

# **Knowledge Translation Training Workshop for Implementation Research Teams**

## ***Moving Maternal Newborn and Child Health Evidence into Policy in West Africa (MEP) Project***

### **Report of workshop at Bauchi State Nigeria**

By

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## Executive Summary

Knowledge translation (KT) has been described as a complex and multidimensional concept that demands a comprehensive understanding of its mechanisms, methods, and measurements, as well as of its influencing factors at the individual and contextual levels—and the interaction between both those levels. In Nigeria, available reports indicate that research evidence rarely gets into the policymaking process. A major factor responsible for this is the lack of KT capacity enhancement mechanisms existing in Nigeria. Some of the problem is also attributed to the differences existing between those who do research and those who may be in a position to use it. To address this challenge, there is a need to strengthen institutions and mechanisms that can more systematically promote interactions between researchers, policy-makers and other stakeholders who can influence the uptake of research findings. In this report, the outcome of the first KT training workshop designed to enhance the KT competence of the IDRC/WAHO supported Implementation Research Team (IRT) of Bauchi State Nigeria is presented. The workshop design was a modified "before and after" intervention study design in which outcomes were measured on the eligible population (target participants) both **before** the training (intervention) is implemented and **after**. The difference between the before and after measurements was taken to be the impact of the intervention (training). (In this instance, the "before"- or "baseline"- measurements served as the control measurements.).

The workshop was developed as a three-day training event. The workshop package consisted of 15 modules, designed to enhance the knowledge and competence of the IRT and other stakeholders closely associated with the research of the IRT. A pre-workshop questionnaire was administered before the commencement of the actual training each day and a post-workshop questionnaire was administered at the end of the training. The outcome of the analysis of the pre-workshop and post-workshop questionnaire indicated a tremendous improvement in the knowledge and understanding of the topics taught as shown by noteworthy increase in the mean rating percentages in each module.

The following are two key recommendations from this initiative: (i). This training programme showed a considerable improvement in the understanding of the participant of knowledge translation processes and strategies. The training package is recommended not only for IRT teams, but all other health research teams supported by IDRC and WAHO. (ii). There is need for follow up meetings with the IRTs to assess their use of KT skills acquired from the training in the process in the implementation of their research.

## 1. Introduction

Canada Institutes of Health Research (CIHR) defines Knowledge translation (KT) as *“a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of people, provide more effective health services and products and strengthen the health care system”* [1]. This is by no means a simple process and involves a range of “interactions between researchers and knowledge users that may vary in intensity, complexity and level of engagement depending on the nature of the research and the findings as well as the needs of the particular knowledge user” [1].

KT has been described as a complex and multidimensional concept that demands a comprehensive understanding of its mechanisms, methods, and measurements, as well as of its influencing factors at the individual and contextual levels—and the interaction between both those levels [2]. Knowledge Translation (KT) is the meeting ground between two fundamentally different processes: research and action. It knits them with communicative relationships. KT relies upon partnerships, collaborations, and personal contact between researchers and research-users. In connecting the purity of science with the pragmatism of policy, the intangibles of trust, rapport, and even friendship can be more potent than logic and more compelling than evidence [3].

In many low and middle income countries (LMICs) including Nigeria, there is an increasing recognition that research evidence is vital to the formulation of effective policies that can strengthen the health systems [4,5]. It is well established in many scientific reports that evidence from research can enhance health policy process and development by informing decisions about policy content and direction [6-9]. Nevertheless the wide spread failure in most LMICs to uptake many of the high quality research can be attributed to the lack of capacity of research teams to undertake KT [10]. This is one of the reasons getting research evidence into policy remains a daunting task [11,12]. If research teams lack the capacity for KT, they will find it extremely difficult to raise knowledge users’ awareness of research findings in order to facilitate the use of those findings.

This is of critical importance to health research, as it has become clear that the creation of new knowledge often does not, on its own, lead to widespread implementation or impacts on health [1]. A research team with a robust KT competence will be able to use research to inspire people to think and/or act differently because the KT process is achieved through transmission and exchange of

information and through extensive dialogue between the producers and users of the research (10). KT skill is therefore of paramount importance to a research team as it will enable the team to carefully consider the experiences and information needs of stakeholders to improve the overall quality of research, and facilitate the application of research to practice and policy [13,14].

In Nigeria, available reports indicate that research evidence rarely gets into the policymaking process [5,15]. A major factor responsible for this is the lack of KT capacity enhancement mechanisms existing in Nigeria [15]. Some of the problem is also attributed to the differences existing between those who do research and those who may be in a position to use it. Some of the differences that pertain include mutual mistrust, career paths and requirements, attitudes towards information among others. These differences persist largely due to the absence of opportunities to bring researchers, policy-makers and managers together to consider issues around the research to policy and practice interface [5].

To address this challenge, there is a need to strengthen institutions and mechanisms that can more systematically promote interactions between researchers, policy-makers and other stakeholders who can influence the uptake of research findings [10]. Stressing on the need to promote the interaction between researchers and policy-makers, Choi and colleagues [16] noted that it is desirable for scientists and policy-makers to communicate their knowledge effectively or run the risks of barriers in language and understanding. They further noted that more incentives and opportunities to collaborate will help scientists and policy-makers appreciate their different goals, career paths, attitudes towards information, and perception of time.

