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Developing research partnerships to bring change: experiences from REACH Trust, Malawi

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Abstract

Drawing on the experiences of REACH Trust, this paper highlights practical lessons of using research processes and outcomes to promote equity in health policy and practice. The REACH Trust is first introduced. Case studies are then used to highlight how REACH Trust has worked in a participatory manner with key stakeholders at community, national and international levels. In addition to participatory working there are a number of cross-cutting themes that facilitate the uptake of research findings which is discussed in turn: (1) multi-disciplinary and multi-method approaches (2) advocating research findings at strategic forums, and (3) the use of strategic frames. In the conclusion it is argued that research has a critical role to play in responding to the urgent need for the Malawian health sector to develop and act on evidence-based practice in a more gender equitable and pro-poor manner.

Background

The Malawi National Tuberculosis Control Programme (NTP) has an excellent record and international reputation for conducting programme-relevant operational research. In 1999 the NTP formed a research collaboration with the Liverpool School of Tropical Medicine and the University of Malawi to expand this operational research base. This collaboration was funded by the Department for International Development (DFID) as the 'TB Equity Project,' with the aim of conducting research to promote access to TB care, particularly for the poorest and most vulnerable populations. Under the TB Equity Project, a number of research studies were conducted, showing the impact that gender, poverty and barriers to access to TB care have on TB control. Since 1999 the collaboration has expanded into a programme of research to promote equity in TB, attracting additional core funding from DFID as well as project grants from the World Health Organisation's Special Programme for Tropical Disease Research (TDR), Stop TB Partnership, the Norwegian Heart and Lung Association (LHL) and the Southern African Health Equity Network (EQUINET).

The REACH Trust was legally constituted under Malawi law in 2005 to reflect a widening research portfolio, which has now grown to embrace HIV and malaria as well as TB. In this way staff at REACH Trust have synthesised approaches and concepts generated in TB research to applied research in these other critical diseases of poverty.

REACH Trust Vision Statement

To be an internationally recognised leading institution in health equity research in Malawi, working to break the cycle of poverty and ill health.

REACH Trust Mission Statement

To conduct research to promote equity in health, that:

- Is close to policy and informed by new developments, such as the SWAp
- Is multidisciplinary
- Strengthens capacity at community and national levels and to promote equitable, pro-poor, gender sensitive health provision, through:
- High quality policy relevant research in diseases of public health and poverty importance, including TB, HIV an malaria
- Developing multidisciplinary and participatory research capacity
- Building collaborative partnerships
- Using research outputs for dissemination and advocacy

The REACH Trust currently has 32 members of staff and is based at the Community Health Science Unit in Area 3 in Lilongwe. It comprises a multi-disciplinary team with expertise in sociology, clinical sciences, health economics, and development (including participatory approaches) and experience in a number of different aspects of equity and communicable disease. REACH has 12 Trustees who oversee and advise the Trust's activities. As an independent trust, REACH has worked to also develop its institutional base with investments in administrative support and infrastructure, externally audited accounts, and a staff development programme that has provided an opportunity to social science graduates for local postgraduate training.

Using research to promote equity in policy and practice: lessons learned

Core to our philosophy and reflected in our mission statement is the focus on conducting research that is policy-relevant. However, the relationship between policy and practice is not linear or straightforward[1]; it cannot be assumed that more research means more evidence-based policy, nor that more policy means improved practice. There are substantial obstacles to translating research findings into policy and practice2REACH Trust has found that participatory working at community, national and international levels alike can reap benefits in ensuring that research findings impact on policy and practice. This is followed by an overview of three key inter-related themes that are central to participatory working (1) multidisciplinary and multi-method approaches (2) advocating research findings at strategic forums and (3) 'strategic framing'.

Participatory working at community, national and international levels

The REACH Trust has grown from a research relationship with the National TB Control Programme (NTP) and other partners. Its relationship with the NTP is further strengthened by working under the same roof and having the Director of the NTP as part of the management structure. Furthermore, REACH Trust sits in all NTP strategic management group meetings. This means that

the two organisations have been able to work together in identifying research gaps, designing and implementing research projects and discussing the implications of research for policy and practice. This strong relationship is illustrated through the following two case studies:

Case Study 1: Translating gendered community needs into practice: working with storekeepers

The REACH Trust conducted qualitative and participatory research in poor areas of Lilongwe to map poor women and men's pathways to seeking care for tuberculosis. This research uncovered many inter-related barriers to accessing formal TB care services[3]. These findings were fed back to community members using participatory approaches, including drama. In the ensuing discussion community members proposed a community-based intervention to shorten the pathway to TB services. They suggested that storekeepers and key community members should be equipped with advisory and health promotion skills since they are first contacts in care seeking, being easily accessible at the community level.

