

# Final Report: Getting Research into Policy and Practice (GRIPP)

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## **SUMMARY OF LESSONS LEARNED**

### **Documentation Process: Lessons Learned**

1. Progress in the initial stages of the documentation process can be slow, though it gathers momentum over time. Successful communication channels such as email are important for maintaining the momentum.
2. Familiarity with applying the GRIPP framework and process and having existing networks in the field adds value to the product.
3. An initial lack of knowledge about stakeholders can slow down the documentation process. However, the documentation process can help discover who these stakeholders are and the usefulness of the study to them.
4. Case study information is much easier to recall and richer when the research is still current or only recently concluded.
5. A snowballing effect, which results in getting more stakeholder perspectives than originally thought, can occur during the process.
6. A study may have clinical and social and other dimensions, which have very different processes and outcomes with relation to a given research study. Each needs to be followed up in order to fully understand the utilisation and effectiveness of the research.
7. A well-positioned facilitator may be the best placed to assume a neutral position and document the research process.
8. Many of the obstacles in relation to the documentation process that were encountered could be overcome if researchers built the documentation process into their research schedule.

### **Scale Up and Utilisation: Lessons Learned**

1. Involvement of stakeholders in the study and good inter-personal relationships with them is important for enabling the scale up and utilisation of research results.
2. Timing of the research and its associated activities is an important factor that may affect scale up and utilisation of research results in a given country context.
3. Communication activities are important for ensuring the right messages about the research get to the right persons at the right time.
4. The way in which research on sensitive issues, particularly those of a social, religious or cultural nature are handled could determine the extent to which the research results are accepted and used on a wider scale.
5. The nature and extent of donor involvement significantly influences the course of the research process and its scale up.
6. Even if the right policies are in place, practices may not follow because of lack of sufficient resources or commitment from those who have the authority to make the changes happen.

## BACKGROUND

The Getting Research into Policy and Practice (GRIPP) initiative, a DFID-funded web-based project, was launched at the ‘Maximising the impact of DFID funded health research’ meeting in 2002. The website<sup>1</sup> had two functions: to build an online evidence base of GRIPP case studies and to provide a web portal via which GRIPP resources could be accessed. The GRIPP case studies were completed by researchers and documented the activities they undertook to maximise the impact of their research. The structure for these case studies evolved from a workshop held in 2001 at the University of Southampton and a subsequent on-line conference on ‘Bridging research and policy’. The GRIPP project was a partnership between Population Council, John Snow International (Europe) and two DFID funded research programmes, *Opportunities and Choices* and *Safe Passages to Adulthood*.

The following were identified as components of the GRIPP process:

- Development of the research question
- Identification of target audiences
- Interpretation and communication of results
- Increasing the utilisation of research findings
- Evaluation of research uptake
- Facilitating factors
- Barriers
- Reflections

The case studies received during the course of the project were essential in illustrating activities undertaken to increase the impact of research.

Through JSI Europe’s experience managing the GRIPP project, it was invited to be involved with the WHO (Department of Reproductive Health and Research) Turning Research into Practice (TRIP) Task Force. The Task Force developed the TRIP toolkit to foster increased research utilisation. The toolkit serves four functions:

1. As an evaluation tool so donors can more easily examine the impact of their research.
2. As an aid to programme design and policy formulation
3. For research design and planning – part of this function is the completion of case studies thus adding to the evidence base on research utilisation.
4. As an educational tool.

There are many elements of the original GRIPP case study common to the Conceptual Framework proposed for the WHO TRIP toolkit, but the latter is a more comprehensive and sophisticated entity (see Appendix A for the Conceptual Framework). In the Conceptual Framework, the GRIPP process is divided into 3 stages:

1. Research – This is divided into 3 phases: Pre-research; Research; Post-research
2. Scale-up

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<sup>1</sup> Website url: <http://www.jsiuk-gripp-resources.net>. The website was closed down after DFID funding for the project ended and the website server lease period expired.

3. Application/Utilisation – This stage looks at the impact of the study at different levels: the contributions made to the evidence base, uptake at the advocacy level, impact on policy, programmes, and practices on the ground.

Unlike the original GRIPP case study which focuses on only the researcher's perspective, the case study based on the TRIP guidelines is comprised of three perspectives: that of the researcher and two other stakeholders. The stakeholders are those who have a vested interest in the outcome of the study and could be, for example, a ministry of health official, a national pharmaceutical association, or members of the community that is being studied.

The GRIPP website design has the opportunity to evolve in line with the WHO framework and support WHO in their collection and management of case studies. However, prior to applying for additional funding to further develop the GRIPP website, it was considered prudent to examine how to achieve a greater variety and number of case studies and the cost of doing so. With this aim in mind, JSI Europe approached the Population Council's FRONTIERS programme for funding for a short-term period (project hereafter referred to as GRIPP II). Lessons learned from this exercise would determine the value of this initiative and whether it would be worthwhile continuing with it. In line with the WHO TRIP initiative all the case studies sought were to be from the arena of reproductive health, including STI/HIV, and maternal health. The duration of GRIPP II was initially 1 January – 30 June 2005. It was later extended to 31 August 2005 to give more time for collecting researchers and lead stakeholder inputs prior to finalising the case studies.

It is intended that all the case studies collected during GRIPP II will subsequently be included in WHO's TRIP Toolkit on Evidence Based Practice.

## **CASE STUDIES: SOURCES**

GRIPP II continued to maintain the focus on researchers, but also included programme managers of NGOs and public health organisations that carry out research and field activities. A variety of strategies were employed to obtain a greater variety and number of case studies:

### **1) Directors of DFID funded knowledge programmes in Sexual and Reproductive Health (SRH)**

The Directors of DFID funded knowledge programmes were targeted as a source for case studies. It was believed that the process would highlight to the Directors of Research (DoR):

- the utility of the process to themselves as researchers.
- a means by which they can show to funders the activities they have undertaken to maximise the impact of their research.
- the value of contributing to, and accessing, this evidence base.
- the need to encourage other researchers in their institution to submit case studies.

## **2) NGOs working in SRH**

In their work in either advocacy and/or programming, NGOs also have to maximise the utilisation and impact of their activities. In the UK, NGOs are currently examining how best to understand, document and build upon their own institution's experience of influencing change. The Civil Society department at DFID is currently undertaking work to further understand why some of the activities it has funded have been successful and how lessons learned might be captured and shared. To have such case studies also contributing to the same evidence base as from academic research will lead to a larger and more diverse field of experience.

## **3) International Stakeholders**

The case studies collected during the original GRIPP project were all success stories. It was believed to be important that less successful stories also be documented, as these would be just as informative, if not more, than the successes. In order to identify and document these stories, and hopefully set a precedent, key international stakeholders, namely DFID, IPPF and WHO, were to be asked to identify a piece of research they were aware of that they feel has not been fully utilised.

## **4) WHO Collaborating Centres**

Individuals at the WHO collaborating centres were to be targeted for case studies. WHO were also to be asked to identify pieces of research from these centres that they would be especially interested in having documented. Time and resources permitting, JSI Europe would edit the case studies received from WHO.

## **5) Listservs**

The listservs of professional organisations were to be used to target researchers, for example, the British Society of Population Science (BSPS) and the Population Association of America (PAA). Regional and topic-based listservs were also to be targeted, for example Af-AIDS and Gender-AIDS.

JSI Europe would not write up case studies obtained via WHO Collaborating Centres and the listservs, but limited support was to be given by way of assistance in interpreting the case study guidelines, if required. However, time and resources permitting, JSI Europe would edit the case studies received from WHO Collaborating Centres and those responding to the call for case studies on listservs.

## **6) Reformatting existing case studies**

Ten GRIPP case studies were collected during the original GRIPP project. During GRIPP II, nine of these were to be reformatted into the TRIP format, and the two additional stakeholder perspectives were to be incorporated in these<sup>2</sup>.

Based on the above criteria, the targeted number for case studies to be submitted to FRONTIERS was set at 22. Table 1 provides the number of case studies expected from each source:

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<sup>2</sup> The tenth case study was previously reformatted by Dr. M Hennick of University of Southampton as part of the WHO TRIP initiative.

