohou V, Bacci A, De Brouwere V, Sahel S, GOUFODJI S, ALIHONOU E, Ronsmans C. How to do (or not to do) … Obstetric audit in resource poor settings: lessons from a multi-country project auditing 'near miss' obstetrical emergencies. *Health Policy and Planning*. 2004; **19**(1), 57-66.
2. Grossmann-Kendall, F., Filippi V., De Koninck M., KANHONOU L. 2001. Giving birth in maternity hospitals in Bénin: Testimonies of women, *Reproductive Health Matters*, 2001; 9 (18): 90-98.
3. ALIHONOU E., GOUFODJI S. et al., 1996. "Morbidity and mortality related to induced abortion (A study conducted in hospitals of Cotonou, Benin in 1993)" *African journal of fertility, sexuality in Reproductive health* 1(1): 58-65

4. Filippi V, Ronsmans C, Gohou V, GOUFODJI S, Lardi M, Sahel A, Saizonou J, De Brouwere V (2005). Maternity wards or emergency obstetric rooms: incidence of near-miss events in African hospitals. *Acta Obstetricia et Gynecologica Scandinavica* 84(1):11-6
5. Behague D, KANHONOU LG, Filippi V, Ronsmans C, Legonou S. Pierre Bourdieu and transformative agency: A study of how patients in Benin negotiate blame and accountability in the context of severe obstetric events. *Sociology of Health and Illness.* 30 (4).
6. Fottrell E, KANHONOU L, GOUFODJI S, Behague D, Marshall T, Patel V, Filippi V. Risk of psychological distress following severe obstetric complications in Benin: the role of economics, physical health and spousal abuse. Accepted in *British Journal of Psychiatry*

Participant 6. Centre d'Appui à la Recherche et à la Formation (CAREF), Mali

CAREF is an independent research and consulting group based in Bamako, Mali. CAREF provides high quality policy analysis on the socioeconomic aspects of health. To date, CAREF has led 60 studies of which 46 relate specifically to health. CAREF works in partnership with research institutions, academic institutions, and nongovernmental organizations. In six years of existence, CAREF has worked with or performed services for 42 organizations throughout the world. CAREF is currently working with the National Directorate of Health of Mali on evaluation of free Caesarean section policy and fee exemption for the treatment of malaria in Mali for the under 5s.

CAREF will lead the FEMHealth research and dissemination work in Mali until M12.

Mamadou Kani Konaté is a senior sociologist with 33 years research experience using qualitative and quantitative techniques. His research for international organizations has covered the health sectors. He has designed and implemented Mali first national Demographic and Health Survey (DHS) and analyzed and published the results. He is former Member of two WHO Geneva Committees: Research Strengthening Group - RSG (2001-2003) and Strategic Social, Economic and Behavioural Research - SEB (2003-2004). He was also Chairperson of the WHO Geneva 'Committee "Research Capability Strengthening Plus (RCS+) for Health Social Sciences in Implementation Research for Tropical Diseases Control" (2003-2006). He will lead WP8 and will supervise the qualitative components of the WP.

Mouhamadou Gueye received his PhD in Demography in 1987 at University of Pennsylvania Philadelphia, PA. USA. His research topics have covered a variety of reproductive health issues, including research methods for reproductive health, adolescent reproductive health and the dynamics of family life and school attendance. He is directing a project (GESTA) which started two years ago and which should over four years collect information on about 200.000 deliveries in 22 hospitals in Mali. He will be in charge of the implementation of the health outcomes component and near miss study.

Professor Mamadou Traoré is specialized in gynaecology obstetrics and senior lecturer at the faculty of Medicine. Since November 2003, is the head doctor of the district reference health centre (CSREF) of the commune V in Bamako City. This centre is the largest in terms of number of births in Bamako (on average 8000 per year). Pr. Traoré collaborates with the CAREF in the project QUARITE (l'Essai QUAlité des soins, gestion du RIsque et TEchniques obstétricales dans les pays en développement) documenting maternal mortality over a period of 4 years by collecting information on 50,000 deliveries per year, based on a national sample of health centres. He will be in charge of the health system component (POEM study and realist evaluation).

Dr Doufain Traoré is a medical doctor and a health economist. She's got a Master in Health economics and Public Health. Dr Doufain was resident at the district reference health centre of the Commune V in Bamako where she in charge of consultations and Emergency Obstetric Care. She is the coordinator the project QUARITE at CAREF. He will be in charge of the implementation of the financing component of the project

Assima Amidou is an economist and statistician. After a licence in Mathematics at the University of Lome and a training of engineer at the National High School of Statistics and Applied Economics of Abidjan, he did a professional training at the Directory of Statistics and National accounts. His background in Econometrics and macro-economics models led him to participate to several studies in Côte d'Ivoire, Benin and Togo. He was in charge of the statistics lectures at the Catholic University of Lomé. In CAREF, he is in charge of study design and sample calculation. He will be in charge of the data management of the project.

Participant 7. National Institute of Health Administration (INAS), Morocco

The National Institute of Health Administration (INAS) is funded by the Ministry of Health and is in charge of training and research in public health and health administration. It has a leader role in promoting and carrying out health system research for the Ministry of Health. INAS is a World Health Organization collaborative centre since 1994 (http://www.sante.gov.ma/Departements/inas/index.asp).INAS' mission, as defined by the ministry of health, is 1°) to develop initial (MPH) and continuous training programs in health program management and health care management 2°) to develop the expertise and technical support in public health and health care management 3°) to undertake research in the domain of the health system 4°) To ensure the dissemination of the information related to its expertise 5°) to monitor the training needs of health professionals and 6°) To develop South–North and South-South collaboration in public health and health administration (research and training).

INAS will lead the FEMHealth research and dissemination work in Morocco.

Abderrahmane Maaroufi is Professor of epidemiology and public health, Head of the Public Health Department at the Faculty of Medicine, University of Casablanca and director of the National Institute of Health Administration. He graduated from the University of Montreal, and is a WHO expert in evaluation, a 'Partners in population and development' expert and an evaluator of research projects supported by the Spanish cooperation. He coordinated many national and international projects such as 'Promotion of physical activity by using marketing methods (Development of multifaceted intervention)'; Co-investigator of the 'Promotion of Clinical Prevention program in Quebec (Canada)'; Epidemiological studies in the field of HIV, HTLV, Viral hepatitis C, Urinary disorders, obesity; Evaluation of the National Health Care Quality Assurance project; Evaluation of the quality of health care in public hospitals; Arabic Translation and trans-cultural validation of Short-Form Health Survey (SF-36). Pr Maaroufi will supervise the research teams and lead the organisation of national and international events.

Amina Essolbi is a medical doctor with an MPH (Boston University) who has worked for 5 years as medical officer before being recruited by USAID-Morocco as health care specialist (1994-98). Then she joined INAS in 1994 where she is a lecturer. She also teaches in different national and international short courses (VIH-AIDS, Ipact, continuing training) matters in relation to planning, project elaboration and epidemiology. She coordinates a 6-month course in advanced epidemiology and disease surveillance. Her current domain of research is related to the role of home caregivers for diabetic patients. She will lead the WP3 on realist evaluation and share her epidemiological skills for WP4.

Hind Filali is a psycho-social scientist (University Paris V). After two years as psycho-sociologist at the Directorate of Population, MOH, she joined INAS in 1992. She led the implementation of the qualitative part of three major EU-INCO researches in Morocco (STD3 on children health seeking behaviour; STD3 on referral and counter-referral; INCO-DEV on near miss cases). Then she worked at CERED from 2000 until 2006 (as a sociologist research) before coming back to INAS in 2006. She is co-author of several articles in relation to the research mentioned above and led the publication of several reports in relation to adolescent reproductive health, abortion, and VIH. She will lead the qualitative work in Morocco.

Hafid Hachri is a medical doctor with a MPH (INAS). He worked as medical officer in a rural district 5 years before joining the Directorate of Hospitals and Ambulatory Care in 2004 where he coordinated an important program (25 million €) on regionalization and strengthening of basic health services. He joined INAS in 2008 to start a PhD on Family medicine and quality of care in health centers. He is a lecturer in different modules taught in the INAS MPH course and coordinates a short course on planning, contracting and evaluating budgets. Dr Hachri will help the WP3 as a resource person for realist evaluations.

