# Strengthening health systems through linking research evidence to health policy in sub-Saharan Africa

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## Abstract

**Background:** Getting research evidence into policy in many countries in sub-Saharan Africa remains a very challenging task and huge gaps still exist between health policy makers and researchers.The health systems performance in these countries has been described as grossly sub-optimal due to increased burden of underdevelopment, political instability, weak institutions, inadequately developed social sectors, scarcity of resources and marked social inequalities.
**Methods:** Via broad criteria the authors made the review as inclusive as possible and online search engines and databases including EMBASE, Google Scholar, Medline, SCIRUS and PUBMED were searched over a period of three months. Key words used to generate articles that fit the review topic included Evidence,Sub-Saharan Africa,Health Policy,and Health Systems.
**Results:** All the included studies revealed the need to link evidence to health policy in order to enhance the performance of health systems in the sub-Saharan African region.
**Conclusion:** Current efforts geared towards strengthening health systems in order to achieve universal and equitable access to health care and improve the quality of health care delivery across the region can only come to bear if health care resources are used wisely through decisions and actions from evidenced-informed policies. Accordingly, a critical way of addressing these challenges facing health systems in the region is through the linking of health research findings to policy.

**Keywords:** Evidence; Sub-Saharan Africa; Health Policy; Health Systems

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## Introduction

Health systems in sub-Saharan Africa face a number of challenges including, poor healthcare financing, poor capacity development, poorly developed health information systems, poor public demand and inadequate utilization of health service facilities.[1] As it were, current efforts geared towards strengthening health systems in order to achieve universal and equitable access to health care and improve the quality of health care delivery across the region cannot come to bear if health care resources are not utilised wisely through evidenced-informed decisions and actions.[2] Accordingly, a critical way of addressing these challenges facing health systems in the region is through the linking of health research findings to policy. Although, the recognition of the importance of using available research evidence to inform health policymaking is a recent development in most developing countries such as those in the sub-Saharan African region[3,4], convincing reports from numerous studies in other regions of the world indicate that evidence from research enhances health policy development.[5-8] This is because evidence-informed health policymaking is characterised by the systematic and transparent access to, and appraisal of evidence as an input into the policymaking process.[9]

In spite of the recognition of the value of research evidence in policymaking, the obvious is that health policies are often not well-informed by scientific evidence across the region.[10-13] Interestingly, the growing global concern in making better use of research evidence in decisions related to health culminated in drawing the attention of the international community by the World Health Organization's (WHO) Ad Hoc Committee on Health Research[14] to the concept of health policy and systems research (HPSR) which identified lack of HPSR as a key problem impeding the improvement of health outcomes in low- and middle-income countries including those of this region.[14] Following the committee's recommendations, the Alliance for Health Policy and Systems Research (AHPSR), an international collaboration based in WHO Geneva, was established, aiming to promote the

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generation and use of HPSR as a means to improving the health systems of developing countries. [15,16] Its aims were necessitated by the discovery that only five percent of global spending on health research went to problems affecting the poorest ninety-three percent of the world's people, known as the "10/90 gap". [17] The World Health Report on Knowledge for Better Health in 2004, focused on linking research evidence to policy.[18] Equally, two subsequent international meetings were held in Mexico City in 2004 and Bamako in 2008 which among other issues, emphasized on the importance of research for strengthening health systems and improving health care delivery, promoting 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. [19,20]The World Health Organization vigorously supports the process of contextualizing evidence and translating it into policy through the utility of policy research in developing regions, including sub-Saharan Africa.[21] However, capacity constraints at different levels are perceived to be major impediments in the use of evidence in health policy making in most countries in sub-Saharan Africa.[22] There is also the dearth of information on the status of evidence use in policy making at the individual and institutional levels in the region. The key challenge now in public health systems in the region is how to better contextualize evidence for more effective policy making and practice.

**Policy Development Process in Sub-Saharan Africa**

There is no doubt that scientific evidence is needful in decision making for health systems and health care delivery in sub-Saharan Africa. However, policy-making as it were is a non-straight process in which scientific evidence is only one of its many inputs. The policy-making process has been described as a slippery interaction between 'four $I_s$':institutions (structures and the rules shaping decisions), interests (the individuals or groups who stand to gain or lose from a policy), incidents (external events that can shape policy) and ideas (the evidence).[23,24]Additionally, it has also been acknowledged that health policymaking is influenced by other legitimate factors which could be social, electoral, ethical, cultural, and economic.[25]

Policy decisions are often made more on the basis of political ideology, structural and situational contextual factors, cost savings as opposed to cost effectiveness, pressure from interest groups and media attention than research evidence. [26,27]One of the major factors responsible for the problem of translating research evidence into policy is the huge gap existing between researchers and policy makers.[28]Research evidence rarely gets into policy as researchers and policy makers appear to lead separate lives, "travelling in parallel universes." Furthermore, most researchers in developing countries lack the knowledge of the policy making process and are producing research evidence that is irrelevant to the policy making process and even when policy relevant evidence is produced they are often inaccessible to policy makers.[26,27]Moreso, health policy needs neither drives nor determine the research priority setting process, thus there is lack of ownership of health research agenda by policy makers and other major stakeholders in the health sector.[29]The more the process is understood, the greater the ability to incorporate research findings in policy. This is true both for the researchers and the policymakers.