The proposal was then presented to providers and policy makers at district and national level through different forums such as conferences and management meetings for the NTP. The community members proposed that addressing barriers should not be limited to tuberculosis, but should also include malaria because it is a major health problem for children, as well as women and men. Mothers and female carers in particular face challenges in seeking care for children with symptoms indicative of malaria, as caring is constructed as a largely female role. Consequently, discussions were also held between the National Malaria Control Programme and the National Tuberculosis Programme. A joint malaria-TB intervention was developed to address issues of improper advice on home management of non-serious malaria and delay in seeking care for tuberculosis. The intervention involves training storekeepers, volunteers and community members in advisory and referral skills, health promotion and referral skills. Early evaluations show that these interventions are increasing women and men's ability to uptake TB and malaria services.

Case Study 2: Integrating gender equity and concerns into NTP core activities

Through advocacy from the REACH Trust, the NTP has strengthened its institutional capacity through **creating the post of Gender and Equity Officer**. The post holder is expected to sustain collaboration, analysis and dissemination of gender- disaggregated data for advocacy. The NTP **integrated equity and gender within their five-year development plan**. This included, for example, the provision of funding for community based initiatives to address barriers to and costs of accessing care.. REACH Trust has produced a policy briefing[4] on the 'how to' of developing partnerships with community organisations or structures (such as store keepers, home based care groups, etc.) to enhance case detection for TB in Malawi. This policy briefing has been circulated to all District Health Officers to inform the process of developing District Implementation Plans (DIPs).

The case studies show how working closely with the NTP has created an opportunity for translating research findings into interventions that meet the needs of poor women and men, as well as developing strategies to institutionalise and sustain a gender equity approach in NTP's core activities.

REACH Trust also works at a regional level and sits on the Steering Committee of the Southern African Health Equity Network - EQUINET. This has enabled it to feed Malawi perspectives into this regional advocacy network. This will be consolidated in 2006 with the development of a Malawi equity analysis, which will be led by the REACH Trust in collaboration with the Malawi Health Equity Network (MHEN), and the Equity and Access Sub Group. Through MHEN, REACH has been able to disseminate research findings and advocate for pro-poor policies at parliamentary fora. The following box summarises the process and focus of the country equity analysis.

A country equity analysis

A country equity analysis is more than a report. It is a process of networking all country personnel working on health equity, including, but not limited to, those working within EQUINET themes and processes. It feeds country experience and evidence and provides an opportunity to draw together perspectives, evidence, experiences and views, to strengthen dialogue and networking and to build shared learning and analysis within countries and within the region on equity priorities identified at country level. It aims to assess 'where things are' at the country level on a range of priority areas of health equity and to propose options for addressing them.

The country equity analysis in 2006 will be guided by the areas of focus of the regional equity analysis, i.e. on **building comprehensive, universal and integrated national health systems**, particularly exploring:

i. Building people-led, people-centered health systems that organize, empower, value and entitle people;
ii. Promoting increased fair, sustainable and equitable financing for health at national, regional and global levels in order to secure the universal right to health;
iii. Ensuring adequate, well-trained, equitably distributed and motivated health workers;
iv. Advocating for fair global policy (just trade, reversing unfair flows of resources) with national and regional policy flexibility to exercise policies that improve health.

Activities and outputs will include the following:

i. A list of equity actors in country shared within the country and in the EQUINET database
ii. A list of country equity priorities and a reference list of published work done to date on these with any electronic documents fed into the EQUINET annotated bibliography database.
iii. A meeting held for country equity actors
iv. A country equity analysis report providing evidence, experiences, positive examples, case studies, voices from civil society (including real stories from community life), ministers and parliament, government commitments, meeting resolutions, and photographs and graphics.

For further information on this please contact Hastings Banda at the REACH Trust in Lilongwe.

This equity analysis will provide an opportunity for further networking and policy advocacy at community, national and regional levels.

