Building a multi-country partnership to conduct inter-country research on community health: Experiences from REACHOUT

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In 2013, the European Commission financed the REACHOUT network to look at the equity, efficiency and effectiveness of close-to-community health programmes within and across six countries (Bangladesh, Ethiopia, Indonesia, Kenya, Malawi and Mozambique) through its FP7 Framework for Health. This grant brought together eight organisations (see Figure 1) in an implementation research partnership. Its aim was to improve community health through research, engagement with policymakers and programmers nationally and globally, and the production of generalisable knowledge.

Health systems research that uses qualitative methods must be interactive, collaborative and based on exploring perceptions and experiences. Both research design and analysis should be rooted in a strong understanding of the local context as well as understanding of the role of the researcher in that community. Continued joint discussion between core researchers strengthens the trustworthiness of the findings.

Multi-country studies face challenges in facilitating inter-country analysis. There are practical financial and logistical challenges to meeting face to face, as well as analytical challenges of interpreting findings across contexts that (despite similarities in public health challenges and socio-economic status) vary considerably in terms of their history, cultural norms, community structures, and health systems.

This brief summarises how we worked to develop our partnership's ability to investigate, reflect on, and share learning on close-to-community providers of health care across contexts. This involved building trust within institutions and between individuals and institutions from different contexts. Collaborative leadership approaches were developed within the consortium involving all partners. This allowed us to contextualise common tools and research approaches to get the best insights from each location. We built individual and institutional capacity for inter-country mixed-methods research, always looking at influencing policy and practice. To achieve influence, we engaged with key health system stakeholders from the outset and throughout the project. The relationships developed within the consortium and in our wider partnerships are the foundation of the REACHOUT network, which continues to grow and develop even as this funding period comes to a close.

What facilitated our inter-country analysis?

Shared values and pre-existing relationships helped build trust

The REACHOUT team developed its proposal on close-to-community providers at a face-to-face meeting which was held in the UK in early 2012. The meeting brought together institutions and countries with a breadth of expertise in community health implementation research, from disciplines as diverse as statistics, anthropology, and medicine. It included several individuals who had collaborated before. Drawing partners from pre-existing networks meant that we started the partnership with a foundation of mutual research interests and shared concerns. This assisted us in building trust over the longer term.

Figure 1: REACHOUT institutions and teams come from a variety of locations, institutions and backgrounds

