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Promoting Evidence to Policy Link on the Control of Infectious Diseases of Poverty in Nigeria: Outcome of A Multi-Stakeholders Policy Dialogue

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ABSTRACT

Background: In Nigeria, malaria, schistosomiasis and lymphatic filariasis are among infectious diseases of poverty (IDP) with severe health burden and require effective policy strategies for their control. In this study, we investigated the value of policy brief and policy dialogue as excellent policymaking mechanisms that enable policymakers to adapt effective evidence informed policy for IDP control.

Methods: A policy brief was developed on the control of malaria, schistosomiasis and lymphatic filariasis and subjected to deliberations in a one-day multi-stakeholder policy dialogue held in Ebonyi State Nigeria. A modified cross sectional intervention study design was used in this investigation. Structured pre-tested questionnaires were used to evaluate the policy brief document and policy dialogue process at the end of the policy dialogue.

Results: Forty-seven policymakers participated in the dialogue. An analysis of the response on the policy brief regarding context, different features of the problem; policy options and key implementation considerations indicated the mean ratings (MNRs) mostly ranged from 6.40-6.85 on 7 point scale. The overall assessment of the policy brief had MNR at 6.54. The analysis of the response on the policy dialogue regarding the level of priority of policy issue, opportunity to discuss different features of the problem and options for addressing the problem, and the MNRs mostly ranged from 6.50-6.82. The overall assessment of the policy dialogue had MNR at 6.72.

Conclusion: Policy dialogues can allow research evidence to be considered together with views, experiences and tacit knowledge of policymakers and can enhance evidence-to-policy link.

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Introduction

Infectious diseases of poverty (IDP) are significant agents in the appalling poverty afflicting so much of the world.[1] "Their impact is felt not only in massive loss of life but also in high-levels of morbidity and the accompanying impact on families, communities and weak and under-resourced health systems in low and middle-income countries".[1]According to the Global Health Observatory Data Repository of WHO, infectious (including parasitic) diseases were together responsible for the death of more than 8.7 million people worldwide in 2008.[2] In 2010, the global deaths from malaria rose to 1.17 million and in the same year mortality from neglected tropical diseases rose to 152,000.[3-5] However, there is a global decline in the burden of some of the IDP in areas where control strategies have been deployed efficiently.[5-8] In the 2014 World Malaria Report,[8] WHO estimated that malaria deaths ranged 367 000–755 000 worldwide, with 90% of the global total, occurring in the African Region and up to 78% of malaria deaths occurring among children aged under 5 years. Despite this decline, the burden of malaria and other IDP is still enormous in Africa. In a recent publication, Bhutta and colleagues,[5] noted that IDP disproportionately affect the poorest population in the affected regions and contribute to a cycle of poverty as a result of decreased productivity ensuing from long-term illness, disability, and social stigma. The severely affected populations are usually the poor and have fewer material, physical, and financial resources to draw from and limited or no access to integrated health care, prevention tools and medications, thus resulting in the most severe adverse impacts.[5]

In Nigeria, malaria, schistosomiasis and lymphatic filariasis are among the IDP with severe health burden and require effective policy strategies for their control.[9]According to the WHO Global Report for Research on Infectious Diseases of Poverty, policy-makers need to have access to the right information at the right time to inform decisions that draw on the evidence of what works, and feed "best buys" into health policy, health budgets and the operations of health systems.[1] The report further noted that research data must be rapidly translated into effective tools for policy-makers to enhance the control of IDP.[1] An important policy tool that is increasingly being engaged to facilitate the use of evidence in policy-making is the policy brief.

Policy briefs have been described as relatively new approach to packaging research evidence for policymakers.[10] According to Young and Quinn,[11] the purpose of the policy brief is to convince the target audience of the urgency of the current problem and the need to adopt the preferred alternative or course of action outlined and therefore, serve as an impetus for action. Policy briefs are excellent policy working tool that enable policymakers and other stakeholders in the health sector to interact and share knowledge and adapt effective strategies for improving health.