In typical low income setting like Nigeria, the process of getting research into policy can work better if researchers take the initiative in approaching policymakers with the view to bridging this gap. In studies conducted in Nigeria which brought policymakers and researchers together to deliberate of how to bridge the evidence-policy gap, the policymakers expressed their willingness to work with researchers if approached by the latter [4,17]. To promote and facilitate the evidence to policy process therefore, it is imperative to improve the knowledge of research teams on KT and also enhance their capacity to function as a KT platform.

In a previous report it was noted that a KT platform is a logical continuation of knowledge brokering and as knowledge brokers, KT platforms are intermediaries between research and policy and their overall goals are to smooth the movement of research to the policy level; to connect the needs of the policy process with research and researchers; and to infuse public dialogue with an appreciation and understanding of research processes and research evidence [18]. Bennett and Jessani [19] observed that KT relies upon key factors such as partnerships, collaborations, and personal contact between researchers and research-users. Every research team that intends to make a lasting impact and with their research findings entering the policy process must necessarily have some KT expertise. Hence the importance of KT training for research teams cannot be overstated.

## **2. Objective of this report**

The main objective of this report is to present the outcome of the first KT training workshop designed to enhance the KT competence of the IDRC/WAHO supported Implementation Research Team (IRT) of Bauchi State Nigeria.

## **3. Description of the KT training workshop**

### **(i). Workshop design**

In this workshop, a modified "before and after" intervention study design was used in which outcomes were measured on the eligible population (target participants) both **before** the training (intervention) is implemented and **after** [20]. The difference between the before and after measurements was taken to be the impact of the intervention (training). (In this instance, the "before"- or "baseline"- measurements served as the control measurements.).

### **(ii). Workshop Participant profile**

A total of 45 participants were mapped out for the workshop. The participants were individuals who are directly involved in the project implementation and include: Bauchi IRT core team Members, Project Management team, Members of Project steering committee, State Primary Health Care Development Agency (SPHCDA) staff, Ministry of Health (MOH) staff, HMB staff, FOMWAN health board Members, Toro LGA staff and other NGO partners.

### **(iii). Nature of the workshop:**

The workshop was developed as a three-day training event. The workshop package consisted of 15 modules, deliberately designed to enhance the knowledge and competence of the IRT and other stakeholders closely associated with the research of the IRT. The workshop consisted of lecture

sessions and group work sessions. The outline of the agenda of the workshop is presented in APPENDIX 1. All teaching sessions were done using power-point presentation and handouts on each topic were produced and distributed to all participants. It was made mandatory for all lectures to be delivered in simplified, practical and easily comprehensible patterns, with little or no emphasis on complex mathematical or scientific computations/models for the benefit of non-specialists. Focus group discussions, dialogues, question/answer sessions, role play, demonstration, simulations, group work and presentations from participants were methods used during the workshops. Personal/private interactions also took place for individuals who desired more information either from the Facilitators/Resource persons.

#### **(iv). Pre-Post Workshop Questionnaire**

A pre-workshop questionnaire was administered before the commencement of the actual training each day. The questions contained in the pre-workshop questionnaire were designed to assess the level of initial knowledge and understanding of the participants regarding the subject matter. At the end of each day's training a similar questionnaire was administered to assess the post workshop knowledge and understanding of the participants regarding the topics and also to obtain the impression of the participants about the training and the materials used for the training.

#### **(v). Group work**

Participants were grouped into three separate groups. A random approach was initially used to select members of groups and where it was realized that a group was not adequately balanced or represented by the different categories of participants an adjustment was done by reorganizing affected groups.

#### ***(a). Day 1 & Day 2: Integrated Knowledge Translation (iKT)***

The group work for Day 1 & Day 2 focused on the iKT. An iKT proposal worksheet was developed from the CIHR Guide to Knowledge Translation Planning document [1] (see APPENDIX 2). This iKT group work was used to train the IRT on how potential knowledge users are engaged throughout the research process. The IRT was shown how this approach can produce research findings that are more likely to be directly relevant to and used by knowledge users. The central premise of iKT was highlighted and the IRT was made to understand that using this process, knowledge users are involved as equal partners alongside researchers and this will lead to research that is more relevant to, and more likely to be useful to, the knowledge users. The iKT group work was originally planned for 45mins each day but it ended up lasting up to 1hr 30mins each day. This was because the

participants were enthusiastic and were glad to be part of discussing and fine tuning the IRT's research. The group discussion focused on the following aspects of the IRT's research.