REACH has also worked in collaboration with core partners at an international level.. It set up a website (www.tb-poverty.org) which has a searchable database of publications relating to TB and poverty, case studies and examples of 'evidence based' best practice in pro-poor approaches from Africa REACH members have also played a role in feeding Malawian experience into the WHO International Guidelines to Addressing Poverty in TB Control: Options for the National TB Control Programmes[6] and are members of the TB & Poverty Core Group of the Global Partnership to STOP TB (http://www.stoptb.org/tbandpoverty/)[7].

These activities have begun a paradigm shift in TB Control with an increasing understanding that pro-poor approaches are important for equitable, efficient and sustainable TB Control Programmes. This approach has been highlighted in a recent editorial[8] and forthcoming commentary[9] in the Lancet. The Secretariat for TB and Poverty will continue its activities in

2006/7 and will be hosted, through an international partnership, by REACH Trust, the Liverpool School of Tropical Medicine, UK and KNCV, who have their head offices in the Netherlands. REACH Trust anticipates that this joint hosting will consolidate its partnerships with these other players, maximising the benefits emanating from their different comparative advantages to continue to promote the need for pro-poor approaches in TB Control.

Multidisciplinary and multi-method approaches

Health research that contributes to change may require more multidisciplinary approaches and methodological pluralism[5]. REACH Trust has used multiple methods including quantitative approaches (questionnaires, simulated client surveys, gender analysis of pre-existing routinely collected health information) and qualitative approaches (focus group discussions, in-depth critical incidence interviews, key informant interviews and participant observation). REACH Trust has found that presenting findings from multidisciplinary approaches and multiple methods can be strategic in advocating for change. This comes down to both personal preference (some policy makers prefer and are more convinced by quantitative methods than qualitative methods and vice versa), but also creates opportunities to present a holistic picture. For example, analysis of questionnaires can produce statistical significance on the numbers of poor women and men failing to access services; whilst the qualitative findings can help contextually explain these figures by describing in poor women and men's own words the barriers, challenges and obstacles they face in service access. Qualitative testimonies can be a powerful tool in highlighting gendered disparities in health experiences and they reveal in-depth information about cases or patients.

Advocating research findings at strategic fora

In collaboration with the Lighthouse, REACH Trust conducted in-depth qualitative work on barriers to access and adherence to ART. This was conducted in 2003/4 when ART was provided at cost, and at the time that there were many policy discussions on how to scale up ART across Malawi. At a number of key policy discussion groups and strategic fora, REACH staff presented findings showing that cost constituted the key barrier to access to ART and that this was gendered, with women in particular struggling to meet the costs required[10]. These findings fed into discussion at the Ministry of Health and were arguably influential in shaping the newest Malawian policy. This includes ART drugs provided free, a particular emphasis on health promotion strategies that are geared towards poor and vulnerable groups and the promotion of harmonised concurrent provision through the private sector. REACH Trust has also advocated for sex disaggregated data collection by the HIV unit in the Ministry of Health, following the production of the Makwiza et al. report on "Monitoring Equity and Health Systems in the provision of ART[10]."

'Strategic framing' - adopting different languages or discourses to discuss gendered research findings

It can be strategic to situate research findings within different languages or discourses depending on the audience. This has been referred to as 'strategic framing' and has been discussed in the gender literature[11, 12]. As individuals, we may believe in and work within a gender equity and rights discourse, i.e. poor women have a right to accessible and quality TB services. But we may choose to situate our research findings within instrumental or technical arguments that prioritise efficiency or sustainability, as these may be more accessible to policy makers than a discussion of gender and rights. It could, for example, be argued that if TB services are inaccessible or unacceptable to poor women, TB programmes will not be cost-effective, nor will they be able to meet their case detection and cure rates targets. With negative repercussions for the community from a large number of unidentified, untreated, infectious TB cases: this clearly threatens the *efficiency and sustainability* of the entire TB programme.

Conclusion

Research is not a passport to policy[5]. For research findings to inform policy and practice there is a need for well thought out strategies and approaches. Key to this is the importance of developing sustained and responsive relationships with policy makers. These relationships enhance the ownership of the research process and hence the likelihood of policy makers adapting policy and practice in the light of research findings. Other strategies to promote uptake of research findings include sustained advocacy at policy fora and technical working groups that uses multiple methods (numbers and voices) to illustrate the main issues and deploy different strategic frames - equity, gendered rights, efficiency, sustainability - depending on the audience. There is a clear need for ongoing discussion and action to address the poor's health needs in Malawi. As researchers there is a need to continue to proactively search for opportunities to use our research to promote equitable policy and practice, so that health services better meet the needs of poor women, men, girls and boys.

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