**Evidence and Policy: The Divide**

Ensuring continuity or change of a practice via health policy will inherently bring about the needed transformation in health care delivery.[30] The challenge facing many health systems in sub-Saharan Africa is the under utilization of evidence from research to drive health policy-making.[2,10] Although, research evidence as it were has been employed elsewhere to influence policy in health systems and international development; however, the under-utilization of available cutting-edge knowledge by those making decisions puzzles academiciansand applied researchers alike in sub-Saharan Africa, clearly showing that research is often ignored and creates a disconnect between policy and evidence.[18] It could be said that a growing list of factors responsible for this divide includes: inadequate supply of and access to relevant information, researchers' poor comprehension of policy process and unrealistic recommendations, ineffective communication of research, ignorance or anti-intellectualism of politicians or bureaucrats, inadequate capacity among policy makers, politicisation of research by using it selectively to legitimise decisions, gaps in understanding between researchers and policy makers and the public, time lag between dissemination of research and impact on policy, as well as research being deemed unimportant or censored and controlled.[30]However,there are cases where evidence from research seamlessly assisted policy-makers, but for the most part it is patchy and unsatisfactory. For instance, there is high-quality evidence showing that magnesium sulphate, a low-cost drug, is effective for the treatment of eclampsia and pre-eclampsia[31,32] and as expected its use will be wide spread in most settings in the region, but on the contrary the drug is still not yet widely used in many settings in sub-Saharan Africa.[33,34]This is because there are policy failures in the registration, procurement, and distribution mechanisms for magnesium sulphate and this has contributed to its poor availability.[33] Besides, health policies have failed to address the lack of guidelines mandating the use of such drugs, failure to include it on lists of essential drugs, and failure to implement existing guidelines have been critical policy

short comings seen in many settings in countries in the region.[34]

***Credibility and communication:*** While it could be said that researchaims to investigate, learn and produce knowledge by gathering information,[30] the sources and the conveyors of the information may be as influential as the content itself. For instance, in settings in the region people will only accept information from sources they can trust. Based on this contextual issue, it could be said that attempts that are made in investigating the impact of research findings locally can raise questions about the credibility of the research evidence (how it was gathered, by whom, whether it was perceived as accurate and how it was communicated to policy makers). Some authors have suggested that the effectiveness of many interventions in improving health in most poor populations in the developing world "remains the subject of doubt and criticism."[35]

Equally, as credibility of evidence and communication are critical issues in linking policy and evidence in settings in the region, it is crucial to state that the way the evidence is presented particularly to policy makers as well as the general public also matters.[30]Accordingly,health policy makers are not empty slates on which it is possible to write new knowledge merely by making it available. What is critical is how exactly information flows, is received, digested and acted upon. A school of thought has identified two processes in this regards: **'snowballs'** (the accumulation of research impacts within policy elites) and **'whispers'** (the reinterpretation of research findings in broader constituencies).[36]There is the possibility that the take-home messages from scientific evidence are often presented to policymakers in an overly complex, confusing manner; the result, which may make "policymakers hear noise instead of music".[37] Besides policy makers and consumers of health care delivery may have their own perceptions which create a gap while trying to link evidence to policy or further still implement such. Sometimes even when information generated from the evidence is well presented, it could also be that it is not relevant to the public health priorities facing policymakers.[38] A good example shows that even when the evidence in support of an intervention is **'high quality'** and has been disseminated to the relevant policymakers, utilization of the evidence may still not be prioritised as seen from strong evidence for the benefits of cotrimoxazole prophylaxis in people with HIV.[39]

**Other Issues:**
Besides the afore mentioned challenges, researchers and policy makers alike are faced with a co-existent of other issues which includes fierce competition between independent bodies and researchers amongst others. As it were, competition for funding tends to pose a problem to linking research to policy as competition in itself could discourage academic researchers, policy makers, health organizations from collaborative research.[40] These issues do come to bear in the synthesis of research evidence. Anecdotal reports have it that often different academic disciplines do compete and sometimes undermine each other for funds for research purposes. Furthermore, there are pressures that affect almost all policy makers (health policy makers inclusive) and this is due to **organisational rules** about how power bases are established. This term is referred to as **'giantism'**.[30] This issue is a common occurrence in settings in the region both in governmental and non-governmental health agencies where more attention is given to projects worth more sums in capital and or recurrent expenditure rather than on evidenced-based findings. The import here is that researchers and policy makers alike in the region will be partly drawn towards large-scale projects to improve their own **''relevance''**. On the contrary health policy researchers emphasizing the need for "smaller" projects that respond to local problems and solutions may meet the barrier of giantism.

