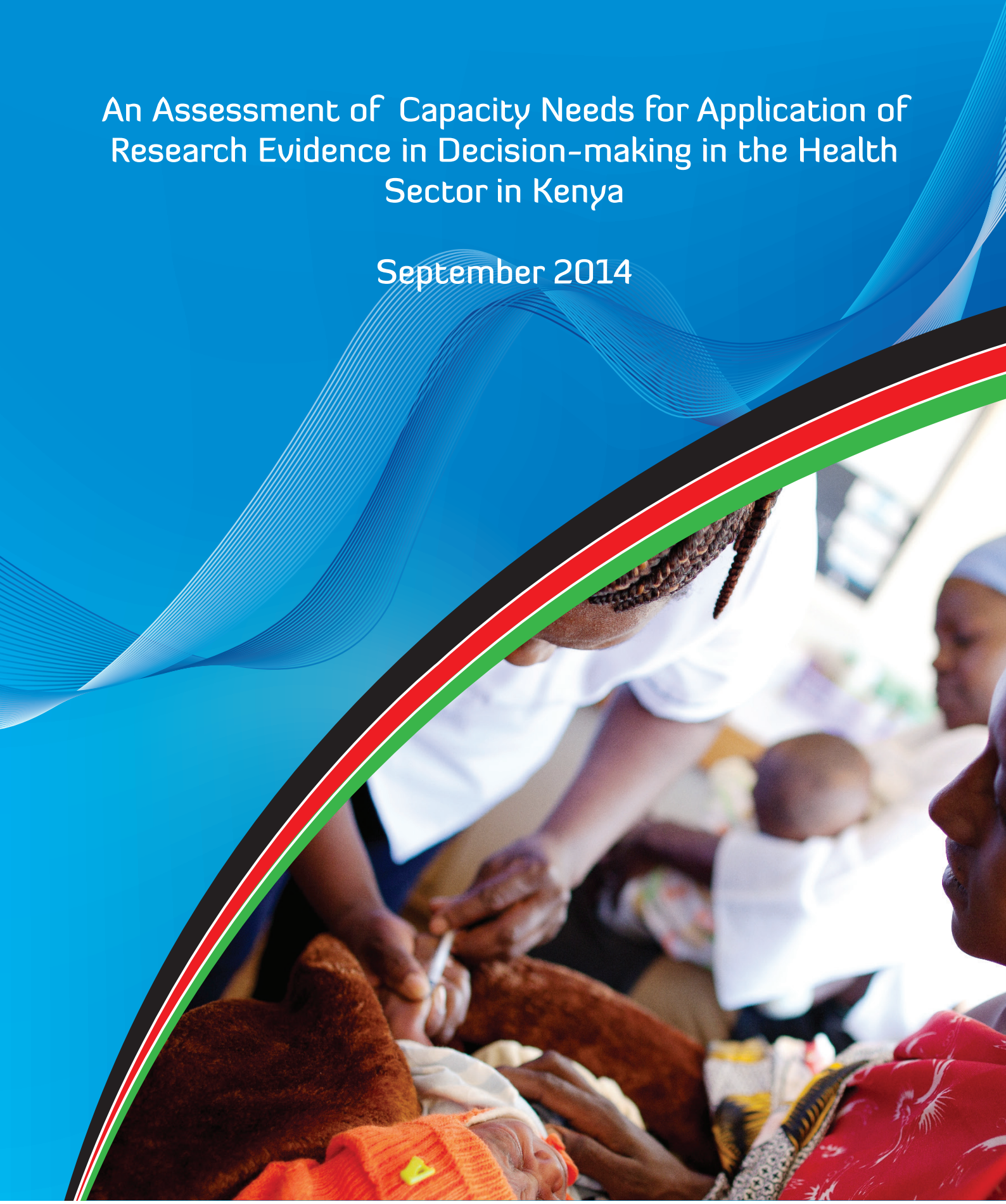
An Assessment of Capacity Needs for Application of Research Evidence in Decision-making in the Health Sector in Kenya

September 2014



Strengthening Capacity to Use Research Evidence in Health Policy in Kenya (SECURE Health)

MINISTRY OF HEALTH

AFIDEP
African Institute for Development Policy
Bridging Development Research, Policy and Practice

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An Assessment of Capacity Needs for Application of Research Evidence in Decision-Making in the Health Sector in Kenya

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Acronyms

AFIDEP	-	African Institute for Development Policy
MOH	-	Ministry of Health
DHRD	-	Division of Health Research and Development
NACOSTI	-	MoH's National Council for Science, Technology and Innovation
CNHR	-	Consortium for National Health Research
DFID	-	Department for International Development
ECSA-HC	-	East, Central and Southern African Health Community
FHI 360	-	Family Health International 360
KEMRI	-	Kenya Medical Research Institute
TWGs	-	Technical Working Groups
KIPPRA	-	Kenya Institute for Public Policy Research and Analysis
KAIS	-	Kenya AIDS Indicator Survey
TIBU	-	Kiswahili word meaning "to treat"- Use of Innovative Technology to Improve Kenya Tuberculosis Programme Management

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EXECUTIVE SUMMARY

Research uptake in public policymaking processes remains sub-optimal, particularly in sub-Saharan Africa, despite the recognised importance of using research evidence in policymaking. Knowledge on how to improve research uptake to enable evidence-informed policymaking in developing countries remains inadequate. In fact, most of the knowledge in this area is drawn from research in developed countries.

In November 2013, a Consortium led by the African Institute for Development Policy (AFIDEP), initiated a programme that seeks to optimise individual and institutional capacity and leadership in accessing and utilising data and research evidence in decision-making for health in Kenya and Malawi. The Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) programme (Appendix V) is being implemented in partnership with the Ministries of Health and Parliaments in both Kenya and Malawi. The SECURE Health Consortium partners include the Consortium for National Health Research (CNHR), the Eastern, Central and Southern Africa Health Community (ECSA-HC), FHI 360 and the College of Medicine at the University of Malawi.