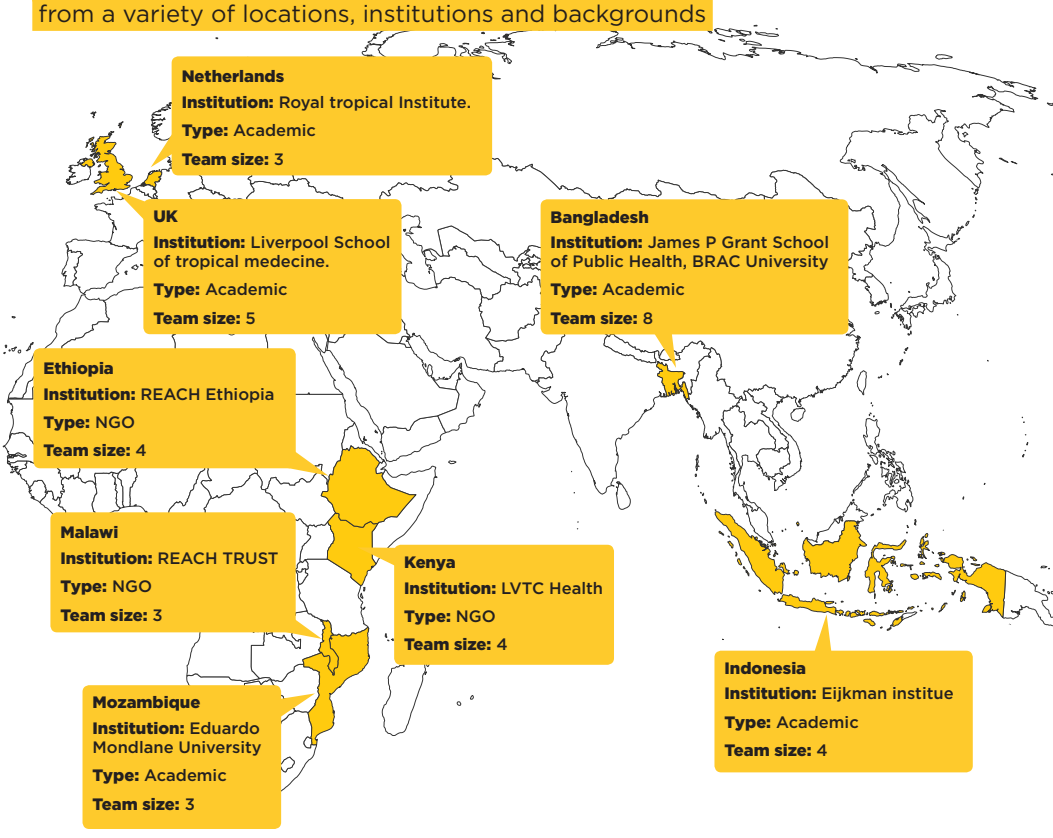

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Figure 2: Team building, even after four and a half years, supporting both formal and informal relationships across countries and hierarchies

Relationships of trust meant that partners were more willing to invest their own resources, particularly in terms of researcher time, to developing ideas and answering donor queries in the long hiatus (almost two years) between the submission of the proposal and the initial transfer of funds. This willingness to co-invest continued during the five-year funding period, where partners devoted in-kind time and resources to mentor early career researchers and ensure research reached the local and international policy-making arenas.

Through the partnership we have tried to deepen our understanding of the contexts in which we work: sharing knowledge, methods and ideas in order to strengthen the quality of our outputs, and the applicability in each context and across contexts. Trusting relationships have helped qualitative researchers to engage with each other in the discussions and deliberations necessary to deepen the analysis. These open discussions were crucial when operating across health systems, borders, and languages.

These relationships have led to further joint projects and successful fundraising, such as in the USAID SQALE program and PERFORM2scale funded by the European Commission, enabling the REACHOUT network and platform to endure.

REACHOUT governance enabled a mix of partner-led and inter-country analysis

REACHOUT has a horizontal governance structure. It is led by two principle investigators from Liverpool School of Tropical Medicine (LSTM) who shared the role and brought differing skills and approaches. In-country work was led by principle investigators from each of the national organisations with support from KIT (Figure 1). The group of eight principle investigators formed a Programme Management Committee (along with the Programme Manager, Project Manager and Communications Manager) which met face-to-face at bi-annual meetings to discuss core governance issues and to provide strategic and ethical oversight.

This devolved governance structure helped to ensure accountability to the donor in terms of financial oversight and programme delivery through LSTM, while ensuring that research and partnership direction and international messaging was steered by a group reflecting the interests of all partners. Meeting minutes helped to formalise and clarify these roles and relationships. The Programme Management Committee clarified structures and expectations through consortium authorship and data sharing agreements which were jointly drafted and signed. For example, REACHOUT's publications policy, which was developed with inputs from all principle investigators, ensured that all staff involved in the partnership had a clear picture of who owns data, how it is shared for inter-country analysis, who has a right to publish, and how disputes should be resolved.

Common research tools and methods were balanced with flexibility to adapt to context

From the outset, the REACHOUT team were convinced that one of the strengths and opportunities of working as part of a multi-country partnership would be the opportunity for researching and developing recommendations for policy and practice across countries. This kind of generalisable evidence helps inform normative guidance and guidelines, adding value to discussion of what to do and what not to do when improving community health. As the foundation of inter-country analysis, we developed common research methods and tools which could be used in multiple contexts. These included qualitative topic guides for discussions with close-to-community providers to explore supervision, motivation, perceptions of quality and links with the health system and a validated quantitative tool to study motivation. These common tools provided a core set of research findings that we could speak about in each country, and we developed them collaboratively at several points in the partnership according to agreed research objectives.

As each of our contexts are different and we were working on different areas of health and with different stakeholders (for example, the private sector in Bangladesh) we adapted these common tools and framed our findings and policy messages in different ways depending on what was required. This approach was mirrored in our communication strategy where common outputs (such as the website and social media, shared branding, policy briefs etc.) were augmented with tailored products that suited local audiences. Yet all this contextualization was founded on a common approach to analysis, using face-to-face meetings to discuss and refine analysis in an iterative process with an emphasis on inter-country, generalizable findings.

Finding the balance between a common approach and flexibility of country teams is not always easy. Keeping the common goal in mind helped: to act purposefully so that close-to-community providers - who are often invisible and ignored - could provide a lead in terms of areas that they considered a priority.