**Bridging The Gap**
As health policy processes necessitates not only an understanding of the dynamics of decision-making and its implementation, but also more complex underlying practices of policy framing, an exploration of the research to policy interface becomes more challenging in the developing world particularly in sub-Saharan Africa. While research evidence is more likely to contribute to evidenced-based policy making in the region, this will only come to bear if it fits within the political and institutional **limits** and **resonates** with the ideological assumptions of policy makers with sufficient pressure being exerted to challenge any impediments. Addressing this challenge will require three steps that are based on evidence.[41]

***i) Recognizing the politicization and complexity of Policy:***
Evidence shows that policy making is a process in which decisions are taken by those with authority and responsibility for an area of interest.[15] The import being that it sets the platform for policy to proceed through a set of stages from understanding the nature of the problem, to exploring options, weighing the benefits and costs, making rational choices on best options and implantation, possibly squealed by evaluation. Accordingly, 'evidence' may be called upon at any or all of these stages.[41] Equally, there is the need to take into cognizance that policy-making is complex as it tends to take place at multiple levels- from regional to national and then to district or local level. It also follows that, implementing policies occurs at multiple

levels and requires much discretion and negotiation at all levels. As it were, the perceptions of different officials (both governmental and non-governmental) at various tiers are of significant consideration. Bureaucrats and policy makers at the regional and national levels in many instances are often influenced by forward-looking policy debates, projections of future developments, and international experiences.[1] On the other hand, sub-national officials often tend to respond to local constraints and support local innovations, while being skeptical of the relevance of ideas from the top.[1] These bother on the synthesis of policy and calls for a clear need to understand how evidence can influence decision making at each of these levels and in addition how the levels interact with each other.[41]

***ii) Engaging key stakeholders:***
A number of key actors who should be considered in health policy formation include the health providers, researchers, and the community. As it were, there is now the increasing realization within the community of researchers and decision makers that scientific evidence can improve management decisions and performance of national health systems.[18]Although this is now the bearing for health systems strengthening, there is the dearth of scientific knowledge on mechanisms to promote such engagement and their level of success, particularly in developing countries, many of which are in sub-Saharan Africa. Research synthesis or the existence of valid evidence does not guarantee its input into the policy development process unless key decision makers are appropriately engaged.[18]This implies that the process of making research findings into pro-policy information is crucial and it needs the right types of people, especially in entities like the health sector. More so, there is the need to understand how policy makers view scientific evidence and what propels them to link evidence to policy. Accepting this would mean that researchers can contribute to framing policy issues by defining what evidence can be synthesized and its policy significance; while policy makers can help in framing scientific enquiry by defining pertinent areas for investigation.[42]Furthermore, in many situations during the process of policy making, the stakeholder group often neglected is the community- the beneficiaries of the health system. Health policy synthesis cannot be complete if attention is given solely to the government and health care providers and community participation is overlooked. In the same way, scrutinizing how policy makers and researchers in sub-Saharan African countries currently place the role of such approaches, or how communities view the national policy making process, is a research issue. Likewise, exploring how communities affect health policy making and its implementation, may prove particularly enlightening.[41]

***iii) Enhancing accountability:***
The role of measuring and evaluating accountability in policy proposals and implementation warrants careful analysis. Not much could be said about this in the region as information about health policy accountability is lacking. Importantly is the need to promote equity analysis in the research-policy interface, as this may include research on the response of the health system to the needs of the poor or specific groups of interest.[43] A more explicit understanding of the role of civil society organizations who often represents the interests of vulnerable groups and the sources of knowledge used is needful. Not to be left out is the human rights dimensions of research for health policy, and this cannot be ignored or underestimated.[44] Needless to say that health policies have an undoubted impact on human rights particularly the most vulnerable as well as main stream populations. In all, as researchers and policy makers share particular kinds of networks and develop chains of legitimacy for particular policy areas, outputs of research evidence should be based on a holistic involvement, while credible evidence should be communicated via the most appropriate communicators and timing.

## Conclusion
Current efforts geared towards strengthening health systems in order to achieve universal and equitable access to health care and improve the quality of health care delivery across the region can only come to bear if health care resources are used wisely through decisions and actions from evidenced-informed policies. Efforts need to be intensified to enhance the competence of policy makers in the region to adopt an evidence-informed process in health policy formulation and inputs from the public must be given adequate consideration in the policy making process. Furthermore, health policy needs should be made to drive or determine the research priority setting process via fostering of health policy maker-researcher forums and creating the enabling environment for researchers to generate evidence through grants.

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