**TABLE 1: Number of Case Studies per Source**

<b>SOURCE</b>	<b>NUMBER</b>
Existing case studies	9
Directors of DFID Knowledge Programmes	7
NGOs	3
International Stakeholders	3
<b>TOTAL</b>	<b>22</b>

**Process**

All the case study sources were contacted by email. They were given a brief description of the project and its perceived value to them, and they were requested to submit case studies. The WHO Conceptual Framework and guidelines for completion of the case studies were also provided (see Appendix B for the case study guidelines). Based on previous experience, it was known that there is limited enthusiasm to write case studies and so JSI Europe offered to interview the researchers/programme managers and write up the case studies (this offer did not extend to those responding to the listserv notices and WHO Collaborating Centres), which would be returned to them for approval. Everyone accepted the offer to be interviewed and for JSI Europe to write up the case study. When asked at the end of the interview whether they found the process useful or cumbersome, they confirmed its usefulness and admitted that it was interesting to reflect on the research process in a way they had not before.

**CASE STUDIES: OUTCOMES**

JSI Europe collected a total of 18 case studies by the end of the project period. Table 2 shows the number of case studies received from each source:

**TABLE 2: Case Studies received per source**

<b>SOURCE</b>	<b>NUMBER</b>
Existing case studies	11
Directors of DFID Knowledge Programmes	3
NGOs	2
International Stakeholders	1
WHO Collaborating Centres	1
<b>TOTAL</b>	<b>18</b>

In the case of existing case studies, in the first instance lead authors were asked to reformat their case studies and collect stakeholder perspectives. JSI Europe ultimately reformatted 8 of the 11, as the lead authors were unable to do so due to reasons such as time constraints or uncertainty of how to proceed with the reformatting.

Table 3 below provides details for all the case studies received by JSI Europe:

**TABLE 3: Case study details per source**

<b>Title</b>	<b>Organisation</b>
<b>Existing Case Study<sup>3</sup></b>	
Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana	Centre for Population Studies, LSHTM, UK
Enhancing the continuum of Care of HIV/AIDS infected and affected Patients in resource constrained settings in KwaZulu-Natal, South Africa: Getting Research into Policy and Practice	Nelson R Mandela School of Medicine, University of KwaZulu Natal, South Africa
Introducing Emergency Contraception in Bangladesh	Population Council, Bangladesh
Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal	Population Council, Ghana
Strategies for managing the dual risks of unwanted pregnancy and sexually transmitted infections among adolescents in rural Kenya	University of Nairobi/ International Institute for Educational Planning, France
Young people's sexuality and sexual behaviour change in Mexico	Division of Epidemiology, Imperial College, UK
Increasing the uptake of IUCD in Nepal	Opportunities and Choices, University of Southampton, UK
Needs Assessment on Adolescent Reproductive Health in Pakistan	Independent Consultant/ PAVHNA, Pakistan
Community-based distribution in Zimbabwe	Population Council, Kenya
Creating linkages between treatment for incomplete abortion treatment and family planning - What works best in Kenya?	Population Council, Kenya
Improving the management of STIs among MCH/FP clients at the Nakuru Municipal Council Clinics	Population Council, Kenya
<b>DFID Knowledge Programmes<sup>4</sup></b>	
Impact of maternal syphilis on pregnancy outcome in Tanzania	Dept. of Infectious and Tropical Diseases, LSHTM, UK
Sex work and migration in Cambodia: the dangers of oversimplification	Centre for Population Studies, LSHTM, UK
Randomised control trial of participatory intervention with women's groups in birth outcomes in Nepal	Institute of Child Health, UK
<b>NGOs</b>	
Youth sexual health radio project	Interact Worldwide, UK
Greater involvement of PLHA in NGO service delivery: findings from a four-country study	International HIV/AIDS Alliance, UK

<sup>3</sup> Case studies not received in this category were: (1) *Barriers and opportunities for the improvement of sex and sexuality education in secondary schools in Nepal* – Safe Passages to Adulthood Programme; (2) *A project to facilitate the establishment of a national confidential enquiry in Yemen* – Opportunities and Choices Programme

<sup>4</sup> Case studies not received in this category were from following programmes: Reducing the dangers of pregnancy and maternal mortality in poor societies; Opportunities and Choices; Safe Passages to Adulthood; HIV Disease, AIDS and STIs.

International Stakeholders	
Social marketing of pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda	Wellcome Trust, UK (recommended by WHO)
WHO Collaborating Centres	
Nevirapine for Prevention of Mother-to-Child Transmission of HIV-1 in Uganda	Family Health International

### Reasons for non-submission of case studies

- **Existing case studies** – Two case studies that were on the original list to be reformatted were not completed. These are:
  - *A project to facilitate the establishment of a national confidential enquiry in Yemen.* Lead author: Jane Diamond
  - *Barriers and opportunities for the improvement of sex and sexuality education in secondary schools in Nepal.* Lead author: Roger Ingham

JSI Europe learned that one of the researchers had changed institutions. Several attempts to locate the researcher through former colleagues and the administrative office at the former place of work as well as the institute where the researcher currently is did not produce any results. In the case of the second case study, there was no response from the lead author despite following up several times.

As a replacement for the above two studies, three Operations Research studies conducted by Population Council were written up and included in the group of Existing Case Studies.

- **DFID Knowledge Programmes case studies** – No response was received from four of the seven directors of DFID Knowledge Programmes despite following up several times.

In the case of the DFID Knowledge Programme ‘Reducing the dangers of pregnancy and maternal mortality in poor societies’ managed by the London School of Hygiene and Tropical Medicine in the UK, two case studies were initially offered to write up. The study on Near Miss Audits led by V Filippi was selected. JSI Europe interviewed the lead researcher and a draft case study was prepared, but on reflection the researcher had reservations about submission of the case study. This was a feasibility study, and the researchers are quite clear that more research is needed, in particular a cost effectiveness randomized control trial. They believe it would be premature for countries to go to scale without investing in more research, at least at the operational level. It is also a long-term intervention, which requires a change of culture. Reactions to the research to date have been very positive and the researchers have concerns that the results may be implemented prior to additional research. The lead researcher feels this research may be a candidate for a case study at a later time when more is known but in its present state is unsuitable, especially as it is to be included in a WHO publication and so may increase the likelihood of premature implementation.

- **NGOs** – Of those initially contacted, case studies were not received from two organisations. In one case no further communication was received from them

after contact was initially established while in the case of the other, the NGO was unable to identify a suitable piece of work that could be written up as a case study

- **International stakeholders** – No recommendations for case studies were received from two of the three sources originally identified by JSI Europe. Once again reasons for this were a lack of response to emails sent by JSI Europe. In the case of one of the stakeholders, initial communication took place between JSI Europe and the stakeholder to identify a suitable person within their organisation who could recommend a case study, but later communication by them ceased before a study could be identified.

JSI Europe may have received a better response from the international stakeholders if a larger number were targeted instead of a select few who were known to JSI Europe.

- **Listservs** - 11 people responded to the call for case studies and requested the case study guidelines. However, JSI Europe did not receive any case studies. The channels used to advertise the call for case studies is provided in Appendix B as well as a list of those who responded to the call.

The types of research on which the case studies were based were varied because of the range of organisations approached. They can be categorised as:

- Clinical research studies
- Social science research studies
- Operations research studies
- Studies based on NGO programmes

## REFLECTIONS

In this section, we examine the 18 case studies received, focusing on three different aspects of the GRIPP II project:

- a. Research documentation process
- b. Scale up and utilisation phase
- c. WHO conceptual framework

### a. Research Documentation Process

This section looks at what enabled or hampered the case study documentation process.

- 1) **Progress in the initial stages of the documentation process can be slow, though it gathers momentum over time. Successful communication channels such as email are important for maintaining the momentum** - Requests for case studies produced very few responses in the first instance and half of those contacted had to be sent a second email requesting a case study. In several cases the initial drafts of the case studies, which were sent to the lead authors to be checked, were returned only after being sent reminders by JSI Europe. This slow progress resulted in having to extend the project period for a further two months in order that the case studies could be completed. By the end of the project period, there were several case studies for which JSI Europe did not receive any stakeholder responses.

Common reasons for the slow response were:

- Respondents were busy with other work commitments or else away on work related travel and hence unable to respond.
- Some of the respondents based in African and Asian countries were unable to send their responses electronically due to regular power cuts.
- Accessing the Internet is a common problem in several developing countries and this posed a problem for respondents when having to send their responses by email.