1. **Research Question:** An explanation of what the research project is aiming to achieve and a justification for the need to conduct the research (i.e. how/why was this topic chosen? What gap will it fill?)
2. **Research Approach:** A detailed description of the research approach and a justification for the proposed methods/strategies
3. **Feasibility:** A clear demonstration that the researcher/knowledge user team has the requisite skills, experience and resources to complete the project in the proposed time frame.
4. **Outcomes:** A description of the potential results expected from the successful completion of the project

***(b). Day 3: Policy review, analysis and contextualization***

The group work for Day 3 was centred on how to undertake a policy review, analysis and contextualization. The policy document titled: The **Nigeria's Call to Action to Save Newborn Lives** (available at: <http://www.healthynewbornnetwork.org/hnn-content/uploads/Nigeria-Call-to-Action-Final-Oct-2014.pdf>) was used. A Policy review & contextualization worksheet developed from the document was used for the group work (see APPENDIX 3). The document was selected because it outlined the action needed to overcome bottlenecks to saving newborn lives targeting the health systems building blocks including: leadership and governance, health finance, health workforce, essential medical products and technologies, health service delivery, health information systems, and community ownership and participation. The objective was to teach the participants how to review and contextualize the policy document to the local Bauchi State setting. They were taught how to do the following:

To review and analyse the policy document to see if it is informed by robust evidence and plausible pathways and which consider the main elements of policy analysis: content of policy, actors, context and processes with respect to Bauchi State context. After the analysis participants were to select the actions recommended in the document that can work in Bauchi State, add some other ones that can work that were not in the policy document and discard those that are not likely to work in the State. Each group was also asked to rank the health systems building block actions that are most relevant to the Bauchi State health needs.

#### **(vi). Analysis of questionnaire**

The data collected via the questionnaire was analysed using the methods developed at McMaster University Canada by Johnson and Lavis [22]. The analysis was based on mean rating (MNR). For instance the figures represent Likert rating scale of 1-4 points, where 1 point=grossly inadequate; 2 points=inadequate; 3 points=fairly adequate; and 4 points=very adequate. In terms of analysis, values ranging from 1.00-2.49 points are considered low, whereas values ranging from 2.50-4.00 points considered high. The percentage differences in the MNR of the pre-workshop and post-workshop were calculated and used as indicator of the level of impact of the training.

### **4. Summary of outcome of the workshop**

#### **Outcome of questionnaire analysis**

The outcome of the analysis of the pre-workshop and post-workshop questionnaire indicated a tremendous improvement in the knowledge and understanding of the topics taught as shown by noteworthy increase in the mean rating percentages in each module. In Table 1 (Day 1), the range of percentage increase in the mean ratings for each module is as follows: Introduction to health policy & health systems (24.0%-37.5%); Introduction to knowledge translation (integrated KT & End-of-Grant KT) (35.0%-55.2%); Research Priority Setting (32.9%-45.5%); Leadership capacity Development & managing political interference (13.3%-31.7%); Getting Research into Policy and Practice (19.9%-45.6%).

In Table 2 (Day 2), the range of percentage increase in the mean ratings for each module is as follows: Knowledge translation models and measures (26.7%-32.2%); Research evidence in health policy making and health policy implementation (17.8%-28.5%); Health policy advocacy, demand creation, consensus building and negotiations (19.1%-24.5%); Knowledge translation tools and strategies for stakeholders and end users engagement (24.9%-34.9%); Policy Formulation and Implementation Process (25.1%-38.4%)

In Table 3 (Day 3) the range of percentage increase in the mean ratings for each module is as follows: Policy review, analysis and contextualization (24.8%-34.5%); Inter-sectoral collaboration in policymaking & implementation (19.6%-37.3%); Knowledge dissemination, exchange & management (20.1%-25.6%); Health policy monitoring, evaluation and performance assessment (18.3%-22.1%); Introduction to policy legislation (28.9%-31.3%). Regarding the overall assessment of the training workshop, 70.4% of participants scored the workshop 81-100%.



### **Outcome of group work on Integrated Knowledge Translation (iKT)**

Generally, the participants were unanimous in their agreement that the IRT sufficiently justified the need to conduct the research and noted that it will provide scientific evidence that can help improve policy on maternal and child health in Bauchi State. Participants also commended the IRT for the research approach which included the involvement of key stakeholders but added that the members of the house of Assembly (ie., the legislators) and also the media workers should be integrated as stakeholders.

In terms of the feasibility of the project, participants were satisfied with the skill and expertise of the team and commended their willingness to work with experts to improve their effort and achieve the objectives of the study. However they called for more capacity building in KT and increased in funding to enable the team to reach other LGAs. Regarding the anticipated outcome, participants were impressed with the IRT plans put in place to disseminate the findings from the study, but advised a more refinement of the indicators and data collection instruments in order to generate more relevant information and also for monitoring & evaluation.

### **Outcome of group work on Policy Review, Analysis and Contextualization**

The participants adopted most of the recommended actions to overcome bottlenecks to saving newborn lives but discarded the recommendations that appear not to work in Bauchi State eg., the inclusion of vital registration as part of the conditional cash transfer programme was rejected. Strategies that were not part of the document were included such as need for active involvement of civil society organizations, need for more capacity training, and need to strengthen birth registration through more awareness creation. The outcome of the ranking of the health systems building blocks action strategies to save newborn lives in the Bauchi State context is presented below. In order of importance the participants ranked the health systems as follows:

1. Health finance (16 points)
2. Health workforce ( 15 points)
3. Leadership and governance (15 points)
4. Health service delivery (13 points)
5. Community ownership and participation (11 points)
6. Essential medical products and technologies (8 points)
7. Health information systems (6 points)

The result showed that the participants identified health finance, health work force and leadership/governance as the most important policy areas that Bauchi state can focus on to achieve greater improvement in saving newborn lives.

