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KNOWLEDGE TRANSFER AND KNOWLEDGE BROKERAGE FOR POLICY MAKING ON HEALTH CARE IN NIGERIA:

The Example of the Primary Health Care Project in Delta State

Andrew G. Onokerhoraye

and

Gideon E.D. Omuta

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Professor Emeritus Andrew G. Onokerhoraye
Executive Director, CPED, Benin City

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TABLE OF CONTENTS

This Publication is supported by the Think Tank Initiative Programme initiated and managed by the International Development and Research Centre (IDRC)

PREFACE

This policy research paper is part of the on-going research of the *Centre for Population and Environmental Development (CPED)* on the research project titled *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region" funded by IDRC and WAHO*. In Nigeria, there is little interest in transfer and uptake of research into policy and practice. Policy-makers in Nigeria rarely convey clear messages about the policy challenges they face in their specific context to allow for timely and appropriate research agendas. Researchers in the country, on the other hand, often produce scientific evidence which is not always tailor-made for application in different contexts and is usually characterized by complexity and grades of uncertainty. Thus, initiatives are needed to facilitate interaction between researchers and policy-makers to foster greater use of research findings and evidence in policy-making and to narrow the gap between research outputs and utilization. This paper outlines one of such approaches being used by the *Centre for Population and Environmental Development (CPED), Benin City* and the *Delta State Government*, Asaba through primarily the Delta State Ministry of Health. The focus is on communication processes for improving the utilization of research results. The paper should allow researchers and policy makers to learn the possible policy entry points for health development research and what role intermediaries can play. This will help to focus health research activities for increasing the utilization of research and engage with the relevant actors.

We are particularly grateful to IDRC and WAHO as well as the *Think Tank Initiative* for the support to CPED which has enabled the Centre to carry out the study and the publication of this policy paper.

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Introduction

The move toward an evidence-based approach to health care has gathered momentum over the past two decades. Consequently, increased attention is being paid to strategies that try to ensure that knowledge gained from the best evidence is actually used in practice. This move to enhance the utility of research involves both making research evidence more usable and improving the capacity of management, policy, and decision makers to use it. There is now a broad consensus in the development literature that successful communication between researchers and research users in developing countries is crucial for the effective utilization of research in decision-making in policy and practice. Communication between researchers and research users can happen in a number of different ways, given the high number of different research users, a variety of research producers and the different levels in the policy and practice domains where communication of research takes place.

Health research and policy-making operate under different settings in Nigeria, each with its own professional culture, resources, imperatives and time frames. In Nigeria, there is little interest in transfer and uptake of research into policy and practice. Policy-makers in Nigeria rarely convey clear messages about the policy challenges they face in their specific context to allow for timely and appropriate research agendas. Researchers in the country, on the other hand, often produce scientific evidence which is not always tailor-made for application in different contexts and is usually characterized by complexity and grades of uncertainty. Thus, initiatives are needed to facilitate interaction between researchers and policy-makers to foster greater use of research findings and evidence in policy-making and to narrow the gap between research outputs and utilization (van Kammen, de Savigny, and Sewankambo, 2006).

It can be stated that the major constraint to the use of evidence in policy and practice with respect to health care delivery in Nigeria is the grossly deficient capacity development at the individual and organizational levels, particularly the lack of formally

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trained human resources among public health policy makers. The problem is further compounded by the existence of few relevant studies for many important health policy issues and much less systematic reviews of evidence. The most prominent reason attributed to the limited usability of existing health information is that policymakers' needs do not drive research. Also conflicts over fundamental political values and interest groups can limit the relevance of evidence to the decision-making process and inundate the policy setting with bad-quality evidence, champion poorly designed studies, and limit the critical analysis of information through the social relations they develop with officials. The strategies to enhance evidence-informed policy making include: enhancing supply of policy-relevant research products; enhancing capacity of policy-making organizations to use evidence; establishing new organizational mechanisms to support use of evidence in policy; promoting networking and; establishing norms and regulations regarding evidence use in policymaking.