Some stakeholders do not speak English and communication in such cases has been a lengthier process. For example, a doctor interviewed for the case study on *'Testing a Model to improve Postabortion care in Burkina Faso and Senegal'* does not speak English. The researcher based in Ghana, contacted his colleague in Burkina Faso who then interviewed the doctor in French and submitted these responses to JSI Europe after which a translator had to be contracted to translate the responses into English. This is resource intensive in terms of time and cost.

Collecting stakeholder perspectives by phone was not an easy option. There were often disturbances on the telephone lines or there was a time delay in receiving the responses over the phone, which made communication difficult. Differences in accents and languages spoken also slowed down communication since information often had to be repeated. In general, those responding preferred to do so by email. This was also most convenient given time zone differences.

Once the initial draft was written up by JSI Europe and checked by the lead author, future responses to drafts and queries were quick. By then the authors were familiar with the case study and the effort required for a final check was not as much as for a first draft where the author had to ensure all the relevant facts were included and accurately conveyed.

Communicating by email also enabled respondents to reflect on the questions sent by JSI Europe and they could respond in their own time rather than being expected to give immediate responses by phone. In the case of Directors of Knowledge Programmes who were often unable to respond to emails promptly as they were away on business, someone in their office would respond in their absence to give an indication of when JSI Europe could expect a reply.

Information technology, specifically email, is a useful tool for communication, especially when communication is between people in different geographical locations and time zones, though it should not be assumed that it is an easy method of communication for all as some may be restricted by problems such as regular power cuts.

- 2) **Familiarity with the GRIPP process adds value to the product** - Having to reformat most of the old case studies and interviewing and writing up the case studies for the Directors of Knowledge Programmes and the NGOs meant that

after doing so a number of times, JSI Europe became very familiar with the case study documentation process, not only in terms of the information that was to go into the different sections of the case study, but thought processes became more structured which made it easier to think of appropriate questions to put to the researchers and the stakeholders.

3) **The lack of knowledge of the existence of stakeholders can slow down the documentation process. The documentation process can help discover who these stakeholders are and the usefulness of the study to them.**

Researchers were sometimes not sure what had happened in terms of the impact of their study findings after the study concluded a while ago. In such cases JSI Europe obtained the information in a round about way. For instance, in the study '*Young People's Sexuality and Sexual Behaviour Change in Mexico*', which was part of a PhD thesis, over time the researcher lost contact with the local organisation, Mexfam that had assisted with the study. Meanwhile the Director of Mexfam also left the organisation. JSI Europe had to, therefore, contact the current director of Mexfam to request contact details for the former director, explain the reason for the request and then contact the former Mexfam director.

The follow up process by JSI Europe has in some cases revealed the extent to which the research findings have been used that even the researcher was not aware of. Once again in the study *Young people's sexuality and sexual behaviour change in Mexico*, the researcher was unaware that the Mexican government body IMSS Oportunidades revised its national strategy based on findings from her study. In the case of the study *Sex work and migration in Cambodia: the dangers of oversimplification* too, the extent of use of the results by the Office of the High Commissioner for Human Rights and Scarlet Alliance, a national Australian organisation representing the rights of sex workers, was discovered during the course of obtaining stakeholder perspectives. In the case of the *Clear Seven study in Uganda*, the lead author was unaware that WHO was aware of the study and was pleased to hear so when informed by JSI Europe.

4) **Recalling case study information is easier when the research is recently concluded** – If considerable time has passed since a study concluded, it is also quite likely that stakeholders will have moved on and their current whereabouts are unknown. Some of the studies concluded several years ago and in such cases it was difficult for the researcher to recall details of the study or provide current contact details for the stakeholders. Sometimes the email addresses or telephone numbers provided for stakeholders were incorrect or outdated and JSI Europe had to spend time locating them through other channels.

5) **Existing networks can be useful for locating stakeholders whose whereabouts are unknown.** This is especially useful in the case of old case studies. The lead author for the study '*Community Based Distribution in Zimbabwe*' was unaware that the Director of the Zimbabwe National Family Planning Council (one of the stakeholders) had in fact left the organisation to join another. It was only after several attempts to contact him produced no

results that JSI Europe used its existing networks to obtain his current contact details.

- 6) **A snowballing effect may result in getting more stakeholder perspectives than originally envisaged** - For several case studies, it has been necessary to contact more than the two stakeholders originally planned. There is a snowball effect where identified stakeholders themselves identify other key persons. This has been necessary in order to get the full picture of the study. For example, in the study *Social marketing of pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda*, in addition to the lead author, seven others were contacted for information. This has time and cost implications. The TRIP Toolkit is strong enough, however, to allow for the inclusion of more than two stakeholder perspectives, which may be necessary for some studies in order to make it a richer evidence base.
- 7) **A study may have several angles and each will need to be followed up in terms of utilisation and effectiveness, each of which may have different outcomes** - In the case of the *Clear 7* study, the stakeholders who were interviewed commented on the study looking at it from different angles. For instance, while the researchers seemed to focus on the clinical/technical aspects of the kit, the CMS project respondent placed greater emphasis on the social marketing aspect.
- 8) **A well-positioned facilitator may be the best placed to assume a neutral position and document the research process** - It would appear fortunate that in most cases harmony existed between the various interest groups during the research process. But it also raises the question whether the lack of critical appraisal was because of the desire not to offend fellow researchers/donors/politicians. It is important that any problems encountered by the researcher or stakeholders due to someone else's actions be expressed so that the problems can be addressed. This is admittedly difficult to do without affecting good relations that may exist, but if not done, it makes the value of the case study questionable.

Researchers and stakeholders may view the outcomes of a study differently. For example, in the case of the study on *Social marketing of pre-packaged treatment for men with urethral discharge (Clear Seven) in Uganda*, this study was suggested by an international stakeholder as a failure case study when, in fact, it is perceived a success in Uganda. Different perceptions could arise because of misinformation or also exist because what one stakeholder views as a success may be a failure for another.

The facilitator could flag issues, whether they are external developments that may affect the study or inconsistencies in perception or opinions of stakeholders. The inconsistencies should be followed up as it may help resolve the differences in opinion and bring about a win-win situation.

- 9) **Many of the issues in relation to the documentation process could be overcome if researchers built the documentation process into their research schedule** - The entire research documentation process, right from the

inception stage up to the point of utilisation and impact of the research results, can be resource intensive as seen previously. Problems such as recollection of study details, and contacting stakeholders could be overcome if the research team carried out the exercise during or relatively soon after the study concluded (though assessing ‘utilisation of study findings’ may not be possible until much later).

## **b. Scale Up and Utilisation Phase**

An analysis of the case studies received has revealed that there are certain common barriers as well as factors that may affect the scale up and implementation of activities based on research findings. This section focuses on these commonalities and the lessons learned from them.

### ***1. Involvement of stakeholders in the study and maintaining good inter-personal relationships with them is important for enabling the scale up and utilisation of research results.***

- *The involvement and support of policymakers in a study right from the beginning is a crucial factor in ensuring that the study findings are accepted and used by policymakers.*

In all the studies that were successful in being translated into policies, we find a strong level of involvement of stakeholders right from the start of the research process. In all these cases a common factor is that the study is a priority for the policymakers, hence their keen interest in the issue and wanting to see the findings followed through to implementation. Many of the studies were based on research that was commissioned by the national government or at least were carried out in consultation with key ministries.

- *Strong interpersonal relationships with stakeholders can be helpful in maintaining their involvement and interest in the study and its future uptake.*

In some studies the importance of face-to-face meetings with stakeholders is stressed. In some cases the ministry officials had previous links with the researchers, perhaps because they had worked with them before or even studied at the institute that the researchers belonged to. This helped establish the credibility of the research team and their findings, which was important in order to get the buy in of the relevant authorities for implementation of study recommendations.

- *Involvement of local personnel in a study or programme is important. Apart from building skills and knowledge of the local staff during the course of the study, which they require to sustain activities beyond the life of the study, this will enable greater buy in for the study and its uptake by the local stakeholders as well.*

Even though most of the studies referred to in GRIPP II appear to have been led by international research groups, they have been carried out in close collaboration with local researchers. The presence of local researchers is an important factor because in the scale up and utilisation phase, they are seen to take a more prominent role than the international researchers. In the *Clear Seven* study, policymakers showed active interest in the study once a local researcher joined the team.

