Development of Health Policy and Systems Research in Nigeria: Lessons for Developing Countries' Evidence-Based Health Policy Making Process and Practice

Développement de la recherche sur les politiques et les systèmes de santé au Nigéria : leçons à retenir pour l'élaboration de politiques et de pratiques de santé fondées sur les données probantes, xdans les pays en développement

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Abstract

Health policy and systems research (HPSR), which aims to produce reliable and rigorous evidence to inform the many critical decisions that must be made about health systems, is a new concept in Nigeria. In this study, policy makers and other stakeholders in the health sector identified the challenges and the potential intervention strategies to HPSR evidence use in policy making in Nigeria. The major challenges identified included capacity constraints at individual and organizational levels, communication gaps and poor networking between policy makers and researchers, and the non-involvement of healthcare recipients in identifying and planning care delivery needs. The main solutions suggested included promotion of strategies to encourage partnership between researchers and policy makers, improvement of staff incentives and facilities for research activities, improved budgetary provision for research, and sustainable institutional capacity development. These strategies have been shown to improve evidence-based policy making in developed countries and are likely to produce better outcomes in the developing world.

Résumé

La recherche sur les politiques et les systèmes de santé (RPSS), qui vise à produire des données fiables et rigoureuses pour éclairer les multiples décisions importantes du système de santé, est un concept nouveau au Nigéria. Dans la présente étude, des responsables de politiques et d'autres intervenants du secteur de la santé ont dégagé les défis et les stratégies potentielles d'intervention en matière d'utilisation des données de la RPSS dans l'élaboration de politiques de santé au Nigéria. Les principaux défis repérés comprennent, notamment, les contraintes en matière de capacité aux niveaux individuel et organisationnel, les lacunes en matière de communication, le manque de réseautage entre les responsables de politiques et les chercheurs, ainsi que la non participation des bénéficiaires des services de santé dans l'identification et la planification des besoins en prestation de services. Les principales solutions proposées sont, entre autres, la promotion de stratégies qui favorisent les partenariats entre les chercheurs et les responsables de politiques, l'amélioration des mesures incitatives, la mise en place d'installations pour les activités de recherche, une amélioration des dispositions budgétaires pour la recherche et le développement durable des capacités institutionnelles. Il a été démontré que ces stratégies ont permis d'améliorer l'élaboration de politiques de santé fondées sur les données probantes dans les pays développés; elles permettraient sans doute d'améliorer les résultats dans les pays en développement.

Health policy and systems research (HPSR) has been defined as "the production of new knowledge to improve how societies organize themselves to achieve health goals" (AHPSR 2007). The attention of the international community was drawn to the concept of HPSR by the World Health Organization's (WHO) Ad Hoc Committee on Health Research (1996), which identified lack of HPSR as a key problem impeding the improvement of health outcomes in low- and middle-income countries. Following the committee's recommendations, the Alliance for Health Policy and Systems Research (AHPSR), an international collaboration based in WHO Geneva, was established. AHPSR aims to promote the generation and use of HPSR as a means to improve the health systems of developing countries. This goal was in line with an earlier report of the Council on Health Research for Development (COHRED 1990), which recommended investment in essential national health research, international partnerships and mechanisms to monitor progress. The recommendation was necessitated by the discovery that only 5% of global spending on health research went to problems affecting the poorest 93% of the world's people, known as the "10/90 gap" (COHRED 1990).

Ten years later, an International Conference on Health Research for Development (ICHRD) was convened in Bangkok, Thailand, by the WHO, World Bank,

COHRED and Global Forum for Health Research (GFHR). At the conference, participants emphasized the need to strengthen national health research systems as a key priority to reduce the 10/90 gap (ICHRD 2000). Two subsequent international meetings were held in Mexico City in 2004 and Bamako in 2008 which, among other issues, emphasized the promotion of the conduct and use of essential health systems research, securing public confidence in research and bridging the gap between knowledge and action in developing countries (WHO 2004; AHPSR 2008).

