Winter February 26, 2021

Knowledge translation platforms to support African evidence-informed policies: challenges and progress

Evidence & Policy • vol xx • no xx • 1–11 • © Policy Press 2021
Print ISSN 1744-2648 • Online ISSN 1744-2656 • https://doi.org/10.1332/174426421X16123456824061
Accepted for publication 02 February 2021 • First published online 26 February 2021

debate

Knowledge translation platforms to support African evidence-informed policies: challenges and progress

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Background: An effective health system that ensures availability and access to quality healthcare produces active human capital. Responsive health systems are the results of evidence-informed policy practice which is mostly seen in advanced countries. Deficiencies in most African health systems are due to the ineffective use of health research to reinforce public health policymaking.
Key points for discussion: This paper discusses the progress and challenges faced by Knowledge Translation Platforms (KTPs) in African evidence-informed policymaking among healthcare systems. Large gaps exist between research evidence and policymaking in Africa due to inefficiencies of the KTPs and the lack of political will to use sound ethical research outcomes to inform health policies. Activities of KTPs in Africa are most often curtailed by many obstacles, but not limited to the following; lack of infrastructure, human and financial capital, high turnover among top-level policymakers, and lack of collaboration between academia and industry.
Conclusions and implications: Evidence informed policymaking is crucial to the achievement of the health-related Sustainable Development Goals by 2030.

Key words knowledge translation platforms • evidence-informed policies • Africa • challenges and progress

Key messages

There is the need for effective translation of scientific knowledge into action where health systems could interrelate closely with health research organisations to create and use available evidence to ensure quality health outcomes in developing nations, including Africa. KTPs are essential players in making this a reality in Africa.

To cite this article: Adu, J., Gyamfi, S. and Martin-Yeboah, E. (2021) Knowledge translation platforms to support African evidence-informed policies: challenges and progress, *Evidence & Policy*, vol xx, no xx, 1–11, DOI: 10.1332/174426421X16123456824061

Background

Research-to-action is very critical in low-and middle-income countries (LMICs), in their quest to attain the Sustainable Development Goals (SDGs), but this seems to be scarce according to the extant literature. The worst-case scenario can be found in Africa, where few countries have knowledge translation platforms (KTPs) with many implementation difficulties (Kirigia et al, 2016). The inadequacy of KTPs together with the unresponsive health system in Africa have given rise to poor health outcomes in the sub-region, particularly maternal and infant mortality (Alvarez et al, 2009; Kalipeni et al, 2017) and mental health problems (Jenkins et al, 2011; Jack et al, 2014). KTPs are associations between policymakers, researchers, Civil Society Organizations (CSOs), and other key healthcare stakeholders established at the local and national-levels by the WHO's Evidence-Informed Policy Networks (EVIPNet) that facilitate the transfer of evidence-informed knowledge into policy and action. EVIPNet is a social network and a form of KTP composed of and led by individuals and institutions from around the world. Other forms of KTPs include: a virtual entity and web-based entity or a network that forms around a specific issue (for example, obesity, mental health) or events such as World AIDS Day or World TB Day (Kasonde and Campbell, 2012). KTPs can be inferred as organisations that do knowledge brokering and foster linkage and exchange to facilitate the transfer of research evidence into policy and action (El-Jardali et al, 2012; Stewart, 2015).

The extant literature is clear that knowledge translation (KT) is both a science and a practice, with an evolving body of data and theory that covers the research process from the formative stages through to implementation (Straus et al, 2013; Sibley et al, 2017). Mediators such as mentorship, experience, training in practice, information sessions, and webinars have been discovered as vital tools to promote activities involving KTPs worldwide (Sibley et al, 2017). For instance, Sibley et al (2017) underscored the need for researchers and practitioners to collaborate across all components of the KT process to bridge existing gaps between health research and practice to provide quality care to patients. There are different versions of KTPs. These include but not limited to the following: '(1) knowledge dissemination (2) communication (3) technology transfer (4) ethical context (5) knowledge management (6) knowledge utilization (7) two-way exchange between researchers and knowledge users (8) implementation research and (9) technology assessment' (CIHR, 2008: 4). It is evident that KTPs work in solving numerous problems around the world (Ongolo-Zogo et al, 2014; Berman et al, 2015; Sibley et al, 2017). Several evaluations of KTPs have pointed out their effectiveness in tackling complex public health problems through research-to-action activities (CIHR, 2008; Malla et al, 2018; Ongolo-Zogo et al, 2018).