Bouchra Assarag is a medical doctor with a certificate in STI/HIV (University of Rabat), a certificate in sport medicine (EHESS Rennes) and a MPH (INAS). She worked as medical officer in a rural district 6 years before joining INAS in 2008 to start a PhD on maternal morbidity. She is an active member of civil associations in the domain of adolescent health, HIV, and family planning. She participated to several studies (national study on burden of diseases, mandatory declaration of diseases in the private sector, the quality of management of STI in the public

sector, children infected and affected by HIV). In INAS, she coordinates a short course on project management in the domain of HIV. Dr Assarag will lead the WP4, focussing on the near miss epidemiological survey.

Amina Abaacrouche is a medical doctor with a MPH (INAS). She has a field experience of 10 years in a rural hospital. Then, she joined the Directorate Population in Rabat where she coordinated an EU partnership program on family planning (93-97) and the monitoring of emergency obstetric care (98-03). She contributed to the writing of many guidelines in the domain of safe motherhood and family planning. She became head of Family Planning Division in 2004 before joining INAS in 2007. In INAS, she is a lecturer of different modules related to safe motherhood, basic concepts in public health and family planning. She coordinates an international short course on maternal and neonatal health (Ipact). She is leading research on maternity waiting homes. Dr Abaacrouche will contribute to WP3 and 4.

Chakib Boukhalfa is a newly recruited assistant professor at INAS. He is an economist graduated from the Université de Bourgogne (Dijon, France), where he obtained his doctorate in economic sciences in 2008. He will coordinate the research project and will work on the financial part of WP2.

Prof. Mohammed Ababou is a sociologist, primarily working in research on health and disease, reproductive health, maternal and child health, chronic diseases and religious beliefs in health, most recently focusing on disease and health vulnerabilities.

Participant 8. IRSS, Burkina Faso

The Institute of Research in Health Sciences (IRSS) is a specialized structure of the National Centre of Scientific and Technologic Research (CNRST). CNRST is a state-owned scientific, cultural and technical institution (EPSCT), in charge of scientific and technological research. It was created in 1997. It has legal capacity and financial autonomy. IRSS is one of the four institutes of the Centre and has the responsibility:

- to undertake research providing solutions to the health priority problems of the country
- to coordinate research in the Health sector in Burkina Faso
- to make use of and disseminate the research findings

IRSS has established, in August 2007, a demographic surveillance site in Kaya (KADESS) in the north part of Burkina Faso. This site covers a population of 48 131 people and will serve as platform of research on HIV and reproductive health. The current director of IRSS is Professor Blaise SONDO.

For FEMHealth, IRSS's main role is to develop the Community of Practice in the region.

Study participants:
Seni Kouanda, MD, PhD is a senior researcher, head of HIV/AIDS and reproductive health unit, site leader of Kaya Demographic and Epidemiological Surveillance system (Kadess), head of public health department. Dr Kouanda will lead in the development of the CoP in the region.

Dr Ridde Valéry is an associate researcher at the IRSS in charge of various research projects concerning the access for health care to the worst-off. VR is the co-principal investigator with JP Olivier de Sardan (LASDEL, Niger) for a research programme concerning the user fees abolition in Niger, Mali and Burkina Faso. With Dr Kouanda (IRSS) and Dr Yaogo (AFRICSanté) they are in charge of the Burkina Faso project. He was a part of the team directed by Dr Meessen for the UNICEF consultation on user fees abolition in Africa. Dr Ridde will support the development of the CoP in the region, and help to link FEMHealth with other relevant regional research efforts.

Abibo Kabore is the Head of Administration and Finance Department.

Kafando Yamba is the research assistant.

Some recent publications:
Ridde V. "The problem of the worst-off is dealt with after all other issues": The equity and health policy implementation gap in Burkina Faso. *Social Science and Medicine* 2008;66:1368-78.
Ridde V, Haddad S. Abolishing user fees in Africa. *PLoS Med* 2009;6((1): e1000008. doi:10.1371/journal.pmed.1000008).

Blandine Bila, Seni Kouanda, Alice Desclaux. Des difficultés économiques à la souffrance sociale des personnes vivant avec le VIH au Burkina Faso. Cahiers Santé vol. 18, n° 4, octobre-novembre-décembre 2008 ; 187-191.
Ridde V, Yaogo M, Kafando Y, Sanfo O, Coulibaly N, Nitiema PA, et al. A community-based targeting approach to exempt the worst-off from user fees in Burkina Faso. *J. Epidemiol. Community Health* in press.

Ridde V, Diarra A. A process evaluation of user fees abolition for pregnant women and children under five years in two districts in Niger (West Africa). *BMC Health Services Research* 2009;9(89 (3 June 2009) doi:10.1186/1472-6963-9-89).

Participant 9. Marikani, Mali

Marikani is an independent research and consulting organisation based in Bamako, Mali. Marikani provides high quality policy analysis on the socioeconomic aspects of health. To date, Marikani has led about 15 studies. All relate specifically to health, including those conducted within FEMHEALTH project. Marikani works in partnership with research institutions, academic institutions, and non-governmental organizations. In one year and half of existence, Marikani has worked with or performed services for 8 organizations throughout the world. Marikani is currently working with the National Directorate of Health of Mali on 2 studies on Family Planning. All staff involved in the newly formed FEMHealth team at Marikani are former employees of CAREF:

i) sociologist 1person 3pm wp2, wp4,wp8
ii) demographer 1 person 3pm wp3,wp4,wp8
iii) health economist 1 person 3pm wp2,wp8
iv) public health 1 person 2pm wp3,wp8
v) statistician 1 person 9pm wp2,wp3,wp4,wp8
vi) research assistant 1 person 9pm wp2,wp3,wp4,wp8
vii) information specialist 1 person 2pm. Wp3,wp4,wp8
viii) secretary 1 person 9 pm to coordinate the work across work programmes, to organise travel and events, to produce periodic project updates and to support M Konate in the direction of the team and the role in the project.

In addition to above, fieldwork carried out in four sites over a period of 12 months and contributes to 4 work packages – wps 2, 3, 4 and 8 required the input of 44pms of midwifery data collectors (12 people) to gather information on obstetric care and outcomes; 72 pms of input from HMIS data collectors (6 people) to gather information on activity in the sample sites and 14pms of input from RAs (4people) to collate and analyse the data. Two drivers (8pms) were needed to transport the data collectors to and from the sites, which were as geographically representative as possible, given the conflict in Mali.

Mamadou Kani Konaté is a senior sociologist with 33 years research experience using qualitative and quantitative techniques. His research for international organizations has covered the health sectors. He has designed and implemented Mali first national Demographic and Health Survey (DHS) and analyzed and published the results. He is former Member of two WHO Geneva Committees: Research Strengthening Group - RSG (2001-2003) and Strategic Social, Economic and Behavioural Research - SEB (2003-2004). He was also Chairperson of the WHO Geneva 'Committee "Research Capability Strengthening Plus (RCS+) for Health Social Sciences in Implementation Research for Tropical Diseases Control" (2003-2006).

Professor Mamadou Traoré is a GP specialized in gynaecology and obstetrics, and senior lecturer at the faculty of Medicine. He holds a professional post at URFOSAME in Mali. From 2007-2010 he was the head doctor of the district reference health centre (CSREF) of the commune V in Bamako City. This centre is the largest in terms of number of births in Bamako (on average 8000 per year). Following this, Pr. Traoré was engaged as Project Co-ordinator for QUARITE (l'Essai QUAlité des soins, gestion du RIsque et TEchniques obstétricales dans les pays en développement) documenting maternal mortality over a period of 4 years by collecting information on 50,000 deliveries per year, based on a national sample of health centres. He is currently involved in a study investigating post-partum haemorrhage and intrauterine tamponades. He will provide advice and supervision for the whole FEMHealth, but will focus on supervising the collection and analysis of data.

Kany Roseline Sidibé is a demographer and analyst with a Masters Degrees in Quantitative Economic Analysis and Policy, and in Demography. She has been involved in studies ranging from poverty and public spending, female genital mutilation in Mali and most recently has been assisting in studies targeting access to family planning services Mali in collaboration with the Norwegian Church Aid and the School of Public Health at Tulane University.