In most developing countries of the world, health outcomes have been described as unacceptably low. At the centre of this human crisis is a failure of health systems (WHO 2007). The health systems comprise all the organizations, institutions and resources that are devoted to producing health actions, and have a primary purpose of improving health (WHO 2000). Unfortunately, in Nigeria – as in many other developing countries – weak health systems are impeding the success of the various health intervention programs being implemented. Bowen and Zwi (2005) have noted that a key challenge to public health in most developing countries is to better contextualize evidence for more effective policy making and practice. There is therefore increasing recognition that strong and effective health systems that are evidence-based in their operations are necessary to achieve continued improvement in health outcomes in an efficient and equitable manner (WHO 2008; Travis et al. 2004).

A number of reports have provided convincing information to prove that evidence from research can enhance health policy process and development by identifying new issues for the policy agenda, informing decisions about policy content and direction and evaluating the impact of policy (Campbell et al. 2009; Dobrow et al. 2004; Hanney et al. 2003; Innvær et al. 2002). HPSR has been shown to have the potential to produce reliable and rigorous evidence that can help inform policy development and the policy making process (AHPSR 2007).

The Alliance for Health Policy and Systems Research aims to produce reliable and rigorous evidence to help inform the many and varied critical decisions that must be made by ministers of health, senior policy makers and health service managers about how to organize the health systems and effect changes (AHPSR 2007). In Nigeria, HPSR is a somewhat new phenomenon; most health researchers, health policy makers, health services managers and other major stakeholders at government and non-governmental levels are yet to fully appreciate its value in policy making and practice (Uneke et al. 2009). However, as a result of the recognition of the importance of evidence-based health policy by the Government of Nigeria – a recognition necessary for the actualization of comprehensive health sector reform – the Nigeria Evidence-based Health System Initiative (NEHSI) was established.

NEHSI is a collaborative project between the Government of Nigeria, Canada's International Development Research Centre (IDRC) and the Canadian International Development Agency (CIDA) as a response to Nigeria's commitment to health sec-

tor reform, particularly in the area of primary healthcare (PHC) (NEHSI 2009). Although NEHSI was developed as a two-year extensive planning phase (2005–2007) to inform the implementation of a six-year initiative (which began 2008) to support a fair, effective and efficient PHC system, it is being conducted in only two states (Bauchi and Cross River) out of the 36 states in Nigeria. Hence, the absence of such a program in other Nigerian states has left these regions with no significant awareness or information on health system research. There is therefore little interest in transfer and uptake of research into policy and practice in most parts of the country, and a major factor contributing to this situation is the lack of recognition of the importance of HPSR (Uneke et al. 2009). There are instances, however, where policy making has involved the use of research evidence in Nigeria, but such use has occurred mainly in clinical decision-making (evidence-based medicine) and only in a number of tertiary health institutions, such as teaching hospitals.

The World Health Organization, like many other international agencies, is currently vigorously supporting the process of contextualizing evidence and translating it into policy through the utility of HPSR in many developing countries, including Nigeria (WHO 2003; AHPSR 2007). This approach is in line with the resolution of the World Health Assembly (WHA) held in Geneva in May 2005, which laid emphasis on how to harness health research more effectively in order to achieve the United Nations Millennium Development Goals in low- and middle-income countries (WHA 2005).

Capacity constraints at the individual and organizational levels are perceived to be major impediments in HPSR evidence use in the health policy making process in most developing countries, including Nigeria (Gonzalez-Block and Mills 2003; Uneke et al. 2009). Green and Bennett (2007) noted that more evidence is needed about how capacity constraints in countries inhibit evidence-informed health policy, and which strategies are effective in addressing these constraints. There is a dearth of information on the status of HPSR evidence use in policy making at the individual and institutional levels in Nigeria. The scarcity of such baseline information hampers effective development of strategies to promote the application of HPSR in policy making. This study was therefore designed to identify the challenges associated with HPSR evidence use in policy making and the potential strategies to address them.

Materials and Methods

Study participants

This research was a subnational study; participants consisted of individuals whose geographical area of operation is southeastern Nigeria, with emphasis on Ebonyi State. Participants included the following: health professionals in charge of the health systems; regional, state and local government directors of the health ministry; health

professionals working with specific programs in the health ministry who wish to use HPSR to improve the impact of their strategies; staff and consultants involved in public health issues within the health ministry; and program/project managers under the health ministry.