In Nigeria the impact of IDP such as malaria, schistosomiasis, and lymphatic filariasis is felt not only in massive loss of life but also in high-levels of morbidity and the accompanying socio-economic impact on families and communities particularly in the rural areas.[9] WHO noted in the Global Report for Research on IDP that poverty creates conditions that favor the spread of infectious diseases and prevents affected populations from obtaining adequate access to prevention and care.[1] There is abundant research evidence indicating that effective and simple interventions to prevent and control these IDP exist, but their delivery to affected populations has proven very difficult due to weak health system infrastructure, lack of evidence-informed policies on their control and lack of strong political will in many low income settings.[5]

One of the hallmarks of effective policy on IDP control is to make evidence-informed policy.[1,6] Consequently, the need to package research data into effective policy tools that will help policymakers to make evidence informed policy regarding IDP cannot be overstated. Malaria, schistosomiasis and lymphatic filariasis are among the IDP with severe health burden in Nigeria which require effective policy tools for their control.[9]

Ebonyi State is one of the 36 States in Nigeria with a high burden of malaria, schistosomiasis and lymphatic filariasis.[12-14] To facilitate the development of effective policy on the control of IDP that is evidence-informed, policymakers and other stakeholders in the health sector of Ebonyi State underwent a capacity enhancement training program on the development and use of policy briefs for evidence informed policymaking. The goal of the program was to enhance the capacity of decision makers to be able to develop evidence-informed policy brief on IDP control and to subject the policy brief to a multi-stakeholder policy dialogue.

According to Lavis and colleagues,[10] there is growing interest in identifying interactive knowledge-sharing mechanisms that allow research evidence to be brought together with the views, experiences and tacit knowledge of those who will be involved in, or affected by, future decisions about high-priority issues. This interest has been fuelled by the recognition of the need for locally contextualized 'decision support' for policymakers and other stakeholders.[15,16] A very important interactive knowledge-sharing platform is policy dialogue. Policy dialogues have been described as a new and evolving approach to supporting evidence-informed policymaking and they are one of many forms of political interaction that could usefully be more evidence-informed.[17] This type of dialogue often described as a deliberative process aims at strengthening the quality and rigor of policy thinking; identifying the most context-resonant framing of a particular issue; and exploring ways in which new knowledge can empower end users thereby assisting policy makers to explore strategic options for health system reform.[18] Moynihan had observed that in the consideration of policy options there exists tension between the local and the global, the center and the periphery and also indicated that evidence is often seen as "global" in nature, and putting that evidence into practice is regarded as a local affair.[19] In an earlier report about using evidence to improve health care quality, the author stressed the importance of individual health care organizations taking the centrally produced evidence or recommendations for best practice and "reinventing" them at the local level.[20]

Multi-stakeholder policy dialogues therefore provide an important avenue for the translation of evidence into local context. Lavis and colleagues,[17] noted that policy dialogues have the potential to improve the use of research and this potential can be realized through support related directly to: (i) interactions between researchers and policymakers (and among a wider range of stakeholders who are able to take action); (ii) the timely identification and interpretation of the available research evidence (when a policy dialogue is organized urgently to address a high-priority issue), and (iii) the 'real time' identification of accord between research evidence and the beliefs, values, interests or political goals and strategies of policymakers and stakeholders.

In this report, we present the outcome of a multi-stakeholder policy dialogue in Nigeria as designed to promoting evidence to policy link on the control of infectious diseases of poverty in the country.

Methods

Study design

A cross sectional intervention study design,[21] was used in this investigation. A policy brief was developed through group work and subjected to deliberations in a multi-stakeholder policy dialogue. Questionnaires developed by Johnson and Lavis,[22] were used to evaluate the policy brief document and policy dialogue process.

Ethical considerations

Approval for this study was obtained from the Directorate of Research, Innovation & Commercialization (DRIC), Ebonyi State University, Abakaliki Nigeria. The approval was based on the agreement that participation in the research was voluntary following informed consent; that participants' anonymity would be maintained; and that every finding would be treated with utmost confidentiality and for the purpose of this research. These were adhered to in this study.