The beneficiaries of the programme are top- and mid-level policymakers in the Ministries of Health and Parliaments. The programme has three main objectives:

1. Optimising institutional leadership and capacity to enhance evidence use;
2. Enhance individual skills and capacity of policymakers in the health ministry and the legislature in accessing, appraising, synthesising, and using evidence

Building on a scoping study conducted in 2013 at the proposal development stage of the programme, comprehensive needs assessments were conducted during the inception phase in Kenya (April-June 2014) and Malawi (September 2014). The assessments aimed to gain a deeper understanding of the individual and instructional capacity gaps in the Ministries of Health and Parliaments in regard to evidence use, in order to refine the programme's proposed interventions in each country. Quantitative and qualitative information was gathered through one-on-one and group consultations, in-depth face-to-face and telephone interviews and an online survey. This report presents the results from the Kenya needs assessment. The study revealed that policymaking in Kenya recognises the importance of using research evidence decision-making but in practice, it is is curtailed by a number of challenges and constraints including:

- Little interest in using research evidence among top level decision-makers due to competing political and personal interests;
- Inadequate technical skills to access, appraise, analyse, synthesise and apply research evidence;
- Inadequate time to access and use research evidence due to competing demands;
- Lack of a mechanism for accessing research evidence;
- Weak institutional linkages with research Institutions;
- Poor data quality and an inefficient health information system; and
- Inadequate funding to support the generation and use of research evidence in decision making.

To address the identified challenges, the respondents recommended:

- Sensitising the top-level leadership on the benefits of research evidence in decision making;
- Inculcating an institutional culture of research evidence use;
- Training staff in accessing, appraising, synthesising, translating and communicating research evidence and data;
- Allocating funding to research application;
- Establishing a repository for health research;
- Establishing or strengthening forums for discussing research evidence and data with decision-makers;

- Providing statistical software to programme staff to use for analysis of data; and
- Strengthening linkages between the Ministry and research institutions.

The findings of the study informed refinements to the proposed SECURE Health programme. The main tenets of the programme have been maintained with refinements mainly focused on emphasising or incorporating (if within the scope of the programme) content and approaches highlighted by the respondents as important.

The results also largely mirror the broader literature on the main challenges and constraints to the application of research evidence by policymakers and legislators. The research will therefore contribute to the existing knowledge base on these issues and inform future interventions aimed at strengthening individual and institutional level capacities relating to research use in the health sector.

1. INTRODUCTION

The use of evidence, which includes research findings and rigorous data, is critical in revealing which development issues should be prioritised and identifying the most effective and impact-driven intervention strategies. Evidence also helps decision-makers monitor and evaluate the efficacy of their policy and programme responses, enabling them to refine their approaches over time and maximise impact. Key decision-makers globally and especially in Africa increasingly recognise the importance of applying and using evidence in policy and practice and its value for sustaining and expanding the progress achieved in health and economic development over the last decade (The Economist, 2011).

Despite the recognised importance of using evidence in policymaking, in practice it remains sub-optimal and research on how to improve evidence-informed policymaking in developing countries is inadequate. Available research shows that a number of well-documented facilitating factors, mostly drawn from research in developed countries, may catalyse the application of evidence in policymaking. These include good networks between users and producers, locally generated evidence, alignment to national research and programme priorities and interaction and trust between researchers and policymakers (Lavis et al., 2005; Innvaer et al., 2002). Broader institutional leadership and organisational support for evidence use in policymaking including incentives, are documented as strong motivational factors (Green & Bennett, 2007).

The likelihood of research being used decreases when Policymakers lack an appreciation of the value of research evidence and relevant skills and expertise in accessing, appraising, interpreting and using available evidence in decision-making processes. The fact that often research is not produced at the time when it is most needed by policymakers also undermines its uptake in decision-making. Finally, the non-linear and multi-faceted nature of the decision-making process presents an additional barrier, as evidence often competes with many other considerations for influence on key decisions, including ideology, politics, personal experience, intuition or conventional wisdom and vested interests (Walt, 1994; Lin, 2003; Green & Bennett, 2007; Buse et l., 2006). The shift in language from striving for 'evidence-based' to 'evidence-informed' policymaking reflects this complex reality.

In the last decade, significant efforts have been focused on improving the 'supply' side of research by building organisational and individual capacities for generating and communicating research evidence. However, less attention has been paid to the 'demand' side (Newman et al., 2012) of research through efforts to raise the priority placed on research evidence in policymaking or by supporting end-users in the utilisation of existing evidence. In particular, there is limited research to demonstrate effective strategies for strengthening the capacity of policymakers in demanding and using evidence.

To contribute to filling this knowledge gap, in November 2013, the programme Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) in Kenya and Malawi was initiated. This capacity-building programme aims to work with the Ministries of Health (MoH) and Parliaments in Kenya and Malawi to jointly address the challenges and bottlenecks to using research evidence and rigorous data in policymaking processes in the health sector. In addition, the programme aims to document the interventions that are effective in optimising individual and institutional capacity and leadership for evidence use in policy and practices. The specific objectives of the programmes are to:

1. Optimise institutional leadership and capacity to enhance evidence use; and
2. Enhance individual skills and capacity of policymakers in the Health Ministry and the legislature in accessing, appraising, synthesising, and using evidence.

The SECURE Health programme is being implemented by a consortium led by the African Institute for Development Policy (AFIDEP), in partnership with Ministries of Health and Parliaments. The SECURE

Health Consortium partners include the Consortium for National Health Research (CNHR), ECSA-Health Community, FHI 360 and the College of Medicine, University of Malawi. The programme is funded by the UK Department for International Development (DFID) for a period of 3 years.

At the beginning of the programme (inception phase), the Consortium, in partnership with the Ministries of Health, conducted a comprehensive needs assessment study with top- and mid-level policymakers in the Ministries of Health, Parliament, the County Health Department and Researchers in Kenya and Malawi.

The assessment aimed to understand the capacity needs, barriers, challenges and constraints to the use of evidence in health policy and practice at individual and institutional levels in order to inform the refinement of the design of the SECURE Health Programme interventions.

The Kenya study was conducted during the inception phase of the programme from April to July 2014 and the Malawi study was conducted at the beginning of the implementation phase from September to October 2014. This report presents the results of the comprehensive needs assessment in Kenya. A separate report presents the Malawi needs assessment results.

