**Conducting High Impact Research**

**Small Group Activity 3 – DIRECTIONS**

**Developing a Data Use Action Plan**

Directions:

1. Stay in the same small groups as in Exercise 2. Locate the Exercise 3 Worksheet.
2. Refer to the Exercise 3 Worksheet and review the research questions listed in the “Questions” column. For the research questions assigned to your group, review the key findings listed in the column titled “Findings.” Based on these findings, develop policy or programmatic recommendations. As you develop recommendations and prioritize them, consider the questions below:
	* Impact – What will be the long- and short-term impacts of this recommendation on health programs?
	* Resources – Are additional resources needed to implement the recommendation (financial, human, material)?
	* Supporting factors – Are policy, operational, or management changes needed to implement this recommendation?
	* Acceptability – Is the proposed recommendation politically and culturally acceptable?
	* Timeliness – Can the recommendation be implemented in a timely manner?
3. Refer to the column titled “Lead Decision Maker (LDM).” Identify the primary decision maker needed to implement each recommendation developed in step 3. Refer to the stakeholder analysis that your group completed in Exercise 2.
4. Refer to the “Stakeholders Impacted” column. Identify the additional stakeholders who will be affected by the implementation of each recommendation and/or the stakeholders who can assist the lead decision maker in the decision-making process.
5. Refer to the column labeled “Communication Channel.” List the ideal communication channel for reaching stakeholders with key findings and recommendations. Select a communication channel for each group of stakeholders. Refer to the chart below for selecting appropriate communication channels based on the type of stakeholder.

**Making research findings actionable: A quick reference to communicating health information for decision making**

|  |  |
| --- | --- |
| **Stakeholder Group** | **Communication Methods** |
| Politicians and government officials | *dissemination workshops, other face-to-face meetings,**policy briefs, brochures, and executive summaries*  |
| Program managers | *summary reports*, *executive summaries,* *audiovisual presentations* |
| Civil society, nongovernmental organizations, and professional associations | *fact sheets, brochures, and other handouts,**audiovisual presentations* |
| Private sector | *fact sheets,**audiovisual presentations* |
| Mass media | *magazines, newspapers,**press releases, fact sheets* |
| Donors/funders | *full research reports,**audiovisual presentations* |
| Academic researchers and international agencies/organizations | *peer-reviewed articles*, *oral/poster presentations*,*research databases, CD-ROMs*, *websites* |

