

To Be of Use:
**An Assessment of FHI's Research to Practice
Initiative**

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The work of the world is common as mud.
Botched, it smears the hands, crumbles to dust.
But the thing worth doing well done
has a shape that satisfies, clean and evident.
Greek amphoras for wine or oil,
Hopi vases that held corn, are put in museums
but you know they were made to be used.
The pitcher cries for water to carry
and a person for work that is real.

-- Marge Piercy, *To be of use*



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Executive Summary

It is said that knowledge is power. But the knowledge generated by research only becomes powerful when it is used. There has been increasing attention in the reproductive health field to this important issue through numerous efforts to improve the process of research utilization. One such effort is Family Health International's (FHI) Research to Practice (RtoP) Initiative, which began in 2001 under FHI's Contraceptive Technology Research (CTR) Program. A three-person team undertook an assessment of the RtoP Initiative through interviews with 48 key informants and document review. The goals of this process were to assess the main achievements of RtoP, identify key lessons learned, and give guidance for future efforts in research utilization.

The RtoP Initiative was launched due to both internal and external influences, primarily with an idea of making research utilization more systematic at FHI. Initial activities included planning, identifying key underutilized research findings, promoting the initiative externally, and promoting change internally at FHI. RtoP has begun the process of changing the mentality of FHI and moving towards institutionalization. Some referred to this as a "*sea change*" or a paradigm shift, while others saw it as systematizing what FHI was already doing. This is still a work in progress, and there has been some resistance due to the general difficulties in creating organizational change and the desire of researchers to be neutral rather than being advocates.

The abstract concept of utilization became more real and meaningful through actual projects, which "*gives you something to talk about, ways to learn, and some credibility.*" These included IUD reintroduction in Kenya and other countries, promotion of the pregnancy checklist, vasectomy, and integration of family planning and HIV/AIDS. An RtoP focus means changing how research priorities are chosen, including more involvement of service delivery organization at the beginning of the process and attempting to merge global and local issues.

There was a strong emphasis under RtoP on building relationships with a range of organizations, and this was achieved because of having dedicated staff and funding; "*it is radically different now that you have staff with the time and the airplane budget... personal follow up is very important.*" Collaboration can sometimes be difficult due to the competitive environment of the USAID world. In addition, research and service delivery groups typically operate in different time-frames, with service delivery organizations focused on immediate needs as compared to the longer time frame of a research study. In discussing FHI's responsibility for utilization, respondents highlighted information dissemination and advocacy. Though hard to define precisely, all agreed that there is a handing off point from the research organization to the service delivery side, or what some referred to as a "*bridging period*" that would include advocacy and technical assistance.

The RtoP Initiative has made impressive achievements in its three years, and now under FHI's new Contraceptive and Reproductive Health Technologies Research and

Utilization (CRTU) Program it will be important to continue efforts to make this a priority and “*to make utilization everyone’s business.*” It will be necessary to prioritize activities for the RtoP staff members, and to strengthen FHI’s field presence and field orientation among its staff. In addition, there is a need for continuing efforts to improve the practice to research aspect. This requires bridging the gap between the research and service delivery worlds; “*we face the problem of distance between information producers and service delivery—that is the fundamental issue.*” Both the research and the service delivery organizations should be held accountable for research utilization. Finally, FHI should work with others to develop a more holistic and inclusive model that highlights how all groups work towards a common goal.

Key lessons learned include the following:

- 1. Research utilization must be viewed in its full continuum—it is not just getting existing findings out there, but a whole new way of doing things**
- 2. Enhancing utilization of research requires dedicated staff and consistent funding**
- 3. Credibility is key; this refers not just to the quality of the research, but also being a responsive organization and a reliable partner**
- 4. The ‘schmoozing process’ is vital to research utilization efforts and has implications for the skills needed in staff at research organizations**
- 5. Expectations of utilization must match the type of research**
- 6. Acknowledge the different time frames of research and service delivery worlds and find ways to bring these two worlds more in synch, for example by researchers having an array of research tools to meet different needs**
- 7. Both the research and service delivery sides need to be held accountable for research utilization; people are more likely to do things that are being measured**
- 8. Up-front involvement by service delivery groups in the research process should greatly facilitate research utilization**
- 9. Utilization is affected by many things beyond the control of researchers, but efforts can focus on those aspects over which there can be some control, such as the choice of projects, involvement of stakeholders at all points in the research process, effective communication, and advocacy to the key audiences**
- 10. Donors and implementing agencies need to reinforce the idea that research and service delivery groups are working towards a common goal; this should include ongoing advocacy efforts and development of a more comprehensive model of how research and service delivery fit together into a cohesive continuum**

I. Introduction

It is said that knowledge is power. But the knowledge generated by research only becomes powerful when it is used. There has been increasing attention in the reproductive health field to this important issue through numerous efforts to improve the process of research utilization. One such effort is Family Health International's (FHI) Research to Practice (RtoP) Initiative, which began in 2001 under FHI's Contraceptive Technology Research (CTR) Program. An evaluation of CTR in 2003 praised the initial efforts of the RtoP Initiative and emphasized the need to build in specific mechanisms for research utilization into CTR's follow-on project.

II. Methodology

With the CTR Program coming to an end in 2005 and the new Contraceptive and Reproductive Health Technologies Research and Utilization (CRTU) Program beginning, FHI decided that this was an opportune moment to conduct an assessment of the RtoP Initiative. The goals of this assessment were to assess the main achievements of RtoP and the challenges faced along the way, identify key lessons learned, and provide guidance for the future of research utilization at FHI.

Data collection took place between April and June, 2005 and included document review and interviews with 48 key informants, representing FHI, USAID, Ministries of Health in Kenya and Uganda, and a number of other collaborating agencies. Documents included materials developed by RtoP, trip reports, Memoranda of Understanding developed with various agencies, and workplans. The interviews explored the RtoP Initiative's collaborations and interactions with other organizations, the successes and challenges faced by RtoP, the impact of RtoP, and suggestions for improving research utilization at FHI and more broadly.

A three-person team undertook the assessment. Julie Solo, an independent reproductive health consultant with extensive qualitative evaluation experience, served as Team Leader and independently conducted the interviews in New York and with several FHI staff. Susan McIntyre, Director of Evaluation for the Contraceptive Technology Research Program, and Elizabeth Warnick, Research Utilization Advisor at USAID, assisted with planning, conducting selected interviews, analysis of the findings, and report writing. Erin McGinn, an FHI Senior Program Officer, provided background materials and made all the arrangements for the interviews.