Dr Mamadou A. Traore is a GP trained at the University of Bamako, Mali. He served at the district reference health

centre (CSREF) (2007-2010) and then alongside other former CAREF colleagues was involved in the QUARITE study examining Quality of Care, Risk Management and Obstetric Techniques in developing countries (2010 -2012). He will participate in the design and supervision of the data collection for Work Package 4 in the FEMhealth project.

Zoumana Daou is a demographer, researcher and analyst. He has Masters Degrees in Development Geography, and in Demography as well as having completed an internship at the National Institute of Statistics (INSTAT) of Mali. His most recent work has been contributions to the quantitative and qualitative aspects of a clinical study into antenatal treatment of malarial parasites; and involvement studies to improve access to family planning services quality in Mali, sponsored by Norwegian Church Aid.

Ibrahima Gacko holds a BSc (Hons) in Mathematics, and also a Statistician Economist honours degree. He is an associate partner in MARIKANI, assisting in the design and undertaking of all studies utilizing his experience as a research assistant, a statistical officer with the Civil Service and a statistician at the National Institute of Statistics (INSTAT) of Mali.

Ndanna Maiga is an IT analyst with a Diploma in Applied Studies (Computer Information Systems) and Masters in Computer Science for Business Management and in Geographic Information Systems. He has 10 years' experience working in research and policy analysis for socioeconomic aspects of healthcare in 20 health studies, contributing to the development of applications, programs, input and management of databases.

B 2.3 Consortium as a whole

The proposed research project brings together a network of institutions with a track record in the evaluation of complex interventions. Some of these institutions have worked together in the past, but with different configurations, roles and responsibilities and on different evaluation questions. Each institution brings its expertise to develop new networks, to test new methodologies and to produce new knowledge on a critical issue for health and development, particularly in the Africa region.

The group as a whole offers a wide range of disciplines, in addition to sharing extensive experience of evaluations. Disciplines include: health economics, health financing, epidemiology, public health, sociology, anthropology, statistics, obstetrics and midwifery.

In addition to their complementary disciplines, the group offers powerful institutional links and personal networks, both internationally and in the focal countries. For example, in Morocco, INAS is represented on the national committee which is implementing 28 actions against maternal and neonatal mortality and participates in their development. This forms a strong base for conducting research that is policy- relevant and also for disseminating lessons from the research and supporting them to be implemented. Similarly, in Burkina Faso, AFRICSanté has for a long time worked closely with the Department of Family Health at the Ministry of Health on maternal and neonatal health issues. The 'capital' built up by these long-term relationships allows for an effective partnership.

While each of the thematic WPs will lead on their area of strength, the previous collaborations between them as individuals and research groups will allow for a high level of cooperation so that work is carried out effectively, with learning across teams and greater flexibility to respond to constraints and opportunities.

The model of interaction is highly participative, with all key players given equal weight within the relationship, subject to delivering on agreed outputs and at a high standard of quality. The approach, which is also very respectful of the local policy-making process, will allow greater engagement with decision-makers.

i) Sub-contracting

Very little of the work proposed by this consortium is sub-contracted. The four elements which will be contracted out (see summary table below) are auditing of WPs, the setting up of the CoP website, payments to ethics committees and some translation of materials from French to English or vice versa for dissemination purposes.

Participant	Amount	Description	Justification for sub-contracting
1	2,340	Auditing	To be independent, it is important that audits are conducted by an external body.
2	3,100	Auditing	To be independent, it is important that audits are conducted by an external body.
	5,000	Setting up CoP website	ITM needs to buy in competence in establishing the CoP website, which is a critical part of its networking approach
	24,500	Translation	ITM is one of the lead partners on the dissemination
3	1,292	Auditing	To be independent, it is important that audits are conducted by an external body.
4	0		
5	0		
6	0		
7	6,000	Translation	INAS has no in-house translation facilities.
8	15,000	Translation	IRSS is one of the lead partners on the dissemination WP and will therefore need to translate many reports and other materials. IRSS has no in-house translation facilities.
9	0		
Total	57,232		

For all sub-contracted costs, the requirements for subcontracting set out in the FP7 guide to financial issues will be applied.

ii) **Other countries**

All partners are from EU or ICPC countries

iii) **Additional partners**

For the CoP, international organisations such as UNICEF have been invited to participate in order to strengthen the network in the region. Other non-partner interested organisations include regional networks of researchers, which will be invited to contribute to the CoP and will, it is expected, strengthen its activities and reach.

B 2.4 Resources to be committed

The FEMHealth research project is a complex international research effort with a planned duration of 3 years (39 months). The project shall be implemented by a consortium of 9 partners from 2 EU countries (3 teams), and 4 African countries (6 teams).(in Mali we ceased to work with CAREF at the end of month 13 and transferred the work to Marikani from month 14) Each of these teams plays a unique role in the project contributing to the collective endeavour with their expertise and capacities whether as project's administrative and scientific leaders , or as experts in particular issues and themes of the project or as teams undertaking a series of studies and quantitative and qualitative surveys in the four African countries. In order to fulfil their duties in the project, the teams shall be allocated appropriate shares of the funding granted by the European Commission, in the case of project approval.

In addition to the requested EU contribution, each team commits to provide their own in-kind contributions, especially additional labour time of staff to cover at least one quarter of all personnel costs by individual teams. More significantly, they will offer free access to the know-how of particular experts based in the partner institutions. In UoA, for example, the advice and support of staff such as Professor Wendy Graham will be made available on the maternal health front. In ITG, Professor Vincent de Brouwere, Dr Bruno Meessen and other staff are associated with the work and will contribute time, even though they are not proposed for funding. In LSHTM, Professor Carine Ronsmans will contribute beyond her funded time. In addition, the Community of Practice will seek financial support from other organisations (such as UNICEF and the World Bank) in order to extend its work and to provide for a continued existence (if judged successful) after the lifetime of this research project.

As will be clear from the description of the work packages and the background of the participants, this project will benefit directly and substantially from the relevant experience and concurrent work being carried out by the partners. This includes the University of Aberdeen's IMMPACT programme for measurement of maternal mortality and assessment of effectiveness of maternal health strategies, a Wellcome grant on community dissemination in Burkina Faso, the "4+5" research consortium at the London School of Hygiene and Tropical Medicine and work carried out by ITM Antwerp for UNICEF on user fee removal reforms in sub-Saharan Africa. In addition, the African partners have been chosen because they have each been involved helping to design or evaluate aspects of national strategies for maternal health in their respective countries. The totality of the resource available to this project therefore greatly exceeds the level for which direct funding is being sought.

The FEMHealth project is costed at near to the maximum allowed for the EC contribution to the FP7 programme at just under € 3 million. The budget is balanced and complies with all the financial rules and requirements for FP7 projects. The sum requested, at the upper limit of what is possible, is fully justified by the scale and complexity of the suggested project as well, as its ambitious reach in Africa and the total number of partners.

The main cost categories on the project are personnel costs (40 % of full costs), survey costs (1 4 %) and travel expenses (5 %). The effective overheads rate in the project is 31% of direct costs.

We believe that the mix of resources identified for this project will enable us to achieve the objectives. Most of the staff, who will form the main resource available to the project, are already employed by the institutions and will be redeployed to this project, so we can be certain that they have required skills and experience. We are confident that because of the reputation and experience of the institutions in the partnership, recruitment to the limited number of new posts will be completed in time for the start of the project in January 2011.

Tables showing the breakdown of costs for each partner are shown below, with additional detail for Marikani, as requested.