## 5. Key Recommendations

(i). This training programme showed a considerable improvement in the understanding of the participant of Knowledge translation. The training package is recommended not only for IRT teams, but all other health research teams supported by IDRC and WAHO. This is imperative because successful translation of evidence to policy is one of the main indicators that funding of a health research was actually justified.

(ii). There is need for follow up meetings with the IRTs to assess their use of KT skills acquired from the training in the process in the implementation of their research.

## 6. References

1. CIHR. Guide to Knowledge Translation Planning at CIHR: Integrated and End-of-Grant Approaches. 2012
2. Sudsawad, P. *Knowledge translation: Introduction to models, strategies, and measures*. Austin, TX: Southwest Educational Development Laboratory, National Center for the Dissemination of Disability Research. 2007.
3. Bennett G, Jessani N. The Knowledge Translation Toolkit-Bridging the Know-Do Gap: A Resource for Researchers. 2011. International Development Research Centre.
4. Uneke CJ, Ezeoha AE, Ndukwe CD, Oyibo PG, Onwe F. Promotion of evidence-informed health policy-making in Nigeria: bridging the gap between researchers and policy-makers. *Glob Public Health* 2012; 7: 750-65. doi: 10.1080/17441692.2012.666255
5. Uneke CJ, Ezeoha AE, Ndukwe CD, Oyibo PG, Onwe F. Development of health policy and systems research in Nigeria: lessons for developing countries' evidence-based health policy making process and practice. *Healthc Policy* 2010; 6: 48-65. doi: 10.12927/hcpol.2013.22749
6. Campbell DM, Redman S, Jorm L, Cooke M, Zwi AB, Rychetnik L. Increasing the use of evidence in health policy: practice and views of policy makers and researchers. *Aust New Zealand Health Policy* 2009; 6: 21. doi: 10.1186/1743-8462-6-21
7. Dobrow MJ, Goel V, Upshur RE. Evidence-based health policy: context and utilisation. *Soc Sci Med* 2004; 58: 207-17. doi: 10.1016/s0277-9536(03)00166-7
8. Hanney SR, Gonzalez-Block MA, Buxton MJ, Kogan M. The Utilization of Health Research in Policy-Making: Concepts, Examples and Methods of Assessment. *Health Res Policy Syst* 2003; 1: 2.
9. Innvaer S, Vist G, Trommald M, Oxman A. Health policy-makers' perceptions of their use of evidence: a systematic review. *J Health Serv Res Policy* 2002; 7: 239-44. doi: 10.1258/135581902320432778

10. Haines A, Kuruville S, Borchert M. Bridging the implementation gap between knowledge and action for health. *Bull World Health Organ* 2004; 82: 724-31.
11. Jönsson K, Tomson G, Jönsson C, Kounnavong S, Wahlström R. Health systems research in Lao PDR: capacity development for getting research into policy and practice. *Health Res Policy Syst* 2007; 5: 11. doi: 10.1186/1478-4505-5-11
12. Young J. Research, Policy and practice: why developing countries are different. *J Int Dev* 2005; 17: 727-34.
13. Canadian Institute of Health Research ( CIHR). Developing a CIHR framework to measure the impact of health research (cihr synthesis report). In: CIHR, editor. *More about knowledge translation at CIHR*. Ottawa: CIHR; 2005.
14. Landry R, Lyons R, Amara N, Warner G, Ziam S, Halilem N, *et al*. Knowledge Translation Planning Tools for Stroke Researchers. 2006. [cited 2014 August]. Available from: [http://www.ahprc.dal.ca/pdf/kt/2006\\_KTP\\_lanningTool.pdf](http://www.ahprc.dal.ca/pdf/kt/2006_KTP_lanningTool.pdf)
15. Uneke CJ, Ezeoha A, Ndukwe CD, Oyibo PG, Onwe F, Igbinedion EB, *et al*. Individual and organisational capacity for evidence use in policy making in Nigeria: an exploratory study of the perceptions of Nigeria health policy makers. *Evidence & Policy: A Journal of Research, Debate and Practice* 2011; 7: 251- 76. doi: 10.1332/174426411x591744
16. Choi BC, Gupta A, Ward B. Good thinking: six ways to bridge the gap between scientists and policy makers. *J Epidemiol Comm Health* 2009; 63: 179-80. doi: 10.1136/jech.2008.082636
17. Uneke CJ, Ezeoha A, Ndukwe CD, Oyibo PG, Onwe F, Igbinedion EB, Chukwu PN. **(2011)** Individual and organisational capacity for evidence use in policy making in Nigeria: an exploratory study of the perceptions of Nigeria health policy makers. *Evidence & Policy: A Journal of Research, Debate and Practice* 7(3): 251-276(26)
18. International Development Research Centre (IDRC) and the Swiss Agency for Development and Cooperation (SDC). The RM Knowledge Translation Toolkit: A Resource for Researchers. IDRC & SDC; 2008.
19. Bennett G, Jessani N. The knowledge translation toolkit: bridging the know-do gap: a resource for researchers/ International Development Research Centre, Ottawa [internet]. 2011. [cited 2014 August]. Available from: <http://web.idrc.ca/openebooks/508-3/>
20. Purdon S, Lessof C, Woodfield K, Bryson C. 'Research Methods for Policy Evaluation', DWP Social Research Division Working Paper 2 <http://research.dwp.gov.uk/asd/asd5/WP2.pdf> (Accessed February 19, 2015).
21. Johnson NA, Lavis JN. Procedures Manual for the "Evaluating Knowledge-Translation Platforms in Low- and Middle-Income Countries" Study. Hamilton, Canada: McMaster University Program in Policy Decision-Making. 17 June 2009