There is evidence in the literature about the effectiveness of KTPs in Africa. Some of this evidence come in the form of policy briefs, capacity-building workshops, and policy dialogues, all of which constitute KT approaches that are examined in Africa (Edwards et al, 2019). Again, there is increasing evidence of regional and international partnerships that are ongoing in many countries to develop the capacity of the health systems towards building locally appropriate KT strategies, such as the EVIPNet in Malawi and Uganda (Ongolo-Zogo et al, 2014; Berman et al, 2015). These capacity-building efforts serve as useful learning opportunities for other settings, including how to strengthen local researchers and policy communities, promote collaboration,

and encourage the formation of KT support networks and the equitable distribution of knowledge (Edwards et al, 2019).

The creation of the Millennium Development Goals (MDGs), by the United Nations (UN) in 2000, set targets to bridge the gap between developed and developing nations, in response to economic development and improvement in health through disease prevention and wealth creation. The MDGs appear to influence the growing interest in KTPs among LMICs, including those in Africa; to hasten the implementation of the MDGs among member nations, and to ensure effective and efficient execution of stipulated programs aimed at achieving optimum results within specified time frames (WHO, 2005; Canadian Coalition for Global Health Research, 2010). For instance, in Africa, KTPs were considered agents of transformation that brought about understanding and approval of evidence-informed health system policymaking for capacity building through manpower training to ensure smooth implementation of the health-related MDGs within the stipulated period (Ongolo-Zogo et al, 2018). This has positive ripple effects on the SDGs which are continuation of the MDGs. Arguably, all the health-related MDGs are fully represented in goal 3 (good health and well-being) of the SDGs as targets with other related issues. The SDG 3 has nine targets whose attainments depend on responsive health systems that require evidence-informed policies (Buse and Hawkes, 2015). The success of the SDGs by 2030 seems to be contingent on the efforts of all individuals, making universal healthcare a vital concern to the developmental agenda. KTPs in Africa still need to partner the various health systems, Ministries of Health, and other CSOs to indirectly influence the enactment of pragmatic policies to possibly achieve the SDG 3 and other goals in the sub-region.

Since 2015, the WHO World report revealed that there have been about 12 countries in the African Continent with EVIPNet and other KTPs: Burkina Faso, Cameroon, Central African Republic, Ethiopia, Ghana, Malawi, Mali, Mozambique, Nigeria, Senegal, Uganda, and Zambia (Kirigia et al, 2016; WHO, 2016). These KTPs are faced with several problems in their line of activities. Various authorities including Abekah-Nkrumah et al (2018), Berman et al (2015), Kirigia et al (2016), and Orem et al (2013) have identified some key factors as challenges hindering the operations of KTPs in their quest to mediate the KT process (between knowledge creators (researchers), policymakers, and other knowledge users) in Africa.

From the extant literature, effective health systems are very crucial in reducing disease burden in every country. This is contingent on evidence-informed policymaking, which is scarce in Africa due to the lack of collaboration between researchers and policymakers, which could be a drawback in the Continent's quest to achieve the SDG targets. KTPs appear to be crucial in filling this gap.