III. Findings

A: The Origins of RtoP

The idea of creating the Research to Practice Initiative (RtoP) came both from within FHI and from external influences, most notably USAID. In particular, respondents noted the central role played by FHI’s Technical Advisor at USAID, Mihira Karra, who was a strong champion for improving research utilization. A number of respondents noted that the idea of research utilization was not new to FHI, “*It’s always been an underlying philosophy of FHI.*” However, it was seen as important that there be a more systematic approach to ensuring that research results were being utilized. In addition, both USAID and its research partners faced increasing pressure to make a strong justification for research by having more systematic documentation and evidence of its impact. As one respondent explained, people were unhappy with “*things which went nowhere, such as Lea’s Shield.*”

And so the Research to Practice (RtoP) Initiative was launched in 2001, with a dedicated budget and two full-time staff. The initial activities included the following:

1) **Planning.** FHI brought in an external facilitator who specialized in program management, and convened a number of staff members, who became known as the ‘brain trust’. The group created a log frame and identified the main areas of focus for the Initiative. According to FHI staff, “*that was a good way to start. We brought a lot of people in to get them vested in the whole process of utilization.*”

2) **Identifying key findings.** At that initial retreat, the group created a rough cut of the key findings that would be emphasized in the initial activities of RtoP. Box 1 shows the selection criteria that were used. This list of findings was later refined, and included the IUD, the pregnancy checklist, and vasectomy. Many acknowledged that this built off a list developed by John Stanback, a staff member at FHI, of the top ten underutilized research findings, which was well-known among respondents.

Box 1: Selection Criteria for initial RtoP findings

➤ Country interest / demand	➤ Providers also interested in use of findings – not just elites
➤ FHI ownership	➤ Practical, actionable steps – flow from research
➤ Global importance / broad potential for PH impact	➤ Timeliness of findings – “News worthy”
➤ Could contribute to international PH dialogue/set the agenda	➤ Packaging of findings (Checklists, etc.)
➤ Close link with CTR objectives	➤ Affordability
➤ Broad consensus among RP Health experts on findings	➤ Findings in alignment with ethical mandates
➤ USAID resources / support for moving findings to prime time	➤ Meeting large public concern – esp. HIV-related findings
➤ Other partners interested in promoting findings /utilization	➤ Easy to implement

3) ***Promoting the initiative externally.*** A significant part of the first year of the RtoP Initiative was spent making people aware of the existence and purpose of the initiative. This included three main areas of activities: a) the ‘road show’—RtoP staff visited 30 organizations to talk about RtoP and about specific research findings; b) specialized targeted materials development; and c) developing strategies around specific topics—IUDs and checklists.

4) ***Promoting change internally.*** One of the other key focus areas identified after the initial planning meetings was institutionalization of research utilization at FHI; “*People were least excited about that, but it probably had the most impact because it was most under our control.*” This included a number of internal workshops in 2003, including broad overviews and specific brown bags. In addition, there was a review of existing policies and procedures and forms in developing projects. In the first year, RtoP staff helped to change seven forms, adding elements to them to obtain research utilization information and/or to prompt thinking about the programmatic implications of research.

B: The Achievements of RtoP

There was universal agreement that the two original RtoP staff (Matthew Tiedemann and Erin McGinn) did a very good job in a short period of time with a limited budget (estimated at \$1.2 million from its inception until June 2005). Table 1 shows some of the achievements organized by the five main outputs from RtoP's initial logframe. What follows in this section is the story behind these achievements.

Table 1: RtoP Achievements for five main outputs

Internal	
<i>Output 1: Research to practice process institutionalized within FHI</i>	<ul style="list-style-type: none"> • FHI forms modified to incorporate RtoP elements • RtoP logo developed and used on materials • RtoP channel created on FHI web site • Sessions of CTR TAC devoted to research utilization (2003- 2005) • Re-organization of FITS and new Director of Research Utilization (2005) • FHI's Publications tracking board revised to include implications for practice for each article.
<i>Output 5: RtoP monitoring and evaluation systems strengthened and staffed</i>	<ul style="list-style-type: none"> • Questionnaires developed to monitor use of checklists • CTR's Semi-annual reporting amended to prompt for impact of utilization efforts • RtoP workplan established and monitored with regular interdivisional meetings.
External	
<i>Output 2: Strategic Alliances established with CAs and others to promote research use</i>	<ul style="list-style-type: none"> • RtoP introduced to 30 organizations (2002-04) • Participation in WHO's task force on research utilization, including assisting in development of research utilization toolkit • Two inter-agency workshops held on IUD (2003) • Vasectomy workshop held in collaboration with EngenderHealth (2003) • CBD workshop held in collaboration with Frontiers • MOUs negotiated and signed with eight partner organizations (CONRAD, ACQUIRE, PATH, Population Council, ADRA, INFO, MSH, Save the Children)
<i>Output 3: Collaboration with USAID/W and Missions to promote research use</i>	<ul style="list-style-type: none"> • Presentations at USAID MAQ Mini-Universities/SOTAs (2003 & 2004) • Participated in Advance Africa's Best Practices Compendium—submitted case studies as part of working group
<i>Output 4: Implementation of FHI country, regional, and topical RtoP strategies</i>	<ul style="list-style-type: none"> • Revitalizing IUD in Kenya • Revitalizing IUD initiated Uganda • Reintroducing IUD work begun in Guinea • Network of Champions launched in 7 countries (Pakistan, India, Ethiopia, Uganda, Tanzania, Zimbabwe, Nigeria) • FP/VCT activities in Kenya • Pregnancy checklist institutionalized within APROFAM in Guatemala, leading to significant decline in # of patients rejected for contraceptive use • Development of RtoP-specific information materials & tools <ul style="list-style-type: none"> * Checklist reference guide developed in English, Spanish and French * List of underutilized research results developed with references * 8 RtoP program and research briefs developed * IUD Advocacy Kit for Kenya

1. A Sea Change

The RtoP Initiative has begun the process of changing the mentality of FHI. There have been many positive steps towards institutionalizing RtoP and towards operationalizing utilization and spelling out how to do it. While some referred to it as a “*sea change*” or a paradigm shift within the organization, many also pointed out that this was not radically different from what FHI had been doing. What was different was making the process of utilization more systematic. Many noted the importance of having dedicated staff and funds allocated specifically for RtoP as a key factor in making this happen.