As noted above, the major constraint to the use of evidence in policy and practice in Nigeria is attributed to the "cultural" differences between those who do research, and those who may be in a position to use it, largely due to the absence of opportunities to bring researchers, policymakers and managers together to consider issues around the research to policy and practice interface. There is generally lack of a health policy research agenda agreed by policy-makers and the research community and the lack of a bridging mechanism between policy-makers and researchers.

It is in this context that there is urgent need to create organs and networks that can enhance improved interaction between researchers and policy makers in the health sector at different policy and decision making levels in Nigeria. This paper outlines one of such approaches being used by the *Centre for Population and Environmental Development (CPED), Benin City* and the *Delta State Government*, Asaba through primarily the Delta State Ministry of Health. The focus is on communication processes for improving the utilization of research results. The paper should allow researchers and policy makers to learn

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the possible policy entry points for health development research and what role intermediaries can play. This will help to focus health research activities for increasing the utilization of research and engage with the relevant actors.

The remaining part of this paper is divided into five parts. The first section provides some perspectives on principles and practice of knowledge transfer and knowledge brokerage in the context of health policy, while section two outlines the main components of the primary health care study being implemented in Delta State. Section three provides the main elements of the knowledge transfer and brokerage used in the primary health care study in Delta State. The fourth section outlines some strategies that can be used to promote knowledge translation and knowledge brokering in Nigeria, while the final section concludes the paper.

Perspectives on Knowledge Transfer and Knowledge Brokerage

According to a recent systematic review of the literature about how policymakers use evidence, one of the most commonly discussed theoretical issues is what is meant by the term use. The most common categorization suggests three different meanings. First, there is direct or instrumental use of evidence, where relevant research results are seen to be directly affecting policy decisions. Second, there is selective or legitimating use of evidence, where evidence is used to legitimate or sustain a predetermined position already taken by policymakers. Third, there is enlightening use of evidence that can help enrich or deepen understanding of a problem. In many research projects evidence is used in all three ways (Clark, 2007; Alker, 2008).

Entry points by health researchers in policy and practice in Nigeria can be defined as those channels through which research results can not only reach their users but also influence decisions. Consequently, an entry point to policy and practice is not only defined through the dissemination pathway used but also defined through other factors like institutional structures and external influences involved. Three different dimensions have to be taken into account when

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assessing entry points in policy and practice. First, the dissemination activities through which research knowledge is distributed, second, the institutional linkages between the different stakeholders have to be considered as they are important for the emergence of routes for disseminating research, and third, the political and practitioners' context for research use and how research can be used successfully in policy and practice. In recent years one group of intermediating actors influencing the dissemination as well as the linkages between research, policy and practice has been recognized as important in linking researchers with policy makers. This group is referred to as knowledge brokering. Because the interaction between the researcher, policy-maker and practitioner is constrained by a number of factors, intermediaries can help to connect the research and decision-making domain. Thus, knowledge brokering can be an important service in this field to secure well-informed decision-taking (Gill and Kelly, 2005).

It is helpful at this stage to make a clear distinction between knowledge on the one hand, and information and data on the other. *Information* can be considered as a message. It typically has a sender and a receiver. Information is the sort of stuff that can, at least potentially, be saved onto a computer. Data is a type of information that is structured, but has not been interpreted. On the other hand *Knowledge* might be described as information that has a use or purpose. Whereas information can be placed onto a computer, knowledge exists in the heads of people. Knowledge is information to which a purpose has been attached. *Knowledge exchange* is collaborative problem-solving between researchers and decision makers that happens through linkage and exchange. Effective knowledge exchange involves interaction between decision makers and researchers and results in mutual learning through the process of planning, producing, disseminating, and applying existing or new research in decision-making. *Knowledge transfer* is a two-way, continuous process where research information is exchanged between the research community and the community of potential users. The two-way exchange of information informs decision-

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making at all levels of the health care system through interactive engagement and participation. *Knowledge Transfer* is defined in the primary health care study as 'the interactive delivery of external social research knowledge and expertise to policy and decision makers in the Delta State Ministry of Health and the Federal Ministry of Health.