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Capacity strengthening was an explicit output of inter-country collaboration

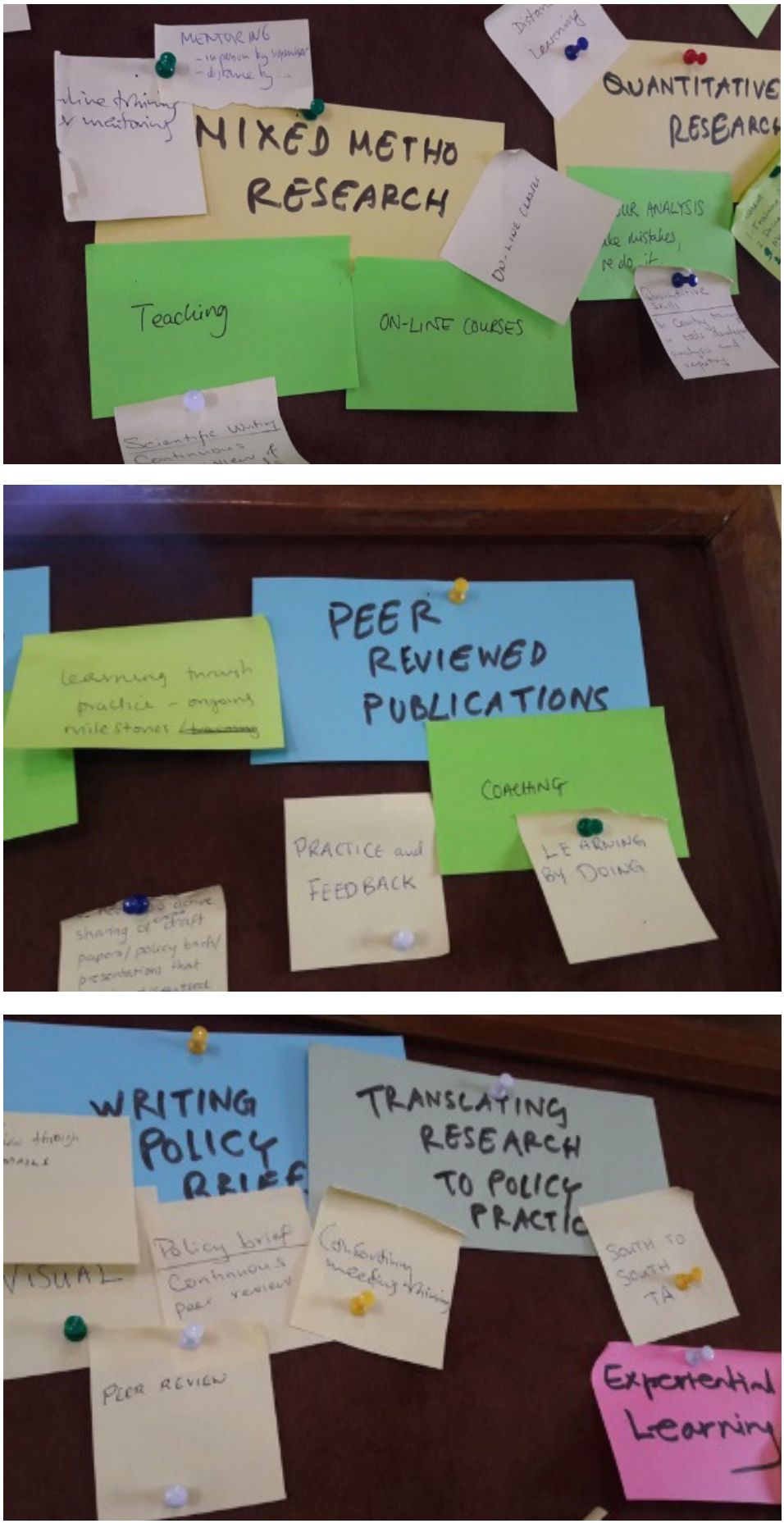
We deliberately fostered a team building and mentorship approach across and within country teams, as we felt this would further enhance trust and data sharing for inter-country analysis. Unusually for a grant-funded research project, a third of our budget was dedicated to capacity strengthening. This stream of work was managed by James P Grant School of Public Health at BRAC University. Our approach was underpinned by an open process of uncovering the strengths and skill gaps of individuals and participating organisations. Questionnaires were used to identify the capacity gaps of consortium members and their institutions, and participatory methods of self-reflection and capacity development priority setting were also employed at face-to-face meetings (Figure 3).

REACHOUT strengthened the quality of the inter-country research and the depth of the analysis we were able to conduct through organized trainings and reflective sessions in each consortium meeting. In the consortium we valued the capacity and contributions of more junior researchers (who conduct and manage most of the fieldwork on a daily basis and thus have much to teach their managers).