A number of comments from respondents highlight the degree to which RtoP has been institutionalized within FHI; “*this conversation is a part of the fabric of the organization;*” “*It is institutionalized in the sense that we think of our work in an RtoP way;*” and “*the ethos has changed from an afterthought, what does this all mean, to thinking about it at the beginning.*” RtoP is frequently discussed in staff meetings and is talked about by senior management. In addition, there is generally more discussion about what projects would have the biggest impact, with people “*thinking more long term about why we’re doing what we’re doing.*” One respondent talked about language conditioning thought; “*FHI has always been doing research to practice, but there is a value to labeling it that.*” After 2000, the words ‘Research to Practice’ became an increasing mantra of FHI, according to one individual. It is also encouraging to note that RtoP seems to have had effects even beyond the CTR Program; one respondent noted that there was a real RtoP approach at YouthNet; “*good to see that it had permeated beyond CTR.*”

In spite of all these changes, respondents still see this as a work in progress, “*it is evolving and developing,*” and note that the changes within FHI have been very gradual. In general, it is difficult to overcome inertia in an organization; “*people want to do things the same way they have been doing them and RtoP means doing things differently.*” There is still a need for more staff development and capacity building around research utilization; “*still about 30-40% of the staff do not understand what an RtoP statement is,*” according to one respondent. In addition, there is a continuing need to provide orientation on research utilization to new staff. There has also been resistance from some researchers about the idea of being an advocate; “*researchers wanted to be neutral—advocating for your results is not being a proper researcher.*” Another respondent echoed this idea: “*once you start pushing, do you lose your neutrality? But why do research if it’s not going to be used?*”

There have been varying levels of acceptance of RtoP in the different divisions of FHI. While RtoP is fairly well incorporated into the HSR and FITS divisions, according to one respondent, “*RtoP is not on the radar screen of people in [CRD].*” When one CRD staff member was asked about how the organization could enhance research utilization, the response was indicative of the division’s separation from RtoP: “*I haven’t thought about it. My goal is to make the clinical trials high quality and reliable.*” Although there is a model of how the different divisions work together, some respondents pointed out that in fact there was still minimal communication between the different divisions.

Interestingly, some respondents feel that *“RtoP might actually facilitate getting people together.”*

Another challenge faced by RtoP staff was the inconsistency in funding. As the budget went up and down, it made it difficult to plan RtoP activities. This was particularly a problem when projects had to be dropped; *“we had to scrap things that had to be done, and this undermined our work and the perception of this as something serious. If you cut the budget in half, people see it as half as important.”* The consistency of funding is particularly important for building relationships with other organizations. In describing the RtoP budget, a respondent highlighted that *“more important than the amount is consistency. We kept having the budget go up and down. We had to cut a whole initiative. We had spent time cultivating relationships and that is harmful. If you are planning long-term, you need some kind of consistency.”* In addition, staff point out that in spite of budget cuts, expectations remained high and often *“were a stress that could have been mitigated a bit.”*

When asked if anything could have been done differently in terms of internal changes at FHI, one respondent pointed out the problem when you push something too much; *“sometimes people hear the phrase too much and you get a reaction against it. I wouldn’t have pressed it too much more than was done.”* However, some others felt that there could have been more strong support from senior staff early on; *“there was talk, rhetoric... but not much muscle behind it.”* Others highlighted the challenges of creating change at FHI, where there is a *“culture of independence”* which makes it difficult to bring about top-down change. In addition, people go into research or programs for a reason and do not tend to think about the other side. Currently, there is more support from senior management, and people are being encouraged to take on research utilization *“not just with a stick. Also this RtoP is a service to you and the work you do will have more impact.”*

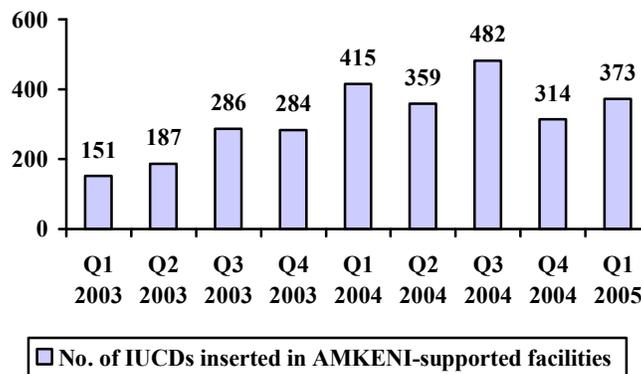
2. Specific Projects and Setting the Agenda

In looking at specific projects under RtoP, it is not surprising that those most commonly mentioned are the topics that were chosen as focus areas: revitalizing the IUD (in particular the experience in Kenya is well-known), the pregnancy checklist, and vasectomy. It was important in the first years of the RtoP Initiative to have some RtoP branded projects to raise the profile of the work and to learn lessons about utilization. In addition, people need concrete examples to show the way, to make conversations about collaboration and utilization more meaningful. Projects such as the IUD reintroduction in Kenya *“give you things to talk about, ways to learn, and some credibility.”* They also help to deepen relationships and build trust; *“you don’t get it because you’ve signed a piece of paper. The way to do that is to have projects.”* Respondents at Save the Children described how there had been discussions between their organization and FHI at the high levels, but the relationship became more meaningful when they started working on the IUD together, a project which addressed their existing needs; *“we were at a point where we wanted to increase our method mix, so that was another opportunity.”* On the

other hand, although FHI signed an MOU with ADRA in August 2004, the two organizations have yet to identify a specific project on which they can collaborate.

Revitalizing the IUD has been a major focus area for RtoP, including the organization of two IUD inter-agency workshops in July and November 2003. The most extensive effort has been a project in Kenya that has been promoting the IUD as part of a balanced method mix. Beginning in 2001, this effort has focused on mobilizing stakeholders and has created a task force with the MOH as the chair. The strategy consisted of sensitization and advocacy, capacity building, demand creation, and monitoring and evaluation, and has generally been viewed as a success; *“We have been able to see that despite biases and service delivery challenges we can still use research to make a difference. Especially for the IUD—it had really gone down in use. All we had in our hands to turn it around was knowledge and information.”* Figure 1 shows the impact up to March 2005, generally indicating increases in IUD uptake. It is interesting to note that there has been great interest in replicating the Kenya model in other countries (e.g., Uganda) even before there was evidence of success.

Figure 1: IUD uptake through March 2005, Western and Coast Provinces, Kenya



In terms of promoting the pregnancy checklist, a respondent said that RtoP staff *“have done about as much as they could do.”* This included following up and tracking where it has been used, putting it on the FHI web site, printing thousands of copies in a package with other checklists and distributing these, and sending letters to USAID Missions and Ministries of Health. Information Programs and the RtoP staff also distributed it through several list serves which *“got a tremendous response. That was one of the best bangs for the bucks.”* *“That checklist is very famous,”* one respondent said. When a respondent in Kenya was asked about the pregnancy checklist, he responded, *“that has been so institutionalized that I forgot about it.”* Despite the numerous and varied means of dissemination and many positive responses, FHI and USAID have had ad hoc reports that the pregnancy checklist list is not known or used by some USAID-supported programs, indicating the difficulty of “handing off” research results to a broad array of service delivery organizations. To encourage use of the checklist in Egypt, it has been necessary to conduct additional research to show that the checklist is appropriate and effective in that setting.

Vasectomy was another area identified as an RtoP focus area. In December 2003 FHI and EngenderHealth jointly held a three-day meeting on vasectomy which brought together experts to discuss current evidence, future research, and programs in different regions. Staff from both organizations talked about the success of this collaboration; *“it was a win-win for everyone.”* This meeting is an excellent example of the benefits of effective collaboration. While FHI focused on the biostatistical side, EngenderHealth was able to bring up the programmatic side, in particular developing messages for clients; *“coming from researchers, the messages would drive clients away.”*

A recent study in Uganda that tested the safety and effectiveness of having CBD agents provide Depo-Provera shows another example of good collaboration and how it facilitates utilization of research results. The implementing partner for this work spoke highly of their collaboration with FHI, how FHI staff *“were very responsive to the team’s needs, and went [to the field] on a regular basis.”* This agency will share the results through their annual program learning groups (one week of technical updates and sharing of program results for field staff). But what is FHI’s role now that the successful results have been disseminated? *“We should get people familiar and comfortable with the idea. Get it into service delivery documents, put pressure on CBD programs to nudge it along, support them in any way we can.”* This will include sitting down with RtoP staff to plan for follow-up activities.