Study area

This study was conducted at sub-national level and the participants were drawn from Ebonyi State in the southeastern Nigeria. Ebonyi State occupies a land mass of 5935 square kilometers. The population of the State was put at 2,176,947 by the 2006 census.[23] With a growth rate of 3.5% per annum, the State has a projected population of 2,565,184 by the end of 2012. Males constitute 48.9% while females constitute 51.1% of the population. The average population density is 286 persons per square km but is higher in the urban areas. A further breakdown of the population shows that Infants (less than one year) old make up 4%, the under-five years old children 20% and women of childbearing (WCBA) (15-49 years) make up 22% of the population. Ebonyi is mainly rural with about 75% of the population living in the rural areas.[23] Due to weak health systems in Ebonyi State; the burden of IDP is high especially in the rural and semi-urban areas of the State. Malaria, schistosomiasis and lymphatic filariasis are among the IDP that constitute severe public health problem in the state.[10-12]

Participants and procedures

The target participants were the career health policy makers, as described by Bammer and colleagues,[24] and these include:

• Health professionals in charge of the health systems;

• Regional, state and local government directors of the health ministry;

•directors of primary health care at the local government level

• Health professionals working with specific programs in the health ministry;

• Staff and consultants involved in public health issues within the health ministry;

• program/project managers under the health ministry;

• Chief executive officers of civil society groups, including non-governmental organizations;

•Leaders of national health-based associations (for example, Nigeria Medical Association; National Association of Nigeria Nurses and Midwives; and Pharmaceutical Association of Nigeria). These individuals all work in Ebonyi State Nigeria and were mapped out as potential participants based on the nature of their jobs, which directly or indirectly influence the health policymaking process. Letters were sent to them inviting them to participate in the study and in the mentorship program meetings for the development of policy brief and the multi-stakeholder policy dialogue meeting.

Process of Development of the policy brief

The policy brief in this study was developed by the policymakers with technical support and mentorship provided by the study team during a mentorship program for policymakers. Briefly, during the mentorship program meetings, participants were grouped into three different IDP policy groups (i.e., malaria group, schistosomiasis group and lymphatic filariasis group). Each policy group worked under a mentor and identified possible policy options for the control of an IDP assigned to the group. Each of the participating groups engaged their professional experiences and tacit knowledge in the identification of the potential policy options for IDP control. The viability of the policy options as control strategies were evaluated through a research evidence synthesis by each group to identify options sufficiently supported by research evidence. The research evidence (mostly systematic reviews) were sought and obtained from PUBMED, COCHRANE DATABASE and GOOGLE SCHOLAR. The policy options with sufficient research evidence were selected and used to draft a policy brief. The policy brief was prepared using the standard techniques outlined in previous studies.[10,25,26] The title of the policy brief was: *"Control of infectious diseases of poverty (malaria, schistosomiasis, & lymphatic filariasis) in Ebonyi State Nigeria"*. The study team worked along with the three IDP policy groups to produce the policy brief.Two members of each group were selected by the various groups to make a policy presentation of each group's recommendations (Table 1) at the scheduled multi-stakeholders policy dialogue

Table 1: Malaria, schistosomiasis and lymphatic filariasis control policy recommendations by the various policy brief groups

Malaria Policy options recommended by malaria policy brief group
(1). Distribution of ITNs to be more effective, proper orientation on the usage (2). Laboratory diagnosis of malaria to be considered along clinical assessment before treatment of malaria should be considered (3). ACTS recommended but quality control must be ensured (4). More funding for research on indigenous malaria drugs (5). Vector control using indoor residual spraying and larval source management
Schistosomiasis options recommended by schistosomiasis policy brief group
(1). Control of snail vectors; (2). Periodic enlightenment of the community/health education/part of school training curriculum on communicable diseases; (3). Mass screening/chemotherapy
Lymphatic filariasis policy options recommended by lymphatic filariasis policy brief group
(1). Establishment of a standard protocol for diagnosis of LF; (2). Vector control; (3). Community directed distribution of ITNs & Mectizan (Mass chemotherapy)/health education (4). Integrated control policy (STH, Onchocerciasis, *schistosomiasis*, lymphatic filariasis); (5). Establishment of policy monitoring/ evaluation (feedback mechanism)/with training & capacity building

ITN=Insecticide treated bednets; ACTS= Artemisinin combination therapies; STH= soil transmitted helminth infection

Multi-stakeholders policy dialogue

The multi-stakeholders policy dialogue was held on 20 January 2015. The policy dialogue event commenced at 9 am and ended at 3 pm. A total of 47 policymakers and other stakeholders in the health sector attended and participated in the program. Their profile is presented in Table 2. Each participant received a copy of the policy brief on arrival. The participants were given 45 minutes to study the policy brief in preparedness for the policy dialogue.

