Policymakers, HIV and evidence

Factors affecting evidence use for HIV prevention policy for key and vulnerable populations in eastern and southern Africa

Summary report

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research and knowledge at the heart of development

Contents

Acronyms

ABC "abstience, be faithful, use a condom"

AGYW adolescent girls and young women

ARV antiretroviral

BCURE Building Capacity to Use Research Evidence

CPT cotrimoxazole prophylaxis treatment

DfID UK Department for International Development

EHPSA Evidence for HIV Prevention in Southern Africa

EIDM evidence informed decision making

EIPM evidence informed policy making

IBBS integrated bio-behavioural survey

KII key informant interview

KP key population

LMICs low and middle income countries

MDA ministries, departments and agencies

MSM men who have sex with men

NCG Nordic Consulting Group

PEPFAR President's Emergency Plan for AIDS Relief

RCT randomised control trial

SRH sexual and reproductive health

TWG Technical Working Group

UNFPA United Nations Population Fund

UNICEF United Nations Children's Fund

UNODC United Nations Office on Drugs and Crime

Glossary of key terms

Evidence: this report follows Jones et al. (2013) in taking a broad view of evidence including research evidence, citizen knowledge, routine data, and practice informed knowledge. This synthesis focuses as far as possible on research evidence.

Policymakers: political, strategic and operational actors within government institutions (including both the executive and the legislative branch). This includes a wide variety of public servants.

In recognition of the key role that multilaterals and donors play in health policymaking in the region, this report also draws out findings about evidence demand and use in those bodies where possible.

Institutions: the main focus of the project is on the policymaking 'demand side' i.e. government institutions (such as National AIDS Commission or Ministry of Health). However, this report also recognises the role that funding institutions and multilateral bodies play in this sector, and the project aims to draw out findings about evidence demand and use in those bodies where possible.

Meso level: this report uses the term 'meso' to refer to issues *within* the institutions described above. It does not use 'meso' in the sense of a larger system of multiple institutions.

EIDM: the literature varies between the terms 'evidence informed policy making' and 'evidence informed decision making'. This report follows EHPSA terminology in using the term 'EIDM'

Use: this report follows Newman, Fisher and Shaxson (2012) and others who emphasise that evidence 'use' goes beyond uptake of a single study and instead can be understood as the processes, relationships and structures that systematically gather, appraise and use a wide range of evidence to inform decision making

Executive Summary

What key meso level factors affect evidence use for HIV prevention policy in policymaking and influencing agencies?

- Organisational cultures including leadership, beliefs and values around evidence are broadly supportive of the use of evidence to inform HIV prevention policy within the health sector. However, these supportive institutional cultures do not always transfer to other institutions outside the health sector, which constitutes a challenge for effective HIV prevention responses which require a multisectoral approach.
- Beliefs and values around the evidence base itself are particularly potent in the HIV prevention sector, where biomedical approaches intersect with social science approaches. Biomedical evidence typically carries more weight, yet in ending the AIDS epidemic by 2030 (as per UNAIDS global targets), biomedical evidence and interventions need to be combined with other approaches.
- Organisational capacity affects evidence use significantly more in government institutions, than in multilateral institutions. The key organisational capacity problems are staffing issues and internal information systems. The main staff departments responsible for gathering evidence are research and M&E units.
- An organisational capacity issue, which is shared by government and multilateral organisations, is the challenge of bringing together the necessary expertise to address the interdisciplinary nature of HIV prevention.
- Relationships between government institutions are an important factor. Particular 'fault lines' lie between national and subnational level, which is important for effective implementation, and between health and non-health sectors.
- Relationships between government institutions and local research institutions are limited. There is a perception among policymakers of lack of interest from researchers within local academic institutions in engaging with policymakers.
- Relationships between government institutions and donors are extensive and influence evidence use in HIV prevention policy to a significant extent.

What types of evidence do policymakers and influencers use, how and why?

- Despite the limited relationships described above, policymakers expressed a preference for research which has been conducted in their own countries and in which they have been involved from the inception stages.
- Data is needed across EHPSA's key and vulnerable populations. In the case of adolescents, the main need is disaggregating existing data, and in the case of MSM and prisoners, new data is needed to gauge the size and behaviour of the populations. Policymakers and influencers expressed varying opinions about the type of data that is required to meet these needs.
- The other main form of evidence required is rigorous practice-informed knowledge, illustrating which combination prevention packages work at scale, and what the contribution of each element is. This is particularly the case for adolescents. Policymakers and influencers expressed a need to know 'what works'.
- A key overarching issue affecting the entire research-to-policy system for HIV prevention is the difference between biomedical and other forms of evidence. The report points to stronger information and evidence systems, clearer results, and more policymaker and donor attention for biomedical evidence than for other forms.
- Sequencing emerged as a key concept, suggesting that operational or implementation-focused evidence may have more traction in countries where there is already strong data to show the size of the key populations and their contribution to the general epidemic.

Which are the main suppliers of evidence? How is evidence provided?

- Multilateral organisations play a leading role in synthesising evidence for policy, and setting guidelines and policy directions for national governments.
- Technical Working Groups do act as channels of evidence supply, but generally have an ad hoc approach to evidence and operate more as forums for informal updates than for systematic, coordinated approaches to evidence.
- Structures and forums which are linked to funding cycles, such as the Global Fund and PEPFAR, are valuable potential avenues of evidence supply.
- Peer learning is an important channel of evidence supply which is valued and used by policymakers.

How would policymakers and influencers like to receive evidence on HIV prevention for vulnerable groups? Why?

- Face-to-face channels emerged as the most preferred method of evidence communication. This was due to a need expressed by policymakers not only to 'receive' evidence from researchers, but to be involved in a two-way engagement involving jointly interpreting it with researchers, collaboratively scoping messages and identifying implications.
- Receiving evidence was seen not as a one-off event but a series of engagements and dialogues.
- The communication outputs which are most preferred by policymakers are policy briefs and PowerPoint presentations. These should be clear, brief, jargon-free, and ideally provided as part of face-to-face interactions.
- The 'messenger' matters. Policymakers showed sensitivity to the tone, demeanour and approach of individuals who present research results.
- Messaging around HIV prevention for key populations and vulnerable groups is particularly challenging and sensitive. To have maximum impact, findings suggest messages need to be clear about the link between these groups and the broader epidemic; be phrased within a health rather than a rights-based approach; and emphasise practicality.
- There are a number of risks involved in communicating evidence around HIV prevention for key and vulnerable populations. These include misinterpretation of results and negative perceptions among policymakers about researchers' motivations.
- The media is an influential player in debates about HIV prevention for key and vulnerable populations. National TV, print and radio were the most popular sources of media among respondents, who engage with media in both English and other languages. However, respondents advised caution when engaging with the media, pointing to the need for building the capacity of media to accurately report on scientific issues. They also suggested that media may be a more valuable communications channel for those wishing to influence public debate than those targeting policymakers.
- Social media did not appear as a significant channel of communication.

1. Introduction

Evidence use in HIV prevention policy in eastern and southern Africa is a complex area that draws out some of the most fundamental questions about the relationship between research and policy. Many health issues, particularly those connected to sexuality, represent the intersection of a wide range of disciplines, values and beliefs. This makes HIV prevention policy a particularly complex area involving diverse stakeholders from academic, legal, civil society and media backgrounds. There is also an international dimension: in the health sector the official recommendations from the WHO, UNAIDS and other multilaterals carry significant weight in national policy making. Related to this is the question of ownership over policy and research agendas, which is potent for sub-Saharan Africa where donors are closely involved in the framing of health policy challenges as well as the implementation of interventions to address them. In a sector which has been heavily influenced by the history of evidence-based medicine, resulting in a favouring of biomedical approaches, there are also strong and at times contrasting beliefs about what constitutes 'good evidence'.

This report explores some of the main factors affecting evidence use in HIV prevention policymaking and policy influencing institutions in EHPSA's network in eastern and southern Africa. It takes a wide geographical scope, and considers EHPSA's three main key and vulnerable populations: MSM, adolescents, and prisoners. It outlines key challenges and opportunities for communication of research results for the EHPSA programme.

An institutional approach to evidence use

Drawing on the work of ODI-RAPID (see Shaxson et al., 2016) as well as the principle of the 'good governance of evidence' (Hawkins & Parkhurst 2016), an institutional approach focuses on the organisational systems and processes that shape how a public institution identifies its evidence needs, gathers and synthesises evidence, and considers it in decision making. Several large synthesis papers and frameworks (e.g. Court and Cotterell, 2006; Sumner at al., 2011, Punton, 2016; Weyrauch et al., 2016; Taddese and Anderson 2017) have conceptualised the complex and interrelated factors within institutions that shape how formal and informal processes, human relationships, incentives, resources and power structures intersect at multiple levels to create enabling or disabling environments for evidence use. Overall there is therefore a mix of attitudinal, behavioural and operational issues which combine to result in this situation described in EHPSA's first symposium report as "lack of capacity and willingness to convert evidence to policy" (EHPSA, 2015:3).