Table 1. Outcome of the pre-workshop and post workshop questionnaire analysis for DAY 1 of the KT training workshop in Bauchi Nigeria

<b>Parameters assessed</b>	<b>Pre-workshop mean</b>	<b>Post-workshop mean</b>	<b>% Mean increase</b>
<b>Introduction to health policy &amp; health systems</b>			
Knowledge of the meaning of policy and policy cycle	2.54	3.39	33.5
Understanding of the critical policy issues and the focus/forms of policy analysis	2.50	3.10	24.0
Understanding of building blocks of the health systems	2.56	3.52	37.5
<b>Introduction to knowledge translation (integrated KT &amp; End-of-Grant KT)</b>			
Knowledge of the meaning and core principles of knowledge translation	2.34	3.16	35.0
Understanding of the four models of knowledge translation	2.21	3.27	48.0
Understanding of Integrated Knowledge Translation (iKT) and End-of-Grant Knowledge Translation (eKT)	2.10	3.26	55.2
<b>Research Priority Setting</b>			
Knowledge of the principles and essential elements of policy research priority setting process	2.21	3.26	45.5
Understanding of the value of public engagement in policy research priority setting process	2.55	3.39	32.9
Understanding of the criteria for priority setting and the process of convening a policy research priority setting exercise	2.25	3.17	40.9
<b>Leadership capacity Development &amp; managing political interference</b>			
Knowledge of the contextual issues about policymaking sector leadership	2.43	3.20	31.7
Understanding of policymakers' leadership capacity development process	2.59	3.28	26.6
Understanding of leadership characteristics for successful policymakers	2.54	3.32	30.7
Knowledge about managing political interference in policymaking and implementation	2.71	3.07	13.3
Knowledge about managing political interference in policymaking and implementation	2.38	3.13	31.5
<b>Getting Research into Policy and Practice</b>			
Understanding of critical policy issues and the focus/forms of policy analysis	2.11	2.96	40.3
Understanding of the concept of policy process and policy assistance	2.41	2.89	19.9
Understanding of research to policy inter-face and systems thinking	2.04	2.97	45.6

Table 2. Outcome of the pre-workshop and post workshop questionnaire analysis for DAY 2 of the KT training workshop in Bauchi Nigeria

<b>Parameters assessed</b>	<b>Pre-workshop mean</b>	<b>Post-workshop mean</b>	<b>% Mean increase</b>
<b>Knowledge translation models and measures</b>			
Knowledge of the characteristics of knowledge translation	2.66	3.41	28.2
Understanding of the frameworks applicable to knowledge translation	2.58	3.41	32.2
Understanding of knowledge management and the strategies	2.81	3.56	26.7
<b>Research evidence in health policy making and health policy implementation</b>			
Knowledge of the quality and relevance of the evidence	2.63	3.38	28.5
Understanding of the role of research evidence in informing health policy decisions	2.73	3.39	24.2
Understanding of use of evidence in health policy implementation	2.92	3.44	17.8
<b>Health policy advocacy, demand creation, consensus building and negotiations</b>			
Knowledge of advocacy strategies	2.82	3.36	19.1
Understanding of constituency-building and resource mobilization	2.76	3.35	21.8
Understanding of the principles of demand creation	2.69	3.35	24.5
<b>Knowledge translation tools and strategies for stakeholders and end users engagement</b>			
Understanding of the tools for knowledge translation and exchange	2.61	3.52	34.9
Knowledge of the preparation and key ingredients of effective policy brief	2.64	3.42	29.5
Understanding of the need and characteristics of policy dialogue	2.85	3.56	24.9
<b>Policy Formulation and Implementation Process</b>			
Knowledge of the meaning and elements of policy	2.63	3.29	25.1
Understanding of policy cycle	2.61	3.47	33.0
Understanding of the concept of policy process and policy assistance	2.45	3.39	38.4

Table 3. Outcome of the pre-workshop and post workshop questionnaire analysis for DAY 3 of the KT training workshop in Bauchi Nigeria