Benificeriary 1 Aberdeen	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	14.50	304,418.34	78,390			229,685	612,493	459,370
Other	6				32,175	19,305	51,480	51,480
Management	30	55,373		2,340		33,224	90,937	90,937
Total	51	359,791	78,390	2,340	32,175	282,214	754,910	601,787

Benificeriary 2 ITG	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	32	160,865	57,860		33,690	151,449	403,864	302,898
Other	18	79,412		29,500	25,255	62,800	196,967	196,967
Management	0			3,100		0	3,100	3,100
Total	50	240,277	57,860	32,600	58,945	214,249	603,931	502,965

Benificeriary 3 LSHTM	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	38	270,828			91,524	217411.2	579,763	434,822
Other	2	14,254			9,715	14381.4	38,350	38,350
Management	0			1,292		0	1,292	1,292
Total	40	285,082	0	1,292	101,239	232567.8	619,406	474,465

Benificeriary 4 AfricSante	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	223	148,853	37,985		70,747	154,551	412,136	309,102
Other	3				7,161	4,297	11,458	11,458
Management	0					0	0	0
Total	226	148,853	37,985	0	77,908	158,848	423,594	320,560

Benificeriary 5 CERRHUD	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	348	193,458	39,416		41,483	164,614	438,971	329,228
Other	3				15,713	9,428	25,141	25,141
Management	0					0	0	0
Total	351	193,458	39,416	0	57,196	174,042	464,112	354,369

Benificeriary 6 CAREF	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	19	19,145			26,469	27,368	72,982	54,737
Other						0		0
Management	0					0	0	0
Total	19	19,145	0	0	26,469	27,368	72,982	54,737

Benificeriary 7 INAS	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	110	174,150	42,360	6,000	22,130	143,184	386,824	290,118
Other	3					0	0	0
Management	0					0		
Total	113	174,150	42,360	6,000	22,130	143,184	386,824	290,868

Benificeriary 8 IRSS	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	0					0	0	0
Other	36	43,200	22,865	15,000	3,000	41,439	125,504	125,504
Management	0					0	0	0
Total	36	43,200	22,865	15,000	3,000	41,439	125,504	125,504

Benificeriary 9 Marikani	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
RTD - Activities	282	100,494			75,998	35,298	211,790	105,895
Other	3				43,119	8,624	51,743	51,743
Management						0	0	0
Total	285	100,494	0	0	119,117	43,922	263,533	157,638

The breakdown of the allocation of RTD other budget (€75,998) for data collection project meetings for partner 9, Marikani is as follows:

- Data collection costs for WP2 €3,400
- Data collection costs for WP3 €6,900
- Data collection costs for WP4 €6,800
- Data collection costs for WP8 €40,200
- Travel, local and international €18,488

The breakdown of the OTHER other budget (€43,119) for dissemination by partner 9, Marikani is as follows:

- two preparatory meetings, one held, one to be held €11,100
- a national dissemination event €32,019

SUMMARY	Person Months	Personnel costs	Travel	Sub-con tracting	Other	Indirect Costs	Total Costs	EC contribution
1 Aberdeen	51	359,791	78,390	2,340	32,175	282,214	754,910	601,787
2 ITG	50	240,277	57,860	32,600	58,945	214,249	603,931	502,965
3 LSHTM	40	285,082	0	1,292	101,239	232,568	619,406	474,465
4 AfricSante	226	148,853	37,985	0	77,908	158,848	423,594	320,560
5 CERRHUD	351	193,458	39,416	0	57,196	174,042	464,112	354,369
6 CAREF	19	19,145	0	0	26,469	27,368	72,982	54,737
7 INAS	113	174,150	42,360	6,000	22,130	143,184	387,824	291,118
8 IRSS	36	43,200	22,865	15,000	3,000	41,439	125,504	125,504
9 Marikani	285	100,494	0	0	119,117	43,922	263,533	157,638
Total	1,171	1,564,450	278,876	57,232	498,179	1,317,834	3,715,796	2,883,142

All of our partners are committed to supporting the project by ensuring that the 25% of personnel costs not covered by the EC funding is made available to the project. The project management arrangements, which integrate all work programme at project board level, and which are supported by senior management in each of the institutions, will ensure that resource use is integrated across the project.

One of the fundamental principles underpinning the project's budget is flexibility of budgetary allocations between partners in the consortium as well as between certain budget categories. As the work of the project progresses, we will ensure that resource allocation is reviewed, taking account of any unexpected difficulties or added complexities, so that work programmes can be completed without delay. The coordinating institution, the University of Aberdeen, has much experience of this through the major Immpact programme which it managed effectively over three countries and five years. The coordinator will of course ensure that the financial flexibility of the project does not exceed the total amount of available funding and that the eventual changes are compliant with the Participation Rules of the FP7.

B3. Impact

B 3.1 Strategic impact

Through its evaluation processes and findings, the project is expected to impact on several main actors or levels: the scientific community working on complex health care evaluations, the global health and safe motherhood community, the women and their families in Africa and other poor settings, and finally the national stakeholders at policy and health service levels.

1. The scientific community

The project will provide much-needed scientific knowledge in two critical areas: (1) enhanced methods for the evaluation of complex interventions implemented at large scale in low income countries and (2) the impact and effectiveness of the removal of user fees for EmOC on maternal and neonatal health outcomes and service quality.

First, better evaluation methods for complex interventions are now recognised as a key research priority.
By working with a multidisciplinary team of policy analysts, health economists, health systems specialists, medical practitioners, epidemiologists and anthropologists; by integrating quantitative and qualitative methods; and by working with primary data as well as routine government statistics we offer a unique platform for the development of enhanced methods for the evaluation of complex interventions. The impact of our methodological developments on the practices of the scientific community at large will be maximised by providing examples of how our tools, and overall evaluation approaches, can be adapted to other health care interventions. Our close links with organizations such as IPACT (http://www.ipact-int.com/), which support countries in the evaluation of MCH programmes, will also inform as well as reinforce the usefulness of our tools.

Second, a rigorous evaluation of the impact of fee exemption schemes is urgently needed. While such interventions are expected to have beneficial effects on timely and equitable access to care and improved health outcomes, they may also adversely affect the health of the population by removing a critical source of revenue for care providers, or by transferring costs to health problems not targeted by the policy. Given the high continuing burden of maternal and newborn ill-health, the knowledge that emergency obstetric care saves lives and that user fees cause unacceptable delays in timely access, and the widespread implementation of fee exemption policies, better knowledge on which policies work best for whom and under which circumstances is urgently needed. Such knowledge, which we will generate, will not only benefit the countries involved in the research but also those involved in the wider community of practice and beyond.

Within the region, our focus on capacity building of partners and building up a network of regional researchers, who can share knowledge through the CoP, will build scientific capacity and confidence, with future knock-on benefits for research and the health of the community.

Receiving EU support for this research collaboration will enable the project to have broader and deeper impact on the scientific community because our different institutions reach different audiences, come from different public health and scientific traditions, belong to different network of influences, and have different disciplinary strength or expertise. Francophone researchers working alongside Anglophone researchers, and African researchers alongside European researchers, will also generate scientific creativity and innovation by breaking the language and cultural barriers which still exist in the sciences.

2. The global health and safe motherhood community

The importance for the global safe motherhood community of knowing the extent to which the strategy of removing user fees can help reduce maternal mortality or improving maternal health cannot be overstated. It is clear that the Millennium Development Goal for maternal heath is very unlikely to be achieved in African countries by 2015. There are no "magic bullets" in maternity care which can be delivered with vertical programmes. Mostly, to reduce the levels of maternal mortality, women must have access to health facilities when they most need it at the time of delivery. Bilateral and international organizations are currently promoting the removal of user fees, with the anticipation that such policy change, if well implemented, could potentially have a huge impact in improving maternal health by reducing the barriers to care.

The global safe motherhood community has clear explicit messages on the type of public health policies that countries should deliver to reduce maternal mortality but not on how to implement these. This project will draw lessons from practical experiences on to how to achieve reducing financial barriers which should be applicable to other countries with high maternal mortality.

Because the project will create a community of practice, which will involve representation from international agencies, some of our early findings can be expected to impact on the messages and tools promoted by the international community before the end of the project. The international safe motherhood community needs positive messages to continue generating interest, political goodwill and financial resources at international and national levels. It also needs practical demonstrations on how progress can be achieved. We hope to impact on international "know how" by presenting practical information to influential groups such as the Countdown to 2015: Maternal, Newborn and Child Survival; the Maternal Health Task Force; and the Partnership for Maternal, Newborn and Child Health, of which some of us are members (see http://www.countdown2015mnch.org/ http://www.engenderhealth.org/our-work/maternal/maternal-health-task-force.php/.http://www.who.int/pmnch/en/).