Data collection

An Evidence–Policy Workshop was organized by the research team in July 2009, and the study participants were invited to it. A total of 73 participants attended. During this forum, a focus group discussion was held, and up to seven discussion groups of between seven to 12 persons per group took part in discussions lasting up to 45 minutes. The issues discussed were categorized into four central themes, with questions within each theme as follows:

1. *Capacity constraints and challenges that impede the development of HPSR evidence use in Nigeria:* (a) What are the individual staff constraints that impede HPSR evidence use in your organization? (b) What are the organizational challenges and constraints that impede HPSR evidence use in your organization?
2. *Identification of critical gaps in HPSR evidence use, with a focus on improving public health:* (a) What are the critical gaps in HPSR evidence use in your organization that have affected efforts to improve public health in your geographical areas of operation? (b) How have the critical gaps identified affected evidence-based healthcare delivery in your geographical areas of operation?
3. *Identification of barriers to and solutions for translating research into policy and practice via evidence use:* (a) What are the barriers to effective utilization of research evidence in policy making and practice in your organization? (b) What possible interventions can be adopted to facilitate the process of translating research evidence into policy and practice?
4. *Identification of potential strategies and solutions that would address capacity constraints and challenges of HPSR evidence use in Nigeria:* (a) What are the possible strategies that can be adopted to improve individual capacity in HPSR evidence use in your organization? (b) What possible strategies can your organization adopt to improve organizational capacity in HPSR evidence use?

Theoretical foundation underlying the methodological approach

The target participants in this study were health service/policy providers because we anticipated a supply-driven outcome that would address capacity constraints in HPSR evidence use in policy making and policy implementation by these individuals. According to AHPSR (2004), the supply-driven model has been used extensively to

design capacity-strengthening initiatives in developing countries, based on the assumption that if the skills of the main actors (researchers and policy makers) are enhanced via training and enough institutional capacity is built, research outputs will be put to good use. Although this argument has intensified in HPSR circles with a focus on the demand side, the supply-driven approach has a stronger tendency to accomplish a high level of ownership of policies, an outcome that has been witnessed in Nigeria and other developing countries. The reason is that health policies are better implemented when those charged with this responsibility are made to identify the capacity challenges and the solutions required to address these challenges.

Capacity constraints at the individual level are perceived as major impediments in HPSR evidence use in the health policy making process in most developing countries, including Nigeria (Gonzalez-Block and Mills 2003; Uneke et al. 2009). Green and Bennett (2007) have noted that evidence is needed about how capacity constraints, particularly among policy makers in various countries, inhibit evidence-informed health policy, and which strategies are effective in addressing these constraints. No other category of individuals is in the best position to identify the capacity challenges of service/policy providers in HPSR evidence use in policy than the service/policy providers themselves. This assumption informed the adoption of our methodological approach. Our intention, however, was not to restrict the investigation to the supply-driven model. The goal was first to generate information using the supply-driven model, and then to use it to stimulate the demand-driven aspect, which is also key to achieving evidence-based policy making and practice. A number of earlier reports provided evidence proving that supply-side capacity-building strategies that do nothing to stimulate the demand for research are unlikely to achieve expectations, and may actually further distort allocations (Bhagavan 1992; Acemoglu 1997). The essence of our approach was to address the uncoordinated "pushing" of research results by scientists and "pulling" of research results by market-oriented users (AHPSR 2004).