**2. *The credibility of a study's findings is enhanced if backed by findings from other studies.***

- *Having an evidence base to back a study's findings is particularly useful in cases where the topic of research is a controversial one. There is also value in having an existing evidence base that can be referred to. The wheel does not have to be reinvented again.*

In the case of the study *Sex work and migration in Cambodia: the dangers of oversimplification*, while there has been no uptake at the policy level, the very fact that there were similar findings from a study in Mali has helped generate debate on the topic rather than it being quashed.

**3. *Timing of the research and its associated activities is an important factor that may affect scale up and utilisation of research results.***

- *If the research topic is a priority at that point in time for not just the researchers but also those who are in positions of authority to implement changes, there is a greater possibility of the research being translated into policy and practice.*

Timeliness of studies and the release of the findings has been an important factor in the uptake of the study results. In most of the studies where there was a positive uptake of findings, this was facilitated by the fact that the stakeholders were ready to act on the study findings, as it was a priority issue for them at that time.

- *Progress on studies can be obstructed by factors beyond the control of the researchers or even policymakers.*

Several studies and extension of activities following conclusion of the studies were hampered due to political unrest at the time.

**4. *Communication activities are important for ensuring the right messages get to the right persons at the right time.***

- *Information dissemination should be a well-targeted activity so that information is provided to those who need to know about it and it should be presented in a way that can be comprehended by the audience.*

The emphasis on dissemination of the research results as widely as possible has been an important factor in some cases as it has increased awareness amongst the relevant groups who are in a position to translate research into policy or practice. This could be a government ministry official who revises a policy based on research findings or health service providers who change training curriculum based on the research recommendations.

- *The media should be engaged wherever possible in disseminating information and they need to be educated on the right messages to be conveyed, especially in cases where a sensitive issue is being dealt with. The research budget should include resources to allow for media involvement.*

In some cases the media community played a critical role in disseminating research findings. This was important in the case of the *Needs Assessment on Adolescent Reproductive Health in Pakistan* where positive information had to be disseminated on the sensitive topic of sexual and reproductive health for adolescents.

**5. *The way in which research on sensitive issues, particularly those of a social, religious or cultural nature are handled could determine the extent to which the research results are accepted and used on a wider scale.***

- *If the study is on a culturally or socially sensitive issue, it can be more difficult to bring about changes in policy or practices on a wider scale. Political leaders who want to be seen in a good light by their constituencies and therefore want to avoid taking action on sensitive issues may shy away from leading on translating findings into policy.*

Where the study is based on a sensitive issue, policymakers in the government may be reluctant to be seen supporting study findings if there is a danger of alienating the constituencies. This may be despite the fact that the study is based on a crucial issue with long-term health implications. Where this is anticipated, extra steps should be taken to help politicians develop strategies for addressing the issue in a way that will help them win their constituents' support for initiatives to address the issue.

**6. *The nature and extent of donor involvement in a study and its scale up is important.***

- *Donor interference, whether it be in the form of restriction of funds or alteration of study results, can be a major factor in restricting the scale up of activities. This may affect the study, uptake of its findings or it may even give a different angle to the study's findings.*

A couple of studies revealed there was some pressure from donors on researchers and programme implementers. This was not well received. In one particular instance, the research team was encouraged to readdress their findings to fit in with the policymakers' current agenda. This could have an impact on the degree to which a study's findings are implemented and how they are implemented. In another case a donor policy resulted in funds being restricted for the scale up activities.

**7. *Even if the right policies are in place, practices may not be because of lack of sufficient resources or commitment from those who have the authority to make the changes happen.***

- *Even if the will exists, limited resources can restrict translation of research into practice.*

In several studies it was found that the scale up and implementation of the study recommendations was hampered by the lack of resources, whether it was financial resources or technical support. In some cases even if the right policies are set in place, practices may not change because the right infrastructure may not exist, whether it be sufficient testing laboratories or the right kits to carry out the tests, for

example as seen in the case study on *Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal*, the lack of PAC care kits in the region initially posed a serious problem.

- *Research may have been translated into policy because of the support of political stakeholders, but policy may not be translated into practice because of lack of appropriate support at the implementation level.*

In some cases those who were responsible for setting changes in motion to improve practices based on a study's findings gave it low priority. This made it difficult for those who were to implement the new practices to do so as they did not receive sufficient support from their seniors. In the study on *Testing a Model to Improve Postabortion Care in Burkina Faso and Senegal*, hospital management viewed the study as merely research, which was not relevant to them. Staff trained in PAC services during the course of the study were asked to perform services other than PAC.

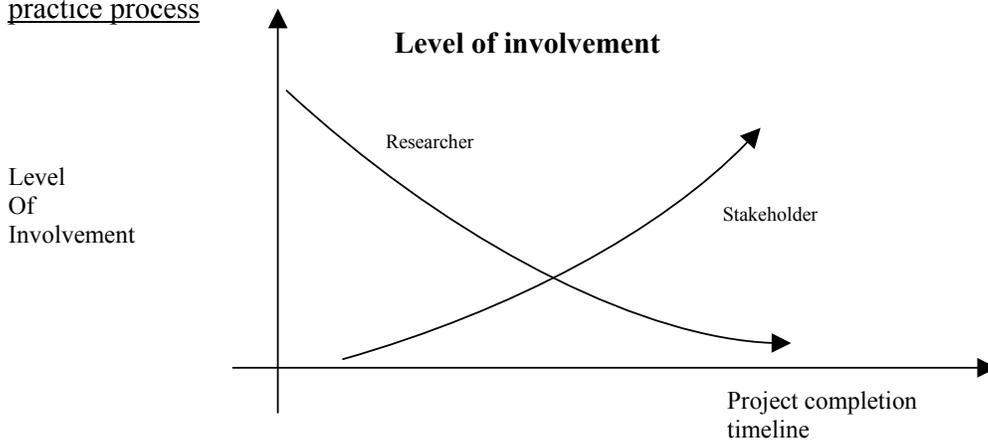
- *In order to ensure sustainability of improved practices, appropriate systems should be set in place eg. training courses for health staff to ensure transfer of new skills acquired by a select few during the course of a study.*

In several cases there was a high turnover of staff, which meant that those who had been trained in improved practices during the course of the study moved on to other locations before they were able to transfer skills to their colleagues. This resulted in a loss of knowledge and skills and therefore slowed down or stopped the implementation of improved practices.

### c. WHO TRIP Conceptual Framework

In this section we look at the conceptual framework to assess the role of different stakeholders in the research process, its ease (or difficulty) of use, the relevance of the different stages of the framework, and ways of increasing the use of the framework in future.

#### Roles of the various players in the different stages of the research into policy and practice process



The researchers were seen to play a more prominent role than anyone else in the first 3 stages ie. during the pre-research, research and post-research stage. While there may be active involvement of other stakeholders as well during these stages, it is the researchers who are driving the activities. Their actions during these stages -- how they carry out the research, interact with stakeholders or deal with any event that may affect the study -- will also determine to an extent what happens after the study concludes. This does not take into account the influence of macro-contextual factors, which researchers have no influence over.

From the scale up stage onwards, the balance starts to shift with stakeholders starting to play a bigger role. Local researchers may be called upon to advise the government in policy formulation or to assist with training in preparation for scale up of activities. Policymakers, donors, and technical bodies play an important role in the scale up phase too. The donor can play an important role in situations where they are relied on to bring in the financial resources and technical know-how in order to scale up activities as seen in study on *Introducing Emergency Contraception in Bangladesh*, where UNFPA played an important role in the scale up stage.

By the time the utilization phase is reached, we find that the researchers tend to have a very limited role to play, particularly international researchers in the case of studies conducted in a specific country setting. Local researchers played a strong role in the ECI study in KwaZulu Natal because they had already been working closely with local hospitals and stakeholders and had a crucial role to play in ensuring that the study results were acted upon. In cases where there is to be national level roll-out, it may be the central government and national bodies such as the pharmacy council in the case study *Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana* that play an important role. With regards to NGOs, those holding decision-making positions would play a role in the scale up phase in determining whether and how to take programme findings forward.