Knowledge brokering links researchers and decision makers together, facilitating their interaction so that they are able to better understand each other's goals and professional culture, influence each other's work, forge new partnerships, and use research-based evidence. Brokering is ultimately about supporting evidence-based decision-making in the relevant government ministry or agency, management, and delivery of health services. Knowledge brokering brings people—health services researchers, decision makers, practitioners, and policy makers—together to build relationships among them. A research institution such as CPED working as a knowledge broker has broad skills that include a thorough understanding of Nigeria's healthcare system and knowledge of communications, as well as the ability to: link people together and facilitate their interaction; find academic research and other evidence to shape decisions; assess evidence, interpret it, and adapt it to circumstances; identify emerging management and policy issues which research could help solve; and create knowledge networks (Lomas, 2000, 2007).

It can, therefore, be stated that knowledge brokering is one of the forces behind knowledge transfer. It's a dynamic activity that goes well beyond the standard notion of transfer as a collection of activities that helps move information from a source to a recipient. Brokering focuses on identifying and bringing together people interested in an issue, people who can help each other develop evidence-based solutions. It helps build relationships and networks for sharing existing research and ideas and stimulating new work. Knowledge brokering supports evidence-based decision-making by encouraging the connections that ease knowledge transfer. The focus of knowledge brokering is not on transferring of the results of research, but on organizing the interactive process between the

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producers (researchers) and users (policy-makers) of knowledge so that they can co-produce feasible and research-informed policy options. In effect knowledge brokering is a two-way process that aims to (1) encourage policy-makers to be more responsive to research findings, and (2) stimulate researchers to conduct policy-relevant research and translate their findings to be meaningful to policy-makers (Michaels, 2009; Ward, House, and Hamer, 2009).

It is against this background that the tasks of CPED as a knowledge broker in the on-going study on primary health care in Delta State can be specified as including: bringing people together to exchange information and work together on the challenges of primary health care provision and utilisation in Delta State; helping policy makers and researchers in health planning and provision to communicate and understand each other's needs and abilities; pushing for the use of research in planning and delivering primary healthcare in Delta State; monitoring and evaluating practices, to identify successes or needed changes in primary health care in Delta State; transforming management issues into primary health research questions in Delta State; synthesizing and summarizing research and decision-maker priorities on primary health care in Delta State; and guiding through sources of research on primary health care in Delta State.

Background information on the Primary Health Care Study in Delta State, Nigeria

Nigeria is committed to primary health care (PHC) as the foundation for its health care system, the approach for ensuring equitable access to health care and the key to achieving the health-related Millennium Development Goals. Although, policies have been developed and substantial resources invested to strengthen primary health care, the utilization of the PHC system remains relatively low contributing to unsatisfactory health outcome indicators. If the health care system in Nigeria is to improve for the benefit of the vast majority of the people at the grassroots level, considerable attention must be focused on promoting and improving the access of the population to primary health care. The success in this effort depends on a thorough

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understanding, through robust research, of the factors influencing the provision and use of PHC services. Yet very limited research has been carried out in Nigeria on PHC in recent years, especially in Delta State. Even then the available research results are poorly disseminated to policy makers. There has always been a wide gap between policymaking and implementation in Nigeria due mainly to the fact that there is often no coordination between research and programme implementation.

The proposed research project titled *"Strengthening the health system in Nigeria through improved equitable access to Primary Health Care (PHC): The Case of Delta State, Niger Delta region"* intends to contribute to health care systems strengthening in Nigeria by examining the PHC situation in one of the states in the country, namely, Delta State. The project is funded by the Canada's *International Development Research Centre (IDRC)*, Ottawa and the *West African Health Organization (WAHO) (*(CPED, 2013).

The general objective of the research programme is to contribute to a body of evidence on the strengthening of the health system in Nigeria that can influence the development and modification and implementation of policies on equitable access to health care. The specific objectives address *knowledge development* (research), *knowledge translation* (influencing policy) and *capacity building* (training of junior researchers and empowerment of key stakeholders) components as follows: (i) To generate robust policy-relevant evidence about access to primary health care in Delta State and the determinants of this access; (ii) To establish a sustainable platform of interaction between researchers, practitioners and policy makers in Delta State that facilitates the systematic use of research evidence to inform policy formulation and programme implementation; and (iii) To strengthen capacity in health systems research and knowledge translation in Delta State. The study intends to provide a better understanding of the pattern of access to primary health care and the reasons behind the use of the PHC system. The findings of the study are expected to help improve the design and implementation of policies that would

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lead to effective, equitable and efficient PHC delivery systems in Delta State. This explains the commitment of the project to knowledge transfer and knowledge brokerage as presented in the next section.