Negative findings can be as important as positive findings. Respondents mentioned a few examples of this, including nonoxynol-9, which was removed from USAID’s procurement when it was found to be potentially unsafe, and the female condom. A study on the female condom in Kenya found that it was no more effective than the male condom and was more expensive. This *“helped to tone down enthusiasm and helped target efforts better. The study was money well spent,”* according to USAID staff in Kenya.

There is a great deal of interest in FHI’s findings on integration of family planning and HIV/AIDS, in particular work on integrating FP and VCT or PMTCT. The Global Leadership Priority (GLP) coordinator for integration at USAID speaks highly of FHI’s work in this area; *“FHI has been the most successful in implementing and evaluating integration.”* GLP funds have supported work that *“is now ready to take to scale”* in particular FP and VCT. The work in Kenya was taken up at the national level, with policy and advocacy work taking place at the same time as research, and integration became a subcommittee within the National AIDS Control Program (NACP). But some ask whether these findings are ready for scaling-up; *“people say let’s scale up integration, but we’re just starting out. There is still a lot of work to do before scaling up.”*

In many cases when people talk about research utilization, they are mostly interested in scaling up projects. A number of respondents both within and outside of FHI raised concerns about the feasibility of effectively scaling up the models that are tested; *“there is a genuine concern that we put so much effort into our operations research that we test*

something that we're not scaling up." It is understandable that there is pressure for scaling up but *"since we're testing under an ideal setting, should we be scaling up if we're not sure it's going to work."* In the words of one respondent, just because *"it works in the test tube does not mean it will work in the cauldron of reality."* *"Researchers want to elegantly show that this thing works—so they control every bit of the environment so it becomes unrealistic and ungeneralizable,"* as one person explained, and so it is important to separate out the research components and service delivery components.

It is also important to note that there are different processes for utilization for different findings. For example, *"we know the IUD is a good method, but there still needs to be operations research. What do we mean by scaling up research with the IUD? There are some pretty good reasons that it hasn't been widely used. The pregnancy checklist is different—we know how it works, so we shouldn't need to do additional research except to get country buy-in."* Vasectomy is similar in that you cannot just say that it is a good method as there are many other issues. It is necessary to determine when you need more research, or when you need to simply encourage utilization of research findings via a meeting, dissemination, or training, for example. Another respondent echoed the same ideas; *"Trying to go global is easier with some things, for example the pregnancy checklist. It is easier because it's a tool, and so you just need TA. The IUD won't happen without a lot of field involvement."*

An RtoP approach has important implications for how research projects are chosen. There needs to be more emphasis initially on thinking through why a certain study is important and what is the potential public health impact; *"that should drive it."* In general, the programmatic research of HSR is easier to justify to RtoP; *"we're trying to solve a problem that someone has raised."* In CRD, on the other hand, *"a lot of our research is not as closely related to practice as HSR. Our research relates to providing evidence for guidelines and policies. We respond usually to a need from USAID or WHO, not from a clinic in Kenya. It is not coming from or going back to the field in the same way as HSR."* Both kinds of research are necessary. As a respondent from HSR explained, *"our job is easier, but someone has to do the epidemiology."*

One of the challenges faced by FHI is that of *"merging the global and the local."* This is in fact a general challenge of core global initiatives and how they can be effectively translated to the field and bilateral activities. Respondents described the differences between Frontiers and FHI's research, stating that research undertaken by Frontiers tends to be country-specific so the *"results are already at the consumer's doorstep"* as compared with FHI's more centralized approach.

It can be a difficult process to determine research priorities, especially when, as respondents pointed out, there are so many actors and so many agendas. FHI has typically been sensitive to needs from USAID, *"but we have to be careful that we're doing it because it's the right thing to do."* Many respondents emphasized the need to focus on practical questions and not just academic questions. Service delivery agencies expressed a strong desire to have more input in developing the research agenda so that there is joint determination of priorities.

Some of FHI's research agenda comes directly from the WHO Eligibility Criteria and the Selected Practice Recommendations. These documents are very influential in programs, and so by having research findings feed into these, FHI is having a strong RtoP impact, but one that is very difficult to measure and quantify. For example, getting WHO to change the eligibility criteria for HIV and STIs and IUDs was described as a "watershed." A respondent from a service delivery organization explained: "*Good quality research gets translated into guidelines, that's where it has biggest influence, then we implement those guidelines. That is the pivotal point, where research affects a worldwide audience.*"

3. Building Relationships

In part due to RtoP, FHI has engaged more in partnering with other Cooperating Agencies (CAs) in the last few years; "*the RtoP process has enhanced collaboration and dialogue with other organizations.*" This was greatly facilitated by having dedicated staff and through the initial 'road show' and extensive follow-up. "*It is radically different now that you have staff with the time and the airplane budget... Personal follow up is very important. You have to develop trust. They have to come to know you to accept you, and you have to know them to produce appropriate materials, etc.*" It can take time for these interactions to lead to concrete activities; "*the targeted outreach to CAs was useful and we should do more—now it is paying off and people are coming to us.*" In the past year, spurred in part by strategic planning for a new Cooperative Agreement, FHI began to develop Memoranda of Understanding (MOUs) with a number of organizations. These relationships should help the CRTU to have a more realistic program perspective, and also allow service delivery organizations to more readily absorb findings since they will have been involved all along.

In addition to the CAs such as EngenderHealth, JHPIEGO, etc., FHI has begun to reach out to the Private Voluntary Organization (PVO) community. This has already been done with groups like Save the Children and the Adventist Development and Relief Agency (ADRA), and these efforts should continue, through umbrella groups like CORE and through implementation of MOUs developed with these organizations. A respondent pointed out that "*if there wasn't a gag rule, FHI could make huge impact through IPPF*" and so FHI could pursue doing this with other funding sources.

Collaboration can be difficult given the state of competition among CAs; "*USAID doesn't foster collaboration—that's hard to address.*" A number of respondents talked about the need for some kind of 'safe space' or 'safeguard initiative'. One respondent described the Maximizing Access and Quality (MAQ) initiative as just such an opportunity: "*the beauty of MAQ is to bring people from different CAs and give them safe space to work collaboratively on common goals.*" Many note that making linkages in-country happens more easily, while at the higher levels people often see each other as competitors. In collaborations, it is necessary to clearly define roles. For example, a respondent mentioned this issue in regards to the integration work in Kenya, explaining how FHI is

“coordinating a lot of things in the FP/VCT work, so we’re going beyond research and probably stepping on other’s people’s toes. They may perceive us as overstepping our research role.”