2. About this report

This summary report condenses the findings of the full report, which included the complete Knowledge Synthesis alongside detailed findings from the survey and interviews. The project was informed by a series of guiding questions (Appendix 8). The purpose of this report is to inform EHPSA's Evidence into Action (EiA) approach by:

- Providing an understanding of how policy makers and influencers currently consume evidence (including the challenges, sources and types of evidence); and
- Identifying opportunities around evidence use for EHPSA specific HIV prevention evidence, mindful of EHPSA's project schedule (project closure mid 2018)

Focus areas

- **Macro/meso:** In recognition of the background papers already prepared by EHPSA, which cover a number of the macro level factors such as political will, civil society engagement, and national research systems, the report is focused at meso (institutional) level.
- **Institutions**: The main focus of the study is on the policymaking 'demand side' i.e. government institutions (primarily National AIDS Councils/Commissions Ministries of Health and Correctional/Prisons Services). In recognition of the key role that multilaterals and donors play in health policymaking in the region, the report also draws out findings about evidence demand and use in those bodies. where possible.
- **Key and vulnerable populations:** In line with EHPSA's programme approach, the report focuses as much as possible on two key populations: MSM and prisoners; and one vulnerable population: adolescents.

Methodology

The investigation was comprised of three main stages. The first stage was a rapid knowledge synthesis providing an overview of the literature on key organisational or 'demand-side' factors affecting evidence use within health policymaking institutions in sub-Saharan Africa. The online survey was the second stage of data analysis; it was sent to a list of 105 respondents provided by EHPSA and there was an 18% response rate during the nine-day open period. Interview questions were drafted in response to the findings from the survey, and nine semi-structured key informant interviews (KIIs) were undertaken with policymakers and policy influencers from EHPSA's network. In addition to the KIIs, INASP also spoke with two external experts to triangulate the emerging findings of the survey and key informant interviews. Further details about the survey and interviews are provided in the appendices.

3. Limitations

The following considerations limit the findings of this project:

- The project surveyed a wide range of contexts: eight different countries and three population groups (24 potential policy scenarios in total). While there were a number of common threads which are drawn out in the report, the extent to which these can be generalized is limited. Namibia was the only one of EHPSA's priority countries which had no survey or interview respondents.

- Survey and interview respondents were not categorised according to level of role (e.g. high-, mid- or low- level civil servants), which has limited the depth of understanding of institutional issues. The knowledge synthesis had suggested that the profile, needs and experience of a high-level decision maker vis-à-vis use of information differs significantly from that of the mid-level technical staff.

- The nuance and depth of the findings on relationships could have benefited from some conversations with researchers to understand their perspective on relating to policymakers.

- There was a lower response rate to the survey (18%) than had been hoped. This meant that it was difficult to generalise findings across the region, or to compare between countries or institution types.

- Some KIIs were cut short due to interviewees' time constraints, which meant that not all questions were covered in every interview.
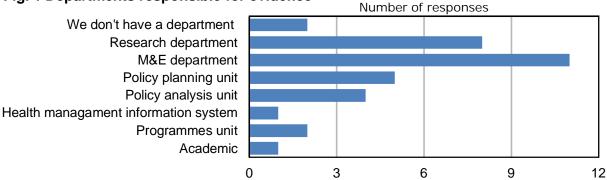
4. Findings

a) Organisational capacity

Capacity constraints are one of the most commonly cited sets of factors affecting evidence use in policymaking institutions in developing countries (see Newman et al., 2012; Weyrauch et.al, 2016; Punton, 2016). Public agencies are often underfunded and overstretched, and human, financial, infrastructural and administrative capacity issues are fundamental factors shaping evidence use in decision making.

Personnel and processes

Of particular relevance is the human resource capacity of staff who are involved in day-to-day evidence gathering, synthesis and analysis—typically researchers, policy analysts, or staff of policy planning or M&E units. They produce a range of reports, policy briefs, fact sheets and presentations to inform decision making[1]. Interviews with higher level decision makers confirmed the importance of these mid-level staff in gathering and communicating evidence. As INT-1 explained, "*often the minister's not really the one who at the end of the day drives the issue forward. They tend to listen to their directors, their subordinates, who if they're well organized and well informed will then develop a policy that is given to the minister*".

Fig. 1 Departments responsible for evidence

Human resource capacity is a combination of a number of sub-factors and can be related to staff skills, or numbers of staff, or both (see Murunga et al., 2014). One overarching issue, which is consistent across the literature on evidence use, is the fact that staff in policymaking institutions do not have sufficient time to gather, read and synthesise evidence. This is a factor both of capacity—for instance if there are not enough staff, or they do not have infrastructure or skills to quickly and easily find and synthesise evidence—and also of organisational culture, which is explored below.

The survey and interviews found that in the context of HIV prevention policy in EHPSA countries, capacity issues are related both to individual capabilities and organisational systems. Notably, they are also much more evident in national government institutions than in multilateral organisations.

• Multilateral staff were more likely to agree or strongly agree that their staff have adequate skills to gather and synthesize evidence (71.4% compared to 44.4% at National AIDS Commission/Government Ministry or Departments). National AIDS

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[1] A limitation of this study was that none of these 'front line' technical staff who are responsible for day-to-day handling of evidence were interviewed.

Commission/Government Ministry or Department affiliates felt more neutral or strongly disagreed (55.5%) with this statement compared to Multilateral respondents (28.6%).
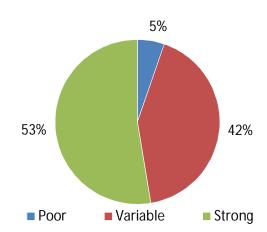
• Multilateral respondents were three times more likely to strongly agree that their organization has effective internal evidence communication and sharing mechanisms at 42.9% compared to 11.1% in National AIDS Commission/Government Ministry or Department respondents. Several national policymakers mentioned ongoing or future capacity building initiatives related to M&E and evidence sharing. As INT-9 explained, *"knowledge management…is something we are battling with. We try to invest in it, we haven't got that much on it"*. As shown below, this significantly greater internal capacity is matched by the more powerful role that multilaterals play in knowledge generation for policy, and is reflective of a sector which is almost entirely donor-funded.

The issue of interdisciplinarity emerged from the interviews as an additional human resource capacity constraint, which the interviews indicated affected both government institutions and multilaterals. Due to the nature of the issues around HIV prevention for key and vulnerable populations, a wide range of medical and non-medical expertise is required. As INT-2 explained, *"it's unusual to find capacity—in a person or a team—that is able to be an expert across the various issues that affect the lives of adolescents... mental health, or training and education, nutritional needs, there's a whole range of things"*. INT-3 saw this as a particular problem at service delivery level: "*Some of the staff have been recruited as medical officers, while their actual work is fieldwork…they need capacity strengthening…to do with key and vulnerable population issues which are beyond the medical issues. Issues related to behaviour and their surrounding...*" [INT-3]

IT infrastructure

The Knowledge Synthesis found that IT infrastructure has a strong influence on evidence use in public institutions. Poor internet connection is a common complaint, and in contexts where staff often rely heavily on internet-based sources of external evidence and do not have access to a library, this can make gathering evidence cumbersome and time-consuming (Hayter and Liebnitzky, 2015; Uneke et al., 2017b; Murunga et al 2014). However, survey results suggested this may not be a significant issue for EHPSA stakeholders, as only 5% reported a 'poor' connection (see Fig.2). A limitation of th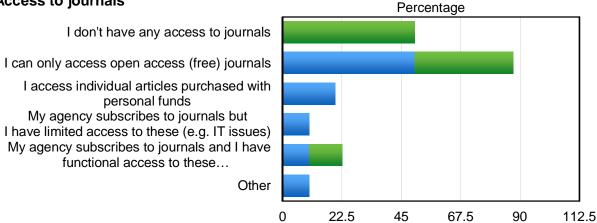is finding is that the survey reached only higher-level policymakers, who may be likely to have access to better IT infrastructure than mid-level policy analysts and researchers.

Fig. 2 Internet connection

5%

53%

42%

■ Poor ■ Variable ■ Strong

Access to research

Systematic reviews covered in the Knowledge Synthesis indicated that access to research is a significant factor affecting evidence use (Oliver at al., 2014; Langer, Tripney and Gough 2016). This is reportedly of particular relevance to the health sector, where as noted below, evidence from academic research (in particular from the biomedical sector) carries particular weight. Uneke et al. (Nigeria, 2017a and b), Sudhaker and Woldie (Ethiopia, 2016), and Murunga et al. (Kenya, 2014) all illustrate how lack of access to research has constrained evidence-informed-decision making in specific health policymaking institutions. The survey

confirmed that access to journals within EHPSA's target policymaking institutions is extremely limited, with most respondents either reporting no access to any journals at all, or being able to use only Open Access journals[2].

