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COMPLEXITIES OF KNOWLEDGE TRANSLATION:

Reflections from REACH-PI Uganda's
rapid response mechanism

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ABSTRACT

Two decades ago, in 1997, the International Development Research Centre (IDRC) partnered with researchers in East Africa to explore and promote the concept of knowledge translation (KT) in low- and middle-income countries (LMICs). This chapter, informed by practical experiences, focuses on the complexities of practising effective KT in LMICs and unconventional approaches to mitigating challenges encountered. Critical to the lessons learned was an understanding that effective KT often requires individual and institutional cultural and behavioural changes. This therefore begs for sustained investment and long-term relationships between the funders, the producers, the brokers, and the users of evidence, among other things. The chapter argues that for effective KT, there is a need for advocacy, long-term investment and explicit support for KT science and mechanisms from all key stakeholders as part of research for development, coupled with an understanding of the local contexts, roles for partnerships and networks, and ensuring quality processes. Furthermore, the usual or conventional approaches to the challenges this introduces are necessary but may not be sufficient to move evidence into policy and practice.

KEYWORDS

knowledge translation, Uganda, rapid response mechanism, community health, East Africa, REACH-PI.

BIOGRAPHIES

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1.1 KNOWLEDGE TRANSLATION

Research has the potential to drive national development. Many low- or middle-income countries (LMICs) have progressed to middle- or high-income status respectively partly as a result of their sustained significant investments in research and use of research for development (Nicolaidis 2014; OECD 2012). Research not used represents wasted resources (Chalmers *et al.* 2014). Increasingly in the last 20 years there have been unprecedented efforts promoting the use of research evidence in policy- and decision-making for health systems (WHO 2005, 2008). One such example results from the Tanzanian Essential Health Intervention Project (TEHIP), which showed that the allocation of health resources guided by evidence generated in the health system led to marked improvements in health outcomes at low cost (de Savigny *et al.* 2004). Other countries such as Ghana and Nigeria are adapting and scaling up the TEHIP experiences and approaches (Awoonor-Williams 2013; IDRC 2014), emphasising the generation and use of evidence on what works and how to make it work in different contexts.

In 2005, building on the TEHIP experience and with external funding mainly from Canada's International Development Research Centre (IDRC), a funder of research for development, the Regional East African Community Health Policy Initiative (REACH-PI), a knowledge translation (KT) platform, was created in an effort to support effective KT in Burundi, Kenya, Rwanda, Tanzania and Uganda (East African Community Health Sector *n.d.*).¹

2.1 REACH VISION

The REACH-PI Uganda country node based at Makerere University was formed with the aim of acting as an institutional knowledge broker, bridging the gap between producers and users of research, addressing barriers identified in the KT process (Lavis *et al.* 2005; Oliver *et al.* 2014). It has been at the forefront of testing and evaluating mechanisms and tools to improve the uptake of research into policy and action (Mijumbi *et al.* 2014).² This includes the appropriate design and structural content of policy briefs and engagement, systematic and rapid reviews, and rapid response services.

3.1 EXPERIENCE WITH A RAPID RESPONSE MECHANISM

The use of the various KT tools and mechanisms has resulted in varied levels of success for effective KT in different contexts and circumstances. One of the KT strategies tested by REACH-PI Uganda to address issues of timeliness and relevance of evidence and to improve its uptake is a rapid response mechanism (RRM) aimed at providing policy- and decision-makers with relevant research evidence to support decisions, policies and action in a timely manner.

The policy- or decision-makers in government, parliament, non-governmental organisations, civil society or the media who urgently need to communicate on a key issue are central to the RRM process. The process is as follows:

1. Evidence users pose a question or questions to REACH-PI Uganda regarding a key challenge on which evidence is urgently required within days or weeks.
2. This causes the RRM to begin a cascade of processes that should lead to identifying high-quality and appropriate local and global evidence, synthesising it efficiently and getting it peer reviewed and packaged for the policymaker or decision-maker in an easily understood manner.

The mechanism has had the intended influence on national health policymaking in Uganda. For example, the RRM was instrumental in providing synthesised evidence to support the policymaking process of the current mandatory food fortification policy enacted in the country in 2011. The RRM is now being piloted and scaled up in other countries (Burkina Faso, Cameroon, Malawi, Zambia, Lebanon, Brazil and Canada) (Mijumbi *et al.* 2016), which will increase our understanding of the conditions under which the mechanism catalyses the use of evidence in decision-making.

With RRM, researchers on the REACH-PI platform are introducing evidence on the functionality and success of RRM in LMICs (Mijumbi *et al.* 2014). However, this raises a larger question – does the RRM have an impact on development process at all? One wonders whether, aside from impacts on decisions made in ‘urgent situations’ and contributions to smaller decisions within the longer policy processes, RRM might be a way in which research entrepreneurs influence policymakers to demand more research for decisions. In this regard policymakers may not only demand research relevant to them but also develop and institutionalise a culture and behaviour that demands evidence generally. This is a change that may start with individuals but when sustained would become an institutional and societal norm. When policymakers greatly value the RRM because it helps them out of critically urgent situations, they will be more likely to be very strong advocates for allocation of resources required for research and speak for the need to have evidence inform all important decisions and policies.