We employed a focus group discussion because our study was intended to draw upon respondents' attitudes, feelings, beliefs, experiences and reactions with respect to capacity constraints in HPSR evidence use in policy making. A focus group was seen as the most feasible method of accomplishing this aim, as other methods such as observation, one-to-one interviewing and questionnaire surveys do not enhance social gathering and interaction the way a group discussion does. The approach that we took to elicit information from key informants in the focus groups has been described by Kitzinger (1995). The theoretical foundations underlying this approach were based on the work of Thomas and colleagues (1995), who described the focus group as "a technique involving the use of in-depth group interviews in which participants are selected because they are a purposive, although not necessarily representative, sampling of a specific population, this group being 'focused' on a given topic." Richardson and Rabiee (2001) have noted that individuals participating in a focus group are usually selected

based on the fact that they have a working knowledge of issues addressed, are within a similar age range, have similar socio-demographic characteristics and are likely to be comfortable talking to the interviewer and with one another. According to Burrows and Kendall (1997; cited in Rabiee 2004), "this approach to selection relates to the concept of 'Applicability,' in which subjects are selected because of their knowledge of the study area."

Data analysis

The responses from the focus group discussion were noted and were analyzed based on Giorgi's (1985) phenomenological approach, which has been elaborated by Albert and colleagues (2007). The analysis followed the following steps: (a) going over all the textual data to gain an overall impression; (b) identifying all comments that appeared significant to the research and extracting these meaning units; (c) independent abstracting of the meaning units, followed by discussion and consensus; (d) independent categorization and summarization of abstractions into challenges of HPSR evidence use in policy making and the solutions as perceived by policy makers, followed by discussion and consensus; and finally (e) returning to the extracted text to ensure a good fit with the final list of challenges and solutions.

Results

The participants' attributes are presented in Table 1; the responses from the focus group discussion are summarized in Table 2.

Concerning *capacity constraints and challenges that impede the delivery of HPSR evidence use in Nigeria*, some participants identified *individual-level constraints* as follows: "There are inadequate facilities for health policy and systems research in our health ministry"; "We lack access to reliable electronic information systems, especially Internet services"; "There are poor incentives and lack of motivation for health policy and systems research"; "I do not have much interest in research since it is not encouraged by my organization," etc.

At the *organizational level*, participants identified a number of capacity constraints: "Our organization has poor capacity to collaborate with partners and other organizations/institutions"; "There is inadequate funding for any research activity including health policy and systems research"; "There is a lot of political interference in our operations, which are not in favour of research"; "We lack sufficiently trained manpower"; "The policy formation processes in our organization are very inconsistent"; "Our organization does not have established capacity development programs," etc.

Participants identified the *critical gaps in HPSR evidence use, with a focus on improving public health*: "There is non-integration of efforts in planning and in deci-

sion-making"; "Non-involvement of health recipients in identifying and planning healthcare delivery needs"; "Non-use of multiprofessional approach in formulating health policy and initiating health research works"; "The existence of poor networking"; "There is a huge communication gap between the policy makers and the researchers," etc.

TABLE 1. Attributes of focus group participants in the Evidence–Policy Workshop for health policy makers in Nigeria

Participant attributes	No. (%) of participants N=73
1. Gender	
Male	44 (60.3)
Female	29 (39.7)
2. Age	
25–34	10 (13.7)
35–44	44 (60.3)
≥45	19 (27.1)
3. Official designation	
Program officers	17 (24.3)
Managers/Heads of departments	39 (55.7)
Directors	17 (24.3)
4. Years of experience in current designation (in years)	
<3	24 (32.9)
3–5	24 (32.9)
5–10	18 (24.7)
>10	7 (9.6)
5. Highest academic qualification	
Diploma	13 (17.8)
Bachelor	40 (54.8)
Master's	18 (24.7)
Doctorate	2 (2.7)

Participants also described *how these gaps affect evidence-based healthcare delivery*: "These critical gaps have led to poor and substandard health service delivery"; "They have hindered the achievement of health sector goals/targets"; "These gaps can lead to the failure of policy process and implementation and so can disrupt priority setting"; "They lead to inefficiency in the use of available resources"; "They lead to service duplication and the generation of irrelevant services"; "They increase mortality and morbidity rates," etc.

Concerning *barriers to translation of research into policy and practice via evidence use*, the policy makers commented: "There is [a] dearth of existing relevant research data";

"There are often interdisciplinary conflicts, that is, lack of interdisciplinary teamwork"; "We have [a] poor logistics system"; "There is lack of knowledge on the part of the policy makers to appreciate the relevance of evidence-based research," etc.