A policy dialogue guideline (Table 3) was provided for the participants to serve as a guide to the dialogue. The 45 minutes policy brief study period was followed by policy groups' presentation session. In this session, two selected representatives of each of the IDP policy groups (malaria policy group, schistosomiasis policy group, & lymphatic filariasis policy group) made power point presentation of how they deliberated and listed potential control policy options of their assigned IDP.

They described how their respective groups subjected the options to evidence synthesis and finally adopted the options that are sufficiently supported by identified research evidence.

The dialogue was conducted and evaluated using the process outlined by Lavis and colleagues.[17]

Table 2: Attributes of the participants at the policy dialogue on the control of infectious diseases of poverty held at Ebonyi State Nigeria (n=41)

Participant (Respondents) Attributes	n (%)
Gender	
Female	17 (41.5)
Male	24 (58.5)
Age (Years)	
25 - 34	3 (7.3)
35 - 44	14 (34.1)
≥ 45	24 (58.5)
Institutional Affiliation	
Federal Teaching Hospital	11 (26.8)
State Ministry of Health	7 (17.1)
Local Government Service Commission	16 (39.0)
Non-Governmental Organization	3 (7.3)
Educational Institution	4 (9.8)
Official Designation	
Programme Officer/Project Secretaries	16 (39.0)
Managers/Heads of Departments	15 (36.6)
Directors/Presidents/Chairpersons	10 (24.4)
Years of Experience in Current Designation	
< 3	1 (2.4)
3 – 5	18 (43.9)
6 – 10	13 (31.7)
> 10	8 (19.5)
Influence on Policy Making	
Direct (DIPP)	20 (48.8)
Indirect (IIPP)	21 (51.2)
Highest Academic Qualification	
SSCE/Diploma	1 (2.4)
Bachelor	24 (58.5)
Masters	12 (29.3)
Doctorate	4 (9.8)

Each policy option contained in the policy brief and the implementation strategies were exhaustively deliberated upon and majority of them were unanimously adopted, however appropriate modifications were made to some of the implementation strategies.

Table 3: Policy dialogue guidelines at the policy dialogue on control of infectious diseases of poverty held at Ebonyi State Nigeria

1. General assessment of the policy brief documents:
►1. Does the policy brief present research findings, policy options and recommendations appropriately? ►2. Does Policy brief synthesize a large amount of complex information and present findings and recommendations in a format that enables the reader to easily and quickly understand an issue? ►3. Was the Policy brief written in clear, jargon-free language, and pitched towards educated non-specialists in the topic? ►4. Are there other features lacking and needed to be included in the policy brief?
2. The policy issues:
►1. Does the policy brief address a high-priority issue and describe the relevant context of the issue? ► 2. Does the policy brief provide adequate background information on the policy issue? ► 3. Does the background information reflect the true scenario in our local context? ►4. Are there other aspects of the background information lacking and needed to be included in the policy brief?
3. Magnitude of the problem:
►1. Does the policy brief provide definition and a short overview of the root causes of the problem such that its features can be understood; a clear statement on the policy implications of the issue; shortcomings of the current approach?► 2. Does the policy brief describe the problem, costs and consequences of past options to address the problem, and the inadequacies or failures of past policies? ►3. Are there other aspects of the problem lacking and needed to be included in the policy brief?
4. Policy options
►1. Does the policy brief provide policy recommendations that are actionable and clearly connected to specific decision-making junctures in the policy-making process? ►2. Was the implementation considerations taken into account? ►3. Are there other policy recommendations lacking and needed to be included in the policy brief?
5. General comments

Policy brief and policy dialogue questionnaires developed by Johnson and Lavis[22] were administered at the end of the policy dialogue for evaluation purpose (Table 3 & 4).