This mechanism continues to get major support from IDRC through KT-specific projects with a long-term commitment to strengthen individual and institutional capacity of producers and users of evidence as well as support their behavioural change for sustained and at-scale implementation of KT mechanisms. Concurrently, efforts are deployed to mainstream ongoing engagement between researchers and policymakers as part of the entire research process while continuing to invest in understanding the drivers of effective KT and the development of tools and methods to support it.

4.1 KEY CONSIDERATIONS

Several questions remain in the midst of what has so far been a successful and promising intervention to improve timeliness of access to research evidence for development. Several countries involved in piloting and scaling up RRM are fully aware of the need to institutionalise these mechanisms but grapple with how best to do it. Part of this institutionalisation is deciding on the appropriate location. So far, the RRM being piloted in the above-mentioned countries are located in different places including academic institutions, departments or ministries of health, and semi-autonomous or non-governmental institutions. Health system researchers are yet to articulate how the different locations affect policymakers' use of the RRM. Aspects such as location affect trust and perceived credibility of the mechanism, which are vital for its functionality.

Resources for many of these mechanisms are indeed another point of concern. It requires adequate sustained and committed domestic (national) investment supplemented by external investments to do several things. These include growing a sustained pool of human and financial resources. Furthermore, they include growing a sustained capacity of policymakers to engage meaningfully and have a great national and/or regional sense of ownership of the KT process. Whereas external funding to get such an initiative started and showing results is critical, LMICs need to start investing significantly their own resources to bridge the gap in research capacity, generate relevant knowledge and stimulate the use of research evidence including data generated from health systems.

Although LMICs need sustained long-term external funding there needs to be recognition that it is not always easy for donors to make commitments because of their own country's different and changing interests and obligations. It is desirable that there should be a gradual increase in domestic investments that run parallel to the improvements in the country's economy. In addition to external funding, LMICs need to consider investing early in research and knowledge as the drivers of sustained economic development. It is clear from several experiences that without sustained external funding to LMICs many promising projects fizzle away and are not scaled up (de Jongh *et al.* 2014). In addition, it should be emphasised that these resources and support are targeted not only towards the technical features of KT alone but also towards the often poorly defined non-technical aspects that ensure changes in the general climate of KT, in behaviour and attitudes through building trust and relationships to facilitate the technical KT aspects. Behaviour change that is necessary for the adoption of KT takes time and steady commitment to take root.

Strategic partnerships both North–South and South–South are essential. The former brings on board among other things the much-needed technical expertise and benefits from bi-directional learning. The South learns from Northern experiences while the North also learns from the South. Indeed with RRM the North has learned and adopted some RRM experiences from Uganda.³ Different partners may be able to provide different resources

at different times. For example, REACH-PI began with the IDRC as one of its funding partners. When the RRM was being piloted, the European Union was a major funding partner; however, IDRC continued its support to REACH-PI through its continued funding for the Evidence-Informed Policy Network (EVIPNet), and for the establishment of the Africa Center for Systematic Reviews and Knowledge Translation and the Research Chair in Evidence-Informed Health Policies and Systems both at Makerere University, Uganda. To ensure scale-up of the piloted RRM, IDRC is also providing support to the REACH team to collaborate with KT teams in Lebanon and Zambia as well. There have also been non-funding partners providing or improving different factors necessary for success and efficiency. For example, partnerships also play a vital role in the peer review processes for the RRM, as it is difficult to get all expertise on any subject in one institution or one LMIC.

Quality assurance in what RRM do, managing the expectations of potential users, and the capacity to deliver quality results, will be a deciding factor for their survival and how they become embraced in their respective countries. Since RRM's work is in the context of rapidity in a bid to meet urgent needs for research evidence, there may be a danger of compromising processes and therefore quality. This is a constant challenge and yet there is a need to ensure the RRM becomes the go-to place if it can sustain the production of quality products. An additional challenge exists when in some cases the available evidence may not provide a clear and straightforward answer for the decision-makers.

5.1 CONCLUSION

We have presented some challenges that create a platform for reflection and debate on the way forward. Through the REACH-PI and RRM example, we ascertain that for effective KT we need advocacy, long-term investment and explicit support for KT science and mechanisms from all key stakeholders as part of research for development, with an understanding of the local contexts, roles for partnerships and networks, and ensuring quality processes. KT for lasting positive impact is not a linear process and it requires specific skills and continuous engagement between researchers and various stakeholders at global, national and local levels. Continued and sustained investment into KT, and especially into building both supply-side and demand-side capacity for it and continued efforts to increase its profile and understanding are crucial moving forward.

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ENDNOTES

- 1 We acknowledge that the term knowledge translation has several interpretations but we use it to mean a phenomenon that involves different actors and activities geared towards incorporating research evidence into decisions, policy and practice, in a systematic and transparent manner.
- 2 See also Africa Center for Systematic Reviews and Knowledge Translation, <http://chs.mak.ac.ug/afcen>; WHO Evidence-informed Policy-making, 'REACH-Uganda Evidence Briefs for Policy', www.who.int/evidence/resources/country_reports/africa/en/index5.html; WHO Evidence-informed Policy-making, EVIPNet in Action, www.who.int/evidence/resources/publication/en.
- 3 Anecdotal evidence from Canada's McMaster Health Forum.