The Kenya IUD experience highlights the importance of engaging stakeholders, particularly at the national level. This national level buy-in has been critical in Kenya for both the IUD and FP/VCT experience; *“you have to work at the national level—that is key.”* The lack of such buy-in can greatly limit utilization of research findings. This was shown in the experience of a case study undertaken in Ethiopia to evaluate different CBD models. The intention of the project was to integrate findings into national guidelines, but this did not happen, probably in part because of the lack of MOH buy-in as indicated by the fact that they refused to sign an MOU with FHI. Collaboration is challenging and time-consuming, but has important payoffs and is greatly appreciated at the field level. According to a respondent in Kenya in describing the IUD reintroduction, *“team work was essential in getting things done. We are research not service delivery. The commitment of the MOH was invaluable.”* In addition, getting leaders such as the MOH and the OB/GYN and Nurses Association to embrace the project *“gives credibility to the data.”* This key issue of credibility was brought up frequently. For example, people stressed the importance of information that comes from WHO, because it has this credibility built into it; *“WHO gets extra weight, but WHO is looking to FHI for the basic facts.”*

In addition to FHI strengthening its relationships with a range of organizations, there is also a great deal of potential in facilitating south-to-south communication and collaboration. For example, the MOH of Uganda went to Kenya to talk with the Kenyan MOH and FHI about replicating the IUD reintroduction model. In addition, teams from other countries came to the dissemination meeting in Uganda for the study on having CBDs provide Depo-Provera. INFO is currently focusing on facilitating the use of information by setting up networks, and encouraging south to south interactions, and FHI should explore collaboration in such efforts.

4. Spreading the Word

The RtoP Initiative produced a number of different materials, including: 1) a list of underutilized research results with references; 2) research and program briefs on ECPs, vasectomy, IUDs, and CBDs; 3) an RtoP channel on FHI’s web site; 4) an issue of *Network* on Research to Practice, in collaboration with Information Programs; and 5) an IUD Advocacy Kit as part of the Kenya IUD reintroduction initiative. People praised FHI’s communication efforts, in particular highlighting the underutilized research findings and the issue of *Network*. Although many people said they used FHI’s web site, most preferred receiving information on a monthly or quarterly basis so that they do not have to go searching for it. A number of people mentioned the importance of using the MOH logo on the IUD materials in Kenya, as this *“made the messages so much stronger.”*

RtoP has had an impact on the way Information Programs operates, as now there is “*so much more on-going sitting down and figuring out communication efforts—What TA can we give to make that more effective.*” A number of respondents cited the recent model of developing a communication plan to disseminate the highly-anticipated findings from a study on hormonal contraception and HIV. This involved working with a range of stakeholders and planning a dissemination meeting in Kenya, a location where the results will be of significant interest and importance.

RtoP also helped FHI’s staff in their interactions with USAID Missions. “*It is much easier to sell what we do when you stick it in an RtoP framework. We had been trying to get field support—this gave it a programmatic spin, which USAID Missions were more interested in. The top ten list gave us something to talk about and made research more exciting to service delivery people.*”

FHI has managed to take advantage of a range of opportunities to get their findings out. For example, the checklists are being considered for inclusion in the New Essentials of Contraceptive Technology handbook that is being developed, and they will also be an insert in the upcoming Pop Report on IUDs. Staff at INFO state that they regularly incorporate FHI findings into their publications.

Many referred to the problem with information overload; “*people are drowning in all these initiatives trying to do the same thing, IBP, RtoP, compendium of best practices, etc.*” INFO, as well as CTR, tries to address this through segmenting their mailing list, which helps to prevent overload and also saves money. Much of research utilization is like match-making and requires matching the information to the relevant groups. When this happens, “*the need meets the information and it is transformed into something that is relevant for that context.*”

Often it is not just information that is needed, but rather it is a question of breaking down resistance, both in carrying out a study and in implementing the findings. For example, the study of Depo-Provera provision by CBD workers took two years of effort just to secure a country and site willing to field the study. Even then resistance might not have been overcome but for a change of staff in a Ministry of Health. Delays were also experienced with the FP and VCT integration project, for as one respondent observed “*four years ago there was a lot of resistance because people have different ideas about what should be integrated.*” Sometimes research is “*obvious stuff, even already in guidelines, it’s just that there’s resistance.*” Addressing this resistance requires active dissemination and advocacy. As one respondent explained, it is necessary to go beyond passive dissemination.

This highlights the need to have more than written materials and engage in more face-to-face interactions and advocacy to move research into practice. This means being present at appropriate meetings, contacting key people and following up with them; “*one on one leads the way more than information on the internet.*” This kind of work-- the “*schmoozing process*”—not only takes time and resources, but also requires skills that researchers might not have. In addition, some researchers are uncomfortable with the

idea of being advocates. This has implications for who does what and what skills research organizations should look for in at least some of their staff. There are some findings that the world is waiting for (e.g., HIV and hormonal contraception), but some results you have to push, and so FHI “*should hire some people who can advocate.*”

Beginning in September 2004, RtoP began an innovative program called Network of Champions with the goal of tapping local opinion leaders to promote utilization of FHI’s underused research findings. Seven individual “Champions” are currently working in Tanzania, Uganda, Ethiopia, Zimbabwe, Pakistan, India, and Nigeria. They have each identified family planning issues that are of particular interest or relevance to their country and are tasked with working to bring about change while continuing in their roles as professors, providers and/or program managers. As one Champion explained, “*Sometimes instead of just doing another research study, it makes sense to consider what other options there are. Maybe a person can help bring change.*” To be truly successful, however, Champions will need to engage others in efforts to bring about change; “*A champion can’t do it all themselves, indeed that would defeat the purpose.*” The program is still new and budgets for the Champions themselves are small, limiting what support they have to host meetings, provide materials, etc. Nonetheless, there is evidence of some early successes with Champions who have presented at regional conferences on underutilized findings, linked with FHI staff to facilitate the visit of an expert on fascial interposition to India, and helped to draft the family planning section of a new training manual to be developed by a Department of Obstetrics and Gynecology. Change is often a long term process and hence long term support is important. This appears, however, a promising new approach to both extending FHI’s “field presence” in a cost-efficient manner while at the same time promoting research utilization by supporting in-country opinion leaders. Ultimately the “*opportunities may not always be those planned but those for which a person is in right place at right time.*”

5. Timing is Everything

Respondents highlighted the different time-frames that researchers and service delivery groups function in, and how this complicates the process of research utilization. While people working on service delivery typically see immediate issues, researchers do not work in the same time frame. “*They are out of sync*” and there is a “*need to synchronize the research world with the service world.*” Another pointed out the “*impatience with research—this won’t have big payoff in a time frame that is relevant to the program.*” In describing a collaborative research project between FHI and a service delivery organization, a respondent explained how “*program people have a very short time frame, not suited for the long time frame with the back and forth of collaboration. It might have been better to use simpler research methods.*” A similar issue arose with another project where the field staff wanted to have the research done within three months, which was not feasible for the type of research that had been planned. There is a need to acknowledge these different perspectives and to “*reduce the time lag,*” which can partially be addressed by researchers having an array of methods, some of which are faster (though still high-quality) to build trust and develop working relationships; “*there*

is a need for faster responses, to have some more rapid research methods, so they can get more credibility with the service delivery side.”