Measures

The policy dialogue outcome evaluation questionnaire developed by Johnson & Lavis[22] was used to assessed the following: (a). If the policy dialogue addressed a high priority policy issue; (b). If the policy dialogue provided an opportunity to discuss different features of the problem; (c). If the policy dialogue provided an opportunity to discuss options for addressing the problem; (d). If the policy dialogue provided an opportunity to discuss options to address the problem, and key implementation considerations;

Statistical Analyses

The data collected via the questionnaire was analyzed using the methods developed at McMaster University Canada by Johnson and Lavis.[22] The analysis is based on mean rating (MNR), median rating (MDR) and range. For instance the figures represent Likert rating scale of 1-7 points, where 1point=very unhelpful; 3 points=slightly unhelpful; 5 points=slightly helpful; and 7 points=very helpful. In terms of analysis, values ranging from 1.00-3.99 points are considered low, whereas values ranging from 4.00-7.00 points considered high. The Pre-Workshop Means were compared to the Post- Workshop Means. The EPi-info software was used for the performance of the data analysis. $P<0.05$ was considered statistically significant.

Results

The profile of participants who responded to the questionnaire at the policy dialogue is presented in Table 2. 41.5% were female and majority of the participants (58.5%) were 45 yrs. old and above. 17.1% were from the Ministry of Health, with up to 48.8% of the participants having direct influence on the policymaking process. Up to 97% of the participants have at least Bachelor degree. An analysis of the response on the policy brief regarding context for the issue being addressed; different features of the problem; options for addressing the problem based on synthesized research evidence; and description of key implementation considerations among others indicated the mean ratings (MNRs) mostly ranged from 6.40-6.85 (i.e., moderately helpful - very helpful) on 7point scale (Table 4). The median ratings (MDRs) were all at 7 (i.e., very helpful) except for one which was at MDR of 6. The range (R) was mostly from 5-7 (i.e., slightly helpful - very helpful). The overall assessment of the policy brief had MNR at 6.54 (i.e., very helpful), MDR at 7 (i.e., very helpful), and range at 4-7 (i.e., neutral - very helpful) (Table 4).

Table 4: Outcome of evaluation of the policy brief used during the policy dialogue on IDP control held at Ebonyi State Nigeria (Total number of respondents=41)

Assessed Items	Mean	Median	Min-Max
A1. The policy brief described the context for the issue being addressed. How helpful did you find this approach?	6.76	7	5-7
A2. The policy brief described different features of the problem, including (where possible) how it affects particular groups. How helpful did you find this approach?	6.76	7	5-7
A3. The policy brief described at least three options for addressing the problem. How helpful did you find this approach?	6.71	7	5-7
yA4. The policy brief described what is known, based on synthesized research evidence, about each of the three options and where there are gaps in what is known. How helpful did you find this approach?	6.78	7	5-7
A5. The policy brief described key implementation considerations. How helpful did you find this approach?	6.62	7	5-7
A6. The policy brief employed systematic and transparent methods to identify, select, and assess synthesized research evidence. How helpful did you find this approach?	6.55	7	5-7
A7. The policy brief took quality considerations into account when discussing the research evidence. How useful did you find this approach?	6.61	7	5-7
A8. The policy brief took local applicability considerations into account when discussing the research evidence. How helpful did you find this approach?	6.66	7	5-7
A9. The policy brief took equity considerations into account when discussing the research evidence. How helpful did you find this approach?	6.40	7	4-7
A10. The policy brief did not conclude with particular recommendations. How helpful did you find this approach?	5.39	6	1-7
A11. The policy brief employed a graded-entry format (e.g., a list of key messages and a full report). How helpful did you find this approach?	6.65	7	5-7
A12. The policy brief included a reference list for those who wanted to read more about a particular systematic review or research study. How helpful did you find this approach?	6.85	7	6-7
A13. The policy brief was subjected to a review by at least one policymaker, at least one stakeholder, and at least one researcher (called a "merit" review process to distinguish it from "peer" review, which would typically only involve researchers in the review). How helpful did you find this approach?	6.59	7	5-7
B14. The purpose of the policy brief was to present the available research evidence on a high-priority policy issue in order to inform a policy dialogue where research evidence would be just one input to the discussion. How well did the policy brief achieve its purpose?	6.54	7	4-7