2. METHODOLOGY

2.1 Target Population

The study population was drawn from Kenya's Ministry of Health (MoH) and Parliament (both the National Assembly and the Senate). The sampling frame constituted all top-level and mid-level policymakers within the MoH and Parliament. The top-level employee group at MoH comprised of the Cabinet Secretary, Principal Secretary, Director of Medical Services and all Heads of Directorates. The mid-level policymakers group was comprised of Heads of Divisions and Units, Programme Managers and Programme Officers. At county level, top-level policymakers included the County Executive Committee Members of Health and mid-level policymakers included Directors in charge of Health and Research Officers.

For Parliament, top-level policymakers included members of the Parliamentary Committee on Health, Clerk of the National Assembly, members of the Senate Committee on Health, Clerk to the Senate and the Director of Information and Research Services. The Chief Research Officer, clerical and research staffs for Parliament (National Assembly and Senate) were mid-level respondents in this study.

Researchers were drawn from the Consortium for National Health Research (CNHR) database of 500 health researchers. CNHR is a consortium composed of key players in health research in Kenya including health institutions, universities, research institutions, government agencies, non-governmental organisations and other research groups concerned with health. The main objective of the Consortium is to improve the quality of health in the country through promotion of quality research, encouraging the practice of evidence-based health policy formulation to improve health care and its delivery, building the research capacity of Kenya's talented youth and the creation of functional strategic partnerships.

2.2 Study Design

The study adopted a mixed methods approach consisting of both qualitative and quantitative data collection. Data were collected through various consultations, including one-on-one meetings and group sessions, in-depth face-to-face interviews or telephone interviews (county officials) and an online self-administered survey (researchers). Consultations primarily collected views of top-level decision-makers on the key barriers to application of research evidence and data in decision-making processes in the health sector and explored existing opportunities for supporting the MoH, Parliament and the Counties to apply research evidence in decision-making. A semi-structured interview guide was used for the in-depth interviews, employing both quantitative and qualitative questions (see Appendix I). In addition, an online survey instrument was administered to health researchers. The assessment sought to answer the following research questions.

1. Do policymakers in Kenya recognise the importance of using research evidence in decision making?
2. To what extent are policymakers using research evidence and data to inform their decisions?
3. What is the status of institutional support mechanisms for enabling use of research evidence in decision-making processes?
4. What are the main challenges and constraints policymakers face in using research evidence and data to inform policy and programme decisions?
5. How do the challenges and constraints reported by policymakers align to those highlighted by researchers?
6. What are policymakers' recommendations on how the challenges and constraints to research use can be addressed?
7. How do their recommendations align to those highlighted by researchers?
8. How do the recommendations align to the SECURE Health programme's proposed interventions?

2.3 Sampling Strategy

The sampling procedure or technique used for the in-depth interviews is non-probability sampling. We adopted this approach because the purpose of the study is to gather views of a specific group of respondents on a specific topic of interest, i.e. views of policymakers on research evidence use within the MoH and Parliament. The sample selection was therefore narrowed to individuals that fitted this description. Due to time and financial constraints, the study was limited to a subset of the population. Another factor that influenced the sample size and sample selection was the need to have a sample from which trainees could be drawn to participate in planned training workshops during implementation of the SECURE Health programme. From the target populations, the samples drawn for in-depth interviews were:

- Fifty staff from MoH;
- Sixteen staff from Parliament; and
- Six staff from the County Departments responsible for Health.

The samples were selected based on the following sampling strategy.

Ministry of Health

In consultation with Ministry of Health officials, specifically officials from the Division of Health Research and Development (DHRD), participants were sampled to undertake in-depth interviews from all the 6 Directorates of the Ministry, which collectively constitute 12 Divisions and 23 Units (See Appendix II). At least one staff member (the Head or the delegated officer) in each Directorate, Division and Unit was selected to be interviewed. Priority Divisions and Units identified in consultation with DHRD officials were oversampled, which involved selecting three staff (the Head and two officers).

Oversampled Directorates, Divisions and Units included those that focus on preventing and controlling illnesses, diseases and other public health conditions (Directorates of Clinical Services and Preventive and Promotive Health Services) and those that are responsible for the generation and use of routine data and coordination of health research (Directorate of Policy, Planning and Development). A total of 64 officials including nine top-level and 55 mid-level were sampled. 78 percent participated including seven top-level and 43 mid-level officials.

Parliamentary Committees on Health

In consultation with the Clerk of Parliament, a convenience sample of 20 Health Committee clerks out of a total of 53 (10 from each of the houses - the National Assembly and the Senate) and 8 Parliamentary Research Officers out of a total of 31 serving both houses, were identified for in-depth interviews. Only 10 clerks (five from each house) and six Research Officers participated.

County Health Departments

Given the programme's lack of funding for county-level work, only three counties (out of 47) were selected for inclusion in the needs assessment exercise. These included Busia, Nairobi and Mombasa. The counties were selected based on their regional distribution, disease burden and ease of accessibility. From each of the counties, we selected and interviewed a County Executive Committee Member of Health, a County Director of Health and a Research Officer.

Eight top-level officials from MoH, Parliament, Kenya Medical Research Institute (KEMRI), the University of Nairobi and the National Council for Population and Development (NCPD) were conveniently selected for one-on-one meetings. In addition, six group consultative meetings (organised or co-convened by the SECURE Health programme and collaborators) were also held with top-level officials from MoH, the County Health Departments and Parliament.

Researchers

A convenience sample of the 500 health researchers on the CNHR database was included in the assessment. The survey was circulated in June over a two-week period. A total of 41 (eight percent) of researchers responded.

2.4 Development and Pre-testing of the Survey Instrument

Three survey instruments were developed – one for conducting in-depth interviews with top-level policymakers, another for conducting in-depth interviews with mid-level policymakers, and an online survey for researchers. Development of the survey instruments for policymakers was a joint process led by AFIDEP with input from Consortium partners and MoH. The survey instrument was adapted from the tools: "Is research working for you? A self- assessment tool and discussion guide for health services management and policy organisations" developed by the Canadian Health Services Research Foundation (undated) and "Operational Manual for Strengthening Institutional Capacity to Employ Evidence in Health Policymaking for Developing Countries: The Nigeria Experience" developed by Uneke, C.J. et al. (2010). The development of the researchers' tool was led by CNHR and CoM, University of Malawi. The tools underwent several iterations, which were reviewed by Consortium partners and MoH officials at every stage.