Figure 3 Access to journals
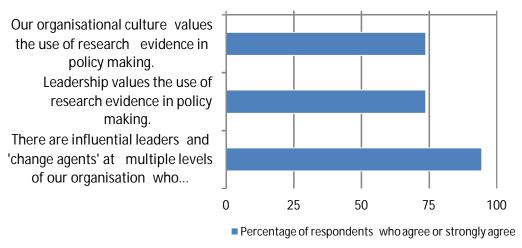

b) Organisational culture

The Knowledge Synthesis showed that organisational culture is a significant factor affecting evidence use. Staff relationships and power structures, attitudes towards evidence and research, and the organisation's flexibility, openness and willingness to change all have a bearing on how available resources and capacity will be deployed within a public institution and whether they are able to meaningfully inform decision making (Sumner at al., 2011; Hyder et al., 2011). Leadership is a key sub-factor within culture; for instance, Ikamari (2005:4) found after interviewing 40 Nigerian and Kenyan policymakers that "a lack of support from key leadership to promote the availability of data" was a "driving force behind both structural and organisational processes." Also, influential at the higher levels of the organisation are the management personnel and structures which operationalise the culture set by the leadership. As Weyrauch et al (2016:49) note, "Senior managers often play an important role in terms of interpreting the evidence as well as deciding who advises them and how".

The survey findings indicated strongly supportive organisational cultures around research evidence for HIV prevention for key and vulnerable populations within health policymaking institutions in EHPSA countries. However, the interviews revealed that this does not extend to other areas of government. As INT-3 explained, "*Those working within the Ministry of Health, they are supportive of public health approaches to the provision of HIV services to key and vulnerable populations. The problem remains to mainstream this knowledge [from the health sector] into non-health centres.*" In addition, this supportive culture was seen to be generally limited to the top levels of government, not extending to decentralised levels of

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[2] Again, a limitation of this question is that the survey did not consult any researchers or M&E staff, who are the main individuals tasked with day-to-day research within policymaking institutions. Those interviewed were higher-level and unlikely to themselves be searching journals.

government: *"most of the people working at the institutions, like the Ministry, are people who have been trained on public health. They have their background on public health. So, they understand the needs…of these groups. But the challenge now comes with…the perception and the behaviour when it comes to service provision"* [INT-3] Thus, organisational cultures *within* health policymaking institutions at national level are supportive of evidence use, but less so at subnational level and in non-health sectors.

Fig. 4 Organisational culture

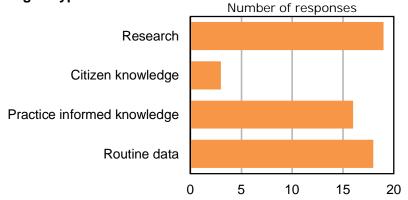Percentage of respondents who agree or strongly agree

Beliefs and values about evidence

Beliefs and opinions about what counts as 'good' evidence are potent in the health sector, where evidence-based medicine has been deeply influential and certain research methodologies are more highly valued than others (Punton 2016; Hawkins and Parkhurst 2016; Sumner et.al 2011, Parkhurst 2012). The literature shows that while the claim to being rooted in evidence is important for all stakeholders in the health sector, understandings about what constitutes good evidence can vary considerably within and between different stakeholder groups, resulting in situations where multiple sides of a debate claim to be 'evidence based'. In addition to questions of methodological rigour, a clear emerging issue related to beliefs and values around evidence is that policymakers can be wary of 'external' sources of evidence (Hutchinson et al., 2011; Murunga et al 2014; Broadbent 2012; Barugahara and Harber 2017). This is heightened for culturally sensitive issues around sexuality and rights, where there may be a perception that 'Western' values around sexual identity, sexual behaviour and relationships are being promoted through local NGOs and research institutions (Broadbent, 2012).

c) Using evidence

Overall, the evidence-informed decision-making literature tends to follow Jones et al. (2013) in grouping evidence used by policymakers into **four main types: citizen knowledge, routine administrative data, research, and practice-informed knowledge.** There is an emphasis on the need for processes within policymaking institutions that systematically consider and balance a wide range of types of evidence, rather than basing decisions on one set of findings alone (see Newman et al in box at right; also Head, 2016). The literature suggests that value and use of different types of evidence can vary within and between health policymaking bodies (Murunga et.al 2014, Sumner et.al 2011). The interviews detailed a variety of ways in which different types of evidence contribute to policy development for HIV prevention for key and vulnerable populations in EHPSA's target countries.

Fig. 5 Types of evidence used

Number of responses

Research	
Citizen knowledge	
Practice informed knowledge	
Routine data	

0   5   10   15   20

"Evidence-informed policy is that which has considered a broad range of research evidence; evidence from citizens and other stakeholders; and evidence from practice and policy implementation, as part of a process that considers other factors such as political realities and current public debates. We do not see it as a policy that is exclusively based on research, or as being based on one set of findings. We accept that in some cases, research evidence may be considered and rejected; if rejection was based on understanding of the insights that the research offered then we would still consider any resulting policy to be evidence-informed."

Newman, Fisher and Shaxson (2012:17)

Research

Interviewees and survey respondents valued the role of research and showed awareness and appreciation for the rigour of scientific methods. As INT-1 explained, *"When I look at evidence, I look at it from a scientific point of view…it's looking at it from an objective, rational point of view—collecting the data in a structured manner, analysing it, presenting the results... that's got to be the way of looking at it to get away from the political"*. Respondents placed particular value on research that had been conducted in the countries where they are working; as INT-5 said, "*we need to localise our research results*". Respondents also emphasised that they are more likely to value research in which they have been engaged from the beginning. "*If the study was not involving national government, nobody will buy in and then their credibility will be extinct. You can do a beautiful research, if it does not involve government from the beginning, if it has not involved other stakeholders from the beginning, then its uptake will be seriously limited*" [INT-7[3]].

A fundamental issue which had been suggested in the Knowledge Synthesis was the dominance of biomedical research. This issue also emerged strongly from the interviews. Interviewees showed an appreciation and value for the essential role of biomedical research in addressing HIV prevention. However, they also emphasised that the research required to address HIV prevention goes beyond the biomedical sector. As INT-6 suggested, *"I think we need a comprehensive research programme that looks into all the important fields…biomedical research, human rights issues, and the law, social protection"* [INT-6]. However, interviewees described a number of challenges with integrating such approaches, including perceptions of non-medical research as less rigorous: *"I could say it's anecdotal, it sounds more anecdotal but it's not"* [INT-4].

Data

It is partially due to lack of quality data that key and vulnerable populations have been 'invisible' in much previous HIV policy. Respondents in both the survey and interviewees showed a keen awareness of the status of the data for the various key and vulnerable populations in their countries, and the details of specific gaps. There were varying views on the level of detail of data that is needed and the merits of stand-alone surveys vs routine data. Interviewees were divided as to whether national size estimates or more detailed, granular data was needed. For example, INT-9 was one of several interviewees who felt *"we*

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[3] These concerns are covered in more depth in the Communicating Evidence section (pp36-40). Interviewees also emphasised the importance of operational research (covered below under 'practice informed knowledge').

need precise estimation of how many MSMs we have in the country". However, INT-7 argued that "*We should not run after the national size estimates and national figure and national this and national that, because…it doesn't help the programmers. We need more granular data, we need data where the epidemic is occurring.*" Several interviewees pointed to the importance of IBBS in generating data to inform policymaking for key and vulnerable populations. However, concern was also raised about the use of such large-scale, resource-intensive surveys, suggesting that these are unsustainable given the current inability of national governments to cover their costs, and that they disincentivise investments in national routine data collection systems and a day-to-day culture of data use.

For adolescents, the emerging issue was less in relation to gaps in data than about disaggregating existing data. Adolescents are the biggest of EHPSA's populations, up to 30% of the population[4], and there is widespread recognition among policymakers of the importance of targeted HIV prevention to reach them effectively. However, at present the data is collected in wide age bands (for example 0-14 years and 15-24 years), and as INT-2 explained, "*what a 15-year-old might need in Zimbabwe is very different to a 24-year-old. The platforms you might use, the kinds of policies you might advocate for, are very different.*" Data which is disaggregated by age is therefore a key issue for this group, to enable targeted interventions for adolescents of different ages.

The question of treatment vs prevention, and biomedical vs public health, approaches emerged again in the context of data. As INT-4 explained,

> *"If you look at the data management information systems that we have, they are more strong in terms of tracking biomedical indicators, so you are…sure to have evidence in terms of how much uptake of medicines, how many clients are waiting…because of good-working databases. You are able to have comprehensive indicators covering those areas. But when we come to the non-medical side…there are demonstrated weaknesses…we don't have a comprehensive set of indicators…there are no reliable reporting systems on the ground."* [INT-4]

Practice informed knowledge

Knowing 'what works' for HIV prevention policy for key and vulnerable groups was a common theme in interviews. Overall, it was evident that while the key ingredients of successful combination programmes are known, how to successfully operationalise such interventions in a combined way at scale is not yet known. Policymakers also reported that they did not have evidence showing the relative contribution of each element of ongoing programmes, particularly for adolescents where in some countries such as Malawi there are many programmes ongoing but the national 'package' of interventions has not yet been defined.