The analysis of the response on the policy dialogue regarding if it was on a high priority policy issue; if it provided an opportunity to discuss different features of the problem; if there was discussion of options for addressing the problem and on the key implementation considerations the MNRs mostly ranged from 6.50-6.82 (i.e., very helpful) (Table 5). The MDRs were all at seven (i.e., very helpful) except for one which was at MDR of 6. The range (R) was mostly from 5-7 (i.e., slightly helpful - very helpful). The overall assessment of the policy dialogue had MNR at 6.72 (i.e., achieved), MDR at 7 (i.e., achieved), and range at 5-7 (i.e., slightly achieved - achieved) (Table 5).

Table 5: Outcome of evaluation of the policy dialogue on IDP control held at Ebonyi State Nigeria (Total number of respondents=39)

Parameters assessed	**Mean**	**Median**	**min-Max**
A1. The policy dialogue addressed a high priority policy issue. How helpful did you find this approach?	6.82	7	5-7
A2. The policy dialogue provided an opportunity to discuss different features of the problem, including (where possible) how it affects particular groups. How helpful did you find this approach?	6.64	7	5-7
A3. The policy dialogue provided an opportunity to discuss three options for addressing the problem. How helpful did you find this approach?	6.71	7	4-7
A4. The policy dialogue provided an opportunity to discuss key implementation considerations. How helpful did you find this approach?	6.64	7	5-7
A5. The policy dialogue provided an opportunity to discuss who might do what differently. How helpful did you find this approach?	6.59	7	5-7
A6. The policy dialogue was informed by a pre-circulated policy brief. How helpful did you find this approach?	6.50	7	3-7
A7. The policy dialogue was informed by discussion about the full range of factors that can inform how to approach a problem, possible options for addressing it, and key implementation considerations. How helpful did you find this approach?	6.72	7	5-7
A8. The policy dialogue brought together many parties who could be involved in or affected by future decisions related to the issue. How helpful did you find this approach?	6.74	7	3-7
A9. The policy dialogue aimed for fair representation among policymakers, stakeholders, and researchers. How helpful did you find this approach?	6.72	7	3-7
A10. The policy dialogue engaged a facilitator to assist with the deliberations. How helpful did you find this approach?	6.74	7	3-7
A11. The policy dialogue allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed." How helpful did you find this approach?	6.56	7	3-7
A12. The policy dialogue did not aim for consensus. How helpful did you find this approach?	5.74	7	1-6
B13. The purpose of the policy dialogue was to support a full discussion of relevant considerations (including research evidence) about a high-priority policy issue in order to inform action. How well did the policy dialogue achieve its purpose?	6.72	7	5-7

Discussion

Purpose and process of the policy dialogue

The introduction of policy dialogues in this study was one of the most outstanding features of this investigation. The policy dialogue elicited an unprecedented tremendous enthusiasm from the participants many of whom were experiencing it for the first time. The policy dialogues were based on the policy brief designed for the control of IDP in the State. The inputs of the participants were obtained through the process of a policy dia-

logue. JATVSI described policy dialogue as the interaction between governments and non-governmental organizations at the various stages of the policy development process to encourage the exchange of knowledge and experience in order to have the best possible public policies. [27] Policy dialogue was used in this study because policy dialogues allow research evidence to be considered together with the views, experiences and tacit knowledge of those who will be involved in, or affected by, future decisions about a high priority issue.[10]

The policy dialogue allowed for frank, off-the-record deliberations by following the Chatham House Rule[17] and offered a neutral forum to the policymakers and other stakeholders to discuss the policy issues based on comparative evidence and experience. Their frank comments and recommendations on the policy brief enabled the policy brief be more specifically tailored to IDP control in the context of Ebonyi State. Lomas and colleagues,[28] had noted that this deliberative process is an effective tool for generating evidence-based, context sensitive guidance, and they point to design features that are likely to be successful. Lomas and colleagues,[28] made an important assertion as follow: *"Participative and consultative, a deliberative process has clear objectives; is inclusive and transparent; challenges science; promotes dialogue, and directly impacts on the decision itself."* It is obvious from the present study that using such a mechanism elicits and combines the various types of evidence to reach an evidence-based judgment to increase the likelihood of making solid decisions as was witnessed in our policy dialogue.