Our approach to training at meetings, which happened approximately every nine months over the five years, allowed junior researchers to learn skills, try them out, and come back with experiences to share away from the hierarchy of their institutions and the pressures of daily lives. These trainings also led to a shared understanding of frameworks, approaches, and expectations of quality which enhanced inter-country analysis. A defined space for early career researchers to meet and share knowledge, informally dubbed the Junior Researcher Network, led to increased opportunities to recognise and progress common themes between countries.

Capacity building was not limited to research skills and competencies. Whilst building the skills of team members we also acted to dismantle the institutional and systemic barriers which may hinder individual career development. Thus, by the end of the funding period we had developed a team in which all staff could confidently represent REACHOUT and speak publicly from their varied positions and viewpoints, generating new ideas for inter-country analysis. For this to occur, senior staff had confidence and faith in

Figure 3: Participatory approach to identifying capacity development gaps and opportunities within and outside the consortium



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LVCT Health Snapshot:

LVCT Health includes capacity development of staff as a core area in its strategic plan. REACHOUT provided an opportunity to actualize that vision, as a project explicitly committed to building the capacity of young researchers through formal training, mentorship and exposure in the institution in various ways:

- Regular skills-building workshops linked to the bi-annual partnership meeting, in which early career researchers could learn about and practice new skills and methodologies (presentation skills, qualitative methods, critical appraisal, quantitative analyses, creative writing, Most Significant Change etc.)
- Through networking and ollaboration, one senior researcher got an opportunity to undertake a PhD with Vrije Universiteit in Amsterdam with a REACHOUT colleague as a supervisor and REACHOUT supporting some elements of the PhD costs.
- Research assistants working in REACHOUT have been exposed to various learning opportunities and subsequently been appointed to positions in other LVCT Health research studies.
- Junior researchers in REACHOUT have grown in their capacity as researchers, have presented in international conferences and lead-authored publications for the first time with mentorship and review from senior principle investigators from across the consortium. These junior researchers are now involved in training others and will all be retained in the organisation to lead other studies that are upcoming.

As an institution, LVCT Health have also benefited from technical assistance on broader aspects of financial sustainability and knowledge management. By deepening research expertise in community health programmes through this inter-country research process, they have incorporated the area of community health as a pillar of our new strategic plan, written in 2017.

their team's ability to lead as well as identify weaknesses in their skill sets and ask for assistance when needed.

Beyond the partnership, we also sought to identify and overcome capacity gaps within the policy and practitioner networks in which we worked to develop and share our research. This process underwent formal evaluation, and gaps were addressed by South-South technical assistance, in addition to more traditional North-South approaches. The bringing in of policymakers from each of the focus countries into our networks to support them in learning about and applying the evidence from different settings was particularly valuable for the partnership to. By holding consortium meetings in each country, exchange trips for both researchers and policymakers between countries allowed them to learn from and reflect on others' work and health systems, enhancing the inter-country analyses through deeper understanding.

"When I first joined REACHOUT in September 2013, my biggest concern was to speak in public. However, this work requires me to communicate with various stakeholders from village to national level in different platforms as well as with REACHOUT colleagues from other countries. Now in 2017 I was able to speak on behalf of my country at the international community health symposium in Kampala, Uganda."

Licia Limato, Indonesian REACHOUT researcher

Table 1: Approaches to engagement

PROJECT PHASE	ENGAGEMENT APPROACHES
Planning the partnership	Communication capacity audit, stakeholder mapping to identify challenges and facilitators, policy and practice analysis
Agreeing research areas	Target audiences supported definition of priorities
Developing methodologies	Focus on simple tools that could be understood and used by local implementers
Data collection	Inclusion of stakeholders throughout process and regular feedback to policy makers
Analysis	Transparency about positionality
Dissemination	In multiple formats for different audiences

"REACHOUT has presented invaluable opportunities for continuous development of capacity. I am truly honoured to have an opportunity to pursue a PhD within REACHOUT as part of the LVCT Health team."

Robinson Karuga, Kenyan REACHOUT researcher and PhD candidate

Communication with stakeholders occurred throughout the research process rather than only at the end

Communication and research uptake are central to the way in which REACHOUT works. Our aim was to embed a quality improvement cycle approach within local structures and systems and provide close-to-community providers, and those who support them, with the skills and tools to better perform their roles. This could not occur without work to build learning networks and to identify and alter working practices, policies, and institutional habits that were acting as a barrier to change. We have communicated with academic and policy stakeholders at the national and international level – not just about our findings, but also about the process of conducting the research and the successes and challenges that we have faced along the way.