Overall it can be said that the support of policymakers has been very important in order to scale up and implement study findings. Even if changing national policy has not been the main aim of a study/programme, success or failure in terms of utilization of study results or maximizing their impact depends on the degree of importance given to it by government bodies or multilateral organisations. It seems to be more effective if (a) the research is a priority for the policymakers and other stakeholders (b) the research establishment has good relations with the policymakers and they can agree on the research goals and findings.

#### Could any of the stakeholders do more to translate research into policy and practice and if so how?

To answer these questions, we divide the players into two broad groups of external players and internal players.

- Internal players
- External players:
  - International researchers/programme
  - Donor

Based on the case studies it would appear that international researchers and programme managers are already going as far as they can in the research into

implementation process. Their roles are earmarked from the start and are usually seen to end once the study findings are known and disseminated, perhaps extending to the point of advocating on certain issues or providing training. Donors could assist by providing technical or financial support, advocating to governments to act on a study's findings, or make researchers account for the efforts undertaken to implement research into policy or practice.

We have seen previously that there appears to be a mismatch between intention to translate research into practice and actual action, probably because of it being accorded low priority. In the case of donors, the limited interest seen during GRIPP II raises the question of their levels of interest. Donors need to drive researchers to document the process. But for that to happen, someone needs to advocate for it, as donors themselves probably need to be encouraged to give it priority.

- Local players:
  - Local researchers/programme
  - Policymaker
  - National body/association
  - Implementing organisation

In order to sustain improved practices or implement new policies, local stakeholders have to take ownership of the processes required to implement research into policy or practice. There has to be close collaboration between researchers, policymakers and implementers so that together they can develop a sustainable system with the right policies and practices in place. The appropriate infrastructure and systems should exist so that the policies can be set in motion. The implementers have to be open to accepting the new policies (which would be the case if they were involved in dialogues during the policy development process). The implementers then have to ensure that personnel are suitably trained to introduce or change practices on a wider scale. This may not happen overnight. If the appropriate skills base does not exist on a nationwide scale for instance, it may require revision of education policies to ensure that over the years the skills gap is reduced. On a micro level, it may mean obtaining resources to train people within an organisation or transferring personnel with the requisite skills into a district where the skills gap exists.

Regarding future use of the WHO framework, despite knowing that there are benefits to be had by documenting the research process, this task may not be undertaken and so the question remains “how do you encourage researchers to document the research process”. The two options are:

- a. Using incentives, e.g. granting additional points to those applying for future funding for other projects if they can demonstrate that they have documented the research process before.
- b. Making it mandatory to document the research process.

Those funding research activities should implement both the above. Research budgets should have a provision for costs to cover the research documentation process.

The existence of an evidence base does not automatically imply the use of the evidence. The right systems need to be in place so that not only is the evidence base referred to, lessons learned from it are used as well. One way of doing this is by

having processes in place so that researchers are required to demonstrate to their funders the extent to which they have learned from the evidence base and have applied the lessons learned. This means not only that they demonstrate the value of a piece of research in terms of potential health or quality of life impact, for instance, but they should also show what efforts have been made to promote the use of the research results or influence policymakers in cases where policy change is an important factor to promote utilisation of research.

Donors should also be held accountable for the use of research funds to the extent that they are able to do so. A transparency and accountability system should also exist so that no one group can create a barrier by not playing their part in the research to policy and practice process, and that the responsible people can be held responsible if there is a failure in the system.

With regards to ways of ensuring that research is translated into policy or practice, a question remains: if the main aim is to get research into policy and practice, should research only be carried out in enabling environments that are conducive to research being translated into policy and practice, forsaking difficult environments where there is the risk of research being abandoned half way through or of it being difficult to apply research findings?

#### Analysis of the Conceptual Framework

- *Recommendation: The WHO Guidelines could be revised so that there is a balance between rigour and accessibility.*

One of the conclusions drawn in previous sections has been that the TRIP guidelines and conceptual framework may make the documenting task seem too cumbersome, which can be a deterrent for researchers and programme managers who already face time constraints and heavy workloads. These may be the reasons why JSI Europe's offer to interview and write up the first draft or to reformat case studies was immediately accepted by some researchers. One researcher admitted not knowing how to reformat her case study to fit the new guidelines while another described it as a "rigorous process". JSI Europe's experience during the course of GRIPP II has shown that documenting a study based on the guidelines and framework is less of an arduous task than might be perceived. Bearing this in mind, the framework has been examined to see how it can be revised so that at first glance, it appears to be a quick and easy process.

Having two sets of instructions (for the Conceptual Framework and the narrative) can be a deterrent in the first instance. The points provided in the Conceptual Framework are self-explanatory and do not require additional notes. Also, the explanation for the kind of information to be provided here is given in the guidelines. What should be made clear instead is that the conceptual framework should be a concise summary of the narrative in bullet-point form.

What would be helpful in the guidelines is a clear demarcation of the questions to be answered by the researcher versus those to be answered by other stakeholders. This will reduce the length of the guidelines relevant to each group and give a first impression of not being a lengthy process. The questions that are more appropriate

for the stakeholders are also the ones where there may be difference of opinion between the researcher and the stakeholders, eg. questions relating to research filling a knowledge gap, credibility of research team, or adhering to ethical protocols throughout study. Knowing this is helpful when preparing to question the stakeholders.

A study may be undertaken for reasons other than wanting to influence policy or practice. GRIPP II revealed that while researchers may at some level want to influence policy, it might not be a primary or conscious aim when they set the research question. While some have been able to directly attribute a policy change or programmatic changes to the findings from a study (eg. the case study on *Pharmacists' role in managing sexually transmitted infections: policy issues and options for Ghana*), there are others where it has been difficult to do so (e.g. *Greater involvement of PLHA in NGO service delivery: findings from a four-country study* which was undertaken to identify conditions that foster PLHA involvement and the strategies that organisations can use to achieve meaningful involvement of PLHA). The study may, therefore, not follow the path as in the WHO Conceptual Framework, which starts from research inception through to the implementation phase.

Some studies cannot be looked at in isolation since they are part of a chain. In such cases when applying the Conceptual Framework to the study, specifically the pre-research stage, many of the questions to be addressed may have to be looked at differently as the influence of other related studies needs to be taken into account. Studies may not necessarily stand in isolation as seen in the study *'Impact of maternal syphilis on pregnancy outcome in Tanzania'*, which fitted in with previous studies carried out by the London School of Hygiene and Tropical Medicine, Institute of Tropical Medicine (Antwerp) and National Institute of Medical Research (Tanzania). Findings from the study led to the development of rapid test kits for syphilis and a pilot scheme is now planned to roll out the test kits in a wider geographical area. This case study shows that there is no straight and obvious path from research to scale up and on to the utilisation phase. There may be other events or studies going on simultaneously that have so far been unrelated but may later cross paths and affect the utilisation of a study's findings, rather than developments within the actual study itself.

Despite some of the shortcomings mentioned previously, this has been a useful process for researchers. One researcher states "... this process has made me much more aware of the need to document the process of our research and utilisation! Luckily, for future case studies, we will be better armed with all the information, because we are keeping notes!" Several other researchers also confirmed that they believed it was a useful process that would contribute to the evidence base.

In almost all the studies documented, it was found that the study was a priority for not just the researchers but in-country partners and stakeholders as well. In fact, researchers have pointed out the importance of getting on board all the stakeholders, especially the regulatory bodies in country in order to facilitate the study and uptake of the results. However, the perspectives of the study population were not collected for any of the case studies, e.g. MUDs in Uganda or women receiving PAC services in Kenya. This does raise the question whether those at the community level have their voices and opinions heard by the researchers. Their role could also be built into the

conceptual framework so that their perspectives on the research process can be ascertained and their level of involvement determined. We can learn whether the study was a priority to the study population or the extent to which their views were taken into consideration when developing the research question. The Conceptual Framework already allows for this in the section on utilisation of research findings at the practice level. The guidelines need to be revised to include a mention of the community perspective.

*Suggestion: It would be useful to follow up with those who had responded to the listserv notices to see why they did not submit case studies as it could help obtain additional feedback on the Conceptual Framework and its ease of use.*

## **COST-BENEFIT ANALYSIS**

A cost benefit analysis of the GRIPP documentation process is attempted in this section. A proper cost benefit analysis is not possible as we are unable to account for the amount of time spent on a case study by the stakeholders, whether it is a doctor or minister for health responding to questions put to them by JSI Europe. Also, the benefit of the case studies cannot be determined at this point as it depends on what is done with these case studies.