TABLE 2. Outcomes of focus group discussion during Evidence–Policy Workshop for health policy makers in Nigeria

	Discussion issues	Summary of responses from discussion groups
1.	Capacity constraints and challenges that impede the delivery of HPSR evidence use in Nigeria	**Individual Staff Constraints** • Inadequate funding for research programs • Inadequate facilities • Lack of access to information (and specifically, Internet services) • Poor incentives/lack of motivation • Lack of interest in research (individuals think it is not their responsibility to initiate/ conduct research) **Organizational Constraints** • Poor capacity to collaborate with partners • Inadequate funding • Political interference • Inadequate manpower • Inconsistency in policy formation processes • Lack of capacity development programs • Inadequate involvement of the appropriate health personnel in policy making • Non-continuity of health programs due to change in government
2.	Critical gaps in HPSR evidence use, with a focus on improving public health	**Critical Gaps in HPSR Evidence Use** • Dearth of qualified personnel (experts) • Non-integration of efforts in planning and in decision-making • Non-involvement of health recipients in identifying and planning healthcare delivery needs • Non-use of multiprofessional approach in formulating health policy and initiating health research works • Poor networking • Lack of functional database • Top-down policy making approach that excludes critical agents at the primary level • Communication gap between the policy makers and the researchers • Non-availability of research units/departments in most health organizations **How the Factors (Gaps) Affect Evidence-based Healthcare Delivery** • Lead to poor/substandard health services delivery • Hinder the achievement of health sector goals/targets • Lead to process/implementation failure, and so can disrupt priority-setting • Lead to inefficiency in the use of available resources • Lead to service duplication and the generation of irrelevant services • Increase mortality and morbidity rates • Affect planning for healthcare delivery • Create gaps between the policy makers and the implementers, giving rise to non-involvement of grassroots in ownership and participation

TABLE 2. Continued

3.	Barriers to and solutions for translating research into policy and practice via evidence use	**Barriers to the Use of Evidence in Policy Making Process and Practice** • Dearth of existing relevant research data • Interdisciplinary conflicts (i.e., lack of interdisciplinary teamwork) • Poor logistics system • Lack of knowledge on the part of policy makers to appreciate the relevance of evidence-based research • Political interferences or influence • Socio-cultural barriers **What Can Be Done to Facilitate the Process of Translating Research Evidence into Policy and Practice** • Increase funding provision for building and maintenance of research evidence database • Ensure institutional/personnel capacity development • Undertake advocacy campaigns • Educate policy makers on the importance of evidence use in health policy making • Promulgate relevant legislation to back up implementation of research results • Fund health research projects • Train health personnel to carry out research • Equip planning and research centres at state and local government levels
4.	Potential strategies and solutions that would address capacity constraints and challenges of HPSR evidence use in Nigeria	**Strategies and Solutions for Improving Individual Capacity** • Train personnel to enable them to know more in their area of specialization • Provide Internet facilities and reference materials • Improve staff incentives for research activities • Motivate personnel through incentives **Strategies and Solutions for Improving Organizational Capacity** • Enhance collaboration and networking among stakeholders in the health sector (including private sector participants and donor agencies) • Initiate and undertake political advocacy on critical health issues • Ensure adequate resource mobilization (especially on how to optimize internal sources) • Improve funding and incentives; provide research budgets • Ensure widespread dissemination of research results and feedback • Develop sustainable institutional capacity • Fund research and utilization of results in decision-making and policy implementation in the health sector • Utilize research findings in quarterly/annual meetings where research evidence can be presented to policy makers • Ensure proper data management • Minimize political interests in the development of HPSR • Introduce effective monitoring and evaluation programs

To *facilitate the process of translating research evidence into policy and practice,* the participants commented: "There should be increased funding provision for building and maintenance of research evidence databases in various health organizations"; "Mechanisms should be put in place to ensure institutional and personnel capacity development"; "It is important for the promulgation of relevant legislations to back up implementation of research results"; "Efforts should be made in equipping planning and research centres at state and local government levels," etc.