A final review meeting was held with MoH officials to validate the tools for policymakers. The tools were pretested among two AFIDEP staff and four staff from the MoH. The draft tools were revised based on the results of the pre-tests and circulated to all the Consortium partners for their final views. Partner feedback from this final review informed the finalisation of the tools.

The tool for top-level policymakers was shorter than the one for mid-level policymakers. The tool for top-level policymakers addressed awareness of and attitude towards the importance of research evidence use in decision-making and views on the institutional support for application of research evidence in decision-making processes. The tool for mid-level policymakers had additional questions on the individual capacities to access and apply research evidence in decision-making. It also explored mid-level policymakers' views of the proposed skills training topics and institutional interventions. The final top- and mid-level tools included 50 and 60 questions, respectively.

The researcher tool included 31 questions assessing institutional arrangements for supporting knowledge translation and research uptake activities, the extent to which research aligns to health sector policymakers' research needs and the barriers, challenges and constraints to promoting use of research evidence.

The three tools used a mix of open- and closed-ended (yes/no, list of choices and five point Likert Scales) question types. Views on research evidence and routine data were assessed separately. This was informed by the pre-test results, which found that most policymakers perceive the two evidence types as having distinct characteristics and are utilised for different kinds of decisions.

2.5 Data Collection

For the in-depth face-to-face interviews, a letter of authority introducing the programme and informing the potential respondents of the activity and requesting the MoH staff and County staff to participate in the assessment was drafted and signed by the Principal Secretary, Ministry of Health (see Appendix III). This enabled AFIDEP to carry out in-depth interviews with the relevant MoH technical staff with ease. For the Parliament (National Assembly and the Senate) interviews, the Director-General, Parliamentary Joint Services accepted a letter of request for authority to interview Parliamentary Clerks and Research Officers.

Appointments were sought through letters (See Appendix IV) and followed up with email messages, phone calls, mobile phone text messages and physical appearances in some instances. The in-depth interviews were administered by seven researchers from AFIDEP, who had undergone a half-day training session. Each interview session with top-level policymakers took an average of 45 minutes while sessions with mid-level policymakers took an average of one hour. One interview with a County official was conducted by telephone.

For the consultations, official letters requesting meetings with identified top-level officials and participation in high-level meetings were sent to respective individuals and institutions. The meetings were used to introduce the SECURE Health programme, gather information on the extent to which research

evidence and data is being used in decision-making processes in the MoH and Parliament, the challenges and constraints experienced by policymakers and researchers in promoting use of research evidence and data in decision-making and recommendations on how these can be addressed broadly as well as by the SECURE Health programme.

Researchers were invited by email to complete the online research survey instrument.

2.6 Data Analysis

Meeting notes of the one-on-one and group consultations were summarised and key messages derived. The internet-based Survey-Monkey software was used to capture both qualitative and quantitative data from interviews, analyse the quantitative data and generate charts and tables. The qualitative data from the interviews was analysed using manual thematic coding.

Emergent themes and key messages from the qualitative data from consultations and interviews and the quantitative analysis from the interviews were synthesised and a report of the findings written.

2.7 Validation

The results of the assessment were presented to officials from the Ministry, counties, Parliament and other key institutions for validation on August 5th August 2014.

2.8 Ethical Considerations

Data collection tools used to conduct in-depth interviews included a consent form that explained the objective of the study, how the data collected would be used and the identities of respondents protected. Participants were informed that their participation was voluntary and hence they could end the interview at any time or refuse to answer questions that they were not comfortable with. The online survey was anonymous and participation was also voluntary. Information on how the data would be used was also stated.

2.9 Study Limitations

The assessment had a few limitations that could affect the reliability of some of the findings. The county sample was very small due to funding constraints and due to the fact that the original design of the programme focused on national-level engagement, not County-level. The sample selection for Counties did not adopt the population groupings as specified by the MoH. The MoH categorises populations in terms of their livelihoods and poverty characteristics as one of the following: Nomadic, agrarian, semi-agrarian and urban poor. The three Counties were selected as pilot counties on the basis of regional distribution, disease burden, and ease of accessibility. Because of the small county sample, most of the data presented on the county situation is qualitative.

Table 1 Summarises the Sampling Frame and the Samples Drawn and Interviewed

	Sampling frame	Planned survey sample (% of sampling frame)	Response rate (% of sample)	Top-level	Mid-level
Technical staff at the MoH headquarters	803	64 (8%)	50 (78%)	7	43
Clerks (National Assembly & Senate) and Research Officers	84	28 (33%)	16 (57%)	0	16
County Department responsible for health	185	6 (3.2%)	6 (100%)	3	3
TOTAL	**1075**	**98 (9%)**	**72 (73%)**	**10**	**62**

Table 2 Summarises the Consultations Held With Top-Level Policymakers in MOH and Parliament

Description of meetings	MoH	Parliament	Other Organisations
One-on-one	• Principal Secretary	• Clerk of the National Assembly, • Clerk of the Senate, • Chair of the Health Committee, National Assembly • Member of Health Committee	• Deputy Director, Research and Training, KEMRI • Deputy Director, Institute of Tropical and Infectious Diseases, University of Nairobi • Director General, National Council of Population and Development
Group meeting	• Top-level meeting organised by the SECURE Health Programme to introduce SECURE Health Programme to the Ministry's top Management • Launch of the Project Steering Committee chaired by the Ministry of Health • The 3rd Annual National Health Research-to-Policy Dialogue on the use of research results for dialogue, action and change	• Senate Committee on Health (met twice) • Committee on Health National Assembly	

3. RESULTS

The study sought to elicit views from a sample of policymakers in MoH, Parliament, the County Health Departments and researchers in order to assess their individual awareness, attitudes and capacity to access and apply research evidence in decision-making processes. The study further assessed the institutional support systems and mechanisms for accessing and applying research evidence in decision-making processes. The specific research questions have been outlined in the methodology section. The results are presented in the following broad themes:

- The importance of use of research evidence and data in decision-making;
- Frequency of use of research evidence and data in decision-making by policymakers;
- Key challenges and constraints policymakers face in using research evidence and data in decision-making from the perspective of policymakers and researchers;
- Recommendations on how identified challenges and constraints can be addressed from the perspective of policymakers and researchers; and
- Policymakers' views on proposed SECURE Health programme interventions.