> *"When you do combination prevention, there are 5-6 elements which go into that package. So what is the impact of each of these elements, that is still not fully understood…in many countries, the same targeted interventions have been going on for years and years and years with condoms, behaviour change communication, and linkages to treatment and services, but the number of new infections is not coming down. So that means that probably we are barking at the wrong tree…initially when the money was comparatively easier to come by…carpet-bombing approaches were done to saturate the area…so we don't know where our interventions are making the difference"* [INT-7]

> "*We cannot actually put our fingers on what is working for this population in terms of prevention. The interventions we've been doing, there's no convincing evidence, for*

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[4] This was an indicative figure quoted by INT-7.

instance, to say…how much had behaviour change contributed to the reduction of new infections among this population" [INT-9]

Policymakers therefore place high value on evidence from implementation. Interviewees pointed to evaluations as well as operational research as means of answering these questions about implementation, emphasising the need for rigour and scale, as well as knowledge about the cost[5]. As INT-2 explained, "*we know that it's a combination of interventions that will likely prevent HIV…but actually finding the operational programme that implements all of those in one place and shows it to work…those kinds of examples are few and far between"* INT-9 added, "*we need to know...what are the expected returns from it, and then how much would it cost to do it?"*.

For prisoners, practice-informed knowledge was also seen as important, but for different reasons. In this case, there was no lack of clarity about the priority intervention. Interviewees felt that condoms are known to work (INT-1, 5, 6], and are included for instance in SADC minimum norms and standards for health provision in prisons. The intervention therefore is known and has a strong evidence base, but cannot yet be implemented in many countries due to laws which criminalise anal sex as well as health service provision for MSM. Thus, there is less of an emphasis on teasing out the different elements of ongoing interventions, and more focus on understanding how to create the space for interventions to be introduced in the first place. Here the experience of Lesotho is instructive. Unlike other countries in the region, service providers in Lesotho are protected by the law and are therefore able to distribute condoms and lubricant in prisons despite laws criminalising MSM.

Biomedical dominance emerged once more as an issue with regards to practice-informed knowledge. *"We, as an HIV community, often go back to the biomedical interventions just because they're easier to track and be able to connect and feel like there's some attribution for the results…it's the other stuff, doing violence prevention, keeping girls in school, looking at some of the behaviour issues that are more difficult"* [INT-2] This is of particular relevance given the aid-dependent nature of HIV response in most countries of the region, and the need to be able to justify results to donors. As INT-8 explained*, "most of the donors…it's easier for them to monitor the biomedical interventions. For instance, to report that 'I disseminated so many condoms.' But when you start saying, you know, 'we invested your resources to sort of create an enabling environment, to sensitise communities'...it's difficult to concretely measure the impact of that intervention".* Incentives, particularly around practice-informed knowledge and demonstrating programme results, are therefore heavily influenced by donor reporting requirements.

Stages of the policymaking process

An outstanding question from the Knowledge Synthesis was the extent to which there might be particular stages of the policymaking process around HIV prevention for key and vulnerable populations which constitute windows of opportunity for evidence use. The findings showed a mixed picture here. Because many key and vulnerable populations have previously been 'invisible', collecting accurate data to quantify the problem is often seen as a key first step for decision makers, which then leads to designing and finally implementing interventions. This is line with the 'know your epidemic, know your response' approach popularised by UNAIDS since the early 2000s. It was evident that EHPSA countries are at different stages of this process for each of the key and vulnerable populations: in some cases, policymakers feel confident they have strong data, whereas in other cases they felt they still needed to know more about the size and behaviour of the populations, and their contribution to the general epidemic.
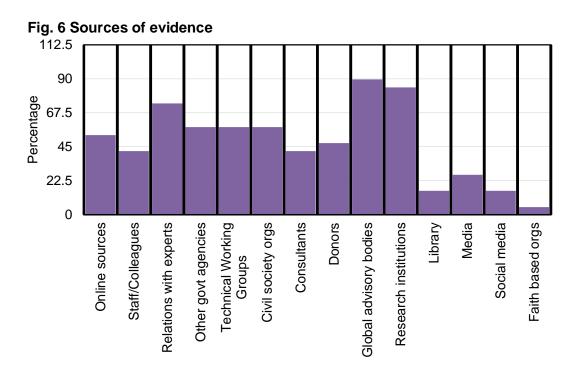
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[5] Interviewees expressed a need for thorough and large-scale practice informed knowledge—not individual case studies or informal technical/experiential advice: "*not just documenting a case like 'here's where it worked in one place for a small number of girls', but 'here's where it worked at a larger scale". [INT-2]*.

However, INT-7 cautioned against a simplistic or linear understanding of the policymaking process, pointing out *"there is never a data perfect situation. It's a utopian concept, that you'll have perfect data and then you'll start using it"*. In many cases interviewees described situations where programming is moving ahead of national policy development, with interventions by implementing organisations and CSOs taking place before the national approach is defined. This suggests that there may be different windows of opportunity for research uptake in practice than for policy.

d) Supplying evidence

Sources of evidence

The most popular sources of evidence used by EHPSA stakeholders are other government agencies, global advisory bodies and research institutions. The interviews confirmed the role of global advisory bodies as key knowledge brokers in HIV prevention policy, with the main

Fig. 6 Sources of evidence

intellectual burden of gathering, synthesising and translating global research results seen to fall with organisations such as UNAIDS and WHO. National-level policymakers described looking to these advisory bodies for high-level policy direction, and gather evidence at the country level to contextualise these agendas. As INT-8 explained, "*institutions such as WHO and UNAIDS are able to…analyse research work that has been done, and then once they pronounce on that, it makes it easier for implementers to adopt or to consider adopting policy shifts*". The interviews suggested that for national policymakers, the use of research institutions as a source of evidence is an indirect one (i.e. via multilaterals), rather than through direct relationships with national research institutions.

Relationships

The web of stakeholders and channels linking health evidence providers and users includes formal and informal structures and relationships within and outside government. The strength of such relationships has been consistently found to have an important influence on the use of evidence (Court and Cotterell, 2006; Mendizabal, 2006; Kok et al., 2016; Shaxson

et al, 2016; Mitton et al 2007)[6]. Importantly, such relationships go beyond the supply of evidence to policy, but also involve the role of policymaking institutions in communicating decision-making back to the public. The literature is increasingly examining the dynamic ways that multiple types and levels of policymakers and researchers engage and the quality of these relationships, rather than approaching relationships as a linear model of 'dissemination' of research from one distinct group to another. The survey and interviews confirmed that relationships within and outside government are key channels of evidence supply, especially in HIV prevention where so many different agencies are involved.

HIV prevention for key and vulnerable populations is a cross-cutting issue that requires health agencies to collaborate with multiple other levels and sectors of government. As indicated above, this is of particular importance given the potentially unsupportive attitudes for evidence-informed approaches to public health within other areas of government, including non-health sectors and subnational levels and the legislature: *"when it comes to the legal department or other ministries which are out of the Ministry of Health, the issues of stigma, the issues of knowledge is still a challenge"* [INT-3] At subnational levels of government, some interviewees reported there are capacity gaps as well as lack of awareness about the needs of key populations. Interviews suggested that relationships with non-health stakeholders, subnational levels, and the legal sector are the three strands of intra-governmental relationships that present the most significant challenges.

Two main types of relationships outside government emerged as crucial in terms of shaping evidence use for HIV prevention policy[7]: Firstly, in line with the findings of the Knowledge Synthesis, relationships with donors and implementing partners such as UNAIDS, UNICEF, UNODC, PEPFAR and the Global Fund were cited commonly in the interviews. Interviewees described complex negotiations between such donors and government players, in some cases illustrating a "*lack of ownership by national authorities"* [INT-8].

Secondly, despite the strong interest expressed by policymakers for locally-relevant research, relationships with national research institutions were described to be challenging for a number of reasons, many of which are already documented in the literature (Hutchinson et al., 2011; Murunga et al 2014; Broadbent 2012)[8]. INT-8 explained that the research done by universities is seen by policymakers to be" *too academic and not realistic in terms of day-to-day implementation".* In addition, there was suspicion among some policymakers about the motives of external researchers, and a feeling that they are operating in different parameters: "*scholars who are just doing studies who just want to produce a journal, or just want to add to their CV that they did such activity and produced such evidence*" [INT-5]. Interviewees were also concerned about a perceived lack of willingness on the part of researchers to engage with policymakers, and limited communications capacity: "*Probably they think that…by publishing, the knowledge is out there, and then we can get it. But…not everyone has the ability to go [to] PubMed or Google and go through all the publications related to a certain thing"* [INT-3] Finally, INT-6 pointed out that even if mutually beneficial relationships could be established with bodies such as the national university, funding would need to be found to support these collaborations.

