Commentary: Equity and Exchange in Global Research-Practice Partnerships

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Some years ago, I as asked to give a plenary address to an international social work conference on translational research across national boundaries. I talked about my efforts and the efforts of others to implement evidence-based practices (EBPs) for the prevention and treatment of mental and behavioral health problems in Low and Middle Income Countries (LMICs) in Africa, Latin America and South Asia. At the completion of my presentation, a member of the audience stood up and asked me if by promoting the use of evidence-based practices, which were usually developed and evaluated in high-income countries (HICs) like the United States, I was merely perpetuating the post-colonial domination of health care in LMICs. The speaker went on to elaborate that the evidence for EBPs is founded on a positivistic view of science, often ignored local evidence based on clinical experience in LMICs, and was in contrast with the social constructivist perspective of critical epidemiology and critical social work. In essence, by dictating that evidence must be obtained through the rigorous conduct of randomized controlled trials and that practices must be evidence-based to insure their effectiveness, EBPs could be perceived as being a tool of oppression and domination.

At the time of the presentation, I was somewhat agnostic on the value of EBPs in LMICs. I was aware that HICs participate in the implementation of EBPs in LMICs for a variety of reasons. Some treatment developers profit financially from such implementation and perhaps represent the most visible form of such domination. Others participate at the request of providers and policymakers in LMICs who believe in the potential of these EBPs to address significant health issues in their countries. Responses to such requests are often motivated by a genuine desire to reduce global health disparities and appreciation of the cultural sensitivities of doing so. However, many HIC researchers exhibit the epistemological equivalent of "implicit racism" by asserting that evidence-based practice outranks practice-based evidence because it adopts the principles and practice of scientific rigor. In each of these instances, although there are solid reasons for viewing the implementation of EBPs developed in HICs for use in LMICs with skepticism (Atilola, 2015), I viewed the value of an EBP in addressing the health care needs of residents of LMICs to be a purely empirical

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question, i.e., does the EBP result in positive health outcomes to the satisfaction of its consumers?

Nevertheless, I should have anticipated such a reaction because it was not unlike the reactions experienced when implementing evidence-based practices here in the United States (Gambrill, 2010). Practitioners often experience feelings of domination and oppression by researchers based on reluctance to incorporate local views of what is needed to address the problems they are experiencing, feelings of abandonment once the researcher has conducted the study, lack of feedback on study findings, and presumption that once the practice has been developed, the evidence will "speak for itself" and not require additional interactions or exchanges with local communities (Rosen, 2003; Stoesz, 2010). After all, any research practice partnership is characterized by disparities in knowledge and resources (i.e., funding), which creates a power differential between researcher and practitioner (Jones and Wells, 2007). When working in LMICs, these experiences are compounded by disparities in resources, expertise, language and culture (Franzen et al. 2017). Partnerships may be short-lived and not structured to provide LMIC communities what they really want or need.

A few months later, I gave a similar presentation to a group of deans of schools of social work based in LMICs. I received a similar response as the one I experienced in the earlier conference. This time, however, I was prepared. I explained that any implementation of an innovative and evidence-based program or practice, whether at home or abroad, required a global partnership between researchers and practitioners. However, the partnership should adhere to principles outlined in such practices as Community-Based Participatory Research (CBPR) (Minkler and Wallerstein, 2003) or Community-Partnered Participatory Research (CPPR) (Wells et al. 2004). CBPR/CPPR is distinguished from other forms of community-based research by its emphasis on developing and managing relationships between university-based researchers and community collaborators, and by its focus on achieving social change through community empowerment. Israel and colleagues (2005) identified four fundamental assumptions that govern the conduct of CBPR: 1) genuine partnerships require a willingness of all stakeholders to learn from one another; 2) there must be commitment to training community members in research; 3) the knowledge and other products gained from research activities should benefit all partners; and 4) a long-term commitment is required of researchers to the community and the community to the goal of improving the health and well-being of its members.

The goal of practices such as CBPR and CPPR is to establish more equitable relationships between researchers and their community partners. Although equity can be defined several ways, I use it here to describe the perception, shared by partners, that the needs and priorities of each member of the partnership are being adequately addressed by their respective partner or partners. In this instance, a partner may be an individual or an entire group. The primary obstacle to achieving equity is the unequal distribution of power. CBPR requires researchers to share power with community members over the direction of the project and the allocation of resources and spending a considerable amount of time building trust in the community (Palinkas et al. 2017a). However, the power dynamics of HIC research- LMIC practice partnerships operate on several different levels, the two most evident being the presumed power of knowledge producers over knowledge consumers (in the shared belief that

knowledge is power), and the presumed power of researchers from HICs over practitioners and policymakers in LMICs (in the shared belief that the former possess greater resources than the latter) (Ordonez and Collins, 2015; Sussman et al. 2017).