KTPs in Africa have, however, had many implementation problems which are largely attributable to the lack of basic infrastructure to facilitate KT activities in all the countries that accepted the initiatives. Although KTPs have taken off in Africa, to ensure knowledge exchange, there is still a gap in the use of research evidence by policymakers (Berman et al, 2015; Abekah-Nkrumah et al, 2018). Moving forward, we discuss the challenges facing KTPs in the pursuit of evidence-informed policymaking in Africa, and further explore the progress of KTPs in the quest for evidence-informed policymaking in Africa.

Discussion

Challenges facing KTPs in evidence-informed policymaking in Africa

We identified the following as challenges confronting the work of KTPs in Africa: lack of human resources, gaps in infrastructure, high turnover among top-level policymakers in government, wider gaps between researchers and policymakers, and inadequate financial capital.

First, a lack of skilled human resources to undertake knowledge translation (KT) activities among local and national KTPs in Africa is a challenge. Human capital remains essential in the dissemination, exchange, and application of ethically sound evidence-informed knowledge to improve health systems in Africa, thereby bridging the existing gaps between knowledge creators and users. The existing literature mentioned the lack of common objectives and trust among researchers, policymakers, practitioners, and other knowledge users as reasons for the non-use of evidence for decision making (Choi et al, 2005; Kirigia et al, 2016). It is important for the workforce of KTPs to have the requisite intellectual abilities to convince policymakers and other stakeholders, such as medical practitioners, on the need to constantly engage with researchers and use research evidence, while developing healthcare policies. Individuals with these strategic marketing capabilities for knowledge brokering are difficult to come by within the continent of Africa and, more to the point, little is known about knowledge brokering strategy in the Africa setting (Dagenais et al, 2015). This could mean that KTPs may have to recruit workers who have no knowledge of the activities of KTPs and retrain them, which could delay their scheme of actions and lead to more pressure on the already limited finances. Another reason for the difficulty in finding requisite personnel for KTP jobs could be the absence of partnerships between academic institutions and industries in Africa. A collaborative working relationship between KTPs within Africa and African universities could give them some trained staff to start with, while taking steps to recruit and train their own staff without much effect on their limited funds.

Secondly, gaps in infrastructure have been pointed out as one of the setbacks in the work of KTPs in Africa (Ehlers, 2014; El-Jardali et al, 2014). There is limited development of infrastructure (in relation to buildings, computers and accessories, and functional internet connectivity, among others). We must admit, however, that the development of infrastructure is capital-intensive, which could increase institutions' financial burden and delay the plan of activities outlined within a given period. For example, activities of KTPs cannot be done within an environment where there is a lack of functional internet connectivity to liaise with knowledge creators and policymakers. Whereas network infrastructures in the developed world, including Canada, Japan, Germany and the UK, in transportation and communication technologies appear as public goods and are easily available, functional networks are difficult to acquire in Africa due to erratic power supply and the lack of internet infrastructure in many parts of the continent.

Thirdly, the high turnover among top-level policymakers in government, and resistance to change regarding the use of evidence-informed knowledge for decision making, have also been mentioned as important factors that impact negatively on the work of KTPs in Africa (Lavis et al, 2006; El-Jardali et al, 2014). Some political systems in Africa seemingly give more discretionary powers for sitting presidents to appoint and reshuffle heads of institutions and ministers. As a result, high layoffs among

