

## Getting research into policy, or out of practice, in HIV?

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Health policy has been dominated by calls for getting research into practice.<sup>1,2</sup> Yet many health interventions are based on hypotheses that are best guesses or gut feelings. The HIV field illustrates this particularly well. Most prevention efforts aimed at changing behaviour will be based on one of several potential theories of behaviour change.<sup>3,4</sup> Similarly, efforts to re-configure health services to improve care (eg, through integration of services or task-shifting<sup>5,6</sup>) are typically not started on the basis of evidence of what works in a given setting, but are based on hypothesised ideas about what might work, or applying what has been successful for other conditions.

The concept of getting research into policy and practice (GRIPP, which we can shorten to GRIP) reflects what has been described as the engineering model of research, in which previously developed evidence is weighed up before selecting an appropriate solution.<sup>7,8</sup> Although appealing, this concept reinforces the notion that a body of evidence should pre-exist before action and implies that those who do research are different from programme officials, which divorces decision makers and implementers from programme research and evaluation.

Yet when facing immediate health challenges, there is not time to wait for all theoretical research to be done. Activities must be developed with reference to what is already known, even if that is limited. A balance is required between; action and contemplation, and research and practice. It is time to mainstream methodologies which can evaluate ongoing interventions as they are implemented, to learn from action in more rigorous scientific ways.

There are many HIV/AIDS programmes which are, in effect, testing hypotheses but often with little inbuilt research.<sup>4,9</sup> Furthermore, there are many gaps in knowledge that can only be addressed through research specifically built into practice. Addressing those knowledge gaps involves a change in focus from getting research into policy, to getting research out of practice—moving from GRIP to GROPP (getting research out of practice, figure).

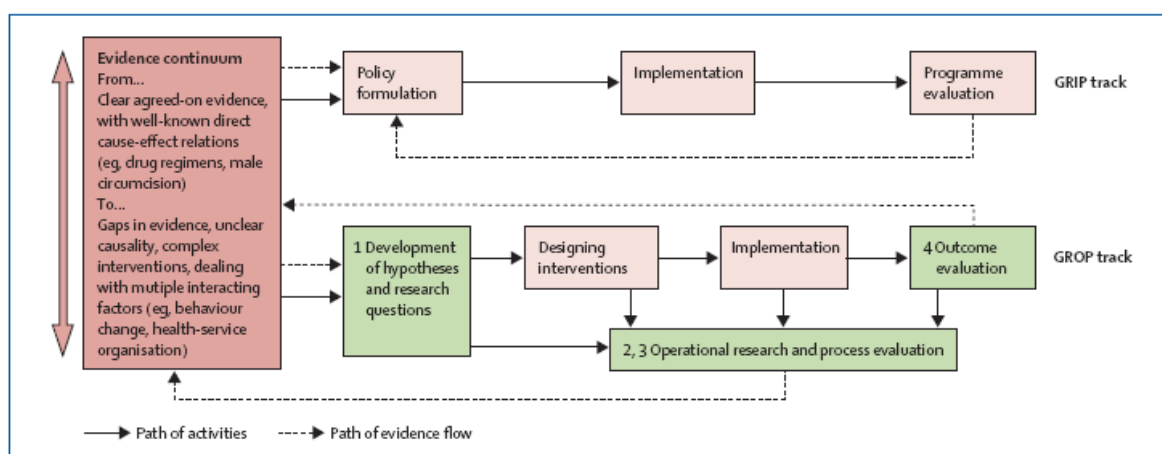


Figure: Pathways of activities and evidence flow into, and out of, policy and practice

Green=new areas for research development (funding and methodology for interventions that test hypotheses): (1) improving hypothesis development; (2) operational research; (3) process evaluation; and (4) outcome evaluations that provides scientifically valid results (epidemiological, social, and behavioural outcomes).

In GRIP, pre-existing research evidence is drawn on when policies are formulated. GROOP applies to policy and practice when there are evidence gaps or when context specificity means that generic interventions cannot be applied. To get research out of practice requires interventions to have a well-developed conceptual basis and be rigorously evaluated. Within the GROOP model, there are four specific areas for research development which need increased international financial and technical support.

First is better, and more explicit, hypothesis development. Better reviews of existing material and explanation of assumptions are important first steps to designing more effective interventions. Second is improved operational research,<sup>10</sup> which Walley and colleagues<sup>11</sup> argue can help move from “getting research into practice” to “getting practice into research” by learning how complex health interventions are implemented, to enable scale-up of what works in particular contexts.

Third is increasing the use of process evaluation. Operational research has tended to focus on health systems, whereas process evaluation derives more from the social sciences.<sup>12</sup> Both, however, look to explain why something is working or failing, attempting to explore how interventions work in different contexts. For social and behavioural interventions (eg, many HIV-prevention efforts), it will be particularly important to investigate the causal mechanisms by which an intervention works for particular groups in given settings.

Fourth, proper outcome evaluation is essential. Countless HIV-prevention programmes provide little more than to measure impact counts of individuals reached or changes in awareness. Yet the ultimate goal is to change HIV-related risk behaviours. Without robust outcome measures, it will be impossible to learn lessons from the diverse range of initiatives being attempted.

Many lessons of complex and innovative health promoting activities are being lost due to a lack of research. The field of HIV illustrates this across both prevention and treatment interventions, for which ongoing activities provide a wealth of information that can help to answer key research questions, and to learn lessons for other programmes. Drawing out the information from existing activities to learn programmatic lessons underlies the concept of GROOP, which recognises how ongoing interventions provide numerous opportunities for integrated research and evidence development. Such work will require financial support, but funding bodies can seize GROOP opportunities in two main ways. First, they can top slice budgets for appropriate evaluation and operational research as part of the intervention projects and programmes they support. Second, donors can identify existing programmes (not already supported by the funding body) in which they can sponsor evaluation and research elements as add-ons.

Policy makers struggle for information applicable to their local context. The hypothesis development, operations research, and process outcome evaluations called for under GROOP can help build understandings of how interventions work in different contexts. Importantly, GROOP requires

much closer partnerships between researchers, donors, implementers, and policy makers. Pursuing GROF research provides enormous opportunity to increase the field of knowledge, and increase the effectiveness of health activities in HIV/AIDS and beyond.

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