The extent of collaboration between researchers and practitioners is often dependent upon the willingness and ability to exchange information and values through their interactions. This cultural exchange is a transaction of knowledge, attitudes and practices that occurs when two individuals or groups of individuals representing diverse cultural systems (ethnic, professional, organizational, national) interact and engage in a process of debate and compromise (Palinkas 2018). Cultural exchange is both a theory and a method of implementing evidence-based practices (Palinkas and Soydan, 2012) and bridging the gap between research and practice that impedes delivery of high quality services to those in need (Institute of Medicine, 2001). As a theory, it explains when, how, and under what conditions research and practice-based evidence are used in policy and practice. As a method, it offers a set of guidelines for facilitating communication, collaboration, and compromise between various stakeholders committed to implementation.

The global cultural exchanges between researchers and practitioners in LMIC settings occur in three stages. In the first stage, members of the two cultural groups interact with one another and in so doing learn about and assess the "other's" shared understandings of normative and pragmatic standards for belief and behavior. In this particular case, what is "exchanged" is the evidence-based global knowledge, attitudes and practices of the researcher on the one hand, and the practice-based local knowledge, attitudes and practices of the practitioner or policymaker on the other hand. This assessment is dependent on the willingness and ability of the stakeholders to communicate with one another.

In the second stage, the culturally influenced knowledge, attitudes and practices of researchers and practitioners/policymakers are subject to debate and compromise. Learning about the cultural systems of the other stakeholder in implementation forces each stakeholder to re-examine one's own knowledge, attitudes and practices. A set of understandings shared by both researchers and policymakers/practitioners begins to emerge. The focus on this set may involve an EBP representing the global culture of the researcher and preferences for adapting the EBP to suit the needs of a specific population and/or organizational setting representing the local culture of the practitioner or policymaker. This accommodation is dependent on the willingness and ability of the stakeholders to collaborate with one another.

In the third stage, a new culture comprised of a set of shared understandings reflected in knowledge, attitudes and practices related to implementation and services delivery is created by the integration of elements of the cultural systems of each stakeholder. This new culture is dependent on the willingness and ability of the stakeholders to compromise with one another. For instance, despite sharing a common priority such as improving the health and well-being of vulnerable populations, researchers often place more value on scientific rigor while communities and practitioners place more value on local relevance. While accommodation is a necessary component of the successful implementation of evidence-based practice in any setting, it also creates a potential that any compromise in methods for

conducting research or practice will result in a decline in quality of work performed. Such a decline is likely to meet with resistance on the part of researchers and practitioners alike. However, this potential must be weighed against the costs of failing to accommodate or compromise. Research and practice conducted independent of one another has no value to the communities and perpetuates health and social inequality.

An example of the practice of cultural exchange between HIC researchers and LMIC practitioners was Mujer Segura, a multi-site, randomized controlled trial (RCT) that tested the effectiveness of a psychoeducational intervention designed to reduce the incidence of HIV and other sexually transmitted diseases among FSWs and a "train the trainer" model of implementing the intervention. In this study, researchers from the United States partnered with the Mexican Foundation for Family Planning (MexFam), a non-governmental organization (NGO) that operates family planning clinics throughout Mexico. The clinical intervention evaluated was a brief (35 to 40 minutes), single-session, intervention that combines principles of motivational interviewing (MI; Miller and Rollnick 1991), social cognitive theory (SCT; Bandura 1986), and the theory of reasoned action (Fishbein and Ajzen 1975). The counselor uses MI techniques (e.g., key questions, reflective listening, summarization, affirmation, and appropriate use of cultural cues) to increase the participant's motivations to practice safer sex (Patterson et al. 2008). In the context of sexual risk reduction counseling, "train-the-trainer" involves identifying a staff member who has some expertise in HIV/STI counseling and teaching that person how to train other staff in delivery of the counseling program. The "train the trainer" implementation strategy is considered a good choice for agencies with limited financial resources, such as family planning clinics and non-profit organizations (O'Brien et al. 2015).

To conduct this RCT, U.S.-based researchers and their Mexican partners engaged in ongoing dialogue facilitated by bilingual Mexican nationals who were part of the research team. Researchers and clinicians collaborated in addressing many of the barriers to conducting the RCT, including distribution of resources to local clinics, limited fidelity to the control intervention and reluctance of some clinicians to work with FSWs. In the process, researchers made certain compromises with respect to study design, relinquishing control for distribution of funds to the central office of MexFam, and lack of practitioner research experience. Practitioners, on the other hand, made compromises with respect to adherence to the study protocol, increased workload, and working with a stigmatized population (Palinkas et al. 2015; Palinkas et al. 2018).