stakeholders in managerial positions within governments have been noted in the past three decades. The continuous turnover of high-profile personnel in government, including policymakers, makes it difficult for KTPs to have firm grounding and to draw relevant support from stakeholders, who share in the values of evidence-informed decision making and the use of ethically sound research outcomes to inform policies that govern practice. Considering that KTPs are agents of change that can adopt evidence-informed health system policy to improve health outcomes, their successes depend on the ability to constantly dialogue with top stakeholders through collaborative networking to share ideas on research evidence (Ongolo-Zogo et al, 2018). The breakdown of networks as a consequence of government reshuffles could result in the loss of gains made previously when starting afresh with new government appointees: a situation that is very common in Africa. This often happens because researchers and policymakers have diverse opinions on what constitutes evidence (McQueen, 2001), hence KTP operatives in most parts of Africa spend time to dialogue with a policymaker to gain their attention and acceptance. Government resistance to change appears to downplay the catalytic role of KTPs in bringing together researchers and policymakers to deliberate on the utilization of right science to inform policies, particularly in the health sector. Even where they agree with the evidence made available to them, most governments find it comfortable to commit to short-term developmental projects compared to long-term programmes to satisfy the populace while in power. Policymakers, in this sense, respond to what is known as political rationality, while researchers deal with scientific rationality (Lin and Gibson, 2003). The bone of contention here is that policymakers and governments view the process of obtaining scientific evidence as one that is very long and complex to comprehend within the shortest possible time, given the four-year tenure most democracies in Africa practice. This appears to suggest that some governments face difficulties in linking up with researchers within the field of academia to find lasting solutions to preventable health issues that are confronting the masses. Nevertheless, if researchers collaborate with KTPs to produce high-quality evidence with viable recommendations and policy options, attention might be received if discussions are made with the right policymakers and stakeholders.

Fourthly, experts have reported that there is a wide gap between researchers and policymakers; which often results in differences of opinion between the two in most parts of Africa (Kirigia et al, 2016; Abekah-Nkrumah et al, 2018). This has created a lack of partnerships between academic institutions, researchers, and policymakers in Africa, making it difficult for KTPs to dialogue and collaborate with various stakeholder groups on the use of evidence to inform health policies (Orem et al, 2013). Undoubtedly, partnerships maintained through organised platforms for interaction among stakeholders, (policymakers) from the formative stages of a research agenda to the implementation of recommendations, is a laudable approach to evidence-informed policy. This implies that the collaboration of researchers and policymakers forms the basis for evidence-informed policymaking that seeks to find pragmatic solutions to health systems' problems in Africa.

The creation of innovative ideas through research has been identified as a critical tool for the advancement in healthcare delivery and strengthening of health systems (CIHR, 2008; Kirigia et al, 2016). Partnerships bring about appreciation, mutual trust and respect among key stakeholders which could result in long-lasting networking (Woelk et al, 2009; Malla et al, 2018). A case in point is a study that reports on how

a team of international researchers, local researchers, health practitioners (academic-obstetricians), and policymakers from three South African countries (Zimbabwe, Mozambique, and South Africa), worked together to draft and implement a policy on the use of Magnesium Sulphate to prevent Eclampsia-related deaths among pregnant women (Woelk et al, 2009). The South African example is the kind of research-to-action approach that policymakers and researchers in Africa could adopt to pave the way for the utilisation of evidence-informed policymaking to strengthen health systems and address health challenges facing the continent. It will be a great achievement to see established structures within academic institutions in Africa collaborating with various KTPs to constantly engage with the research community and policymakers on policy-related issues and to ensure unity of purpose, moving forward.

Lastly, financial capital has been cited as another important factor that impedes the activities of KTPs in the African continent. The absence of governmental support in the activities of KTPs indicates that all finances are footed by KT institutions themselves. Most KTPs, therefore, depend on international agencies for funds to undertake their respective operations (El-Jardali et al, 2014; Kirigia et al, 2016). For instance, a study in Africa observed that 'lack of long-term funding means that efforts are focused on looking for funding instead of focusing on implementing activities effectively' (El-Jardali et al, 2014: 9). So far, it appears continued financial support is key to the sustainability of KTPs set up in Africa, since lack of funding could eventually render the institutions non-functional. Despite this presumption, it must be emphasised that some KTPs in Africa are housed within the Ministry of Health and universities, therefore, they receive support from government through the Ministry of Health and various academic institutions (Berman et al, 2015). These KTPs include E2P Nigeria-University EVIPNet, Burkina Faso-Ministry of Health, EVIPNet Cameroon-Hospital EVIPNet, Central African Republic-University EVIPNet Ethiopia, Sudan KTP-Ministry of Health, and Malawi- Ministry of Health (El-Jardali et al, 2014).