<b>Parameters assessed</b>	<b>Pre-workshop mean</b>	<b>Post-workshop mean</b>	<b>% Mean increase</b>
<b>Policy review, analysis and contextualization</b>			
Knowledge of the policy review process	2.86	3.57	24.8
Understanding of the success factors for multi-stakeholder policy review methods	2.81	3.57	27.0
Understanding of review tasks to guide the multi-stakeholder review	2.75	3.70	34.5
<b>Inter-sectoral collaboration in policymaking &amp; implementation</b>			
Knowledge of the meaning of inter-sectoral collaboration in policymaking & implementation	2.70	3.60	37.3
Understanding of what makes collaboration work	2.91	3.48	19.6
Understanding of the roadblocks to effective collaboration	2.73	3.57	30.8
<b>Knowledge dissemination, exchange &amp; management</b>			
Knowledge of fundamentals and approaches of knowledge dissemination	2.92	3.57	22.3
Understanding of knowledge exchange and what makes the integrated KT process work effectively	2.81	3.53	25.6
Understanding of the effective ways of disseminating policy information	2.94	3.53	20.1
<b>Health policy monitoring, evaluation and performance assessment</b>			
Understanding of value of policy monitoring and evaluation	2.81	3.43	22.1
Understanding of the concept of policy process and policy assistance	2.81	3.38	20.3
Knowledge about steps to building a performance based monitoring and evaluation system	2.73	3.23	18.3
<b>Introduction to policy legislation</b>			
Knowledge of the meaning of a bill for legislation	2.65	3.48	31.3
Understanding of the mechanism of the development of a bill	2.70	3.48	28.9
Understanding of the bill legislative process at the House of Assembly	2.69	3.48	29.4
<b>General Questions on the training workshop outcome</b>			
Facilitators' mastery & ability to deliver the lessons in an understandable manner		3.79	
Scope/coverage of the training workshop in relation to health policy and knowledge translation		3.55	
Duration of the programme sufficient to address major individual knowledge & capacity constraints in evidence-informed health policymaking		2.93	
<b>Overall assessment of the training workshop</b>			
Participants score	41-60%	61-80%	81-100%
	3.7	25.9	70.4

## **APPENDIX 1: WORKSHOP AGENDA**

### **IDRC WAHO Moving Maternal Newborn and Child Evidence into Policy in West Africa (MEP) Project.KT Training for Bauchi IRTs Programme Agenda**

<b>DAY 1</b>				
<b>S/No</b>	<b>Activity</b>	<b>Facilitator</b>	<b>Time</b>	<b>Duration</b>
1	Arrival/Registration of Participants	IRT officials	8:00am-8:45am	45mins
2	Welcome & Introduction; House rules/information	IRT officials	8:45am-9:00am	15mins
3	Keynote remarks by Hon Commissioner for Health Bauchi State	Hon Commissioner for Health	9:00am- 9:15am	15mins
4	Introduction to WAHO IMCHA-Moving Evidence into Policy Project	Dr. Ermel Johnson	9:15am- 9:45am	30mins
5	Overview of the video edutainment to the doorstep impact on maternal and child outcome in Toro LGA Bauchi State, Nigeria	Yagana Mohammed Gidado	9:45am- 10:15am	30mins
5	Pre-workshop questionnaire	Dr. Jesse Uneke	10:15am- 10:30am	15mins
6	Introduction to health policy & health systems	Dr. Jesse Uneke	10:30am-11:05am	35mins
	Coffee break		11:05am-11:20am	15mins
7	Introduction to knowledge translation (integrated KT & End-of-Grant KT)	Dr. Jesse Uneke	11:20am-11:50noon	30mins
9	Research priority setting for knowledge translation	Dr Henry Uro- Chukwu	11:50noon-12:20pm	30mins
10	Leadership capacity development & managing political interference in policy making	Dr Henry Uro- Chukwu	12:20pm-1:00pm	40mins
11	Lunch Break		1:00pm- 1:45pm	45mins
12	Group Work/presentation	IRT officials	1:45pm- 2:30pm	45mins
13	Getting Research into Policy and Practice-GRIPP- The knowledge-to-action cycle	Dr. Jesse Uneke	2:30pm- 3:10pm	40mins
14	Post-workshop questionnaire	Dr Henry Uro- Chukwu	3:10pm-3:25pm	15mins
15	Announcement/closing	IRT officials	3:25pm-3:35pm	10min
<b>DAY 2</b>				
<b>S/No</b>	<b>Activity</b>	<b>Facilitator</b>	<b>Time</b>	<b>Duration</b>
1	Opening formalities	IRT officials	8:30am-9:00am	30mins
2	Recap of Day 1 activities	IRT officials	9:00am-9:15am	15mins
3	Pre-workshop questionnaire	Dr Henry Uro- Chukwu	9:15am- 9:30am	15mins