In addition to the safe motherhood community, there is considerable interest in the wider health and development community on the role of cost-sharing and in particular on ways to reduce dependence on user fees. The lessons learnt from these major national evaluations will feed into that body of knowledge too.

3. Women and their families

The project will ultimately benefit reproductive age women in Africa, but also in other developing countries, particularly those who are in the poorest quintiles.

It will first benefit women by evaluating interventions which could remove a risk of further impoverishment. There is a clear link between maternal mortality and poverty, as 99% of maternal deaths occur in developing countries. In addition, we know that women who are poor within these countries are more likely to die during pregnancy and childbirth than richer women, because they are less likely to use maternity services. We know too that user fees for emergency care in childbirth lead to catastrophic costs for women, for example forcing them to sell assets, which in turn can have dramatic impact on their future lives and the lives of their children. This project will document the extent to which removing user fees promotes the timely use of services, and by extension reduces the number of complications and potential adverse impact of catastrophic costs on the future health and financial status of women and of their children.

In addition, detailed information on the way the policies in Benin, Burkina Faso, Mali and Morocco are implemented will help ensure that ultimately the poorest in those countries can benefit from these policies. Other experiences in reducing health care financing, for example with cash transfer in Nepal, were designed to reach the poorest but sometimes have benefited richer groups. Whether our evaluation findings are positive or negative, our project dissemination strategy will aim to facilitate impact on the poorest, either by suggesting a new design of the policy or by reinforcing its success, if results are encouraging.

4. Stake holders at policy and health service levels

A key target group for our research are the people who are responsible for implementation of policies at national, regional and local levels, and for providing services, such as health managers, doctors and midwives. Research has shown the important role these actors play in determining the use of evidence-based policy.

By involving policy makers in the evaluation process from the outset – through a community of practice, with a strong regional networking facility, as well as through our research management processes – we will make sure that the knowledge generated responds to an expressed local need and encourages an active engagement of policy makers in adapting the policy if and where required on the basis of evidence and shared experiences. In addition, through our bottom-up approach of the policy implementation process and our focus on the district and hospital levels, FEMHealth will yield evidence on how health service managers "deal with" the policies within their constraints. This information will be very useful to programme managers and national policymakers alike and will be shared further through the CoP.

In health facilities, the project will also impact on the way staff manage and interact with women in labour by documenting the quality of care that is provided. We know for example through mostly anecdotal evidence presented in a report prepared by Amnesty International on Maternal Mortality in Burkina (to which some of us contributed research as technical advisors), that the use of informal payments is the norm in Burkina Faso, and that it undermines the speed and the quality of the care provided to women, in spite of the removal of user fees. We also know that the University Teaching Hospital in Ouagadougou, Burkina Faso already operated at full capacity before the policy was implemented, and may struggle to cope with the increased demand for care that may result from the reduction of user fees. We will be able to document quality of care indicators, such as delays, in a detailed or systematic fashion through our qualitative observations, our women's interviews and our quantitative analysis of health care near-miss events. Presenting data on indicators of quality to health service professional through our dissemination strategy can be a powerful tool in initiating changes in practice, as illustrated by Cochrane reviews on audit and feedback.

5. Impact on priorities disease

Several health problems already benefit from the removal of user fees (such as PMTCT or impregnated bednets) or are likely to be exempted in future. Ensuring that the investments made in the removal of user's fees in the four FEMHealth focal countries are well spent will benefit beyond the programme in question, and provide useful lessons for the whole health sector. In addition, we will make our tools adaptable to other disease and health system monitoring and evaluation needs.

6. Risks and assumptions

Risks that may undermine the potential impact of this project and mitigating actions are summarised in Table 2 below.

Table 3 Risks and mitigating actions

Risks	*Mitigating actions*
Failure to obtain a clear picture of the impact of the removal of user fees on maternal health	We hope to be able to distinguish patterns by focussing in different countries, and including control groups, with the inclusion of high performing and low performing districts or hospitals. Preparatory activities, including literature and tools reviews, pretesting and piloting, will maximise validity of tools.

Scientists involved in other evaluations of complex interventions are unwilling to use our tools or approaches	Convincing results will be critical, and this will require valid and reliable tools as well as robust comparative designs (see above). The dissemination strategy will illustrate how our tools can be adapted to other health care interventions or health problems
Failure to work closely with key staff in the Ministry of Health and the Ministry of Finance could be an obstacle to impact	All four southern partners have close relationships with key staff in ministries. Project activities encourage regular meetings with policy makers. Project encourages responding to policy makers' data needs through participation in community of practice.
Changes in governments and policies may threaten the relevance of this study.	We hope to anticipate these changes through the community of practice and to provide sufficient evidence before the end of the project to inform new governmental policy if needed
Other evaluations of removal of user fees may produce different results	When preparing for this project we surveyed other evaluations that are taking place to understand and promote complementarities in the countries in which we work. Many of these, sponsored by UN agencies, do not focus on the local policy level, or on health outcomes or quality of care, thus minimising the risk of duplication with this project. We have already established links with some of the evaluations initiatives which have started and about to start, in particular in Mali and Burkina Faso. We have agreed that we will critically assess our respective findings to understand any discrepancies that may arise.
Lack of impact on policy in real time in spite of the creation of the community of practice	Selection of influential participants to the community of practice will be critical. Regular meetings as well as regular communication outside meetings will be ensured
Our findings may not be welcome by the government or wider global health community, especially if these are negatives.	Our close relationship will ensure that trust is optimal between policy makers and scientists involved in implementation or evaluation. We will apply equally rigorous analytical standards to negative as well as positive results.

B 3.2 Dissemination

This project gives the highest priority to getting research into policy and practice (GRIPP). It was designed on the basis of the hypothesis that national policy-makers, international agencies and health managers will use the results of a well-designed and implemented multi-disciplinary study in formulating policy and improving local practices provided (1) it addresses a high-priority problem; (2) they are involved in all phases of the project; (iii) they perceive researchers as experts contributing to the development of appropriate knowledge for current policies; and (4) the findings reach all relevant stakeholders. We are confident on the high priority of our work area (point 1). We will engage with actors at national, regional and international levels in order to maximise the chances of meeting the conditions for points (2) and (4). The quality of work and engagement with local policy priorities will aim to ensure that (3) is also met.

A dissemination plan will be developed within the first few months of the project. This will focus on the arena and activities outlined below.

National level

The project builds on long-standing relationships between individual partners and actors active at national level. This is of course true with national health authorities, but also with international agencies and NGOs. Letters of cooperation have been signed with Ministries of Health in all four focal countries. Ministry staff and other relevant stakeholders will be engaged actively from the start in both the research and the CoP.

We will seek to disseminate to popular audiences through media and direct feedback to research participants. Radio, television and internet sites provide mechanisms for popular dissemination, as these are widely used in the focal countries and in the region more generally, where the results will also be of interest.

Regional

Several members of the project are in close connection with regional actors, which will help disseminate the research tools and findings to this level. In the preparation stage of this project, the regional offices of several agencies have been consulted. Among other things, a concept note on the community of practice has been circulated. We also met several persons in face-to-face meetings. UNICEF WCARO, WHO-AFRO for Western Africa and UNFPA regional office in Dakar have all expressed an interest in participating in and possibly supporting the community of practice.

It has been agreed with the "Réseau Population et Santé de la Reproduction en Afrique" (a network gathering 11 training institutions based in Western Francophone Africa) that it will be a full member of the community of practice. Representatives of this network will attend the three international events. They will integrate the lessons from the research in the syllabus of the different courses that they deliver at regional level (in close coordination with the World Bank, the UNFPA, WHO and UNICEF).

International

The experiences in Francophone Africa and Morocco will have considerable interest for other parts of the world. UNICEF New York has expressed an interest in learning from and supporting the experiments with selective fee removal focussed on women and children. Other agencies, such as DFID, strongly support national policies to remove user fees. The recently launched Centre for Progressive Health Finance in the UK may well be a useful partner and outlet for FEMHealth's work.