Where relevant, results are disaggregated by type of Institution (MoH, Parliament and County) and policymakers (top- and mid-level) and the evidence type (research evidence and routine data).

Overall, the study revealed that policymakers in Kenya recognise the importance of using research evidence in decision-making, but their use of evidence is curtailed by a number of challenges and constraints. The results mirror the international literature on application of evidence in policy and practice. The study results are discussed in detail below.

3.1 Policymakers' Views on the Importance of Using Research Evidence in Decision-Making

To assess the extent to which policymakers in MoH and Parliament understand the importance of using research evidence and data in decision-making, respondents were asked to explain what the use of research evidence and data in decision-making means in relation to their job.

Responses provided by all the policymakers indicate that both top- and mid-level, in the Ministry of Health, Parliament and the County Health Department (referred to simply as County) recognise the importance of using research evidence and data to inform policy, legislative and programme decisions, as illustrated below.

> *"Even when doing a budget you need to show evidence to make a case for the budget. It has become crucial to have evidence. Within the Ministry, we are finalising the Kenya Health Policy. We involved KIPPRA to do a policy analysis. We are applying the evidence from the assessment to inform the policy."* - Top-level policymaker, MoH.

> *"We need evidence to enable us develop policies based on what is working. For example, in the development of guidelines on treatment we need evidence on what medicines are effective for various disease conditions. Whereas routine data tells us the coverage of interventions such as how many malaria cases were seen at the facility."* -Mid-level policymaker, MoH.

> *"Our role as researchers is to provide technical backstopping on policy analysis to MPs, Parliamentary Office holders such as the Speaker as well as Majority and Minority leaders; provide research-informed policy analysis (like policy briefs, reports) to individual MPs and Parliamentary Committees; and review the research content of the abundance of information that are sent to the Parliamentary Committees, like petitions and bills."* - Research Officer, Parliament.

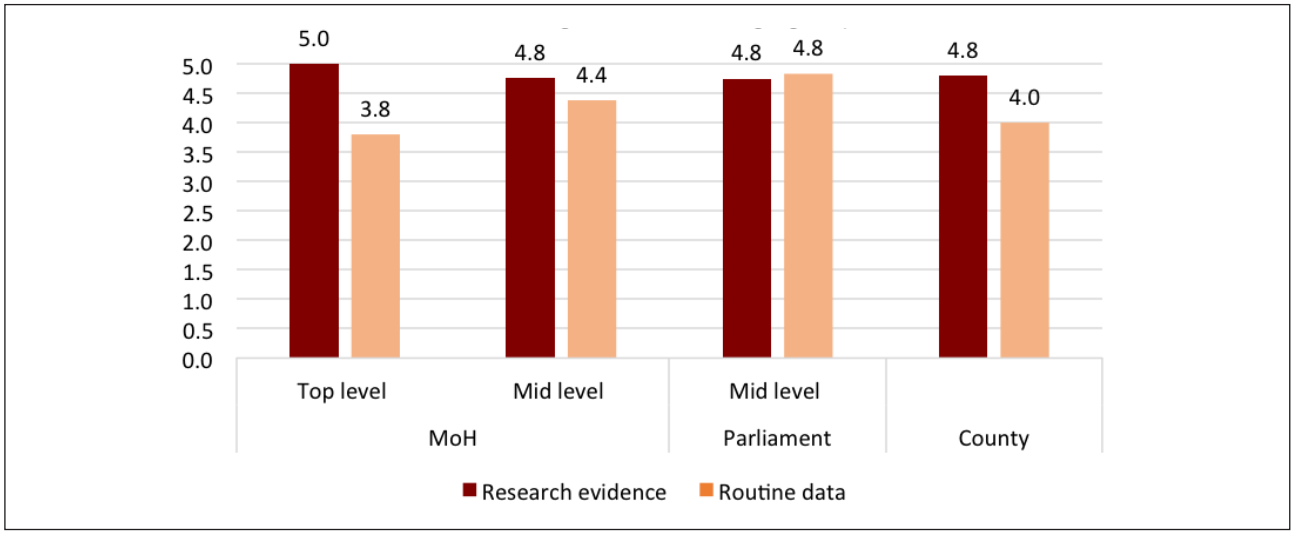
> *"Research evidence informs the structure of the Parliamentary Committee agenda and considerations in decision-making. Routine data provides important information for estimates in budgeting."* - Committee Clerk, Parliament.

"I am in the technical field of health at county level and would say research evidence informs our decisions on various interventions whether in curative or promotive service delivery. Routine data helps us to measure how we are performing so that we can improve the way we implement our strategic plans." - Mid-level policymaker, County Department for Health.

"No intervention in public health can be implemented without reference to research evidence and data. For example, we use the community strategy to deliver services based on tested interventions that are evidence-based. Use of routine data is important as one can quickly analyse it to help inform decision-making." - Mid-level policymaker, County Department for Health.

To get a more objective measure of how policymakers value using research evidence and data in decision-making, respondents were asked to rate the importance of using research evidence and routine data for decision-making using the Likert 1 to 5 scale, with 1 being the lowest and 5 the highest. All categories of respondents, both top- and mid-level policymakers, from Ministry, Parliament and the County, rated the importance of using research evidence high, at an average of 5 (Figure 1).

Figure 1: Rating Importance of Using Research Evidence and Data in Decision-Making



The average rating given by respondents for the importance of using research evidence and data in decision-making (using the Likert Scale 1 to 5, with 1 being lowest and 5 being highest)

The rating for the importance of using routine data in decision-making, however, varied slightly by end-users. Ministry top-level and county-level decision-makers rated the importance of using routine data in decision-making lower than mid-level policymakers in the Ministry and Parliament. Ministry top management frequently cited deficiencies of routine data as the main reason for the discrepancy in rating, with most of their explanations agreeing with one top-level official in the MoH, *"that routine data is incomplete, often not well analysed to enable decision-making and also not timely."* Consequently, Ministry top-level policymakers place more value on using research evidence to inform their decisions frequently, citing that *"research evidence is often more rigorously collected and analysed."*

3.2 Policymakers' Use of Research Evidence and Data in Decision-Making Processes

To get a sense of the extent to which policymakers use research evidence to make policy and programme decisions, respondents were asked to provide their most recent experience in using research evidence and routine data in their policy and programme decisions. Responses provided indicate that despite the recognised importance of using research evidence and data, the actual application is inconsistent and varies across the end-users, as demonstrated by the responses below.