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[6] There is an extensive literature on macro-level research-to-policy systems, networks and communities, which is beyond the scope of this report. As this project focuses on institutions, the focus of this section starts with the institution and considers the main types of external relationships it holds that affect evidence use. Such relationships constitute one part of much broader national and international networks and systems, encompassing many other actors and relationships.
[7] Relationships with CSOs, community groups and/or KP representative organisations were also mentioned but to a lesser extent.
[8] A limitation of this area of enquiry was that no researchers were consulted to understand their views on the challenges of engaging with policymakers.

TWGs as channels of evidence supply

Many of EHPSA's countries have newly established TWGs for key and vulnerable populations, and the Knowledge Synthesis had suggested these may be important channels through which EHPSA could communicate research results. The interviews confirmed that TWGs have the potential to provide much-needed coordination and learning within HIV prevention, and a number of interviewees recommended EHPSA consider using them as a channel to disseminate results. However, they also described a number of limitations to the influence and efficiency of TWGs[9], which were generally described more as optional 'ad hoc' forums for information updates than spaces for systematic coordination. Challenges included competition for funding among TWG members, limited numbers of researchers involved in TWGs, limited power/authority of TWGs, and lack of funding for collaborative projects of TWGs (each member has their own project funding, rather than the TWG itself holding any funding). As INT-1 observed, *"everyone wants to coordinate, but no one wants to be coordinated"*.

Therefore, while TWGs are valuable spaces for stakeholder engagement and relationship-building, they may not offer the most potential for translation of research results into future programme and policy design. Interviewees pointed to several other potential channels and structures which EHPSA could consider engaging with, including funding structures (for instance trying to contribute to the review and planning processes of PEPFAR and Global Fund); regional influencing and decision-making structures such as SADC and EAC; and internal management and research committee meetings within national policymaking institutions.

e) Communicating Evidence

The Knowledge Synthesis illustrated the importance of strategic and targeted approaches to communication for research uptake in policy, moving beyond a simple 'dissemination' model and instead facilitating joint interpretation and dialogue. It showed that communications skills are not only relevant for researchers aiming to influence policymakers, but also for different types of policymakers to influence each other—for example, technical staff providing briefings to their superiors, or parliamentary researchers providing evidence to a committee of MPs. As shown above, organisational cultures, hierarchies and politics are crucial factors affecting evidence use on the 'demand side', and strategic and effective communication is fundamental to navigating these dynamics. Communication can therefore be thought of as a cross-cutting theme affecting not only how evidence is supplied by researchers to policymakers, but also how it is used within policymaking institutions.

Overall, the survey and interviews indicated a preference for face-to-face channels and hard copy outputs: presentations, policy briefs and face-to-face meetings. Interviewees pointed to the importance of engagement over a period of time, combining multiple channels and outputs, rather than any single event. Some interviewees also cautioned that poorly managed relationships with policymakers can not only damage research uptake from a specific programme, but also affect other researchers: "*you'll destroy your relationship but you'll also make it extremely difficult for others to do research in the future*" [INT-1].

Face-to-face channels

Face-to-face channels were seen as important because of the need to facilitate joint interpretation of findings. "*It's not enough just to send the report and expect that we will all have the same understanding and all be on the same wavelength. We still need to talk about*

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[9] These findings draw on interviewees' experience in TWGs in individual EHPSA countries, but also on the experience of INT-8 who has recently carried out a regional scoping visit exploring the effectiveness of the coordination function of TWGs for adolescent girls and was able to draw more general conclusions.

it, just so that we understand each other…[and] have a similar understanding of what the results are saying to us" [INT-6] Such face-to-face engagements are also crucial for building trust and navigating the challenges which arise from conflicting approaches and incentives between researchers and policymakers. As INT-5 explained, "*you need to sit with a researcher and see the face of a researcher and… interpret whether the researcher really is in the research...whether they are affected by the situation and environment of what they found out, and whether they are there to help*". [INT-5]

The issue of ensuring that policymakers understand the research and its implications was felt to be especially significant for vulnerable and key populations. As described above, there is often limited capacity among any one group to engage with research from the many different disciplines that inform HIV prevention policy. INT-8 pointed out that "*when you are presenting your findings, you are able through body language to get a sense where there is…a misunderstanding which you can then try to correc*t". There is thus an important educational element of communicating results.
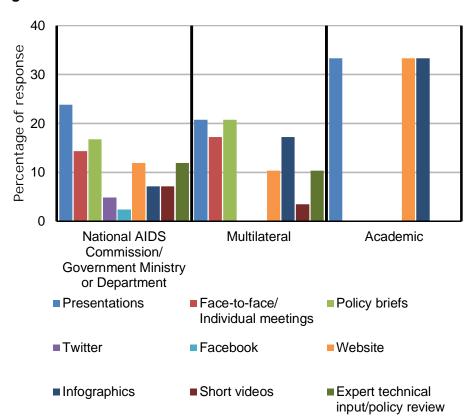
Fig.7 Preferred communication methods

A third reason for policymakers' preference of face-to-face channels is the sensitivity of issues related to HIV prevention for key and vulnerable populations, and the importance of clear and appropriate messaging. Interviewees described risks of unclear or mixed messaging which could damage prevention, including incidents they had experienced where different researchers at the same meeting gave contradictory messages to policymakers, or where results were misinterpreted. Interviewees provided examples of the potential risk of misinterpretation of results:

> *"If I were a government official and somebody did a study that said, "Treatment as prevention programming works in a prison. We tested everybody and those who are positive, we immediately get them onto ARVs."… If I were that government official*

then I would say, "Ok, testing is mandatory in all my prison systems and everybody who tests positive will have to accept ART." And that contravenes a number of human rights principles. It has that potential, unless it's carefully marketed… if it went the other way, and they had results that said look, it doesn't work for these reasons, you'd have someone saying, "Aha! See, treatment doesn't work for prisoners. Therefore, we're not going to run a treatment programme at all." [INT-1]

"In some countries, people talk about male circumcision being protective, then some people could go to the extent of saying 'we don't need a condom because it's protective" [INT-8]

An important element of such dialogue which emerged from the interviews is the space for joint analysis, and even re-interpretation of results where necessary. As INT-7 explained, "*there should always be some room after the research is completed to take the feedback on board and customise your findings and re-analyse…to suit the needs of the programme implementers or the policy makers. If that space is not there, if we['ve] got…a very rigid, 'Ok, this is my study and this is the output and this is data of it, and I have presented and that's the end'…it will never work*". Other interviewees confirmed the importance of ensuring that communication is not seen to be a one-directional approach 'telling' policymakers what to do, and that joint interpretation is enabled as much as possible.

Key communications outputs

Policy briefs and presentations emerged as the most important communication output for research results. Interviewees pointed to several considerations to maximise the impact of these outputs. First, minimising jargon and technical language is important, particularly for audiences outside the health sector, which, as shown above are key in HIV prevention for key and vulnerable groups. *"There's a whole language that's very technical…you have to be a part of it to get the acronyms, and get the data, and the modelling….Engaging outside of the health sector is critical but I think it's still a challenge"* [INT-2] Clarity and brevity of messaging was also important: *"the evidences have to be clear, simple to understand, very crisp, and brief…any finding of any research should not be more than one page. It should be put out clear, the message, what is coming out from the research finding, rather than being ambiguous"* [INT-7]

In terms of distribution of outputs, there were diverse preferences among interviewees, suggesting that the most appropriate route may to be prepare both. Hard copies of policy briefs could be distributed at meetings and events, but some interviewees said that soft copies are easier for them to share. Importantly, however, the findings were clear that policy briefs or other written products should be combined with other outputs, such as presentations, as part of a holistic approach which also includes the face-to-face channels outlined above. For specific academic or research-focused policymaker audiences, interviewees indicated that it can be appropriate to supplement these with the full research paper.