Other regions are also actively pursuing related policies at present. For example, Nepal announced free delivery care for all women in 2008, and the consortium coordinator (Dr Sophie Witter) is involved in monitoring the impact of this policy. Dr Witter is also leading an evaluation of free health care for under-fives and caesareans in Sudan. There are many opportunities to feed knowledge and good practice from one site to another.

The consortium also offers many opportunities for academic dissemination, as its members are world-leaders in their fields with exceptionally strong track-records for peer-reviewed publications. Articles will be submitted for publication, including in 'high impact'scientific journals, such as the Lancet, Social Science & Medicine, Health Policy & Planning and Tropical Medicine & International Health, as well as ones that have an explicit aim to speak to policy-makers, such as the World Health Bulletin and Reproductive Health Matters. Special emphasis will also be placed on disseminating findings through open-access journals that are freely accessible to stakeholders in Africa, and every effort will be made to disseminate findings to French academic journals. Additionally, abstracts will be submitted to major global conferences in the fields of maternal health, health policy and health financing. If appropriate, papers will be collected at the end for a book.

The various types of dissemination tools are summarized in Table 3 below. These will be further elaborated in the dissemination plan which will be drawn up in the first phase of the project.

Table 4 Dissemination table

Stakeholders	Domains of interest	Communication tools	Lead work programme(s)
Scientific community *includes staff working in academic institutions and organizations specialised in evaluations*	Interested in methodologies	• Journal publications, open access • "worked out" examples on websites • research summaries • conferences • proactive distribution of maternal to networks such as IPACT	WPs 2-4
Managers responsible for M&E of policy implementation	Interested in methodologies	• ''worked out" examples on websites • research summaries guidelines	WP 1 & 5
Policy makers at national level	Clear and concise information on substantive findings, including lessons learnt on processes	• Policy and research briefs • Community of practice meetings • Web-based materials • Face to face meetings	WP 5
Health Professionals	Practical implications that are relevant for their job, in particular related to quality of care	• Policy and research briefs • National dissemination meetings	WP 5, 6,7,8,9
International community	Practical policy implications, lessons for other countries/settings Best practice	• Policy and research briefs • Case studies • Face to face meetings • Conference such as "Women Deliver" • Influential groups such as Maternal Health Task force	WP 1 & 5
Women and their families	Substantive findings on impact	• Local or national press, local meetings or workshops	WP 6, 7, 8, 9

Management of intellectual property

FEMHealth partners will sign a Consortium Agreement that sets out the operational procedures, the approaches to confidentiality issues, the approaches to ownership and exploitation of intellectual property, and publication rights, using Annex II of the Grant Agreement (Intellectual Property rights, Use and Dissemination) and the Guide to Intellectual Property Rules for FP7 Projects as guides. The Consortium Agreement will ensure that the intellectual property rights of the members of the consortium are protected and that the publication process is organised in a fair, balanced and transparent manner. Briefly, commercially valuable intellectual property (IP) generated by the consortium will be protected. The generation of agreements and the exploitation of IP will be overseen by the Project Management Board and is the overall responsibility of the Scientific Coordinator. The creation and signature of the Consortium Agreement will be overseen by the coordinating institution, which has a contracts officer dedicated to European contracts, who will create the Agreement, ensuring that all partners have input into the document.

Standard communication material to be provided to the European Commission

In support to the communication activities of the Commission services, and in addition to a presentation leaflet that it may initiate, the consortium will provide the Commission, within 3 months after the start of the project, with a 2-page information sheet (double sided A4) which will be drafted in a standard format communicated by the Commission. The consortium will also provide an updated version of this information sheet on an annual basis. The Commission services may also request one illustration (picture, schema or drawing) to illustrate such communication material.

Project web site and EU acknowledgement

In support to its activities including the dissemination activities, the consortium will set up a specific project web site. The structure of this web site will contain minimum information about the project, its objectives, work plan and involved partners. It will also acknowledge European Commission's FP7 support and display the EU flag and FP7 logo. It will be maintained by the University of Aberdeen and will focus on research objectives, activities and outputs (which will be in English and French).

Linked, but separate, will be a francophone website managed within the region for the Community of Practice. This aims to live beyond the project and involve many actors. Having one single website, open to many, is part of our strategy to engage actors (e.g. UNICEF), to get their ownership and to influence policy. FEMHealth will be acknowledged on the site, but so may other actors be, if they provide support to the CoP.

In general, any dissemination activities and publications in the project will acknowledge the European Union's FP7 funding.

B 3.3 Ethical issues

It should be noted that FEMHealth will include primary data collection, including surveys and in-depth interviews and participant observation and secondary analysis of data pertaining to human subjects. FEMHealth will not carry out biomedical research dealing with therapeutics, diagnostics, clinical trials, or human tissues. The study is an evaluation of an existing programme, not an intervention with new technology. It includes 'human data' in as much as it collects information relating to an identified or identifiable person ('data subject' or research participant). Specific measures are in place to ensure the anonymity of such individuals (see below).

FEMHealth will adopt an explicit position regarding ethics. Before discussing some guiding principles, it is useful to distinguish between the two paramount components of research ethics: (1) the selection and achievement of morally accepted ends in terms of benefits of research and (2) the morally acceptable means to conduct research in order to attain those ends. In practice, *biomedical* ethical codes focus predominantly on analysing harms and benefits at the level of the individual relationship between researcher and research subject. In ethical assessments of HSR research, the concern needs to be extended beyond the research subjects to include the social groups they belong to.

Several guiding principles have been proposed to reduce the potential harms for participants in HSR (Anonymous 2005, Richards & Schwartz 2002, Denscombe 2003). These include:

- Respect for human dignity
- Balancing harms and benefits (minimising harm, maximising benefit, reduce anxiety)
- Respect for the research subject (including respect for privacy and confidentiality, justice and inclusiveness, power relations, opportunity cost, etc.)
- Respect for free and informed consent (see below)

The issue of minimal risk in HSR

In HSR, assessment of minimal risk is less straightforward than in biomedical research. For the latter, the risk is usually related to being exposed to a new intervention (intake of a drug, surgical procedure, etc). For the former, participants may incur risks beyond the patient-provider relationship and outside the medical domain. We may be able to define different *domains* in which participation to a study can represent a risk:

- Risk of damaging the patient-provider relationship, including the risk of reducing access to care
- Risk of damaging the staff-management relationship
- Risk to the research subject's personal social standing, privacy, their links to their family and wider community, including stigmatisation
- Potential adverse effects of revealing sensitive information
- Potential risk to the group, community or organisation they belong to.
- Potential risk that research process or results interfere with power relations in non-anticipated ways

Some types of study have been identified as likely to involve *more than minimal risk* for the research subjects (ESRC 2005):

- Research involving vulnerable groups: children, young people, individuals in a dependent situation, cognitively impaired persons etc.
- Research involving sensitive issues: research subjects' sexual behaviour, their illegal or political behaviour, their abuse and exploitation, their mental health, ethnic status or gender…
- Research for which a gatekeeper's permission is required for initial access to research subjects.

A major problem arising in HSR in developing countries is the cultural differences in appreciating 'minimal risk'. The basic principles underlying these codes are indeed very Western concepts, steeped in a utilitarian framework (Denzin & Lincoln 2005). They may be less applicable in field settings than their general acceptance by institutional review boards in low and middle-income countries may suggest. Furthermore, these institutional review boards mostly apply biomedical ethical frameworks. On the other hand, such assessment should neither be left to researchers from outside (and certainly not only to a foreign ethical committee). Some argue that the collectivity involved in the research should determine the costs and benefits of participating in the research (Smith 2005).

We propose to use the notion of 'minimal risk' to address ethical aspects in the research protocol:

- In function of the research carried, the list of domains in which participation to a study can present a risk should be discussed
- Study protocols should specify how the researchers assessed the potential risks in which domains
- This assessment is done as much as possible through a joint review with local research partners

Issues regarding informed consent

Informed consent will be sought from all adult respondents at the time of the first contact. The interviewer will provide or read an information sheet specifying the objectives of the research and future use of the data. Different information sheets will be specified for healthcare users, healthcare providers and policy-makers. The information sheet will emphasise the possibility of withdrawing from the study at any time without any consequences. This includes reassurance that healthcare will not be affected (where relevant) that information will remain confidential. The information sheet will also provide a clear explanation of the study aims and procedures and any social, emotional or physical risks that participants may face. For in-depth interviews, the information sheet and consent form will inform participants about the nature of the questions that may arise during interviews, and participants will be informed that they are able to refrain from answering questions should they so wish.