The specific research questions being addressed in the project are as follows:

1. To what extent do people in Delta State utilize the primary health care system for their primary health care needs?
    a. To what extent have standards set for the delivery of PHC services been adhered to in Delta State?
    b. To what extent do users' perceptions of the quality of services influence their choice of primary health care service provider in Delta State?

2. Have free health care programmes in the public sector and private sector initiatives to reduce out-of-pocket expenses enhanced access to primary health care particularly amongst rural dwellers and the poor in Delta State?
    a. What factors limit or facilitate the uptake of free and fee-paying primary health care services in Delta State?

3. What is the nature of the participation of key stakeholders, particularly decision makers, practitioners and users/clients in PHC delivery In Delta State?
    a. Is there planned and systematic involvement of health service providers and communities in the design, delivery and monitoring of programmes to enhance access to primary health care in Delta State?

4. What strategies and key interventions should be put in place to improve the accessibility of PHC in Delta State?
    a. Which observed determinants of access

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can be acted on in the short to medium term to significantly improve equitable access to primary health care in Delta State?

Knowledge Transfer and Knowledge Brokerage Strategies in the Primary Health Care Study in Delta State, Nigeria

Generally, there is a spectrum of strategies for knowledge transfer and knowledge brokering. The six common ones which are being used in this study include: informing, consulting, matchmaking, engaging, collaborating and building adaptive capacity. Each of these strategies serves complementary functions and could be appropriate for different policy issues or for the same issue at different points in its evolution. The knowledge transfer and knowledge brokerage strategies of the primary health study in Delta State are based on the principle that personal contact between researchers and the potential users of research seems to be the most important route for research to enter policy and practice in Nigeria. This supports the assumption that research use is a social process where interacting stakeholders representing policy makers and researchers jointly examine research evidence through debate, interplay and exchange. The key organs in the knowledge transfer and knowledge brokerage of the primary health care study in Delta State comprise the *Centre for Population and Environmental Development (CPED)*, *Project Management Committee* of the Primary Health Care Study, *Project Steering Committee* of the Primary Health Care Study in the Ministry of Health, Delta State, the *Executive Governor* of Delta State and *Project Steering Committee of the Primary Health Care Study in the Federal Ministry of Health*.

Centre for Population and Environmental Development (CPED): The Centre for Population and Environmental Development (CPED) is coordinating a range of tasks aimed at fostering better links between researchers and policy-makers. CPED is an independent, non-profit and non-governmental organization registered in Nigeria and dedicated to reducing poverty, inequality and environmental degradation through policy-oriented research and active engagement on

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development issues. In collaboration with civil society, the private sector and state agencies, CPED seeks to use the results of its research to influence development and implementation of policy that will promote equitable development and poverty reduction in Nigeria. CPED is currently one of the 24 IDRC *Think Thank Initiative* grantees in sub-Saharan Africa. CPED has experienced research staff that are imaginative, intuitive, inquisitive, and inspirational and who are capable of managing human intellect and helping to convert it into useful products or services. Over the years of action research and policy engagement, CPED has acquired considerable competence in dealing with policy makers including mediation skills, the ability to build teams, and considerable diplomacy, since people with very different goals and experience do not always work well together (Fielding and Briss, 2006).