The ability to exercise compromise in conducting this study may be attributed to several different factors embedded in the individual participants, the relationships among partners, the organizations represented in the partnership, the environmental context in which the partnership existed, and the cultural systems that governed and emerged from these partnerships. All partners exhibited considerable flexibility in adapting the train-the-trainer model as well as clinic operations to accommodate the clinical trial (Palinkas et al. 2015; Palinkas et al. 2018). Partners also exhibited a high degree of sensitivity to the needs of individuals and the organizational cultures they represented as well as features of the organizations and the external environments that created constraints on or presented opportunities for engagement. Participants acknowledged the openness and honesty

exhibited by their partners, which was considered to be key to building and maintaining trust. Each partner also recognized that while not all of their needs and priorities were being addressed by the partnership, they were generally satisfied with the outcomes. Finally, all partners asserted that they had learned much from one another; at the same time, they expressed confidence in their ability to teach one another as well.

As a consequence of these compromises, researchers were able to conduct the RCT and publish their findings (e.g., Palinkas 2018; Pitpitan et al., 2017). They also succeeded in reducing the stigma attached to working with FSW among local practitioners. Practitioners reported increased knowledge and experience gained from having been trained in the intervention and participating in the project, personal satisfaction in contributing to improved community public health and social welfare, and improved clinic efficiency and services delivery (Palinkas, 2015; Palinkas et al. 2018),

The experience of cultural exchange in Mujer Segura demonstrates that equity in global research-practice partnerships occurs when researchers HICs and practitioners in LMICs feel they have something to contribute to the partnership and something to gain from the partnership. Successful global research-practice partnerships satisfy the specific aims of the HIC/LMIC researchers, and LMIC practitioners engaged in the partnership. Some aims are shared among all partners (e.g., improved client and clinic outcomes), while other aims are specific to each partner (e.g., more publications for the researcher, reduced costs for policymaker, more satisfied clients for practitioner).

In contrast with the principles of Community-Based Participatory Research, successful global research-practice partnerships do not always involve training of community partners in collecting and analyzing data, but they do involve some form of mutual dependence among the partners. Typically, researchers collect and analyze the data while community partners provide access to participants, review study protocols, and disseminate study findings. In implementation research, community partners play an important role in using EBPs that are being implemented. Each partner is considered essential to achieving the aims of all.

While successful global research-practice partnerships do not always achieve a balance between knowledge generation and dissemination (Palinkas 2018), they do yield improved outcomes, improved quality of services delivered, more cost-effective care, and innovative approaches to services delivery (Annan et al. 2017; McBain et al. 2015; Murray et al. 2015; Puffer et al. 2016). Partnerships may be viewed as successful if there is sustainability of the products of the partnership (i.e., an EBP). Although similar outcomes have been linked to processes of cultural exchange in HICs, the extent to which they can be tied to similar processes involving HIC researchers and LMIC researchers, practitioners and policymakers remain to be determined.

Successful global research-practice partnerships also strive to reduce power differences and create a sense of equity among all partners that may be assessed in two different ways. Qualitatively, a partnership is equitable when HIC researchers and LMIC researchers, practitioners and policymakers all feel their needs and have been met and priorities

adequately addressed and when they feel they have met the needs and adequately addressed the priorities of their partners. Quantitatively, the Cultural Exchange Inventory (Palinkas et al. 2017b) assesses the extent to which the partner has contributed to changes in one's own knowledge, attitudes and practices, and the extent to which one feels she or he has contributed to changes in the knowledge, attitudes and practices of the partner. Comparisons of both measures as reported by a single member of a partnership and comparisons of both measures as reported by both partners would provide two indices of equity.

Finally, a successful, sustainable and equitable global research-practice-policy partnership builds upon the existing organizational cultures of research, policy, and practice. It is not merely an aggregation of these cultures, however, but the product of their transformation as a result of exchanges of understanding, values, attitudes, and rules of engagement between researchers, practitioners, and policymakers. This exchange occurs through a process of debate and compromise. It requires identification of areas of convergence and a willingness to either eliminate or accommodate divergence. It assumes that there is mutual self-interest in learning how LMIC policymakers and practitioners view research and how HIC researchers view policy and practice. And it requires the ability to communicate in a common language and a willingness to collaborate and compromise.

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