The *potential strategies and solutions that would address capacity constraints and challenges of HPSR evidence use in Nigeria* were identified as follows: "There should be the provision of functional Internet facilities in health-based organizations"; "Each organization should ensure the improvement of staff incentives for research activities"; "It is vital to establish processes that are capable of enhancing collaboration and networking among stakeholders in the health sector"; "Establish ways of ensuring adequate resource mobilization, especially on how to optimize internal sources"; "The organizations should improve budgetary provision for research"; "It is vital to ensure that there is widespread dissemination of research results and feedback, particularly to health ministries"; "There should be sustainable institutional capacity development"; "Funding research works and utilization of results in decision-making and policy implementation in the health sector should be made mandatory"; "There should be minimization of political interests in the development of health policy and systems research," etc.

Discussion

Although HPSR evidence use in policy making is a new concept in Nigeria, the results of this study indicate a willingness on the part of policy makers to embrace it in the health policy development process. The reason is that HPSR is seen to have the potential to play an increasingly important role in strengthening the health systems upon which health priority programs and interventions run. HPSR is also seen as a key source of understanding about the nature both of how health systems operate and the content of policy making in the country. It was the consensus of the policy makers in this study that capacity constraints constitute the major challenge in the delivery of HPSR evidence use in policy making in Nigeria, as exemplified in the participants' comments: "Our organization does not have established capacity development programs"; "Our organization has poor capacity to collaborate with partners and other organizations/institutions"; "There is inadequate funding for any research activity, including health policy and systems research"; "There are inadequate facilities for health policy and systems research in our health ministry."

Gonzalez-Block and Mills (2003) have defined HPSR capacity as "the level of expertise and resources at the researcher, project and institutional levels for the production of new knowledge and applications to improve the social response to health problems." Also included is the capacity to engage stakeholders in policy and program development. Weak capacity at a number of levels in the institutions and interfaces between knowledge generation and use in policy making has been identified by the Alliance for Health Policy and Systems Research as a key strategic issue, but one about which there is still inadequate understanding (AHPSR 2007). Specific capacity constraints identified in this study – such as inadequate facilities, particularly lack of

access to information (specifically, Internet services); poor capacity to collaborate with partners, e.g., researchers; inadequate funding/lack of incentives for research; and lack of capacity development programs – appear to be widespread challenges to HPSR evidence use in most developing countries (Gonzalez-Block and Mills 2003; Green and Bennett 2007).

The participants generally agreed that the transfer and uptake of research into the health policy making process are not widely practised in Nigeria. Thus, evidence-based policy making and practice still attract very low attention and interest. Critical gaps in evidence-based policy making, especially communication gaps/poor networking between policy makers and researchers, and of course non-use of multidisciplinary approaches in formulating health policy and initiating health research – all have a negative impact on the country's health systems. As some participants noted: "There is a huge communication gap between the policy makers and the researchers"; "Non-use of multiprofessional approach in formulating health policy and initiating health research works"; and "The existence of poor networking."

O'Neill and Nath (2005) have noted that "rapid progress towards disease-control targets in developing countries is greatly hampered by weak, poorly functioning or in some cases non-existent health systems" and that "it is critical to know how to strengthen the health system and the specific actions appropriate for different settings." It has been established that HPSR is key to strengthening the ability of national health systems to achieve the United Nations Millennium Development Goals. The reason is that the health system functions of stewardship, regulation, organization, information provision, financing and delivery of services are the focal subjects of HPSR. Even the broader determinants directly affecting the health system are also considered within the purview of HPSR, such as social and economic policies affecting key health system structures and processes (Gonzalez-Block and Mills 2003; Green and Bennett 2007; AHPSR 2007). Thus, the need to enhance capacity for HPSR in developing countries cannot be overstated, in spite of the fact that HPSR has remained relatively neglected alongside its better established and resourced counterpart, biomedical research (AHPSR 2007). Green and Bennett (2007) have noted that "capacities to make critical choices for limited HPSR resources must be a primary concern of countries since it is axiomatic that capacity to direct the focus of HPSR is pivotal to shaping evidence-informed national health policies and systems."