If we look at the cost of the GRIPP project itself the breakdown of the budget for GRIPP II according to cost categories is as follows:

- Personnel – 96.33%
- Travel: 0.19%
- Other direct costs (phone calls to researchers/stakeholders in the UK and overseas) – 3.48%

As is apparent from the above, the personnel component accounts for most of the costs. This in itself is fine as by now it is apparent that documenting the research process is a labour intensive task. People have to be involved in the process as they are the repositories of the knowledge that needs to be documented. If a full cost estimation is made to include the time spent by the stakeholders on the documentation process, it can only be more than it already is with only the documenter's costs taken into account.

The cost should be weighed against the benefits derived from a case study. Despite being unable to quantify these at this point, the lessons learned during the course of GRIPP II have revealed that the potential benefits of documenting the research process should not be underestimated. In terms of the benefits, they can be looked at, at different levels:

- i. Research Structure - The research documentation process can help structure the research itself by organising a researcher's thinking. The conceptual framework can highlight the key requirements of a study in terms of what steps need to be taken to enable its translation into policy or practice. For instance, if the research process is looked at before the study commences, it could help identify a target group for the study that may not have otherwise been thought of, e.g. it may initially be felt that government policymakers

cannot be influenced, but by looking at the process, it may help one come up with ideas to attempt it, perhaps by identifying a way to involve them in the study right from the start and keep them interested in it. The WHO tool is also useful for anticipating possible hurdles or even successes. Measures can then be taken to create an enabling environment to facilitate the research translation process or devise measures to address any obstacles if they arise.

- ii. Research systems - The reluctance to contribute to case studies, whether by the researcher or stakeholder could be because they do not see the benefit of the case studies themselves. This is probably also the reason why no case studies were received from those responding to listserv notices. With the exception of the unique case of Near Miss Audits, the fact that the case studies were to be included in a WHO toolkit was perhaps an incentive to submit case studies. The benefit from the case studies can be realised only if findings from are pursued further. Appropriate systems should exist so that researchers/ stakeholders are easily able to take the necessary steps required to take research findings forward or address obstacles highlighted through the documentation process, without having to deal with several layers of bureaucracy. Support should be provided to them, whether it is by donors or policymakers, whether it is in the form of financial resources, systems to enable discussion of policies, or technical support to improve services.
- iii. Research Outcomes – In addition to anticipating events, the documentation process for an ongoing or completed study can also reveal not only how things can be done better next time, but it can highlight the weak points that are seen to hinder the implementation of findings. Once such points in the research to policy and practice process are identified, it should be easier to identify who needs to address these. In cases where a stakeholder group is perceived to be the obstacle to others implementing findings, it could be the starting point for dialogue between stakeholders. Even strengths in the research process can be identified through the WHO TRIP framework and these can be further built on.

Documenting various perspectives for a research process can also promote dialogue between the researchers and stakeholders and encourage further action. In the case of the study *Introducing Emergency Contraception in Bangladesh*, a stakeholder has along with feedback on the study requested advice on ways to increase the utilisation of emergency contraceptive pills in Bangladesh. Such concerns and requests for assistance may have remained unasked or delayed if GRIPP II had not been undertaken.

While admittedly it has not been researched fully, it is conceivable that the documentation process may indirectly improve the outcome of research by improving health statuses. Given that research or programmes are generally carried out for a sizeable population, the benefits of solving a problem that may result in action being taken to improve the quality of life or perhaps even morbidity and mortality levels are significant.

Very few of the studies in GRIPP II were old enough to determine long-term sustainability or had been evaluated to see how successful the implementation of

study findings has been. It would be useful to assess these later on, especially to see if and how the barriers have been addressed.

## NEXT STEPS

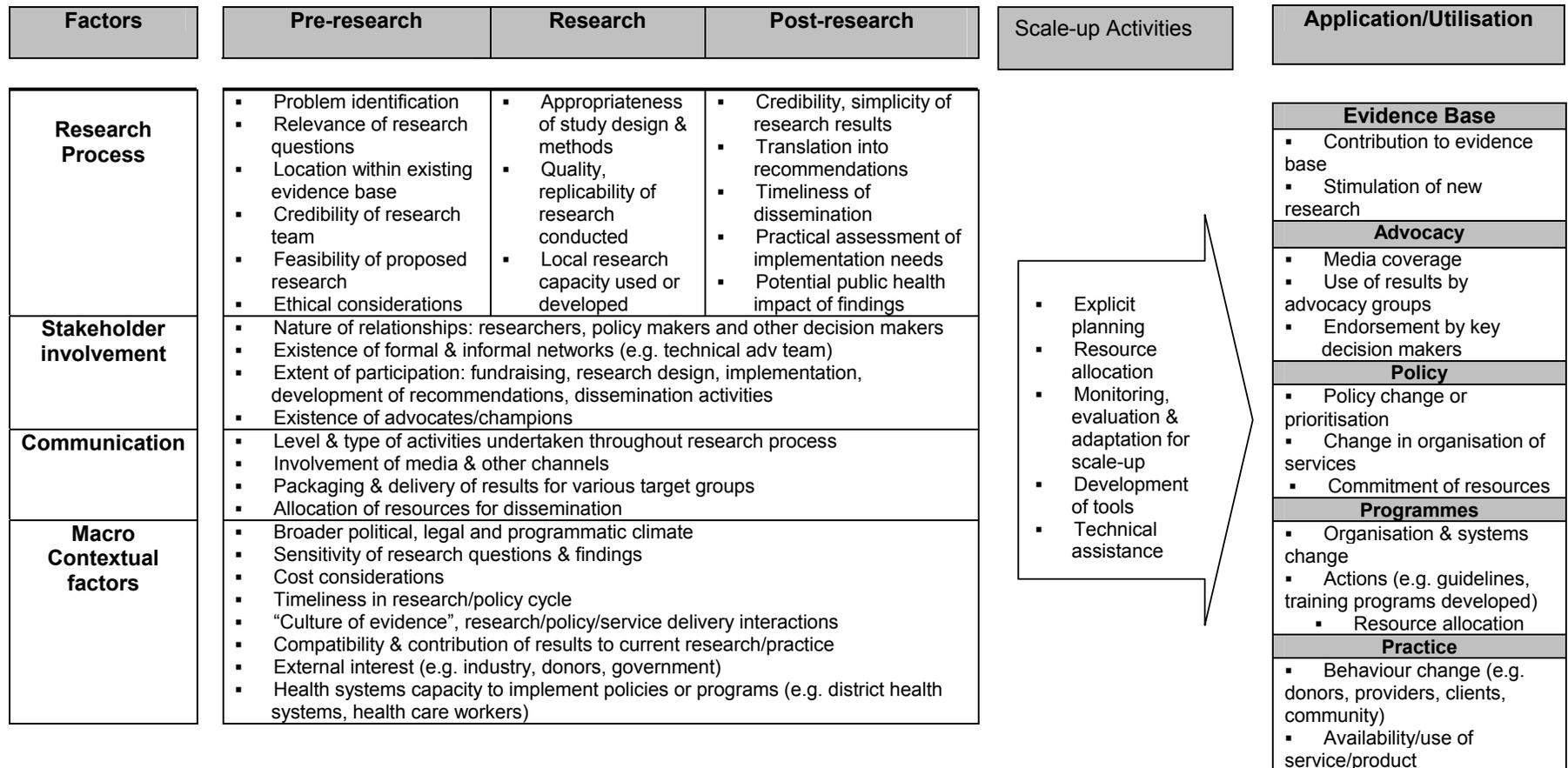
The aim of this exercise was to determine the cost and ease of obtaining additional GRIPP case studies, based on which JSI Europe would determine whether it was worthwhile pursuing additional funding for the GRIPP website to collect further case studies. The project has shown that it can be costly especially in terms of time and personnel. Also, the reluctance to submit case studies would mean that if a less expensive passive form of collecting case studies is adopted such as the GRIPP website, very few would be obtained. **JSI Europe, therefore, does not consider it worthwhile to pursue this line of action. Instead a more active method of sourcing case studies should be adopted, which whilst more expensive, has more potential to reap tangible benefits.**

If the main aim of the WHO TRIP Toolkit is to help increase the evidence base, a strategy would be to demonstrate the benefits of documenting the research process. The best way of doing this is by showing what can be done with the studies that have been documented. The following steps can be taken in this regard:

1. **A couple of case studies should be selected from the current collection and taken a few steps further.** One study could be that on *Introducing Emergency Contraception in Bangladesh* as JSI Europe has received recent communication requesting further assistance from one of the study stakeholders. The stakeholder has expressed concern about the utilisation of ECP in Bangladesh and sought advice on how to increase the utilization and awareness of ECP. A request has also been made for advice on whether or not a KAP study should be conducted to assess the utilization of ECP and determining ways of improving it.
2. As part of the project process, each lead author gave final approved of the final drafts of their respective case studies, which contained their perspectives. The perspectives of the stakeholders for their case studies were not shared with the lead authors. As a next step it would be worthwhile **sending the entire case study, which includes stakeholder perspectives, to the researcher**, especially where the stakeholder has a concern that the researcher could respond to. This could generate a debate that would help clear misunderstandings or result in concrete action being taken in terms of implementing study findings or addressing any problems encountered since the conclusion of the study. In the case of *Introducing Emergency Contraception in Bangladesh*, the researcher could approach the relevant stakeholders to discuss the concerns further. This could be a start to a solution to the problem faced.
3. **The studies can be followed further to see what steps have been taken or are to be taken to address any problems that may have been encountered during the scale up or implementation process.** Where study recommendations have been implemented on a wider scale, these can be evaluated to see how effective they have been.

4. Once this is done, the case studies can be used as examples to demonstrate the benefits of documenting the research process. Rather than using a passive method such as publishing them in a publication, a more **proactive method could be used such as an event held specifically for the purpose of reaching a wide research audience**. The TRIP Toolkit and documentation process could also be explained at such an event.
  
5. Having collected the case studies, it is important to maximise their benefits. In order to so, the **case studies should be made available to the right people** and as large a number as possible should be reached. A systematic approach is required to achieve this. A **central clearing house could be set up to collect all the case studies and disseminate the same**. A centre such as this should be well publicised amongst all research and academic institutions, policymakers and implementers of programmes and be known as "The Hub" for information on evidence based practice. Regional clearing houses could be an alternative to a single centralised one, if more realistic.

## Appendix A: Conceptual Framework for Research Utilisation



## Conceptual Framework for Research Utilisation

### 1. BACKGROUND

The following conceptual framework (CF) for research utilisation has developed over the course of the WHO and Partners Technical Consultation (Geneva, March 2003) on Turning Research into Practice (TRIP)), a subsequent TRIP Working Group meeting (UK, July 2003), and TRIP Workshop (RSA, June 2004). It has evolved through an analysis of definitions and determinants of research utilization, as well as an examination of existing case studies, conceptual pathways and key elements to research utilisation (described in detail in the TRIP meeting report - reference). Its utility as a tool for documenting and examining research utilisation through analysis of case studies was tested and refined during the TRIP workshop, with input from policy makers, researchers, and programme managers in the field of reproductive health.

Several **guiding principles** have informed the development of the conceptual framework, and include the following:

1. There are many existing models and pathways to describe research utilisation, and analysis often reveals common concepts or elements. Therefore a useful CF should draw on, and distill these common elements.
2. Many existing models have developed from an academic perspective, and are quite complicated in order to capture the complexity of the processes involved. As a result, from a practical standpoint, such models may not be user-friendly for programme managers or policy makers in the field. The purpose of a CF should therefore *not* be to describe every potential pathway or factor (exhaustive, descriptive), but rather to *simplify* elements for purposes of analysis and learning (conceptual, analytical).
3. It is not feasible to identify a “generic pathway” or steps to ensure research utilisation. Instead, it would be more useful to identify common factors (facilitating and impeding) that influence research utilisation. Therefore, rather than being seen as prescriptive, the CF should stimulate thinking about a range of options and approaches to enhance RU.
4. It is often helpful to think of factors influencing research utilisation in relation to 3 phases within the research cycle: Pre-research, Research, and Post-research. The CF should incorporate these phases, understanding that in reality, they reflect a continuum.
5. Because more distal impacts are often more difficult to document, there may be a tendency to assess the end-point of research utilisation as its impact at policy levels (vs. tracing impact on programmes or practice). The CF should therefore encourage assessment of research utilisation along a continuum of potential applications, including: further research, advocacy, policy, programmes, and practice.
6. Often, critical factors influencing research utilisation are “beyond the control” of the researcher (e.g. the prevailing political climate, or evolving district health systems). Moreover, influential relationships or events may be unplanned or serendipitous. Therefore the CF should capture these broader “macro/contextual” factors and should refrain from imposing a false sense of order on what is often a chaotic, non-rational process.

These considerations have emerged from the above TRIP consultations, and have been incorporated into the conceptual framework as much as possible.

## 2. USING THE CONCEPTUAL FRAMEWORK

The conceptual framework may be applied both prospectively and retrospectively. **Prospectively**, it may be used in the planning stages, by donors, researchers, or programme managers, to assess, and potentially influence factors that may enhance research utilisation. **Retrospectively**, the framework may be useful for analysing case studies (both “success stories” and “failures”), in order to document and learn from prior experience. The CF is intended to be applicable across a range of research domains (e.g. basic, clinical, epidemiological, social sciences, or operations research), although it is expected that the research questions, stakeholders, communication strategies, and utilisation goals may well vary. It is worth noting that although the CF may be applied within the scope of a particular research initiative, in reality, it should locate such work within the context of a broader body of pre-existing and accumulating research evidence. Thus, in some cases, utilisation of research may be measured by its contribution to a developing theoretical base, or its influence in stimulating further areas for investigation. Finally, although the CF may be useful for highlighting where further attention to certain factors may be critical, it does not necessarily follow that these factors lie within the responsibility or influence of the researcher. In this respect, the CF may be a useful tool for engaging the perspectives and participation of multiple stakeholders, including donors, government, advocacy groups, policy makers, and programme managers.

The following section describes the main components of the Conceptual Framework for Research Utilisation.

### A. FACTORS

There are a range of factors to consider, which may impact on research utilization. These are divided into 4 broad categories in the first column of the conceptual framework.

#### 1) **Research process**

These factors relate to the research process itself, and are divided into 3 phases:

- **Pre-research:** factors primarily relevant to the research planning stage
- **Research:** factors relating to the conduct of the research
- **Post-research:** factors of importance in the post-research period

Although the separation of factors into these phases is not always distinct, for clarity, it is helpful to consider them as part of a continuum.

2) **Stakeholder involvement:** There may be a diverse range of stakeholders who need to be engaged in order to strengthen research utilisation, and these may vary according to the type of research (basic research, operations research, etc.) under consideration. Stakeholders include both potentially supportive and dissenting groups, and the nature and extent of their involvement may vary throughout the 3 phases described above.

3) **Communication:** These factors relate to activities that aim to communicate and disseminate research findings to relevant target groups

4) **Macro Contextual factors:** Although many of the above factors are, to some extent, within the influence of researchers, there are a range of contextual factors which may impact on research utilisation, yet are generally *beyond* the control of researchers.

## **B. UTILISATION AND SCALE-UP ACTIVITIES**

These factors (represented as an **arrow** bridging the gap between research process and research application) refer to activities that may play an influential role in the utilisation of research findings. In the absence of explicit planning, resource allocation, and modifications (e.g. adaptation from pilot phase to scale-up), the ultimate application of research findings may be limited.

## **C. APPLICATION**

The last column documents the extent of research utilisation through its potential applications at 4 levels: research, advocacy, policy, programmes, and practice. The relative contribution of a particular piece of research to these levels will vary, as will the directionality of influence (e.g. research influencing policy, and hence programmes, or vice versa).

## **Appendix B: Case Study Guidelines**

It is believed that through the sharing of experiences and ideas from a range of projects and programmes, researchers will be able to achieve greater utilisation of their own research be it in advocacy campaigns, policy formation, programme implementation or individual practice. Case studies should focus on the processes undertaken to optimise the utilisation of the research at one or more of these levels. The case studies should not include a detailed discussion of research results, but should instead describe the process(es) involved to enhance utilisation at each stage of the research, from the pre research phase, through to the final completion of the study and beyond.