The progress of KTPs in Africa

Despite the many challenges connected with the activities of KTPs in Africa, some progress has been made. As of 2015, there were about 12 KTPs across Africa, and each of them has since been working hard to influence policymaking decisions within their respective countries. Notwithstanding the challenges in patronage of KTPs, the training of KTP staff, leadership, funding for KTPs, and availability of robust evaluation methods and tools for KTPs, appear to be making some progress in their respective locations through the assistance and guidelines of EVIPnet Africa (AFIDEP, 2019). EVIPNet has made pragmatic efforts in building the capacities of KT institutions through various workshops to train them on policy briefs. The first edition focused on grounding and planning for policy evaluation and briefs, while the second focused on developing and planning appraisals for nationwide policy discourses. This series of workshops has contributed towards the fight against diseases such as malaria in Africa, with the use of artemisinin-based combination therapies for treating uncomplicated falciparum malaria (Lavis et al, 2009; Lavis and Panisset, 2010). Again, these policy briefs have, by extension, contributed to the dialogue on health systems' provisions that are cost-effective and geared towards the prevention of diseases (Lavis et al,

2009). For instance, it is reported that an exclusive partnership between Dignitas International, a medical and research NGO, and the Malawi Ministry of Health, has been established in order to enable KTP Malawi to collaborate with national-level policymakers and researchers in co-creating and utilising health-sector research that could better inform policy decisions (Berman et al, 2015).

Again, it is documented that EVIPNet Cameroon and REACH-PI Uganda have positively affected policy decisions through their engagement with various interest groups at the local and national levels. Such healthy engagements bring about exchange of information and distinct ideas that strengthen evidence-informed stakeholder dialogues, aimed at diagnosing health system problems to offer practical and affordable options for achieving major health goals such as the MDGs (Ongolo-Zogo et al, 2014; 2018). The work of EVIPNet Cameroon and REACH-PI Uganda have promoted a policy learning environment that helps to deal with policy-related issues required to strengthen the weak health systems in the two countries. KTPs in Cameroon and Uganda produced 12 evidence policy briefs between 2008 and 2012, as well as 10 policy dialogues, that were necessitated by the evidence briefs (Ongolo-Zogo et al, 2014). The activities of both KTPs impacted immensely on the development and testing of new resources and tools for evidence-informed health system policies. That said, the Health Policy Advisory Committee (HPAC), established in Nigeria through the Alliance for Health Policy and Systems Research of the WHO, undertook similar activities to those in Uganda and Cameroon, to bridge the gap between researchers and policymakers. The HPAC consists of 18 members, including top managers from the Nigerian Ministry of Health and researchers from Nigerian universities, executive directors from NGOs, and the MDGs' state focal person (Uneke et al, 2015). In an attempt to ensure capacity building of stakeholders in evidence-informed policymaking, the members were made to undertake three months of certificate training on Health Policy and Health Systems at the Ebonyi State University in Nigeria. The HPAC had a good working relationship after the training, and produced various policy briefs and dialogues on high-priority health issues that contributed to progress made towards the achievement of the health-related MDGs in Nigeria. The policy briefs and dialogues further serve as a useful guide for health-related policies in Nigeria and Africa at large, while HPAC continues to improve and extend their scope of activities to promote evidence-informed health system policies.