"A year ago, I was the principal investigator for the KAIS study. We were able to learn the situation of HIV including [evidence on] whether we are having gaps and how we are bridging the gaps." - Top-level policymaker, MoH.

"I am always looking out for research evidence. Currently, the routine data shows that the TB incidence rate in Kenya is declining. However, the puzzle is that the health information system is not able to identify 10,000 cases missed. We are now using the TIBU system, the only available reporting system in Kenya and Africa that provides real time case reporting. It is a web-based reporting system. The clinicians are able to report through the web. They can be able to see what medications a patient is on and other details." - Mid-level policymaker, MoH.

"There was a news report of high pregnancy rates in the Mt Elgon area and it was publicised by media. There was a public debate on the issue. I accompanied the Parliamentary Committee on Health to investigate the matter. We obtained routine data from the health facilities there and talked to community members to try to verify the news reports. We prepared a report to be adopted in Parliament that is recommending a number of interventions." - Research Officer, Parliament.

"Last week we made reference to the evidence on increasing uptake of tenders by youth in respect to the public procurement bill. The paper was authored by the Brookings Institute in the USA and KIPPRA in Kenya." - Committee Clerk, Parliament.

"I have not applied any research evidence in the recent past." - Mid-level policymaker, Department for Health.

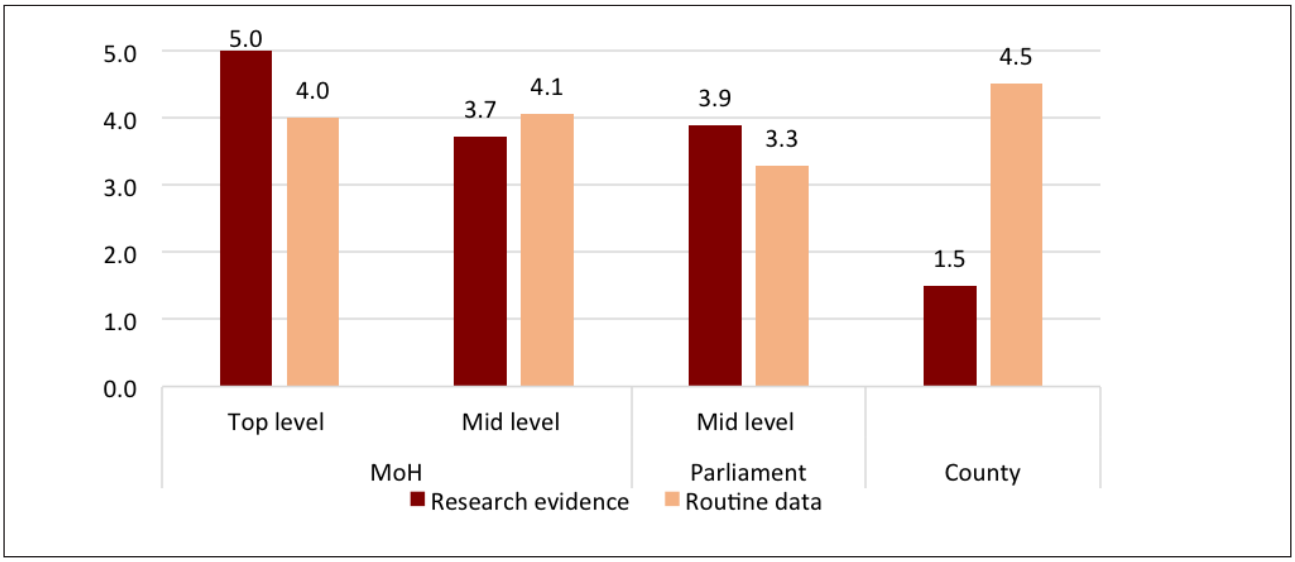
"I made reference to research evidence in the last week while disseminating infection prevention and control guidelines." - Mid-level policymaker,County Department for Health.

To get a more objective measure of policymakers' frequency of using research evidence and data in decision-making, respondents were asked to rate this on a scale of 1 to 5, with 1 being the lowest and 5 the highest. Results varied by end-user (Figure 2). Ministry top-level policymakers tend to use research evidence more frequently than routine data. This finding is consistent with the higher value Ministry top-level policymakers place on research evidence than on routine data. On the other hand, Ministry mid-level policymakers and County officials tend to use routine evidence more frequently than research evidence.

Most mid-level Ministry and county respondents cited lack of knowledge of where to access relevant research evidence, a lack of institutional culture promoting evidence use and inadequate capacity to conduct operational research to support decision-making and to synthesise, translate and use research evidence. Parliament mid-level policymakers also tended to use research evidence more than routine data. They used routine data less frequently than their Ministry counterparts. This was attributed to the difficulties parliament officials experience in accessing routine data from government agencies.

Some views explaining the rating for the frequency of using research evidence and data in decision-making are presented below.

Figure 2: Frequency of Use of Research Evidence and Data



The average rating given by respondents for how often respondents from Ministry/Parliament/County use research evidence and data in their work (using the Likert Scale 1 to 5, with 1 being the lowest and 5

"Research is not consistently done in the Ministry and routine data is available once a quarter. We cannot make policy on monthly summaries of routine data because it has errors that need to be removed, which is done on a quarterly basis." - Top-level policymaker, MoH.

"Use of research evidence is not well institutionalised. The newly created Research Unit is a good start but there is need to develop a framework to guide its work." - Mid-level policymaker, MoH.

"When one needs data from a government agency, there is so much bureaucracy. One has to get a letter from the Clerk to get information from the Ministry. In addition, it is not readily provided, and when it is provided it is not well analysed to inform decisions and it is also not compiled regularly to offer timely information."- Research Officer, Parliament.

"Some personalities in government agencies do not release needed data because Parliament does oversight and government officials feel like they are being scrutinised when data is requested…and when it is finally provided, it is usually outdated or comes in too late." - Committee Clerk, Parliament.

"Data is not easily available for the County; what is available is not collected in the right way. Some data is actually cooked. Many areas have no facilities and so data is not routinely collected; only people with the means or ability to have data collected have their data collected while many others are left out." - Top-level policymaker, MoH.