CPED's role as the coordinator of knowledge transfer and knowledge brokerage in the primary health care study in Delta State can be outlined as follows:

(i) Constitution of a health systems research team that will carry out CPED's coordinating role during the period of the implementation of the study;

(ii) Knowledge generation and critical appraisal of the primary health situation in Delta State which is being carried out through the research team using the agenda approved by IDRC and WAHO;

(iii) In Nigeria, healthcare is embedded in many social and political contexts; therefore, in addition to the knowledge of primary health care operations in Delta State that the research will produce, CPED is familiar with the broader health care pattern in Nigeria, in particular and other developing world, in general, its players, and controversies, as well as the political issues and public attitudes toward it. All of these factors influence decisions and CPED must be able to articulate them to policy makers;

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(iv) Packaging of research syntheses. CPED will develop a range of materials designed to provide user-friendly access to complex research information on primary health care in Delta State. These materials will include executive summaries, cost/benefit breakdowns, press releases, posters, and so forth;

(v) Presentation and communication of the key and policy oriented findings to policy and decision makers and other stakeholders within Delta State and beyond;

(vi) Even when research influenced policy well, there is a need for follow-up research agenda. CPED will be involved in the post-policy period of the study to monitor its performance and sustainability;

(vii) CPED will convene meetings of other organs of the primary health care study's knowledge translation and knowledge brokerage activities;

(viii) Fill research and policy gaps. CPED will inform policy makers and other stakeholders about the neglected primary health policy issues in Delta State that ought to be addressed, and about deficiencies in available research. In general CPED will call for increased support for health systems research and policy-making on the basis of the findings of the study;

(ix) Train policy-makers and researchers. CPED will strengthen the capacity for knowledge translation by providing briefings and roundtable meetings that coach policy-makers to access and use primary health care information, and will also mentor junior researchers to understand the policy context of their investigations; and

(x) Monitor and evaluate the impact of knowledge translation and knowledge brokerage activities. CPED will monitor awareness of and attitudes toward its own activities, especially on the part

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of policy-makers, and other stakeholders, with particular attention to any influence on primary health policy change or practice.

Project Management Committee

The Project Management Committee is constituted to promote the participation of all key stakeholders in the implementation of the primary health care study. The Committee is chaired by the Project's Principal Investigator and is composed of members of the research team that represent researchers; policy and decision makers that represent the Delta State Ministry of Health; health practitioners including medical doctors, nurses and other health professionals; representatives of the private sector involved in primary health care delivery; and representatives of users of primary health care services and community members. The main responsibility of the Committee is to collaborate with the research team to implement the research component of the project by making necessary input into its execution from the perspective of policy and decision makers, health practitioners/professionals, and the users. Thus, the role of the Management Committee includes the following:

(i) Collaborating with CPED research team in knowledge generation and critical appraisal of the primary health situation in Delta State;

(ii) Ensuring that the perspectives of policy makers, practitioners and users of primary health care services are reflected in the study and its findings;

(iii) Collaborating with CPED research team in the communication of the policy oriented findings to policy and decision makers and other stakeholders in Delta State; and

(iv) Participating in the monitoring and evaluation of the impact of knowledge translation and knowledge brokerage activities of the study.

Project Steering Committee in the Delta State Ministry of Health

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The ultimate aim of knowledge translation and knowledge brokerage in the primary health care study in Delta State is to influence policy with its findings. It was, therefore, necessary to reach key policy and decision makers in the Delta State Ministry of Health right from the commencement of its conception and implementation. This was done through the constitution of Project Steering Committee. The Committee is composed of all the policy and decision makers in the Delta State Ministry of Health including permanent secretaries and directors as well as representatives of the research team and project management committee. The chairman of the Steering Committee is the Delta State Honourable Commissioner for Health who is represented by the Permanent Secretary in charge of the administration of the Ministry. The purpose of the Steering Committee is to promote the ownership of the project by policy makers. In this way, policy makers are part of the findings and policy recommendations and are in a position to articulate and implement such policies. The research proposal and protocol were reviewed and approved by the Steering Committee before the commencement of the study. The Steering Committee is expected to meet two or three times in a year during the period of the implementation of the project so that policy makers can be kept informed of the on-going project activities. The Steering Committee initiative is expected to be a permanent, dedicated, professional mechanism operating in the Delta State Ministry of Health and serviced by CPED. It will serve health researchers by harvesting, synthesizing, re-packaging, and communicating the policy-relevant evidence of their studies – and in user-friendly terms that lay persons will understand. It will serve policy makers by expressing their policy needs in the form of questions that can be investigated scientifically.