"We have placed an emphasis on the supply side – communicating with stakeholders who we feel are key to the change process about what we believe needs to happen. But we have also focused on the demand side - through research uptake work. If you are a farmer you cannot just throw seeds on the ground and expect them to grow. You need to take account of the soil, the climate, any pests etc. These will differ depending on where you are planting. That is research uptake work, preparing the ground so that ideas can bed-in and flourish, so the seeds of your research can grow long roots."

Kate Hawkins, Communications Manager

By working with key stakeholders throughout the research process as shown in Table 1, country-level understanding and ownership of the results was greater. Bringing local policymakers to other countries for visits, involving them in consortium meetings, and then bringing inter-country findings to the table has made REACHOUT's influence on policymaking and programming disproportionately large for its budget.

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Engaging policymakers: when is the best time?

At its inception, the REACHOUT project in Malawi worked with district-level Health Management Teams and officials and policymakers from the national Ministry of Health (MoH) through a series of preparatory meetings providing feedback on the context analysis findings and aimed at getting buy-in for the project. Participants jointly developed and refined the intervention package, how the interventions should be implemented, and the monitoring and supervision process. Working with district coordinators of several programmes in this project (i.e. iCCM and Maternal and Child Health) improved coordination between the existing vertical programmes.

In parallel, we established a Country Advisory Group (CAG). The group was responsible for supporting the review of data from proposed districts to identify gaps and challenges and informing choice of the implementation districts. The CAG was comprised of policy makers from the MoH, experts from international NGOs, academics, and district managers.

We worked particularly closely with one policymaker, the head of the community health worker programme within the preventive health services directorate at the national MoH. REACHOUT engaged this policymaker along with those from other implementing countries in training of trainers for embedding quality improvement into community health services, developing joint understanding and ownership.

"It all goes back to the design and approach of the project. It was such a flamboyant approach especially the cross-learning among partner countries during the annual consortium meetings... I was in class yet also being made able to make contributions during discussions of your meetings.

This experience helped me champion discussions or make very relevant contributions to policy and strategy formulation back home...Especially during the development of the community health worker strategy – when I worked with the consultants I was able to articulate issues with confidence because of the way I was exposed and capacitated by REACHOUT and that is the sort of influence I made... If you engage the right players at the outset of your research or intervention, you get the right gaps. If you follow and work within the chain of command and not miss the line of communication upwards you will succeed. If you engage wrong people you are likely to get locked up somewhere along the hierarchy." National community health worker programme manager, Malawi

Conclusion

The REACHOUT consortium was formally brought together by European Commission financing, and the relationships built by individuals and institutions through inter-country analysis mean that the network is going to flourish and grow beyond this funding period. Future collaborations within the network in research, communication, and capacity development are ongoing and in development.

The biggest lesson from REACHOUT's experience for future inter-country research partnerships is to share the ownership. Whether it is through inclusive approaches to engage all member teams and all levels of staff involved in the project or longitudinal engagement with stakeholders for research priority setting and co-creation of knowledge, broadening the ownership of the project can lead to greater impact. This wider audience may challenge us to reflect on our performance, just as inter-country work does when we compare to what others do and how they work. Co-ownership moving beyond research audiences will help us to embed the results in a deep understanding of context, aligning the needs of the health system with the power that inter-country recommendations can bring.

Further reading

Edwards, S. Ritman, D. Burn, E. Dekkers, N. Baraitser, P. (2015). Towards a simple typology of international health partnerships. Globalization and Health, 11(49).

John, CC. Ayodo, G. Musoke, P. (2016). Successful Global Health Research Partnerships: What Makes Them Work? The American Journal of Tropical Medicine and Hygiene, 94(1), pp. 5-7.

Larkan, F. Uduma, O. Lawal, SA. Bavel, BV. (2016). Developing a framework for successful research partnerships in global health. Globalization and Health, 12(17).

(2013) Montreal Statement on Research Integrity in Cross-Boundary Research Collaborations. In 3rd World Conference on Research Integrity [online] Montreal: National Research Council Canada, Available at: http://www.researchintegrity.org/Statements/Montreal%20Statement%20English.pdf

Lau, C. Wang, C. Orsega, S. Tramont, EC. Koita, O. Polis, MA. Siddiqui, S. (2014). International Collaborative Research Partnerships: Blending Science with Management and Diplomacy. Journal of AIDS Clinical Research, 5(12), pp. 385.

Ramaswamy, R. Kallam, B. Kopic, D. Pujic, B. Owen, MD. (2016). Global health partnerships: building multinational collaborations to achieve lasting improvements in maternal and neonatal health. Globalization and Health, 12(22).

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