Many see the IUD work in Kenya as successful, but point out that it has been a very lengthy process. The challenge now is to find ways to do similar work but in a faster time frame. It will be useful to document the process of IUD reintroduction in Uganda and see if and how this is done more efficiently, and how this impacts the results.

Some aspects of research utilization are beyond the control of the research organization; sometimes it is really a question of timing. Respondents frequently talked about this issue; *“the right time, the right finding, the right place, a receptive government—a lot of it is out of your control.”* Part of the reason the Uganda MOH was interested in the IUD work was that concurrently they were looking at revitalizing family planning more broadly, and so the work on revitalizing the IUD fit nicely with their existing needs. In addition, EngenderHealth had just received funding to work on long term methods in Uganda, including the IUD, and there was already a strong relationship developed between FHI and EngenderHealth. This kind of timing and synergy cannot necessarily be created, but FHI can continually keep its eyes and ears open for such opportunities.

6. Measurement

Table 1 at the beginning of this section showed the five outputs that were initially identified for RtoP. In describing its key accomplishments for the purpose of this assessment, however, the following categories were used: 1) collaboration with other organizations; 2) advancing use of results, which included materials development, IUDs, Checklists, and Female Condom; 3) conceptualizing and advancing research utilization; and 4) institutionalization of RtoP. These seem to be more useful categories than the five outputs in terms of effectively capturing what RtoP has done.

The team asked all respondents for their input on how utilization should be measured and up to what point in the process of utilization FHI should be held accountable. Very few could give a definitive answer, as this is a question that many are still grappling with. Many cited the adage, ‘You can lead a horse to water, but you can’t make him drink.’ But as one respondent added, *“you can also facilitate drinking. If they still refuse, probably the responsibility shifts.”* Another felt that it was better to hold dyads—that is research and service delivery organizations working in partnership-- accountable, rather than just the research organization.

The two main areas of responsibility that were highlighted by respondents related to information dissemination and advocacy activities. *“Our responsibility is to get information in a good, timely way to program managers and policy makers. We should have some responsibility for checking in with those people.”* Some respondents emphasized the way the results are packaged as an important part of FHI’s responsibility; *“make sure the results are packaged in a way so that we can use them safely in our programs.”* [this was mentioned in terms of nonoxynol-9 and the worry that they might

use the information in a wrong way]. Many referred to FHI's role as that of catalyzer or facilitator; *"I would hold them responsible for jump-starting the idea."* There is a need for FHI to develop workable indicators to measure this concept, and FHI should consult with advocacy groups to see if there any appropriate indicators to use. Overall, as one respondent asked, *"what would we do to demonstrate that every effort has been made?"*

Many talked about the idea of a hand-off point, where the burden of the responsibility shifts from the research organization to a service delivery group. But defining exactly when and how this occurs is more difficult. Another referred to the *"bridging period,"* which would include advocacy, technical assistance, monitoring, and coaching. But projects are rarely structured to include this; *"funding usually ends after getting the information out. If you are really interested in use, there is a bridging period of 1-2 years."* This requires someone dedicated to work on it, preferably someone easily accessible to the policymakers, program managers and providers, as was done with the IUD work in Kenya. Gradually the role of the researcher decreases over time and it also changes character; this becomes harder to measure, and harder to define concretely.

There are a number of aspects of utilization that are very difficult to measure. For example, *"the further it gets from the research, the harder it is to attribute."* This is illustrated by the replication of the Kenya IUD experience by Uganda because from an evaluation standpoint, it will become less attributable to FHI's RtoP efforts, even though it is still building off the initial research and inputs of FHI. It is also challenging to get information on all the supportive things that FHI does, such as influencing donors and capacity building. FHI's impact goes beyond the findings, as they also impart information and skills on the research process. For example, many people cite the training in ethics, stating that *"FHI has raised the standards on ethics."* Finally, while many people talked about how they go to FHI's web site to get information, and how useful *Network* is, this is difficult to capture, particularly in terms of then seeing just what impact that has on programs or policies.

An issue that arose repeatedly in interviews was the importance of documentation and effectively telling stories. This is an important need that FHI meets and can continue to help meet for implementing agencies. In describing FHI's work in integration, a respondent explained that *"FHI surfaces as a leader because they have done a good job in evaluating. Others can't tell their story. Without evaluating, we lose the experience."* Service delivery CAs are engaged in implementing programs *"but there is not a big impetus for evaluating, so give some money to FHI [to do this]. We need to do more and more of that."* A respondent from a service delivery agency highlighted how FHI was very invested in communication and said that they liked collaborating with FHI because *"we know the results will be communicated."* Respondents at another implementing agency echoed the idea of needing assistance in documenting program experience to assist with replication; *"we're not too good at documenting. We're too busy implementing to do formal documentation."*

C: The Future of RtoP

1. Where do we go from here?

The beginning of the new cooperative agreement—CRTU—provides an important opportunity to “*build RtoP in how we do business so it’s part of our evaluation structure, our goal structure, our priority setting.*” RtoP was added into CTR, but CRTU was designed specifically with a research utilization approach. In theory, FHI is moving away from having an RtoP Initiative to there being consideration of research utilization in everything FHI does. There are clear signs of research utilization becoming a more integral part of CRTU, including appointment of a Director of Research Utilization who oversees both RtoP and Information Programs staff, and modification of concept proposals to include stronger emphasis on utilization (see Table 2). It will be necessary to continue this process of institutionalization; “*it will require constant vigilance to make this a priority*”. Staff involved in RtoP said that in retrospect they should have done more regular convening of the brain trust group to look at priorities. It will be important under CRTU to continue to have regular meetings to assess the progress of research utilization within FHI, with representation from all divisions.