Furthermore, activities of KTPs in Africa have contributed to global research through publications of policy briefs and other peer-reviewed journal articles on evidence-informed policymaking or evidence-informed health system policy (Lavis et al, 2009; Lavis and Panisset, 2010; Uneke et al, 2015; Ongolo-Zogo et al, 2018). Though limited in number, KTPs in Africa have been able to create some level of awareness on the essence of policy dialogue between researchers, policymakers, and other stakeholders to strengthen health systems while indirectly improving health outcomes (El-Jardali et al, 2014; Berman et al, 2015). Partnership between some KTPs and government institutions, such as the Ministry of Health and academic institutions, have also fortified the working relationship among researchers and policymakers. This, in turn, deepens the trust between them, and paves the way for the exchange of information and ideas through the KTPs. Sustainability of funding has often been cited as a major problem for KTPs in Africa, especially those which are funded by international partners, compared to those who are fortunate to be in partnership with national institutions (AFIDEP, 2019). The success stories and lessons learned

by KTPs affiliated with national health systems and academic institutions could be shared among African leaders at regional fora, such as the Africa Union annual meetings, for other nations to emulate. The adoption of KTPs in close partnership with national institutions in Africa could be the springboard for improving the ailing public health systems that are mandated to prevent illness and improve health. This way, the growing disease burden in the continent will stall, while reducing the high premature deaths among the population.

It is worth noting that the successful implantation of KTPs in Africa thrives on the strong commitment of international partners for financial support, co-creation and utilisation of health-sector research to inform policy decisions, and capacity building through workshops, cheap labour, availability of quality research relevant to local contexts from partnered local universities, credibility, and the availability of technical supports. Credibility herein is strongly connected to trust between researchers and policymakers in decision making (Edwards et al, 2019). Other drivers included robust institutional ties and networks that bring partnerships and collaborations to bear, especially KTPs sheltered within the various Ministries of Health and universities on the continent, such as E2P Nigeria-University EVIPNet, Burkina Faso-Ministry of Health, Malawi-Ministry of Health (El-Jardali et al, 2014).

Conclusions and implications of the piece

The uptake of evidence-informed policymaking is crucial to improving health systems in Africa to curtail the numerous health challenges facing the continent. Evidence-informed health-system policy demands proactive collaboration between academia and industry (policymakers and other stakeholders) to close the existing gap identified in the literature. Vibrant KTPs are needed to mediate between researchers and policymakers for exchange and application of ethically sound evidence-informed knowledge to inform policies. This is achievable in Africa, but very few of these KTPs are currently established and functional in Africa. There are several challenges hampering the activities of these KTPs, due to the lack of enabling environments for sustainability, and the absence of partnerships with academic and other governmental institutions. Despite the challenges, KTPs are doing well in their capacity to bridge the gap between researchers and policymakers, offering clearly defined options to problems that require urgent informed decision making. The KTPs that are in partnership with the Ministry of Health have influenced health-related policies to make their respective health systems more responsive. The implementation of KTPs throughout Africa can serve as a valuable platform to encourage evidence-informed policymaking to support and promote the attainment of the health-related SDGs by 2030. It is, therefore, imperative for African governments and CSOs to endorse the activities of KTPs and support them to partner institutions towards effective collaboration that informs policy change.

The prospects of KTPs in Africa are very high, but their eventual success may depend on the willingness of researchers and policymakers to open up and partner with them. This way, KTPs may contribute effectively towards the developmental agenda of building responsive health systems with evidence-informed research to inform policies. It is obvious that effective KTPs are key to improving and sustaining functional health systems in Africa, through evidence-informed policy formulation to help curb the myriad health challenges facing the continent. The successful transfer of

research evidence into implementable knowledge requires three things: political will of successive governments; proactive collaboration between academia and industry; and the sustainability of functional KTPs in Africa. All in all, the availability of human and financial capital is crucial in ensuring research-to-action in Africa.

Acknowledgements
The Authors wish to express their deepest gratitude to Anita Kothari and Abe Oudshoorn of the Western University for their initial thoughts and comments on our earlier draft.

Research ethics statement
The Authors of this paper have declared that research ethics approval was not required since the paper does not present or draw directly on data/findings from empirical research.

Contributor statement
JA conceptualised and prepared the initial draft of the manuscript.
SG and EMY made substantive changes to the manuscript.
JA, SG, and EMY participated in the final preparation of the manuscript.

Conflict of interest statement
The Authors declare that there is no conflict of interest.

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