Other communications considerations

Peer learning was an area of significant value that emerged from discussions about communicating evidence. Several non-government interviewees observed the influence of leaders or 'champions' from one country on other countries in the region, with INT-1 stating that such individuals can *"sway significantly the political positioning of a country"* with regards to HIV prevention interventions. Interviews with government interviewees confirmed this, with many interviewees demonstrating awareness of specific developments in their sector in neighbouring countries, and an interest in knowing how other countries have approached prevention for key and vulnerable populations. Face-to-face methods of peer learning were most often emphasised, with no interviewees referencing online networks or groups.
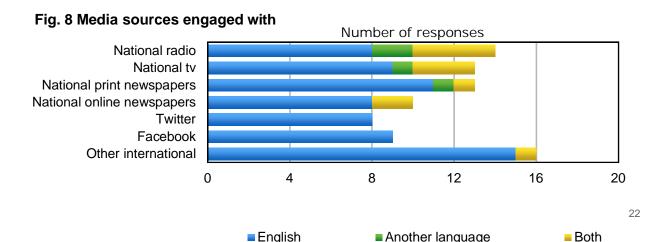
Another emerging issue concerning communication was the importance of the 'messenger'. Several interviewees felt that national (rather than foreign) messengers were most appropriate and were most likely to secure local engagement with the results. As INT-5 explained, "*If I have the evidence in my hand, and I go to explain it, the people, because we live together and they have trust in me…they are able to understand… if it's a project that has come and is disseminating certain information... it causes a bit of doubt as to whether that disseminator genuinely wants to sort out any issue on the ground".* Regardless of who delivers the initial research findings, another important observation from several interviewees was that the policymakers who participate in any results/dissemination workshops will themselves become future messengers about the study within government. As INT-1 observed, "*they're going to be the ones who then have to answer to others who weren't involved or just heard, "Oh I heard on Facebook that blah blah blah." So they're going to be the ones who have to say, "Well actually no, it doesn't mean that, it means this and this.*"

Interviews also offered insight into the issue of how to communicate evidence on HIV prevention for MSM in contexts where legal frameworks and public attitudes do not facilitate HIV prevention for them. While interviewees all recognised the criminalisation of homosexuality as a barrier to HIV prevention for MSM, some felt that directly tackling the law using moral or rights-based arguments would be an inappropriate approach. Instead, they emphasised decriminalisation of health service providers as a starting point: "*my advice would be, let us not try to challenge the law in terms of trying to decriminalise sodomy…but let us ensure that [we]…do provide some sort of protection for people who have to give services without judging them*" [INT-6]. This was the approach in prisons in Lesotho, where the law enables the Correctional Services to provide condoms despite the existence of sodomy laws.

In a similar vein, interviewees pointed to the importance of phrasing MSM issues predominantly as a public health issue, and not engaging in moral or religious arguments. Experience suggests that a public health argument can act as a gateway to other rights—for example, where a key population is 'put on the map' by the health sector and is able to access health services, this can lead to other forms of recognition and rights. A key part of putting such a population 'on the map' is being able to demonstrate the actual or potential link to the wider epidemic, as *"when you look at KPs, the tendency is to basically dismiss them as a minority group"* [INT-8]. Interviewees described this approach with relevance to prisoners and sex workers as well as MSM.

Media

The Knowledge Synthesis illustrated the importance of the media in shaping debates about evidence use for HIV prevention policy. The survey and interviews confirmed the media as a key stakeholder in debates around HIV prevention for key and vulnerable groups, but outlined some potential considerations for EHPSA if the programme does choose to engage with media.

Fig. 8 Media sources engaged with

Number of responses

The interviews confirmed the findings of the survey, in that traditional media is a more influential channel of evidence supply for policymakers than social media. Many interviewees provided examples illustrating importance and influence of the media over evidence issues; for instance, INT-1 said that "*one of the biggest challenges we have in the region is there's a lot of stuff out there that is called evidence that is misinformation, that is biased reportage…if you look at MSM, if you look at sex workers, if you look at people who inject drugs there's a lot of information out there that is not consistent with scientific principles*". Therefore, while acknowledging the importance of the media, many interviewees were very cautious about engaging with media and had experienced challenges communicating research results to journalists. One national policymaker interviewee described positive experiences using national radio as a way to communicate evidence about KPs, and another policymaker explained that they were more likely to trust government-owned media. The survey was clear that while the majority of respondents engage with media in English only, a significant group engage with media in other languages as well.

Findings from the interviews suggested that specific communications approaches are necessary for engagement with media, and that simply inviting journalists to a dissemination meeting would not be sufficient to mitigate the risks of misinterpretation. Several interviewees suggested capacity building for journalists in science communication in order to ensure that research results are accurately and responsibly reported. INT-8 suggested that an editors' meeting can also be an effective way to share results with media. Interviewees were divided, however, over the importance of the mass media for influencing policymakers, as opposed to influencing the public. Some felt that engaging the media would be a more suitable route for programmes hoping to influence public opinion, and that since EHPSA's results are specifically targeted towards policymakers, the programme should prioritise some of the other channels described above. If EHPSA does choose to engage with media, there was a suggestion that government media sources may be the most likely to influence policymakers.

5. Conclusion

This report has explored factors that affect how policymakers in EHPSA's network currently consume evidence for HIV prevention policy. These include organisational culture and capacity, relationships with government institutions and external bodies. The report shows that the main types of evidence used in policymaking in HIV prevention are research, data and practice informed knowledge. Policymakers pointed to significant gaps in all of these areas, particularly in data and practice-informed knowledge. A number of key debates emerged from consideration of the particular context of HIV prevention for KPs. Key among these is the tension between biomedical and social evidence for HIV prevention, which affects all stages of the policy cycle in the sector, from gathering to synthesis, use and funding of evidence. Other influential issues include the need for multi-disciplinarity both in research and implementation around HIV prevention, the question of whether to prioritise routine data or stand-alone surveys, and the sensitivity of messaging and communication around key and vulnerable populations, which will be key considerations for EHPSA going forward.

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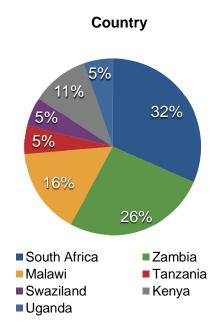
Appendix 1: Case studies from the literature: evidence in health policy in Africa
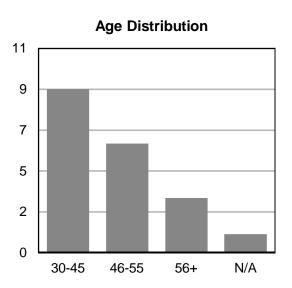
Country	Policy	Author
Malawi	Guide for Management of Malaria (2007)	Longwe-Ngwira et al. (2016)
Malawi	Guidelines for Clinical Management of HIV in Children and Adults (2011)	
Malawi	National Sexual and Reproductive Health and Rights Policy (2009)	
South Africa	Male circumcision for HIV prevention	Tulloch at al. (2009)
Tanzania	Male circumcision for HIV prevention	
Ghana	Maternal syphilis screening	
Ghana	Legislative change for sexual violence survivors	
Ghana	Herpes simplex treatment and HIV infection	Burris at al. (2011)
Kenya	Voluntary counselling and testing for HIV	Theobald et al. (2009)
Malawi	Provision of TB testing in grocery stores	
Nigeria	Community diagnostics for anaemia, TB and malaria	
USA/Uganda	PEPFAR's ABC approach to HIV prevention	Parkhurst (2012)
Uganda	HIV/Aids Prevention & Control Bill (2010; became an Act 2014)	Broadbent (2012)
Rwanda	Several including National Strategic Plan for HIV/AIDS 2009-2012; also penal code	MEASURE Evaluation (2012)

Appendix 2: Survey Respondents

Socio-demographic background
- 52.6% of respondents were female, 47.4% were male.
- Location of respondents can be seen below. There were no respondents from Namibia or Lesotho.

- Age group distribution can be seen above.
- The majority of respondents at 68.4% hold a Masters degree. 15.8% of respondents have a PhD, 10.5% have an undergraduate degree and 5.3% have a postgraduate diploma.
- Organisational affiliation can be seen below. Three respondents chose to identify as 'Other', specifying National Assembly of Zambia, UN agency, and academic. The responses of the UN agency member will be classified with the multilateral responses, the national assembly member will be classified with the national government or ministry responses, and the academic will be in a unique category.

Country

■ South Africa   ■ Zambia
■ Malawi   ■ Tanzania
■ Swaziland   ■ Kenya
■ Uganda

Age Distribution

Organisational Affiliation

■ National AIDS Commission/Government Ministry
■ Multilateral
■ academia

Appendix 3: Interview Summaries

INT-1

INT-1 spoke about macro challenges for evidence informed policy, such as laws, attitudes, and social issues. The interview also discussed aspects of the EHPSA programme design. The importance of peer-to-peer spaces for influencing evidence uptake was highlighted, as well as multi-sector approaches to the use of evidence generation for policy, including non-health stakeholders and technical staff and civil servants, not just high level policy makers. The need for data to quantify the problem was explained, not repetition of existing knowledge about prevention. Relationships, hard copy, face-to-face methods of evidence dissemination were highlighted as opposed to online methods for sharing. Some specific suggestions were given for the sequencing and design of meetings or roundtables to preserve relationships and shape messaging, relating particularly to messaging around MSM and prisons.

INT-2

This interviewee explained how data gaps make particular KP and vulnerable groups invisible. This is compounded by a lack of knowledge about an appropriate operational model for a successful programme, necessitating practice informed knowledge. Importance of the interdisciplinary response was identified, as was the clash between biomedical evidence and other forms of evidence. The interviewee expressed a sense that treatment and biomedical interventions are 'easier' in terms of evidence, and that evidence discussions in HIV prevention are still led by biomedical knowledge. The difference between adolescents and EHPSA's other KPs was identified. The importance of bringing people together for meaningful dialogue, 'not just a talk shop,' at a country level was expressed. Appropriate packaging of messages around results was also highlighted.