**Designing High Impact Research**

**Small Group Activity 3 – WORKSHEET**

**Developing a Data Use Action Plan**

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **1** | Can injectable contraception (DMPA) be provided safely by paramedical workers to increase CPR? | – All paramedical workers provided DMPA services according to the standards that the MOH had established.– No adverse events were reported. |  |  |  | 1.2. | LDM1.2. |
| **1a** | Were clients and nurse supervisors satisfied with the new service? | – 96% of women had a favorable interaction with the paramedical worker.– 84% of supervisors were in favor of scaling up the program to the national level. |  |  |  |  |  |
| **1b** | Did contraceptive use increase? | Of the clients who accepted DMPA, 41% were either new users of family planning or were resuming family planning after a hiatus. |  |  |  |  |  |
| **1c** | Did clients return to the paramedical worker for repeat injections? | Of women who had initiated DMPA by the paramedical worker & were eligible for a 2nd injection, 96% received 2nd injection. |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **2** | Is HIV mortality,incidence, or prevalence improving in countries with the largest Global Fund (GF) programs, compared to control countries? | – The annual change in the number of HIV-related deaths in high-investment countries was 10.5% lower than the control countries. The difference in trends before GF programming is not significant.– The change in adult HIV prevalence did not significantly differ throughout the study period.– The change in infant HIV incidence decreased by 5% in high-investment countries. |  |  |  | 1.2. | LDM1.2. |
| **2a** | Which programs (or combination of programs) were responsible for better outcomes? | All high-investment countries actively promoted the integration of family planning services in PMTCT services. |  |  |  |  |  |
| **2b** | Were there similarities among countries that contributed to positive outcomes? | The high-investment countries ranked higher than the control countries on all good governance indicators.  |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **3** | Is the completion rate for the recommended 4 ante-natal visits better in clinics in which there is a higher staff-to-client ratio? | – In clinics with 1–2 providers, completion rate for 4 visits was 33%. – In clinics with 2–4 providers, completion rate was 73%. – In clinics with more than 5 providers, completion rate was 77%. |  |  |  | 1.2. | LDM1.2. |
| **3a** | In clinics with a higher staff-to-client ratio, do providers spend more time in one-on-one interactions?  | In clinics with more than 2 staff, counseling visits averaged 13 mins. In clinics with less than 2 staff, visits averaged 8 mins. |  |  |  |  |  |
| **3b** | Is there a relationship between clinics implementing the recommendation of 4 prenatal visits and the implementation of outreach activities (i.e., community education on the benefits of prenatal care not done because of the need for follow-up activities to locate clients having fewer than 4 visits)? | – Women who attended clinics with 1–2 staff did not report exposure to outreach activities.– 50% of women who attended clinics with more than 2 staff reported exposure to outreach activities. Of those women, 90% had completed all 4 prenatal visits. |  |  |  |  |  |
| **3c** | Is there a relationship between clinics with a high completion rate for all 4 prenatal visits and resident providers having received in-service training on counseling skills in the last two years?  | – In clinics with 1–2 providers, 10% received training.– In clinics with 2–4 providers, 12% received training.– In clinics with more than 5 staff, 8% received training. |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **4**  | Does marrying before age 15 result in higher levels of adolescent pregnancy and other negative health outcomes? | – Levels of childbearing were consistently higher among girls who married before 15 than among those who married at older ages or never married.– Among girls who married before age 15, 23% said they lost sleep over worry, 33% said they felt constantly under strain, and 21% said they felt helpless. Among girls who never married, 11% said they lost sleep over worry, 15% said they felt constantly under strain, and 7% said they felt helpless. |  |  |  | 1.2. | LDM1.2. |
| **4a** | Does family socioeconomic status affect the age of first marriage? | 67% of girls who married before age 15 were from families in the poorest wealth quintile. |  |  |  |  |  |
| **4b** | Does participation in extracurricular activities result in delayed first marriage?  | 20% of girls who delayed marriage until after 15 years of age were involved in extracurricular activities, compared to 18% who did not delay marriage until 15 years of age.  |  |  |  |  |  |
| **4c** | Is there an association between poor birth outcomes and mothers younger than 15 years of age? | – Mothers younger than 15 years of age were more likely to deliver a low-birth-rate baby.– Child survival rates were significantly higher for mothers over 19 years of age. |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **5** | Are OVC programs improving the well-being of OVC and their families?  | – Children and families receiving OVC services scored in a lower ‘at risk’ category than those not receiving OVC services. – Children receiving home visits by a trained volunteer for more than 6 months showed a better health status than those not receiving visits.  |  |  |  | 1.2. | LDM1.2. |
| **5a** | Does providing free health services to OVC and their families improve their health-care-seeking behavior? | – Health-care-seeking behavior increased by 35% for urban OVC families and 11% for rural families. – Regular visits by trained volunteers appeared to be associated with increased health-care-seeking behavior for rural OVC families. |  |  |  |  |  |
| **5b** | Do OVC programs affect children’s attendance in school? | – Of OVC attending school and receiving OVC services, 71% missed more than 5 days of school in the last 6 months, compared to 69% of OVC not receiving services.– Of OVC attending school and receiving school fee vouchers, 48% missed more than 5 days of school in the last 6 months, compared to 69% of OVC not receiving vouchers. |  |  |  |  |  |

|  |  |  |  |  |  |  |  |
| --- | --- | --- | --- | --- | --- | --- | --- |
| **#** | **Questions** | **Findings** | **Recommendations** | **Priority** | **Lead Decision Maker (LDM)** | **Stakeholders Impacted** | **Communication Channel** |
| **6** | What is the status of health-care-seeking behavior of caretakers for children under 5 years of age?  | – 25% of caretakers whose children displayed one or more illness danger signs did not seek care outside of the home, while 35% did not take any action at all. Lack of health-care-seeking behavior outside of the home was directly correlated with younger age of child. – Of the caretakers who sought care outside of the home, 55% consulted a traditional provider and 45% sought help from a modern provider (health center/hospital). |  |  |  | 1.2. | LDM1.2. |
| **6a** | What factors affect the health-care-seeking behavior of caretakers?  | – 46% of caretakers live more than 9km from a health facility.– 99% of caretakers follow cultural practices that require the mother and child to remain in the home for the first 7 days of life. |  |  |  |  |  |
| **6b** | Do caretakers recognize illness danger signs in children under 5? | – The majority of caretakers recognized a number of danger signs, but not necessarily the severity of those signs. |  |  |  |  |  |