Following review of the information sheet, participants who accept participating in the research will be presented a consent form and be asked to sign or leave a fingerprint (depending on their literacy status). Consent will be verified at any successive contact. Interviews and other exchanges will be led by respondents and care will be taken that the mode of communication between interviewer and respondent is appropriate to the context in which the interview is taking place.

Data protection issues

Specific procedures will be developed and implemented to ensure that the primary data collected are protected from abuse. Access to the data will be restricted to consortium members. Names or any other information which could identify respondents will not appear on questionnaires. Instead identification numbers will be used.

Across all data collection activities, appropriate measures will be taken regarding storage and security of records during and after fieldwork to ensure that participants' identities are not revealed. Individuals' people's place of residence will be noted for those included in in-depth interviews simply for the purpose of locating the individual for the interview. This information will be obtained following informed consent and will not be stored after the interview has been completed. For quantitative data, only two individuals will have a copy of the file linking names and identification numbers. Qualitative data will use identifiers and pseudonyms. When providing case studies or illustrative quotes, we will not provide data that can identify a healthcare user (such as address or occupation), healthcare provider or other respondent. Interviewers and anyone else who has access to the data will be required to observe absolute confidentiality and protect participants' anonymity.

Specific risks relate to confidentiality in in-depth interviews with policy-makers, given the relatively limited size of policy communities, which may make it possible to identify respondents from the nature of their responses, even where identifiers are not used. The same issue may emerge with interviewees at operational health service level. In these cases, it will be made clear to participants that despite efforts to maintain confidentiality it may not be

possible in field notes or publications to totally conceal identities and that despite researchers' concerted efforts to ensure anonymity, anonymity may be unintentionally compromised.

Minimising risks and discomfort to participants

There are no physical risks associated with the research. The emotional and social risks for healthcare users who participate might be more important as questions will be asked on topics such as perceived quality of care and difficulties managing the costs of care. There are also social risks associated with visits to women's homes to conduct interviews, as the community may speculate on the reasons for such visits. Interviews will be arranged at a time that suits the respondent to ensure privacy and minimise social risks and income loss. Small but suitable incentives (e.g. soap) will be provided.

Given the focus on obstetric emergencies, researchers will likely witness life-threatening conditions in women (near-miss events) that can be solved with appropriate treatment. Indeed, observing such events is a specific activity within WP 4. Specific procedures will be developed for appropriate ethical response to situations in which the intervention of a researcher can contribute to saving a woman's life or non-intervention can contribute to exacerbating the situation. An example of such an event may be when medicines have to be bought outside of the hospital. If a researcher observes corruption and/or malfunctions that may endanger the researcher will discuss this with the health care providers and explain clearly what the consequences would be of corruption and/ or malfunctions. The timing of such discussions (before or after the situation) will depend on the context.

Furthermore, researchers may encounter healthcare users who are faced with catastrophic costs, or who are experiencing acute poverty or hunger. The research team must intervene when they consider that there is a high risk of death/debilitating illness. A local protocol will be developed to help the research team decide whether, when and how they should intervene. Participants who in interviews at home (after discharge from hospital) are found to have life-threatening or debilitating health problems will be referred to a provider and an initial payment for transport or treatment will be made. There will also be procedures in place for referral to appropriate services even if the participant's health is not in immediate danger.

Ethical procedures in focal countries

Ethical review and approval will be requested from the appropriate regulatory bodies pertaining to all the participants in the consortium. These include:

Participant	Ethical regulatory body
1	Follows in-country ethical procedures alone
2	Institutional Review Board, adhering to Helsinki Declaration and Belgian law (double ethical review with focal country)
3	The London School of Hygiene & Tropical Medicine Ethics Committee (double ethical review with focal country)
4,8	Comité d'éthique pour la recherche en santé
5	Comité National Provisoire d'Ethique pour la Recherche en Santé (CNPERN)
6,9	Comité National d'Éthique pour la Santé et les Sciences de la vie (CNESS)
7	Comité d'Ethique de la Recherche Biomédicale (CERB), Faculté de Médecine et de Pharmacie de Rabat, Université Mohamed V

ETHICAL ISSUES TABLE

	Research on Human Embryo/ Foetus	YES	Page
*	Does the proposed research involve human Embryos?		
*	Does the proposed research involve human Foetal Tissues/ Cells?		
*	Does the proposed research involve human Embryonic Stem Cells (hESCs)?		
*	Does the proposed research on human Embryonic Stem Cells involve cells in culture?		
*	Does the proposed research on Human Embryonic Stem Cells involve the derivation of cells from Embryos?		
	I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL	X	

	Research on Humans	YES	Page
*	Does the proposed research involve children?	x	
*	Does the proposed research involve patients?	x	
*	Does the proposed research involve persons not able to give consent?		
*	Does the proposed research involve adult healthy volunteers?		
	Does the proposed research involve Human genetic material?		
	Does the proposed research involve Human biological samples?		
	Does the proposed research involve Human data collection?	x	
	I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL		

	Privacy	YES	Page
	Does the proposed research involve processing of genetic information or personal data (e.g. health, sexual lifestyle, ethnicity, political opinion, religious or philosophical conviction)?		
	Does the proposed research involve tracking the location or observation of people? I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL		

	Research on Animals	YES	Page
	Does the proposed research involve research on animals?		
	Are those animals transgenic small laboratory animals?		
	Are those animals transgenic farm animals?		
*	Are those animals non-human primates?		
	Are those animals cloned farm animals? I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL	X	

	Research Involving Developing Countries	YES	Page
	Does the proposed research involve the use of local resources (genetic, animal, plant, etc)?		
	Is the proposed research of benefit to local communities (e.g. capacity building, access to healthcare, education, etc)?	X	
	I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL		

	Dual Use	YES	Page
	Research having direct military use		
	Research having the potential for terrorist abuse I CONFIRM THAT NONE OF THE ABOVE ISSUES APPLY TO MY PROPOSAL	X	

B.3 4. Consideration of gender

Gender equality will be mainstreamed within the management of the project consortium. The consortium pledges to promote and maintain gender balance within the consortium. The consortium has several female scientists in leading positions within the respective work packages and an overall female leader. Maintaining gender equality within the team composition will be a priority also in the recruitment of research partners in the European and African focal countries. In addition to its general aim of improving research and evaluation capacity in African countries, the consortium will pay particular attention to promoting opportunities for female African researchers. In addition to ensuring equal opportunity in career advancement and opportunity, each partner institution's policies regarding flexible working will be respected within the consortium structure.

The project's thematic focus on maternal health is consistent with the goals of gender mainstreaming in international health and development work more broadly. Maternal mortality is a leading cause of premature death among women of reproductive age in low- and middle-income countries. Gender-based discrimination in social and economic autonomy and access to health care are well-recognised predisposing risk factors for maternal mortality. The policies studied within the project aim to reduce financial barriers that contribute to such unequal access to life-saving care. By improving women's access to life-saving care and ensuring their health, such policies can potentially facilitate women's ability to build their capabilities and take advantage of economic and political opportunities. It is therefore essential to evaluate whether and how such complex policy interventions are effective.

The consortium activities (such as the 'community of practice') and the dissemination of the findings will hopefully contribute to greater awareness of maternal mortality as a gender-based issue indicative of women's limited financial and physical access to health care in low- and middle-income countries.