Reaching the Executive Governor of Delta State with the findings and policy recommendations of the Project

The likelihood for the speedy acceptance and implementation of the findings and recommendations of the project will be greatly enhanced if the Executive Governor of Delta State, who

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is also a medical doctor, is put in the study's picture. While the Project Steering Committee will ultimately report to the Executive Governor, CPED through the Project Research Team and the Project Management Committee is making another direct contact with the Executive Governor so that there can be another channel of communication on the study to him. The first contact with the Executive Governor was made at the commencement of the study and more progress reports will be presented to him before the final report is made available to him at the end of the study.

National Project Steering Committee in the Federal Ministry of Health

The findings and policy recommendations of the primary health care study in Delta State are expected to influence policy at the national level. The last comprehensive study of primary health in Nigeria, which covered three states, Bauchi, Lagos and Kogi, was carried out about ten years ago. The present study in Delta State will provide contemporary information on the patterns and challenges of primary health care in the country. It is in this context that the Federal Ministry of Health is involved in the present study in terms of the utilisation of the policy recommendations for national primary health care planning and implementation strategies. The Federal Ministry of Health's involvement is promoted through the *National Project Steering Committee,* based in the National Primary Health Care Development Agency (NPHCDA) Abuja. While the National Project Steering Committee is being regularly briefed on the project activities and results, its primary role is to review the findings and recommendations of the Delta State study for their adoption at the national level.

Strategies to enhance evidence-informed health policy making in Nigeria

Despite the current challenges associated with evidence-informed health policy making in Nigeria, they are not insurmountable. The experiences of the on-going knowledge translation and knowledge brokerage strategies in the implementation of the primary health care study in Delta State

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have the potential of contributing to addressing some of these challenges. A number of strategies to enhance evidence-informed health care policy making in Nigeria are outlined below for the attention of researchers, policy makers and funders (Iqbal and Tulloch, 2012).

Encouraging Nigerian policy makers to become better users of evidence

Governments at various levels in Nigeria need to establish norms and regulations that support the development and use of research evidence. There is increasing recognition of how health system constraints impede progress in scaling-up service delivery. Therefore support for evaluative and operational research should be part of the norm for researchers and funders of health systems. One key factor in promoting the use of rigorous evidence in health policy is to build the capacity of practitioners to find, assess and incorporate rigorous evidence in their work. In this respect, government and funders should support various seminars and courses designed to empower key policy and decision makers on the use of evidence in policy making and implementation. Skills in using evidence may be improved through training and development programmes for policy makers and other policy agents. Educating administrative officials who can then introduce new decision-making approaches to their agency is one important way to effect systemic change (Uneke, Ngwu, Ogbonna, Ezeoha, Oyibo, and Onwe, 2009).

The importance of capacity development among policy makers and other stakeholders in the Nigeria health sector can not be over stated. This is a major factor that has the potential of boosting the interest in the transfer and uptake of research evidence into policy and practice as it will positively influence governance and leadership, resources (human, material and financial), communication and quality of research. It is already a well established fact that skills training could help policy makers and their aides not only identify research evidence that has policy relevance but also distinguish research of high and low methodological quality. Targeted, evidence-based training of policy and

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decision makers in charge of the health systems; national, regional, state and local officers of the health ministries; staff and consultants involved in public health issues within the health ministries; political/legal advisers on health related matters; and programme/project managers under the health ministry, could provide a powerful means for influencing how research is used and how policy issues are framed in larger legislative and administrative settings in Nigeria (Federal Ministry of Health, 1998).