If the gaps in evidence-based policy making must be bridged, then it is of fundamental importance to pursue a process of getting research into policy and practice. This goal is important, because – as identified by the policy makers in this study – failure to enhance the evidence-based health policy making process, especially as it affects healthcare delivery, can lead to poor/substandard health services delivery; hinder the achievement of health sector goals/targets; and lead to process/implementation failure, thus disrupting priority setting. However, because government

health officials and bureaucrats often lack the ability to translate policy challenges into demands in the health research agenda (van Kammen et al. 2006), it is therefore imperative that those who produce the research and those who use their work be encouraged to get together to define priorities, synthesize knowledge, commission research, learn from the findings and put them into practice (O'Neill and Nath 2005; Hanney et al. 2003).

One participant in this study suggested that "it is vital to establish processes that are capable of enhancing collaboration and networking among stakeholders in the health sector." Such a researcher–policy maker partnership has been described as a crucial element for promoting the use of health research for policy development, and has been used successfully in many developed countries (Innvær et al. 2002; Hanney et al. 2003; Campbell et al. 2009). Therefore, this partnership between researchers and decision-makers requires greater attention and consideration in developing countries, including Nigeria, where its potential utility has not been fully evaluated. Hyder and colleagues (2007) have observed that the process of translation of research outcomes into policies is a critical and yet under-studied process in most developing countries and as such, both informal and formal mechanisms used for such translation, and the types of people involved, especially in entities like health policy units, all merit consideration.

One significant observation made by the policy makers in this study was the non-involvement of health recipients in identifying and planning healthcare delivery needs. This is one of the major critical gaps in HPSR evidence use in policy making that is very common in developing countries. Hyder and colleagues (2007) have stated that health policy making is not complete if the focus is mainly on government and providers; community participation is a vital element that cannot be overlooked. At the conclusion of Forum 8 of the Global Forum for Health Research held in Mexico City, November 16–20, 2004, article 8 of the resolution stated as follows:

> Civil society, NGOs and communities must be involved in the governance, definition, generation and conduct of health research; in the application of the knowledge and technologies it provides; in monitoring progress and in maintaining the public debate about resources and priorities. (GFHR 2004)

To enhance the appreciation of research evidence and promote the process of its translation to health policy, it is imperative for developing countries to implement the Essential National Health Research concept of establishing multi-stakeholder triads, consisting of researchers, community members and policy makers, to jointly establish local health research agendas (Green and Bennett 2007). This approach is capable of enhancing the potential for translating needs analysis into demands, a vital step in the evidence-to-policy process, and also placing the focus on equity (including gender con-

sideration), social justice and the poor, as well as addressing social, economic, political, ethical and management dimensions important to public health and health systems in general (COHRED 2000).

One further point raised by our participants: Even when researchers collaborate with policy makers and other stakeholders (including community members) in health policy/research priority setting, the research must be relevant for the policy makers. The policy makers in this study noted that there is a dearth of research evidence that is relevant to their needs or tailored to the policy making process. As one participant observed: "There is [a] dearth of existing relevant research data." Decision-makers and managers want research that is relevant to real life and that can address prevailing needs, not results written up in esoteric language and published only in inaccessible journals (O'Neill and Nath 2005). Policy makers often argue that the constraints to use research include lack of understanding of health systems and policy processes on the part of researchers; research that fails to address the most pressing concerns of decision-makers; research reports that are difficult to read; and research results that are not timely (Choi et al. 2005; O'Neill and Nath 2005). The solutions to this problem are not simple. However, Choi and colleagues (2005) have suggested that

> if researchers and policymakers can fully recognize their incompatibility problems and promote successful experiences in the collaboration such as establishment of observatories on Health Systems and Policies and use of the knowledge brokerage mode, facilitators to the use of research by policymakers can be promoted while the barriers can be suppressed.

The policy makers in this study further emphasized improvement of staff incentives for research activities in policy making institutions; sustainable institutional capacity development through training of policy makers; provision of functional facilities, such as Internet access, to encourage research; and improving budgetary provision for research. These strategies have been shown to improve evidence-based policy making in developed countries (Green and Bennett 2007), and are therefore likely to produce better outcomes in the developing world.

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