INT-3

This interview highlighted the need for staff to be well informed about the interdisciplinary aspects of HIV prevention, along with having appropriate training. This interviewee expressed the sense that health sector policymakers understand the public health issues, yet at the level of service provision and other non-health sectors, there are challenges. Specific suggestions on how to communicate research through three key government channels (TWGs, research subcommittee and management meetings) were outlined. This interviewee did not believe media would be an effective way to communicate results as journalists need training. Researchers are explained to be on the TWGs but are not always engaged because of different motivations. The importance of the national context was highlighted.

INT-4

This interview outlined how biomedical data collection systems are stronger than non-medical indicators, explaining the preference for biomedical evidence. Moreover, local, national evidence is needed to understand the size of KPs and behaviour mapping, especially for MSM. A challenge facing data on adolescentsis lack of disaggregation by age. Face-to-face sessions and dialogues for dissemination of data are key. The interviewee explained that not only do results need to be shared but they need to be explained to policymakers to ensure they understand. Citizen knowledge is also highlighted as a key component for complementing research, done by including KPs representatives are part of TWGs.

INT-5

This interviewee expressed a strong conflict between public health and social/religious/cultural norms regarding evidence which shows MSM exist in prisons. The legal status of MSM was highlighted, alongside the need to provide condoms to inmates

within this grey area (e.g. not abolishing the law against sodomy). The interviewee noted the need to look to regional examples, such as Lesotho, for evidence. The interviewee supports biomedical evidence and emphasising the need to 'localise' research results, stressing the importance of the messenger in disseminating results.

INT-6
This interviewee emphasised the importance of data for MSM in prisons because the scale of HIV for prisoners is still not known. Biomedical research was highlighted because of the different strains of HIV, as well as the need to improve and standardise data collection methods. Issues of causality were also outlined and the need to address these with data. Practice informed knowledge was identified as key, as Lesotho is an example for other countries of condom distribution programming in prisons, and the need to know if it is working and what more can be done is vital, not only for Lesotho but also to share with the rest of the continent. The interviewee explained how this was possible within the legal confines of the country by addressing HIV prevention for MSM in prison as a public health issue and making sure service providers are not criminalised. This interviewee preferred a mix of electronic methods for sharing evidence with face-to-face discussions and radio can also be effective. The interviewee explained the importance of messaging for the general public and policymakers, i.e. multiple concurrent partnerships as a driver of HIV.

INT-7
This interviewee emphasised data and practice informed knowledge, though disagreed that standalone surveys such as IBBS, are useful as they are costly and unsustainable, arguing instead for investment in routine data. The lack of knowledge about prevention packages for adolescent girls is highlighted, as well as the different approaches by different donors and lack of agreement. Detailed explanation of donor funding cycles is given along with suggestions and advice about communicating evidence to policymakers.

INT-8
The need for multidisciplinary approaches to HIV prevention policy was highlighted by this interviewee. Practice informed knowledge and research about what works, especially for adolescent girls, was emphasized. This interviewee provided insight into issues with TWGs following a regional review in which he/she participated. The interview also gave insight into the donor landscape and ownership of policies and implementation plans. A number of opportunities for communication of results, influencing policy and supporting uptake of evidence were outlines, particularly at regional and international levels.

INT-9
This interview highlighted the need for evidence for adolescents and the impact of behaviour change interventions, including both biomedical and non-health evidence. The need to strengthen routine data for policy was identified. The need to disaggregate data for adolescents was highlighted as well as the need for evidence to show which intervention plans are cost effective. Size estimate evidence was also highlighted as lacking for MSM. A combination of soft copy dissemination of evidence was preferred, yet the need for appropriate messaging of non-medical evidence was highlighted for policymakers, as structural issues around evidence for MSM were identified.

Expert advisory interview 1: Andrew Koleros: Director, Research, Monitoring and Evaluation at Palladium (formerly of MEASURE Evaluation)
Andrew discussed his experience conducting the first study on MSM in Rwanda, while working as a Resident Technical Advisor for MEASURE Evaluation at the National AIDS Control Commission (CNLS). The study contributed to Rwanda securing funding from Global

Fund, MSM being recognized for the first time as a KP in the national strategic plan as well as operational grants, and the establishment of a TWG on KPs with a subgroup on MSM—as well as the first national baseline on MSM[10]. The interview explored the role of policymaker 'champions' and the personal, professional and political considerations which motivate them. Andrew shared his perspective on some of the common challenges emerging from this EHPSA report, including criminalization of MSM, tensions with the biomedical sector, and communicating evidence about HIV prevention for KPs from a public health vs. human rights framing. He also outlined the sequencing of evidence needs for HIV prevention and discussed the role of donors in shaping HIV prevention policy. Andrew shared insights largely from his work with MSM but also from work with other KPs including sex workers.

Expert advisory interview 2: Rose Oronje: Director, Science Communications and Evidence Uptake-- African Institute for Development Policy (AFIDEP), Nairobi
Rose discussed AFIDEP's experience working on issues of evidence use in health policy in Kenya and other east and southern African countries, and sitting on several TWGs related to HIV. She shared insights from AFIDEP's experience leading the SECURE-Health Consortium, a sister consortium to INASP's VakaYiko Consortium funded under the DfID BCURE programme, and her own research on evidence use in policy for adolescent girls. She drew on her experience to confirm and expand upon a number of the emerging findings from this report, including policymakers' need for practice informed evidence; the tension between biomedical and social research to inform HIV prevention policy for KPs; the role of TWGs; and the debate about routine data vs standalone surveys. In addition, she drew on her experience working with the Kenyan and Malawian parliaments on evidence use for health issues to consider how evidence could be communicated to legislators.

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[10] This is the subject of a research impact case study by MEASURE Evaluation (2010): 'Improving Demand for and Use of Data Strengthens HIV/AIDS Programs in Rwanda'.

Appendix 4: Interviewees

Interviewees are listed in alphabetical order. *Note that in order to protect interviewees' anonymity this list does not correspond to the numbering system used in Appendix 3.*

Name	Organisation	Country	Interview duration
Anurita Bains	UNICEF	Kenya	35:50
Chileshe Chilesha	Correctional Services	Zambia	33:36
Jason Eligh	UNODC	South Africa	51:39
Khanya Mabuza	National Emergency Response Council on HIV/AIDS	Swaziland	35:23
Neema Makyao	Ministry of Health-National AIDS Control Programme	Tanzania	47:37
Alankar Malviya	UNAIDS	South Africa	49:09
Innocent Modisaotsile	UNFPA	South Africa	54:17
Scout Phoka	Correctional Services	Lesotho	1:10:22
Joel Suzi	National AIDS Commission	Malawi	51:08

Appendix 5: Interview Guide

Interviews are expected to last 30-45 minutes. Interviews begin with request for permission to record and to use direct quotes. Interviewees are offered the option not to be quoted directly.

After each main question the arrow symbol indicates possible follow-ups/prompts.

Questions are drawn from the gaps and priority themes identified in the Knowledge Synthesis (Section VI and Appendix 2).

Background: explain the purpose of the project and the role of INASP. Confirm whether interviewee gives permission to use direct quotes.

1. Opening question: could you tell me in your own words what your role is in relation to HIV prevention policy?

2. What are the main challenges you face in using evidence for HIV prevention policy for KPs and vulnerable groups in your institution?
   - Ø Prompt with examples from survey: main challenge= staff capacity (numbers, skills or both?)
   - Ø Also prompt re: org procedures, do they have these?
   - Ø Prompt to keep it personal (ie in your particular role in your institution, not in general)
   - Ø Prompt for any challenges around effectively combining the different types listed above—evidence use not about responding to one study but systematically combining different types of evidence to inform a decision

[looking for: how the various factors identified manifest in particular for HIV prevention for these groups; and to what degree these issues identified in govt institutions are also present in donors, multilaterals etc. Particular attention to org culture]

3. Our literature review and survey have shown that there are many different kinds of evidence that inform decision making, including routine data, research evidence, evidence from programme implementation, and 'citizen knowledge', which is often tacit in nature and gained through lived experience. What kinds of evidence do you think are most needed to inform HIV prevention policy for KPs and vulnerable groups?
   - Ø Prompt specifically for the KPs/vulnerable groups
   - Ø Prompt using examples from survey (eg survey found research most cited as important, why do you think that is, what kinds of research specifically)
   - Ø Why is this needed?
   - Ø Is this evidence currently being used? If so, how? And who is supplying it?

[looking for: where do PM get their evidence from, how evidence it provided to PM, what kinds of evidence are valued and used by policymakers for HIV prevention for KPs, insights on what the evidence is used for and what moments in policy cycle it is used]

4. What are the main opportunities you see for evidence use for HIV prevention policy for these groups in your institution?
   - Ø Survey found that there are leaders/champions driving evidence use: can you tell me a bit more about them
   - Ø Survey also found there was a positive organisational culture for evidence use in many policymaking institutions, would you say this is the case in your institution?

Ø   Are there any upcoming windows of opportunity in the policy process for evidence to inform decision making?

5. Could you tell me a bit about your new TWG for KPs and/or adolescents?
   Ø   How is it going so far, would you say it's strong/productive, are there any challenges
   Ø   Where does the TWG get its evidence from? Does it have any formal structures or relationships in place around evidence?