Need to build strong long-term relationships between Nigerian policy makers and researchers, while maintaining objectivity in reporting results

Establishing institutional links between researchers and decision makers is necessary in order to improve the communication and utilization of research in Nigeria. Policy makers can be better encouraged to use evidence in their decisions when they have closely partnered with researchers in all steps of the research design and have benefited from feedback from the field to tackle unanticipated implementation roadblocks. The institutional links between researchers and decision-makers influence at what levels and at what stages of decision-making processes research results can be fed in as well as demanded for. Research institutions such as CPED can be an important link. This requires the support of researchers, research funders as well as decision makers. Researchers and policy makers can jointly disseminate the lessons from research programmes and their evaluations to other policy makers so that they can benefit from these dual perspectives. Such collaborative processes can encourage evidence-based decision-making at different levels of government. Governments in Nigeria as in other developing countries are often the biggest funders and implementers of social programmes, and working with them offers the chance to influence policies in different sectors of the economy. We must emphasize that working with governments can however involve long and cumbersome bureaucratic approval processes, a significant risk of projects being discontinued when the civil servants who championed the programme are transferred, and wide variation in the skills and enthusiasm

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for change among civil servants. There is also the possibility of civil servants trying to influence researchers to effect changes in research programme design or in the publication of results to accommodate political pressure.

Removing the barriers that limit partnership between researchers and policy makers in Nigeria

In building a stronger culture of evidence-based policy making, there is a need to work towards eliminating the barriers that reduce partnerships between researchers and policy makers in Nigeria. There are many barriers to such partnerships, but it is important to promote them as not only do policy makers benefit from close interaction with researchers, but researchers also have much to gain from such partnerships. First, policy makers understand well the pressing issues facing their constituents, the local context and what the primary constraints on programme options are, and they can therefore guide academics to the most relevant research questions, and also give them a sense of the difficulties that new programmes may encounter. Second, researchers are reliant upon their implementing partners for the smooth implementation of any of their research programmes. A close feedback loop between researchers and policy makers ensures that any challenges are addressed quickly and effectively so that programmes do not fail due to avoidable implementation problems. Third, when policy makers see the researchers contributing positively by providing evidence from existing research and giving feedback on programme design, they are more likely to be motivated to support considerations of future research.

The development and improvement of dissemination strategies of research results

A major strategy to improve the relationships between researchers and policy makers in Nigeria is the development and improvement of dissemination strategies of research results. This should focus primarily on how to package research results to be easily understood by and applicable for decision-makers. Actively involving knowledge brokers can be part of a dissemination strategy. The

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dissemination strategy can be designed and implemented by researchers as well as research funders.

Establish and support policy research organizations such as think tanks to promote use of evidence in policy

Supporting research organizations so that they are dedicated to supporting evidence use in policy is essential to effective use of evidence in policy making in Nigeria. Such research organisations if properly funded will be able to collate, summarize and package research evidence relevant to policy concerns and present this in a timely fashion to policy makers. Such knowledge brokers are primarily intended to act as bridges between policy- and decision-makers on the one hand, and researchers on the other.

Promote networking

Institutions for health policy should be established so that they can train students who would then go on to assume posts in health-related ministries, departments and agencies. This would enhance research-related capacities of government institutions and can facilitate academics' access to policy processes.

Conclusion

The justification for knowledge translation and knowledge brokering in Nigeria is based on the recognition that evidence from research when available could contribute to rational policy decision-making; and that clarifying the information needs of policy-makers could help direct research. The lack of knowledge brokers is acute in Nigeria, where the relatively inefficient researcher–push approach is common. Nigeria is characterized by few independent think tanks that can take the initiative of knowledge translation and knowledge brokering. One of the main complaints of policy makers in Nigeria is the queue of advocates for various results and experiences, sometimes conflicting or confusing, seeking the attention of the policy maker. In this context, CPED's knowledge translation and knowledge brokering initiative in the primary health study in Delta State is an interesting and attractive idea that is establishing a permanent brokerage available to influence policy for

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primary health care research, and for influencing the research agenda in turn. It would provide a single, or at least predominant, conduit of evidence to policy makers and is thus more likely to command their attention than the current fragmented approach. It should also serve to strengthen the relationship between the research and policy communities and hence a move towards a stronger culture of evidence-based policy and policy-relevant research in Nigeria. CPED believes that the knowledge brokering approach is the most appropriate way to institutionalize the use of evidence in primary health care and recommends the need to support and learn from the brokerage approach over the next few years to overcome the long-standing barriers to amalgamate research and policy and therefore promote more policy-relevant research in the country.

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