Table 2: Changes in Concept Proposal Forms at FHI

CTR subproject description	CRTU subproject description
1. Background	1. Background/ potential for public health impact
2. Objectives	2. Basic study/ subproject design and methods
3. Describe the potential policy or programmatic implications	3. Expected outcomes (include policy and programmatic implications)
4. Basic study design	4. Feasibility
	5. Potential for scale-up and/or replication
	6. Ethical considerations

Just what will true institutionalization look like? One respondent described it as follows: “*You wouldn’t do a clinical trial without a biostatistician telling you the sample size needed to show what you want to show, and utilization should be as automatic as that. We should think about the end product at the beginning—what it will do to change policy and improve programs, then how do we move that product into wider scale use.*” Another explained how the plans for pre and post-study utilization activities will be just as important in research proposals and budgets as the statistical and the monitoring plans. When asked how to make utilization a reality, respondents highlighted the need to get rewarded for it and get credit for utilization; “*just as important as a good clinical trial is good utilization.*” In the first few years of the CRTU, FHI will have to show that procedures are in place “*to make utilization everyone’s business.*”

But if utilization is everyone’s business, then what exactly is the role of RtoP staff? As research utilization gets more institutionalized in the organization, there needs to be discussion of exactly what the role is for RtoP staff. “*We’ll never have a big RtoP army. The question is how to leverage that expertise and build it into orientation of employees and processes so research utilization becomes a part of what everyone does.*” It will be

essential for RtoP staff to continue to build the capacity of FHI staff and to provide technical assistance internally. In addition, these staff members play a key role in establishing and maintaining relationships with partner organizations and in implementing specific RtoP activities.

A great deal of RtoP's success has been in Kenya, and much of this is due to the presence of a field office in Nairobi. Under CRTU, FHI will explore ways of expanding its field presence. It would be interesting for FHI to set up different models of creating a stronger field presence and then use this as a natural experiment. For example, in the first year of the CRTU, FHI's Institute for Family Health could set up a new field office in one or two countries, and then in one or two other countries work through partnership and capacity building of a local partner. At the end of five years, there could be an assessment to look at the different costs and effectiveness of these two different approaches. Also, as noted earlier, the Network of Champions is a potentially promising approach to extend FHI's field influence in a relatively inexpensive way.

In addition to strengthening field presence, FHI staff need to incorporate more of a field orientation and create closer collaboration with field offices of FHI and other organizations to help roll out findings; *“people in the field have a genius for this [research utilization] that scientists in the office here don't have.”* Some staff have that field orientation—they *“know what the slums are like in Pumwani”*-- but few of FHI's clinical researchers have that long-term overseas experience. Headquarters staff need to keep an ear to the ground and listen to the field. One FHI researcher suggested that FHI staff spend as much time as possible in clinics, *“look at the records—things pop out at you.”* Another pointed out the same idea of the usefulness of analyzing service data when you meet with service providers in order to identify important research questions; *“that might lead to a better outcome—ask them about trends and it starts clicking.”*

There is also a need to further strengthen the Practice to Research aspect, to ensure that the CRTU makes greater efforts to answer the questions that service delivery programs see as most important. This requires working closely with service delivery groups to identify these key issues and jointly implementing activities to find answers. In addition to working with the MOU partners, another avenue to explore is CORE, the group of PVOs engaged in reproductive health. Some respondents suggested distributing a questionnaire among CORE members to look at both underutilized findings and how much they are being used and to identify their needs. Another non-FHI respondent suggested that the CRTU take greater advantage of its strength in health economics and cost effectiveness research as this is an area of great interest to service delivery groups.

Doing all of this will require funding; *“If we're serious, we have to have funding for it. We need extra money, not just reallocating existing money.”* As was noted in the first three years of RtoP, consistency in funding is particularly important for planning purposes and for establishing trust with collaborating groups.

It will be important to have some RtoP or Research Utilization branded projects to keep focus and attention and make sure not to lose momentum. Respondents suggested at least

two more activities like the IUD reintroduction in Kenya, or choosing four or five countries for focused activities. In terms of choosing topics or sites, respondents highlighted identifying the strongest bodies of evidence and places where there is MOH interest; *“Look for right question in right country with the right partnerships and understand the proper pathway.”* Several respondents feel that one of the key areas will be FP/HIV integration.

FHI has contributed to the field of research utilization, and should continue to do so through collaboration with Frontiers, WHO, Knowledge to Practice staff at EngenderHealth, etc. It would be useful to conduct some research on research utilization, and this could be done by building in research components into some of the RtoP projects; *“we need funding to use these projects as ways to learn about the process, and the documentation will help build credibility and then we’ll be able to do more RtoP.”* One respondent suggested that it may be worthwhile to look at what programs are doing—for example, are they conforming to these major 10 or 12 items—and such an exercise could be used as a baseline/introductory phase to a research project on research utilization.

FHI should continue to revise their model for utilization to make it more practical and clear. The model should integrate the idea of a common goal for research and service delivery organizations. The starting point should not be the research, but the idea of a coherent approach to improving health through both research and service delivery. It is important to keep in mind that as much as there is a model, *“it is somewhat ad hoc the way this happens. Any idea that it is systematic is somewhat flawed. There is a limit to how much you can control it.”*

FHI is a research organization. Part of why it can have such a strong impact in RtoP is because of the high-quality of its research—*“FHI brings scientific cache”*--and this cannot be lost. Credibility was consistently cited as important, and this must not be compromised. *“FHI is highly regarded because of its long history in the realm of contraceptive technology. We’re the go-to organization on this topic. We have a certain credibility that we need to take advantage of.”*

There is a need for a public relations campaign for research, and while this is not solely FHI’s responsibility, the organization can play an important role. Research utilization work can greatly assist such efforts by highlighting the usefulness of research. Stronger relationships with service delivery organizations will hopefully help break down some of the biases against research. It can help bring it down to earth rather than being viewed as up in the rarefied air of the ivory tower. You still hear service delivery groups saying things like *“we are scared of high level research”* and in terms of getting their voices heard at meetings like FHI’s TAC, they say it *“might be a bit intimidating. We are not on top of things, because we don’t have as much chance to keep up on things.”* As a respondent from a research organization explained, *“we face the problem of distance between information producers and service delivery—that is the fundamental issue. We need some engagement in that larger relationship.”* Another explained that, *“The researcher’s job is to generate knowledge, service providers support programs, and each*

is a full-time job. The challenge is to get people to think beyond their own work week.” There should be more emphasis on describing the research process as “how can knowledge generators help service delivery organizations function more effectively.”

With a more holistic and thorough definition of research utilization, the utilization process can be more inclusive, both within and outside FHI. For example, doing high quality work and producing credible results is essential to enhancing utilization, but staff that are focused on ensuring high-quality clinical trials do not see themselves as part of RtoP. In fact, they are integral to research utilization, even if these staff are not the ones doing the advocacy and follow-up. A separate, distinct initiative was probably essential to raise the profile of research utilization and begin to change the mentality of the organization; *“unless you have a systematic way to take research to practice it won’t happen on its own—so such an initiative is necessary.”* But the danger of this approach is that utilization becomes seen as the responsibility of just a few, rather than being clearly seen as relevant to everyone’s work, just in different ways.

Change is not only required on the side of research organizations. There needs to be more pressure on service delivery agencies, and the cost of implementing evidence also has to be born by these agencies; *“if we could see a shift in service delivery groups, that would be a real step forward.”* For example, USAID could make sure that project papers and workplans explicitly include utilization of research as a responsibility of both research and service delivery groups. Many staff at USAID recognize this need to create better linkages between the service delivery and research divisions. And service delivery organizations see their responsibility; *“we have a role in this once we have the information, we take it to the field.”* But people will be more likely to do things if they are being held accountable for it.