4	Knowledge translation models and measures	Dr. Jesse Uneke	9:30am-10:15am	45mins
5	Principles of evidence acquisition, assessment, adaptation and application	Dr. Jesse Uneke	10:15am-11:00am	45mins
6	Coffee break		11:00am-11:15am	15mins
7	Health policy advocacy, demand creation, consensus building and negotiations	Dr Henry Uro-Chukwu	11:15am-12:00noon	45mins
8	Knowledge translation tools and strategies for stakeholders and end users engagement	Dr. Jesse Uneke	12:00noon-12:45pm	45mins
9	Lunch Break		12:45pm- 1:30pm	45mins
10	Group Work/presentation	IRT officials	1:30pm- 2:15pm	45mins
11	Policy formulation and implementation process	Dr Henry Uro-Chukwu	2:15pm- 3:00pm	45mins
12	Post-workshop questionnaire	Dr. Jesse Uneke	3:00pm-3:15pm	15mins
13	Announcement/closing	IRT officials	3:15pm-3:30pm	15min

**DAY 3**

S/No	Activity	Facilitator	Time	Duration
1	Opening formalities	IRT officials	8:30am-9:00am	30mins
2	Recap of Day 2 activities	IRT officials	9:00am-9:15am	15mins
3	Pre-workshop questionnaire	Dr Uro-Chukwu	9:15am- 9:30am	15mins
4	Policy review, analysis and contextualization	Dr. Jesse Uneke	9:30am-10:15am	45mins
5	Inter-sectoral collaboration in policy making and implementation	Dr Henry Uro-Chukwu	10:15am-11:00am	45mins
6	Coffee break		11:00am-11:15am	15mins
7	Knowledge dissemination, exchange & management	Dr. Jesse Uneke	11:15am-12:00noon	45mins
8	Health policy monitoring, evaluation and performance assessment	Dr Henry Uro-Chukwu	12:00noon-12:45pm	45mins
9	Lunch Break		12:45pm- 1:30pm	45mins
10	Group Work/presentation	IRT officials	1:30pm- 2:15pm	45mins
11	Introduction to policy legislation	Dr. Uneke	2:15pm- 3:00pm	45mins
12	Post-workshop questionnaire	Dr Uro-Chukwu	3:00pm-3:15pm	15mins
13	Announcement/closing	IRT officials	3:15pm-3:30pm	15min



**APPENDIX 2**

**Integrated Knowledge Translation (iKT) BAUCHI Project Worksheet**

<b>Factor</b>	<b>What is it?</b>	<b>Key questions</b>
<b>Research Question</b>	An explanation of what the research project is aiming to achieve and a justification for the need to conduct the research (i.e. how/why was this topic chosen? What gap will it fill?)	<p>(i). To what extent does the project respond to the objectives of the funding opportunity?            .....            .....            .....</p> <p>(ii). To what extent does the research question respond to an important need identified by the knowledge users on the research team?.....            .....            .....</p>
<p><b>What does this really mean?</b></p> <p>(i). Has the research question been clearly articulated?.....</p> <p>(ii). Be clear about the origin of the research question.</p> <p>(a). Why is it interesting? .....</p> <p>.....</p> <p>(b). Who is interested in it?.....</p> <p>.....</p> <p>(c). How do the knowledge users' partners view it? .....</p> <p>.....</p> <p>.....</p> <p>(d). What potential benefit does it bring to the knowledge users?.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>		

<b>Research Approach</b>	A detailed description of the research approach and a justification for the proposed methods/strategies	<p>(i). To what extent is it likely that the proposed methods will address the research question?  .....  .....  .....</p> <p>(ii). To what extent is the study design appropriate and rigorous?.....  .....  .....</p> <p>(iii). To what extent are the knowledge users meaningfully engaged in informing the research plan?  .....  .....  .....</p> <p>(iv). To what extent does the research team have the appropriate expertise to utilize the best methodologies?  .....  .....  .....</p>
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**What does this really mean?**

(i). Are the project methods clear and specific and is it evident that the project team knows what it wants to do/study?.....  
.....  
.....

(ii). Has the participation of and commitment to the project by the knowledge users been demonstrated eg, through written text or shown through letters of support?.....  
.....  
.....

(iii). Are the letters of commitment unique and specific about the knowledge users' expectations.....  
.....  
.....  
.....  
.....

<b>Feasibility</b>	A clear demonstration that the researcher/knowledge user team has the requisite skills, experience and resources to complete the project in the proposed time frame.	<p>(i). To what extent are the knowledge users committed to considering application of the findings when they become available and is this application achievable in the particular practice, program and/or policy context?  .....  .....  .....</p> <p>(ii). To what extent does the researcher/knowledge-user team have the necessary expertise and track record to deliver on the project’s objectives, including the objectives of the end-of-grant KT plan?  .....  .....  .....</p> <p>(iii). To what extent is the project accomplishable in the given time frame with the resources available/described?  .....  .....  .....</p>
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**What does this really mean?**

(i). Has the expertise of all team members and their role in the project documented?.....  
.....  
.....

(ii). Has it been demonstrated that this is a doable project from both a scientific and a practical perspective?.....  
.....  
.....

(iii). Has the knowledge users’ partners demonstrated an interest in the results of the study and the willingness and ability to use the results and move them into action (when appropriate)?.....  
.....  
.....

(iv). Has it been demonstrated that the budget is appropriate for the iKT plan, including the engagement activities/communication needed.?.....  
.....  
.....