"There is need to analyse routine data at county level. Instead, right now, it is transmitted to national level and then back to county level." - Top level policymaker, County Department for Health.

3.3 Policymakers' Views on the Main Challenges and Constraints to Using Research Evidence and Data in Decision-Making

Policymakers were asked to highlight the main barriers they face in using research evidence and data for decision-making. Specifically, they were asked to highlight the general barriers, institutional bottlenecks and personal constraints. The emergent issues can be summarised into 3 main categories, namely access, institutional and individual barriers (Table 3).

Table 3: Summary of Challenges and Constraints to Research Evidence and Data use in Decision-Making

Access barriers

• Lack of a mechanism for accessing research evidence:
  o No repository
  o No subscriptions to journals
  o Poor dissemination and packaging of research evidence
• Lack of or limited access to operations research or research in some specialised fields
• Poor data quality and a deficient health information system

Institutional barriers
• Weak leadership for evidence use in decision-making • Inadequate institutional incentives for promoting evidence use in decision • Inadequate funding to support the generation and use of research evidence in decision-making • Understaffing • Weak institutional linkages with research institutions • Lack of institutional forums for communicating research evidence to top-level decision-makers • Lack of guidelines for research evidence and data use • Suspicion about motives of research funders and the validity of their research evidence • Politics and personal interests driving decision-making • Lack of equipment, software and systems to support sourcing and using research evidence and data
Individual barriers

• Inadequate technical skills to:
  o Analyse routine data
  o Access research
  o Interpret and synthesise research
  o Summarise research into clear policy messages
• Inadequate time due to competing demands, made worse by the fact that research evidence is often not well-packaged for ease of consumption by policymakers.

3.3.1 Access Barriers

MoH and Parliament frequently reported that the main challenge to evidence use in decision-making was lack of a mechanism for accessing research evidence and data. Among Ministry respondents, one noted that "the research evidence I need could be available somewhere but may be it is not available in a central location such as a repository or library where I can easily source for the research evidence or data." These views were reiterated by the majority of the respondents, as illustrated below.

> *"Research evidence is scattered all over - there is no portal. At least one can get routine data from the DHIS. But for research even the one the Ministry is involved in, it is not posted in one place."* - Mid-level policymaker, MoH.

> *"No repository for research evidence or data exists and there is no electronic access to routine data."* - Mid-level policymaker, MoH. *"There is limited knowledge about how to access research evidence. There is a lot of research knowledge but it is not compiled."* - Mid-level policymaker, MoH.

> *"There is no infrastructure to access research evidence. For example, good internet connectivity, a web portal or repository or a database. A top leader who values using research evidence should be supported by the institution and those who do not, need to be sensitised."* - Mid-level policymaker, MoH.

Respondents from Parliament cited the existence of a well-equipped library, but self-reported use of the facility was mixed. One respondent noted that she lacks the time to go to the library because it is in a separate building and in addition, the library does not have online access to research databases. Therefore, she resorts to sourcing for evidence from other largely unreliable sources such as the national dailies and news reports. We did not conduct an

Table 4: Rating of Frequency of Use of Various Sources of Research Evidence and Data

	*Rating		
	MoH	**Parliament**	**County**
Health Management Information System (HMIS)	3.7	2.9	3.0
Library	2.4	2.7	1.0
Research Organisations	3.1	3.0	2.0
Online resources and databases e.g. Google, PubMed, Medline, Cochrane etc.	4.1	4.2	2.0
Colleagues	3.6	4.1	3.0
List serves	2.9	2.6	1.0
Technical working groups	3.8	3.1	3.5
Conferences & seminars	3.4	3.9	4.0

Average rating using the Likert Scale, with 1 being the lowest and 5 the highest

audit of the library to ascertain to what extent it is well-equipped. However, there is an indication that it may not be well-equipped. One respondent noted that the library mainly contains references to previous Acts and Bills discussed by Parliament on various issues. Another noted that the Parliament subscribes to some publications, but only those that are relevant to Members of Parliament.

Policymakers also frequently cited that most research evidence is published in journals that require payment of a subscription and permission from the authors to access the research papers. This is a problem since their institutions (MoH and Parliament) do not offer subscriptions for relevant journals and databases, and while some staff resort to paying for the subscription "out of their pockets," this is largely out of reach for the majority of staff who cannot afford to do this. The lag time between the generation of research evidence and publishing research papers in peer-reviewed journals was also noted as a constraint to being able to acquire and use up-to-date research. Peer-reviewed journals do not allow researchers to disseminate their research findings before publishing, as noted here by one respondent:

> *"Access to critical evidence is a problem. It takes long for research to be published after its completion."* - Mid-level policymaker, MoH.

At county level, lack of access to research evidence was also frequently cited as a challenge and this was linked to two issues: lack of County-level research and data, and poor dissemination of research evidence at the County-level. The county governance systems are newly created and most of them lack structures and facilities for promoting the generation and use of research evidence and data, among other things.

To get a sense of the respondents' experiences with accessing research evidence using common sources of research evidence and data, respondents were asked to rate how often they use a number of sources of information that were listed for them (Table 8). Only mid-level policymakers were queried on this. Respondents from the Ministry tended to cite online resources including Google searches and online databases and journals as their main source of research evidence and data. Other frequently-cited sources among respondents from the Ministry were the Health Management Information System (HMIS) and the respective programmatic technical working groups they convene. Routinely-conducted surveys such as the Demographic and Health Survey were also frequently cited as key sources of data.

Respondents from Parliament tended to cite online resources, their colleagues, and conferences and seminars as their main sources for research evidence and data. They also frequently cited newspapers and TV news as key sources of information, whereas respondents from counties tended to cite conferences and seminars as their main source of research evidence and data.

Poor Data Quality and a Deficient Health Information System

Poor data quality and a deficient health information system were frequently cited as major disincentives to using routine data for decision-making. Most respondents noted that routine data is often unreliable for use in decision-making because it is incomplete (reporting rates from health facilities is low), inconsistent (validation of reports sometimes reveal inconsistencies in the data), often not well analysed (the data is often summarised, making it difficult to access data disaggregated by various characteristics), and not timely (the data cannot be made available any time a decision needs to be taken).