FHI, and the reproductive health field in general, could benefit greatly from reinforcement of the idea that we are all working towards the same goal, so we *“see this as one enterprise.”* That research and service delivery are not two different worlds, but just two different parts of the same continuum working towards the same goals. This continuum is a win-win for the research and service delivery sides. As a respondent from USAID explained, *“there is a lot of value in working together towards a common goal. That is a pretty potent thing.”*

2. Summary of Recommendations for FHI and the CRTU

The Research to Practice Initiative has been successful in beginning the process of changing the mindset of FHI to have a more systematic approach to ensuring that research be as useful as possible. It is difficult to pinpoint exactly which of the activities of RtoP were most important, as different audiences and different situations required different sets of methods and materials. However, based on information from this assessment, the team makes the following recommendations.

- √ Reenergize participation by all divisions in quarterly meetings to assess progress on fully institutionalizing research utilization, including examining what is working well and what needs to be adjusted, and ensuring that the internal systems are in place and being used and that studies are being planned and conducted taking into account research utilization
- √ FHI needs to prioritize which activities will be undertaken by RtoP staff. While research utilization will be everyone's responsibility, there will be specific activities for RtoP staff to focus on, such as providing TA to FHI staff, building and maintaining relationships with collaborators, and implementing some specific RtoP activities
- √ A stronger focus on research utilization will require that FHI develop different skills among its staff, including strengthening the field orientation of headquarters staff and identifying either new or existing staff with strong advocacy skills to work on pushing research findings
- √ Develop a model that shows more clearly how research and service delivery are part of the same continuum and working towards the same goal
- √ Continue to define and refine workable and useful indicators for research utilization
- √ Partnerships become meaningful through concrete projects, and so FHI should ensure that each of its MOUs leads to a specific project within the first one-two years of CRTU; each MOU partner should have an FHI staff person assigned as the primary contact, responsible for following up and making sure partnerships are developing and proceeding smoothly
- √ The IUD advocacy materials were highly praised for having the Kenya MOH logo, indicating strong local ownership. This way of doing things should continue in developing materials under CRTU
- √ Implement at least three RtoP-branded projects so as to continue momentum and lesson-learning
- √ Incorporate research on research utilization in some of these activities
- √ In exploring ways to increase field presence, compare the advantages of setting up a field office as compared with building capacity of local partners in terms of cost and effectiveness

IV. Lessons Learned

In addition to giving guidance to FHI specifically, there are a number of lessons learned from this assessment with broader applicability to the reproductive health field. And so in the spirit of the initial top ten list of underutilized research findings, the following is a list of the top ten lessons learned about research utilization through the RtoP Initiative:

- 1. Research utilization must be viewed in its full continuum—it is not just getting existing findings out there, but a whole new way of doing things**
- 2. Enhancing utilization of research requires dedicated staff and consistent funding**
- 3. Credibility is key; this refers not just to the quality of the research, but also being a responsive organization and a reliable partner**
- 4. The ‘schmoozing process’ is vital to research utilization efforts and has implications for the skills that research organizations should look for in some of their staff**
- 5. Expectations of utilization must match the type of research**
- 6. Acknowledge the different time frames of research and service delivery worlds and find ways to bring these two worlds more in synch, for example by researchers having an array of research tools to meet different needs**
- 7. Both the research and service delivery sides need to be held accountable for research utilization; people are more likely to do things that are being measured**
- 8. Up-front involvement by service delivery groups in the research process, including strong field representation, should greatly facilitate research utilization**
- 9. Utilization is affected by many things beyond the control of researchers—but efforts can focus on those aspects over which there can be some control, such as the choice of projects, involvement of stakeholders at all points in the research process, effective communication, and advocacy to the key audiences**
- 10. Donors and implementing agencies need to reinforce the idea that research and service delivery groups are working towards a common goal; this should include ongoing advocacy efforts and development of a more comprehensive and clear model of how research and service delivery fit together into a cohesive continuum**

Appendix 1: List of Contacts

Organization	Name	Title
FHI/Institute of Family Health	Ward Cates	President
	Gary West	Senior VP, Operations
	JoAnn Lewis	Senior VP, Reproductive Health Programs
	Matthew Tiedemann	Country Director, YouthNet
	Erin McGinn	Senior Program Officer, FITS
	Beth Robinson	Deputy Director of Research Dissemination, FITS
	Jason Smith	Director, Research Utilization, FITS
	Mike Welsh	VP, FITS
	Tara Nutley	Deputy Director, FITS
	Barbara Janowitz	Director, HSR
	John Stanback	Scientist II, HSR
	Heidi Reynolds	Scientist I, HSR
	Teresa Hatzell	Scientist I, HSR
	Larry Severy	Director, BASS
	Julia Welch	Director of Implementation, CRD
Beth Raymond	Scientist II, CRD	
David Sokal	Scientist II, CRD	
Reshma Naik	Program Officer, FITS	
Abigail Haydon	Assistant Program Officer	
FHI/Kenya	Dr. Maggwa Violet Bukusi	Director, Technical and Field Programs, FITS Program Assistant, FITS
USAID/Washington	Jeff Spieler	Division Chief, Research, Technology and Utilization
	Mihira Karra	Technical Advisor, CTR
	Jim Shelton	Senior Medical Advisor
	Sarah Harbison	Senior Research Advisor
	Dana Vogel	Division Chief, Service Delivery and Improvement
	Nomi Fuchs	Senior Technical Advisor, FP/HIV Integration
USAID/Kenya	Dr. Mike Strong	Reproductive Health Officer
MOH/Kenya	Dr. Marsden Solomon	Manager, Division of Reproductive Health
MOH/Uganda	Dr. Miriam Sentongo	Programme Manager, Reproductive Health
Addis Ababa University, OB/GYN Dept., Ethiopia	Dr. Ahmed Abdella Mohammed	Part of Network of Champions
EngenderHealth	Roy Jacobstein	Clinical Director
	John Pile	Senior Technical Advisor
	Karen Beattie	Technical Program Director
	Jan Kumar	Senior Manager
	Ines Escandon	Senior Program Associate
Population Council/ Frontiers	John Townsend	Director
	Ian Askew	Regional Associate Director, Sub-Saharan Africa
Save the Children	Winnie Mwebessa	Family Planning & Reproductive Health Advisor
	Susan Otchere	Maternal Health Advisor
INFO	Ruwaida Salem	Research Writer
Adventist Development and Relief Agency International (ADRA)	Debbie Herold	Associate Director for Health
	Anne Woodworth	Technical Assistant
	Erin Anastasi	Technical Advisor for Family Planning
Futures Group/Policy Project	Carol Shepherd	Deputy Director, Reproductive Health
JHPIEGO	Ron Magarick	Director, Family Planning & Reproductive Health
	Harshad Sangvhi	Medical Director
WHO	Mike Mbizvo	Senior Scientist