6. How would you like to receive evidence for HIV prevention for KPs/vulnerable groups?
   Ø   Survey showed a preference for face-to-face and hard copy methods as opposed to online/social media. Why do you think that is?
   Ø   Prompts: specific: what exactly should policymakers receive, should it be the full paper, policy briefs, presentations etc Presentations, policy briefs and f2f meetings were the top 3 in survey. More detail on how these should be provided (what kind of presentations, where/when, are these 3 distinct methods or should they be combined etc)
   Ø   What advice would you have for researchers hoping to get their work considered by policymakers?

7. We know that the media can be influential in shaping evidence use in HIV prevention policy. What media sources influence national debates around HIV prevention for vulnerable groups in your country/region?
   Ø   Are there any examples you can share?
   Ø   What media sources do you engage with most often in relation to your work? (survey said national radio & international media—which ones?)

Appendix 6: Survey Questions

What do policymakers really want?

The EHPSA programme is in its final year. We would like to know how evidence is used in HIV prevention policy making for EHPSA's target populations (adolescents, men who have sex with men and prisoners) so that we can produce and disseminate our evidence in a form that is most useful to you. Please help us by taking 10 minutes to complete this survey.

We have commissioned INASP to collate and analyse your responses.

How will the results be used?
- This survey is anonymous and responses will be treated in strict confidence
- Responses will be grouped into a database for statistical analysis

Evidence: We use a broad definition of evidence, encompassing research evidence, M&E information, statistics, citizen knowledge and expert knowledge. In some questions, we specify a focus on research evidence.

Evidence at your workplace

The following questions will help us understand how you use evidence in your work and how your workplace environment affects evidence use.

1. Which departments in your organisation are primarily responsible for gathering and synthesising evidence? [select all that apply]

We don't have a department that is responsible for this
A research department
M&E department
Policy planning unit
Policy analysis unit
I don't know
Other (please specify)

2. Select up to 3 types of evidence that you personally use most frequently in your work.

Research (defined as formal academic research, e.g. a journal paper)
Citizen knowledge (citizen 'lived experience' and perceptions, e.g. gathered through a community consultation)
Practice informed knowledge (knowledge from practical experience, e.g. from a programme evaluation or an expert opinion)
Routine data from national information systems

3. Where does the evidence you use at work come from? [select all that apply]

Online sources
Staff/colleagues
Relations or dialogues with researchers or experts
Other government agencies
Technical Working Groups
Civil society organisations

Consultants
Donors
Global advisory bodies (e.g. WHO or other UN agencies bodies)
Research institutions
Library
Media (newspapers, radio, TV etc.)
Social media (Twitter, Facebook etc.)
Other (please specify)

4. What do you mainly use this evidence for? [select 3 main areas of use]

Setting policy agendas
Understanding the policy problem
Developing policy content
Informing policy implementation
Informing resource allocation decisions
Designing operational strategies or guidelines
Other (please specify)

5. Which statement best describes your access to academic journals?

I don't have any access to journals
I can only access open access (free) journals
I access individual articles purchased with personal funds
I access individual articles purchased with agency funds
My agency subscribes to journals but I have limited access to these (e.g. IT issues)
My agency subscribes to journals and I have functional access to these (i.e. can easily access as needed)
Other (please specify)

6. How would you describe the internet connection in your workplace?

Poor
Variable
Strong

7. What kind of device do you primarily use in your work?

Own desktop computer
Shared desktop computer
Own laptop
Shared laptop
Own tablet
Shared tablet
Other (please specify)

8. Please indicate to what extent you agree with the following statements about the environment in your workplace around evidence use.

9. Which media sources do you personally engage with most often? [please select all that apply]

10. Please indicate any other fora you use to engage with HIV evidence [tick all that apply]:

None
I attend national conferences on HIV
I attend international conferences on HIV
I am involved in a Technical Working Group
I participate in webinars and other online forums
Other (please specify)

11. Have you attended an EHPSA technical forum?

No (to Q15)
Yes (to Q12-14)

12. Have you been able to use the evidence presented at the EHPSA fora you attended?

No
Yes (please specify)

13. Have there been any long-term relationships/networks established as a result of the EHPSA fora you have attended?

No
Yes (please specify)

14. Did the evidence from the EHPSA fora support further policy discussions?

No
Yes (please specify)

15. If you could choose to receive research evidence about HIV prevention in any forms what would they be? [select 3]

Presentations
Face to face/individual meetings
Policy briefs
Twitter
Facebook
Website
Infographics
Podcasts
Short videos
Expert technical input/review of existing policies
Other (please specify)

About you

To help us understand the different experiences of people working in policymaking institutions, it is useful to know some contextual information about you.

16. Country

South Africa
Malawi
Zambia
Tanzania
Lesotho
Swaziland
Kenya
Namibia
Other (please specify)

17. Sex

Male
Female

18. Age

19. Type of organisation

National AIDS Commission/Government Ministry or Department
Multilateral
Other (please specify)

20. Highest level of education

school leaving certificate
undergraduate
postgraduate diploma
masters degree
PhD
Other (please specify)

Thank you. Your results will be collated and will directly help EHPSA to effectively disseminate their evidence on HIV prevention. We thank you for the time you have taken in completing this survey.

Appendix 7: Outcomes of EHPSA Technical Fora

Summary: The majority of respondents (85.7%) stated that the evidence shared at EHPSA technical fora was then useful in their work. Some of this evidence was incorporated into policies or programming or was shared among other groups and colleagues. There was a lower tendency for continuous or stable relationships or networks to form following EHPSA technical fora. Slightly more than half of respondents built connections across stakeholders (e.g. researchers, health care providers, CSOs) or with EHPSA itself through updates. The majority of respondents indicated that evidence from EHPSA fora were used in policy discussion, either generally or in more specific policy planning discussions. A small proportion of respondents did not use the evidence in their work or in policy discussions, nor did they establish any relationships from the EHPSA fora.

EHPSA fora attendance

73.7% of respondents had attended an EHPSA fora, while 26.3% had not.

EHPSA evidence use

Of those who have attended EHPSA fora, the majority (85.7%) have used the evidence presented at the fora they attended. The responses for how this evidence was used can be categorised as the following:

- Type of fora attended: evidence into action; key populations

- Method in which respondents used evidence in their work: in PPTs; incorporated into revised policies; a feasibility study; during departmental, interdepartmental and national programme

- How evidence was shared: followed up with organisations working in MSM to develop a focus article and referring prison work to a colleague; shared lessons from technical forum on AGYW and used evidence to guide the design of national interventions for the Global Fund for AGYW portfolio; during HIV country meetings

- How evidence supported professional responsibilities: during field work as an HIV and sexual reproductive coordinator of activities

Establishment of stable relationships/networks

Of those who have attended an EHPSA fora, 42.9% say that no relationships/networks were established as a result of the fora. 57.1% said that relationships were established. The types of relationships can be categorised as below:

- Collaboration with colleagues: study among KP with Malawi university and potential internship; shared data with colleagues and those met at EHPSA forum; collaboration with health service providers such as Ministry of Health and civil society; Correctional Service

- Information sharing: EHPSA updates; updates on emerging issues at global and local levels

Policy discussion

Following the EHPSA fora, 21.4% of respondents said the evidence had not supported further policy discussion. The 78.6% who said that the evidence had supported further policy discussions. General uses for evidence use in policy discussions were given (54%) and specific policy discussions were described (45%).

- general policy discussions: ongoing work with EHPSA on evidence to policy; discussions on disaggregating data; changes of approach on key populations; management and TWG meetings; generally where there are gaps

- specific policy discussions: adolescent SHRH; stigmatization of KPs and legal barriers to accessing health services; current HIV challenges with prisoners; pre-exposure prophylaxis; development of the South African LBTI HIV plan; establishment of the national KP HIV TWG

Appendix 8 Guiding Questions

The project was informed by the following guiding questions:

1. What key meso level factors affect evidence use for HIV prevention policy in policymaking and influencing agencies?
    o How do these factors affect evidence use?
2. What types of evidence do policymakers and influencers use? (key types: research, citizen knowledge, practice informed knowledge from self or others, data)
    o Why do they use these forms of evidence?
    o How do they use research evidence in particular?
3. What do they use the evidence for?
    o Are there particular stages of the policymaking process when evidence is used (eg problem definition/agenda setting vs improving delivery)
4. Which are the main suppliers of each type of evidence?
    o How is the evidence provided (eg via formal channels/fora, informally via networks, via formal reporting processes)
5. What media sources influence national debates around HIV prevention for vulnerable groups?
    o What media sources do respondents themselves engage with most often?
6. How would policymakers and influencers like to receive evidence on HIV prevention for vulnerable groups? Why?
    o What would their advice be for researchers hoping to get their evidence on HIV prevention for vulnerable groups considered by policymakers?
7. What have the outcomes been of EHPSA's Technical Fora? *This last question is not covered in the main report but is addressed in Appendix 6*

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