<p><b>Outcomes</b></p>	<p>A description of the potential results expected from the successful completion of the project</p>	<p>(i). To what extent will the project have relevant findings that may ultimately have a substantive and sustainable impact on health outcomes, practice, programs and/or policies?  .....  .....</p> <p>(ii). To what extent will the project’s findings be transferable to other practice, programs and/or policy contexts? .....</p> <p>(iii). To what extent will knowledge users be involved in interpreting results and informing KT plans/activities?.....</p> <p>(iv). To what extent does the end-of-grant KT plan detail strategies appropriate for its goals and target audiences?.....</p> <p>(v). To what extent does the evaluation plan demonstrate that it will enable researchers to assess the project’s impact?.....</p>
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**What does this really mean?**

(i). Has the potential impact of the study and its transferability been considered?  
.....  
.....

(ii). Has a detailed plan for end-of-grant KT been included?.....

(iii). Has a reasonable evaluation plan to be able to measure the outcomes and impacts of the study been developed?.....

**APPENDIX 3**

**Policy review & contextualization worksheet**  
**NIGERIA’S CALL TO ACTION TO SAVE NEWBORN LIVES**  
**ACTION NEEDED TO OVERCOME BOTTLENECKS TO SERVICE DELIVERY**

SUMMARY OF PRIORITY BOTTLENECKS BY HEALTH SYSTEM BUILDING BLOCK	STRATEGIES AND ACTIONS NEEDED TO ADDRESS IDENTIFIED BOTTLENECKS
<b>1. LEADERSHIP AND GOVERNANCE</b>	
(i). No focal person or responsible person at state and local government authority (LGA) levels. (ii). Birth registration policy exists but not enforced. ..... ..... ..... ..... ..... .....	(a). Develop and strengthen the capacity of MCH focal persons at the State and LGA levels to take on newborn health. (b). Increase advocacy for newborn health at all levels of government. (c). Strengthen birth registration and include provision of certificates. (d). Include vital registration as part of the national conditional cash transfer programme. ..... ..... ..... .....
<b>2. HEALTH FINANCE</b>	
(i). Very low coverage of health financing schemes. (ii). No specific line item for tracking financial resources for maternal and newborn health at all levels. ..... ..... ..... ..... ..... ..... ..... ..... ..... ..... .....	(a). Global backing to support signing of the National Health Bill by the President and implementation at all levels to ensure adequate resources for implementation of MNH interventions at primary health care (PHC) level. (b). High level advocacy to improve financial access to MNH services. (c). Establish government budget line for maternal and newborn health. (d). Appropriate legislative bodies to support MOH to track expenditure, to ensure prompt fund release and strengthen accountability on health expenditures. (e). State government to expand community-based health insurance schemes. ..... ..... ..... ..... .....

<b>3. HEALTH WORKFORCE</b>	
<p>(i). Inequitable distribution and poor retention of health workers when posted to remote and security challenged areas</p> <p>(ii). Poor remuneration of health workers.</p> <p>(iii). Health worker skill gap for management of newborn conditions.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>(a). Train and deploy skilled health workers and expand the MSS to cover more PHC centers.</p> <p>(b). Provide incentives for health workers in remote and unsafe areas.</p> <p>(c). Maintain health worker skills up to date through quality pre-service and in-service training.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<b>4. ESSENTIAL MEDICAL PRODUCTS AND TECHNOLOGIES</b>	
<p>(i). Ineffective coordination for purchase and distribution of supplies and equipment.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>(a). Integrate all existing procurement systems.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>
<b>5. HEALTH SERVICE DELIVERY</b>	
<p>(i). Inadequate funding.</p> <p>(ii). Supervision not regular at sub-national level.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>	<p>(a). Make funding available for supervision at all levels of the health system.</p> <p>(b). Ensure regular integrated supportive supervision (ISS) is conducted.</p> <p>(c). Link Information from ISS with PHC reviews.</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p> <p>.....</p>

**6. HEALTH INFORMATION SYSTEMS**

- (i). Ineffective engagement of the private sector
  - (ii). Weak reporting mechanisms
  - (iii). Socio-cultural issues prevent reporting of deaths
  - (iv). Poor use of data for action
  - (v). Stillbirths and newborn deaths not counted
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

- (a). Provide incentives for private sector reporting
  - (b). Implement Public-Private Partnership policy
  - (c). Increase supervision of private sector
  - (d). Use HMIS tools to capture MNH indicators at community level
  - (e). Improve Behavior change communication (BCC) strategies around making newborns count
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

**7. COMMUNITY OWNERSHIP AND PARTICIPATION**

- (i). Sub-optimal engagement of community structures (ward development committees, women’s groups, community based associations etc.).
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....

- (a). Establish sustainable system for engaging and strengthening existing community structures.
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....
- .....



**FIGURE 1:** A cross section of participants at the KT training workshop, Bauchi State Nigeria



**FIGURE 2:** Participants of Group 1, during the group work at the KT training workshop, Bauchi State Nigeria





**FIGURE 3:** Participants of Group 2, during the group work at the KT training workshop, Bauchi State Nigeria



**FIGURE 4:** Participants of Group 3, during the group work at the KT training workshop, Bauchi State Nigeria