Annex 1 Summary of recent policies to improve maternal health in focus countries

	Benin
Policy initiatives to improve financial maternal health care, especially EMoC	- Emergency kits available in 33 referral hospitals with support from UNFPA and World Bank. Women have to reimburse the kits after emergency treatment according to a pre-agreed fee - Introduction of funds to assist the poorest women who are accessing EMOC services. Social workers in hospitals identify women belonging to this category - Free caesarean section in private and public hospitals
Date of introduction	- 2006: kits for obstetric emergencies - 2007: funds for the poorest - 1/04/2009: free c-sections
Funding	- UNFPA and World bank for kits - National budget for the other two interventions
Scope of services and geographical coverage	- Emergency kits for all complications in 33 (later reduced to a smaller number of hospitals – see below). Those hospitals are private and public, but excluding private for profit clinics. - Funds for the poorest cover all complications in all hospitals - Free c-section is taking place in 43 private and public hospitals that provide emergency care, excluding private for profit clinics. Hospitals are reimbursed 100, 000 CFA per woman with a c-section to cover: check-up costs before medical intervention, drugs, kits, surgery, blood, hospitalization for 7 days. The women pay for any costs arising before hospitalization, or any other complication which may arise during the hospitalization. Treatments for other complications which require surgery (GEU, uterine rupture) are not free.
Any studies to date or ongoing (and main findings)	No external studies have been conducted yet DSF monitoring for the emergency kits policy showed that some hospitals charged patients above the pre-agreed charges. Emergency kits are no longer provided to these hospitals. Procedures for replenishing funds for the poor are complex, involving 4 invoicing stages: the hospital, the district, the prefecture, and the public treasury.
Outstanding policy questions in-country	Shall Benin go for free care for all types of obstetric complications? A feasibility study has indicated that this would cost 25,000,000,000 CFAs.
Planned future initiatives at national level	Free care for newborn is under discussion.

	Burkina Faso
Policy initiatives to improve financial maternal health care, especially EMoC	- Donation of medicines for emergency care and C-section at 10,000 CFA in regional hospitals in 1999 - Free ANC introduced in 2002 - Cost-sharing system in several rural districts supported by UNICEF & DSF started in 2001- Est region (Bogande, Diapaga, Pama), Central Est (Koupela, Ouargaye) and Sahel (Sebba) in 2003 - National subsidy for delivery and EmOC started in 2006
Date of introduction	October 2006 for c-sections and April 2007 for deliveries and complications
Funding	National budget
Scope of services and geographical coverage	Covers all public health facilities 80% reduction of fees at CSPS, CMA, CHR/CHU level for: - C-sections - Complications - Neonatal care 80% reduction of fees for normal deliveries at CSPS and CMA level 60% reduction of fees for normal deliveries at CHR /CHU 100% for worst-off pregnant women Covers all the cost (bed-stay, medicine, surgical kit, postoperative care and transport to the hospital from CSPS, lab exams, medical acts)
Any studies to date or ongoing (and main findings)	Evaluation after 6 months by Grefsad (2007). UNICEF evaluation done by ITM (2009) and University of Montréal/SERSAP. Main findings: - lack of information for providers and users because communication plan was not financed - transport: theoretically included in the scheme but families continue to pay in some districts, reimbursement of transport cost between different level of care not clarified - deliveries costs estimation need to be reviewed (overestimated for normal delivery, delivery with episiotomy cost estimation not done) - system to exempt the worst-off pregnant women not effective - no standardization of the policy implementation in the different hospitals of the country - management tools of the subsidy (forms, software): no clear communication, burden for the teams in the field (time-consuming)
Outstanding policy questions in-country	- Shall Burkina go for full exemption? Promised by the President in Feb 2010 after the Amnesty International Report - How to identify the worst-off (within the community or at hospital level)?
Planned future initiatives at national level	1. Project AFD-CRDI in Burkina, Niger and Mali: evaluation of the policy of fee- exemption implementation (FEM Health to coordinate with them) Sites in Burkina: 2 rural districts (Tougan & Toma) and 1 urban district (secteur 15 Bobo Dioulasso) 2. Evaluation of the policy implementation planned by DSF through IRSS 3. UNFPA/AMDD evaluation of EmOC (based on the 2009 monitoring EmOC guideline) FEM Health which is concerned with evaluating the policy's impact will complete the other evaluations (already implemented or to be done) as they focused on the policy's implementation and functioning.

	Mali
Policy initiatives to improve financial maternal health care, especially EMoC	Free C-sections Input-based scheme: kits and medicine are given to the facilities according to their activities (no cash transfer)
Date of introduction	2005 Circulaire of MOH n°1003 MS/SG du 27 juin 2005 Décret N°05-350/P-RM du 04 août 2005
Funding	National budget
Scope of services and geographical coverage	National - Theoretically all C-sections but ECRIS study shows that programmed C-sections are not free (lab exam are charged) and for anesthetic medicine only one is free, others are charged to the patients…
Any studies to date or ongoing (and main findings)	- University of Montreal project (Pierre Fournier) in Kayes region : free C-section and referral system (Programme de recherche sur les Politiques publiques I, II, III) - ECRIS study done in 2008 (MISELI) in Commune 1 of Bamako - MOH monitoring (document of march 2009) - LASDEL (JP Olivier de Sardan) and UdeM (V Ridde) research program implemented in Mali, Burkina and Niger. Sikasso, Diema and Commune 1 of Bamako are selected as case studies for this 3 years research project on user fees abolition, mostly qualitative study - UdeM (V Ridde, S Haddad) with DNS and MSF-OCB launched in April 10 a research districts network (Observatoires de la gratuité) about user fees abolition, mostly based on National health statistic data in Commune 5 of Bamako, Kangaba, Kayes and Sikasso. - Thesis ongoing "Evaluation de la gratuité de la cesarienne sur la mortalite maternelle et néonatale au CSREF de la commune VI". Dr Sango Hammadoun, MD, MScCM (Master in diseases Control), Faculté de Médecine Bamako
Outstanding policy questions in-country	This policy didn't address the other barriers and there's a lack of: - skilled attendance - equipments - blood, oxygen - transport facilities for referral
Planned future initiatives at national level	- Project AFD-CRDI in Burkina, Niger and Mali: evaluation of the policy of fee-exemption 2009-2011. Sites in Mali: 2 rural districts (Sikasso & Diema) and 1 urban district (Commune 1 du district de Bamako). Focusing mainly on the development of the policy. - Project financed by USAID: ATN Plus and Health Systems 2020 together with the Planning division of the MOH and the National Direction of Health. CAREF conducted a study on free c-section policy and already finished the data collection. Analysis and report writing are ongoing. CAREF is also in the process to start a study about user fee exemption policies for children. This study funded by Presidential Malaria Initiative (PMI) Washington, seek to address barriers raised by user fees to malaria treatment for children under five years old within West African countries implementing the Bamako Initiative. - Management Leadership Initiative (funding from Gates Foundation) works in Health system strengthening and is also interested in the free c-sections study

	Morocco
Policy initiatives to improve financial maternal health care, especially EMoC	- ANC is free in the public health sector. If the woman utilizes the private sector, she is reimbursed for 4 ANC, ultrasonography included (since 2007), provided she is an official employee (covered by an insurance) - Delivery is free in public sector and reimbursed in private sector (if she has an insurance) - Free C-section in public sector (see below) - Free transportation from maternity to hospital (woman and/or newborn) - Delivery and c-section kits distributed. Essential drugs provided. Blood supposed to be available in all maternities - Creation of a free rural SAMU (Emergency ambulance medical care) for obstetric and neonatal emergencies - Humanization of care in all the public facilities
Date of introduction	Official ministerial circular n°118, 11 December 2008
Funding	- National budget
Scope of services and geographical coverage	- Nationwide - Covers: normal and complicated delivery in all public facilities (including university hospital IF the woman is referred from a public facility), resuscitation, transport to the appropriate level, care for mother and newborn as long as they stay in the facility. - Not included: miscarriage/ abortion, ectopic pregnancy.
Any studies to date or ongoing (and main findings)	No, so far. Two Masters' theses on the topic will be finalized by July 2010. Studies are carried out at district level and explore the effect of the policy on the c-section rate and on the health workers. One of them will also explore the actual cost (direct cost for families) and the perception by families
Outstanding policy questions in-country	- What are the indirect costs incurred to the woman and her family? - Was there a shortage of kits (c-section and delivery)? How much? - What is the population perception of this huge effort made by the MOH? - Is the MOF committed? And the other actors?
Planned future initiatives at national level	- 3 to 5 MPH students intend to make their MPH thesis on the issue - There is a demand for a consultancy to assess the free c-section planned for 1st trimester 2010

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