Adapting to local context the policy options from the policy dialogue

The participants in the policy dialogue adopted all the policy options from the policy brief on IDP control. Participants specifically noted that the government has the political will and the resources to adopt and implement the policy options in policy brief. The need for the creation of enabling environment for policy implementation was also stressed in addition to granting all stakeholders equal opportunity to participate in policy development and implementation processes. The goal of the approach we employed in the policy dialogue was to let the policy makers, researchers and other stakeholders in the health sector identify the most feasible policy options that will likely ensure the control of IDP considering the local context. This approach was informed by the report of GHAIN,[26] which noted that policy brief should be part of any comprehensive communication strategy and should be used when: (i) research results are applicable to specific national and sub-national contexts in which policymakers operate; (ii) researchers are prepared to make value-driven judgments about the outcome that would best address the specific problem; and (iii) recommendations are feasible and actionable and are clearly connected to specific decision-making junctures in the policy-making process.

The quality of the design and process of the policy brief and policy dialogue

Concerning the quality and the relevance of the policy brief used in this study, the policymakers and other stakeholders rated them very high with the mean ratings (MNRs) generally ranging from 6.40-6.85 (i.e., moderately helpful - very helpful), with median ratings (MDRs) mostly at 7 (i.e., very helpful). The issues assessed and rated by the policymakers and stakeholders included the context for the issue being addressed; different features of the problem; options for addressing the problem; key implementation considerations quality considerations; local applicability considerations, and equity considerations. The MNRs for the overall assessment of the policy brief was very high at 6.54 (i.e., very helpful). This outcome did not come as a surprise because the policy brief was prepared based on well-proven and established principles and guidelines outline by a number of authorities in policy brief preparation. [10, 25]

The policymakers and other stakeholders in this study also rated the policy dialogue very high. Issues assessed included whether the dialogue addressed high priority policy issue; provided an opportunity to discuss different features of the problems; provided an opportunity to discuss options for addressing the problems; an opportunity to

discuss key implementation considerations; provided an opportunity to discuss who might do what differently. The assessment also determined if the dialogue was informed by a pre-circulated policy brief; allowed for frank, off-the-record deliberations; and engaged a facilitator to assist with the deliberations. The MNR for these issues ranged from 6.50-6.82 (i.e., very helpful). It is interesting to note that the MNR for the overall assessment of the policy dialogue was very high at 6.72 (i.e., achieved). This outcome was expected because as in the preparation of the policy brief, the policy dialogues were conducted according to well-proven and established guidelines. [17, 28, 29] The major objective of adopting policy dialogue in this study was to improve the likelihood of taking up research into the policymaking process and this to a great extend was realized.

Conclusion

It is a well-established fact that policymaking process is complex. This is why a stronger body of knowledge and capacity among policymakers are urgently needed about which health policy, health system strengthening and disease control strategies are effective, and which are not.[30] The need for policymakers to acquire the capacity to translate effectively international and national health policy recommendations to local context cannot be overstated, and policy dialogues provide a very important platform to accomplish this. The Netherlands Development Assistance Research Council (RAWOO) has argued that support to capacity development should not just include capacities related agenda setting but also capacities related policy dialogue.[31]Nigeria is a very vast country with more than 160 million people and 36 States. There are socio-economic, political, religious and cultural differences from one state to another. Therefore, the capacity to adapt international or national policies and translate their objectives and operational targets into State specific strategies, policies, and action plans becomes a necessity.

Lomas and colleagues,[28] earlier noted that policy dialogue as a deliberative process is an effective tool for generating evidence-based, context sensitive guidance, and they point to design features that are likely to be successful. They further added that participative and consultative mechanism, a deliberative process "has clear objectives; is inclusive and transparent; challenges science; promotes dialogue, and directly impacts on the decision itself." In the case of Ebonyi State, we are confident that such a mechanism can elicit and combine the various types of evidence on IDP to reach an evidence-based judgment and increase the likelihood of making solid decisions that can ensure IDP control.

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Competing interest

The authors declare that there is no conflict of interest.

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