It is hoped that these case studies will be reflective pieces that critically discuss what worked and what did not, what changes were made to the TRIP strategy during the course of the research, barriers encountered, opportunities missed and innovative approaches taken. Since this is a relatively new area it is important that the case studies provide an opportunity for reflection and thereby the potential identification of new and innovative approaches.

### **Completing a case study**

Submitted case studies should document a piece of completed piece of research.

For each case study three perspectives should be included, that of the researcher or programme manager in charge of the research and those of two other key stakeholders. Examples of key stakeholders include; programme managers, policy makers, advocacy groups, national or international NGOs, donors and service providers. The researcher or programme manager should identify the two additional perspectives and either forward the case studies guidelines and conceptual framework to them or provide JSI(Europe) with names and email addresses.

Key features of a case study should be summarised within the conceptual framework with greater explanation, including strategies and the justification of these strategies being included in the accompanying text. The following pages outline issues to be considered in completing a case study. It is not expected that all case studies will undertake all activities, nor would it be practicable to do so. In addition, the guidelines may not cover all relevant issues, therefore authors are advised to use the following only as a guide.

In addition to the completion of a conceptual framework and accompanying text, please provide a paragraph describing the research. What is the title of the research? Please give a description of the research. What were the research questions? What methods were employed to examine these questions? Who was the study population? What were the main results of the study? Please list the research team and their organisations.

	In the Conceptual Framework	In the accompanying text
<b>Research Process</b>		
<b>Pre- research</b>	Problem identification	What methods were used to identify the problem? For example, literature review, previous research and/or stakeholder discussions. Was the research commissioned (e.g. government, donor) or driven by the researchers?
	Relevance of research questions	How was the relevance of the research question(s) to stakeholders assessed? For example, via personal discussions, a research workshop, stakeholder meetings.
	Location within existing evidence base	Is the research topic required in view of the existing evidence base? Did it attempt to address a research gap?
	Credibility of research team	How was the credibility maximised? For example, through partnership with respected NGOs, local researchers or key stakeholders? How was this credibility highlighted? For example in some or all printed communication.
	Ethical Considerations	Were the ethical implications of the research adequately addressed? How? What procedures were put in place to address ethical issues? Were changes made to the study design to address these issues? From whom was ethical approval attained? For example institutional, national and/or donor ethical approval.
<b>Research</b>	Appropriateness of study design and methods	Why was the research design deemed the most appropriate? If there is a logical alternative, why was this not used? Was there any change to the study design? Who ratified these changes?
	Quality and replicability of research conducted	Were the ethical protocols adhered to?
	Local capacity used or developed	
	Feasibility of the research.	

<b>Post-research</b>	Credibility, simplicity of research results	Are the results seen as credible? Have the results been presented in a format easily accessible to the target audience?
	Translation into recommendations	Have stakeholders been involved in formulating the policy recommendations of the study? Which stakeholders were involved? Were different stakeholders involved for different recommendations? For example, policy recommendations for programme managers as opposed to recommendations for advocacy purposes?
	Timeliness of dissemination	What formats of communication were used for the different groups? (The rationale for these types on format and the timing of them should be included in the text accompanying the communication section). Have the result been disseminated to all identified formats/ events held? How long after the completion of the research did the different types of communication occur?
	Practical assessment of implementation needs	Have the implementation needs of the research results been adequately addressed? Who was involved in identifying these needs?
	Potential Public health impact of findings	Have the public health implications of the research been adequately communicated?
<b>Scale Up Activities</b>	<i>This section refers to activities that may play an influential role in the utilisation of research findings</i>	
	Explicit planning	Were the resources necessary for these activities included within the research funding or applied for later?
	Resource allocation	What activities were undertaken during the research process to facilitate scale up? For example, stakeholder involvement in design, and their subsequent endorsement, of training materials or the adaptation of the intervention for scale up.
	Monitoring, evaluation & adaptation for scale up	
	Development of tools	Was there external dissemination of transferable materials for example, training manuals?
	Technical assistance	Did members of the research team provide technical assistance in scaling up?
<b>Application</b>	In the following please clearly identify the research's <u>target level of application</u> , as identified in the funding proposal. For example results taken up by NGOs in addition to the <u>MoH</u> (the initial target), but also taken up by international advocacy campaign.	

<b>Evidence base</b>	To what extent was the research able to contribute to evidence base?	Please list all academic dissemination: publication, conference presentations, internet publication. Has additional research been stimulated? Within what time frame?
<b>Advocacy</b>	Was the research used for advocacy?	Who were the advocacy groups? International and/or national? On exactly what aspect of the research results, targeting whom, using what methods? At what level were they campaigning? What outputs did they achieve? For example, MoH meets with advocacy groups, MOH addresses rally on the issue. Did this occur during or after the research had been completed?
<b>Policy</b>	What area of policy was targeted by the research?	What level of research utilisation was achieved? For example, Public Stakeholder endorsement. What additional levels of utilisation, beyond the research aims, were achieved? For example, strategic planning for implementation, resources allocated.  How long after the research was completed were the results used?
<b>Programmes</b>	What level of research utilisation was achieved?	For example, strategic planning for programmatic change, resources allocated, request to help scaling up results.  How long after the research was completed were the results used?
<b>Practice</b>	What level of research utilisation was achieved?	For example, public recognition of the need for additional methods to be available or actual changes to client management  How long after the research was completed were the results used?
<b>Communication</b>	Level and type of activities undertaken throughout the research process  Involvement of media & other channels  Packaging and delivery of results for various target groups.  Allocation of resources for dissemination	How was the communication strategy developed? List the different types of communication used for the different levels of stakeholders and indicate if the communication was only at the beginning and end or throughout the research process.  What were the strategies for the different stakeholders?  How were the formats tailored for these different groups? For example, policy briefs, final reports or press conferences. How did these differ to make the findings accessible, convincing and relevant to the different target groups?  When were the communications made and why?  Who was involved in the communication process? Mediators, users, or policy makers themselves? Was there a dedicated member of the research team? For example, a

		<p>communication specialist or editor.</p> <p>To what extent did the quality of the research and nature of the research findings lean themselves to clear interpretation and recommendations?</p> <p>Were sufficient resources allocated to this process? Was contingency planning included in the funding application?</p>
<b>Macro contextual factors</b>	<p>Broader political, legal and programmatic climate.</p> <p>Sensitivity of research question and findings</p> <p>Const considerations</p> <p>Timeliness in research/policy cycle</p> <p>“Culture of evidence”, research/policy/service delivery interactions</p> <p>Compatibility &amp; contribution of results to current research/practice</p> <p>External interest (e.g. industry, donors, government)</p> <p>Health systems capacity to implement (e.g. district health systems, health care workers).</p>	<p>How were the macro contextual factors relevant to this research identified and assessed? Which factors were identified and which simply emerged? What strategies were identified to optimise the impact of these factors? Were all of these strategies implemented?</p> <p>Were sufficient resources allocated to this process? Was contingency planning included in the funding application?</p> <p>What macro contextual factors were identified as critical to this research? For example, ability to feed into the policy cycle, poor culture of evidence among the target stakeholders, political instability, plethora of other health initiatives being implemented. When were the issues identified and what was done to optimise the situation?</p>

## Appendix C - Listservs, mailing groups, publications advertised on

- Af-AIDS
- AIDS-India
- British Society of Population Science
- Reuse Female Condom discussion group
- Gender-AIDS
- GenSalud PAHO
- Population Association of America

### Responses received from:

NAME	ORGANISATION	LISTSERV NOTICE RESPONDING TO
Riffat Sardar	Unicef, Pakistan	AIDS-India
Dr Rajani R.Ved	Public Health Physician, India	AIDS-India
Dr Rrmeli Das	Assistant Director, Child in Need Institute, India	AIDS-India
Serge Doussantousse	Burnett Fellow, Laos	AIDS-India
Arun Virk	Sahara Research Department, India	AIDS-India
Lisette Bernal	Acquire - EngenderHealth, USA	Af-AIDS
Kai Crooks-Chissano	UNAIDS Intercountry Team for East and Southern Africa	Af-AIDS
Amy Qi	Futures Group Europe, Beijing Office, China	Reuse Female Condom discussion group
Kasinath Panchangam	Insight International Trust, India	Reuse Female Condom discussion group
Ellen Weiss	Horizons Program, USA	Af-AIDS
Dr Manickam	Department of Clinical Psychology, SRMC&RI University, Chennai, India	AIDS-India