A number of respondents highlighted that the health information system is inefficient because it is still paper-based at the health facility level, making the process time-consuming in the context of understaffed health facilities and overwhelmed health workers. Some highlighted that health workers also lack the appreciation of the importance of data as well as the skills required to report and analyse data. Furthermore, because health facilities are not networked, health staff are unable to share relevant information real time to inform decision-making.

The assessment revealed that legislators also face similar problems with the data they obtain from government agencies. One respondent from Parliament noted that there are many instances where the data retrieved from government institutions does not tally with what they find on the ground when Parliamentary Committees undertake their own assessments, making it difficult to rely on government-generated data for decision-making. In addition, there is often a time lag in getting the data they request from government agencies and when they receive the information, which does not facilitate the high pressure environment in which they operate where decisions need to be made quickly. As a result, decisions are often made using inaccurate or insufficient data. Some of these views are highlighted below:

> *"Routine data has problems: 1. Incompleteness of reports; 2. Reports are not timely; 3. Public and private sector use different tools; and 4. A paper-based reporting system is still being used and data is highly summarised in reports."* - Top-level policymaker, MoH.

> *"For routine data, staff have capacity challenges and they will require training. The method used to collect data is manual and the data is not being analysed at the source"*- Top-level policymaker, MoH.

> *"The issue of routine data is the completeness (it has less than 50 percent reporting rate) and timeliness (it comes too late)."* - Mid-level policymaker, MoH.

> *"We don't have up to date data so we rely on old DHS data. There is lack of confidence in the quality of routine data."* - Mid-level policymaker, MoH.

> *"For routine data, quality of data is poor from under reporting and inaccuracy in reporting."* - Mid-level policymaker, MoH.

Limited or no Access to Operations Research or Research in Specialised Fields

Respondents working in highly specialised fields such as medical engineering in the MoH noted that they are unable to find local research focusing on these issues. They are therefore limited to making decisions based on research from other contexts. Respondents from Parliament working in specialised fields also cited this as a major challenge to their work. Lack of a research culture and capacity and limited funding allocation for conducting operations research in the Ministry were also frequently cited as limitations in the efforts to use research in decision-making in the Ministry. It was often highlighted that health workers at facility level do not have the mindset for interrogating the data they collect and report and have limited or no capacity or motivation to do so. Some views are presented below:

> *"Most of the research conducted has not been done by the Ministry. The Ministry does not allocate funding to research. In addition, most of the research generated is diseases-oriented. Operational research is negligible. Research on local medical engineering is also negligible. Research in this field is not well-developed in*

Kenya. Research undertaken at KEMRI is mainly clinical." - Mid-level policymaker, MoH.

"We have no mechanism for obtaining local research evidence or data on medical engineering. We rely on externally generated data which may not apply in our local context." - Mid-level policymaker, MoH.

3.3.2 Institutional barriers

Weak Leadership for Evidence Use in Decision-Making

Weak leadership for evidence use in decision-making was frequently cited as one of the main institutional bottlenecks to application of research evidence in policy and practice in the Ministry. However, policymakers also acknowledged and commended the recent establishment of the Division of Health Research and Development, many noting that this "is a step in the right direction," from a situation where evidence played little role in decision-making:

"Research evidence not given priority." - Top-level policymaker, MoH.

"Decisions are made in the boardroom without much regard for research evidence or data." - Mid-level policymaker, MoH.

"Top-level leadership in MoH are not demanding research evidence or data to help improve care." - Mid-level policymaker, MoH.

"We have just established a research unit but it has been a neglected area. People who are here now are people who are very decisive. We have realised that without data we cannot move. We need to demonstrate baseline and current data and targets when talking about progress and strategies for achieving the targets." - Top-level policymaker, MoH.

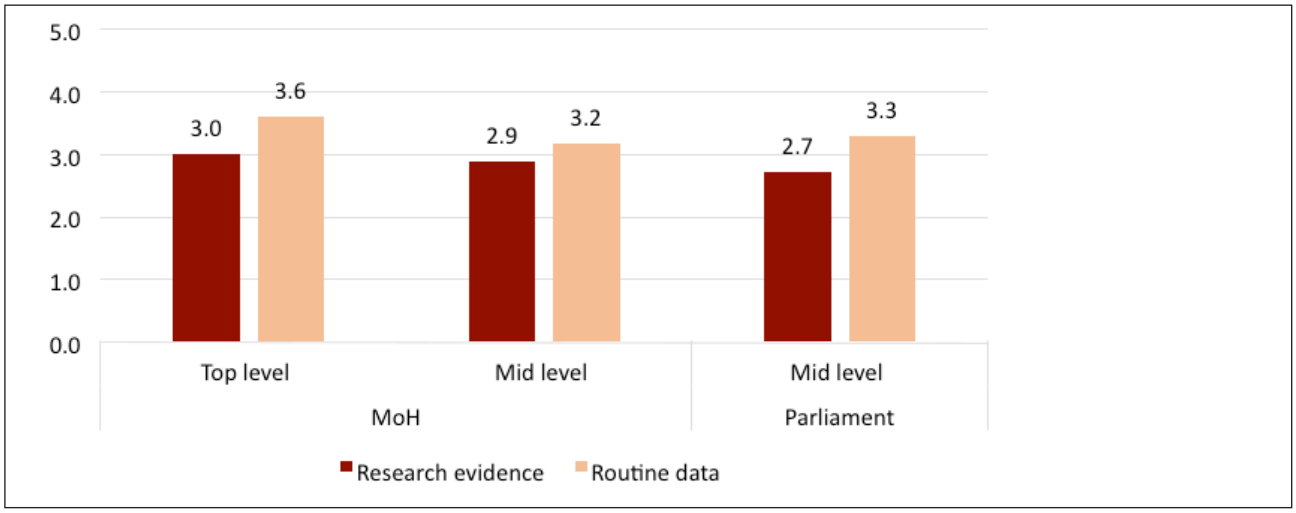
"I am happy that the government has created a Division of Health Research and Development to lead the process of coordinating research evidence and promoting its application." - Top-level policymaker, MoH.

"Recent creation of the division of Health Research and Development is an indicator that the current regime is serious about research." - Mid-level policymaker, MoH.

To obtain an objective measure of the institutional prioritisation of use of research evidence and routine data in decision-making, policymakers were asked to rate it using the 5-point Likert Scale 1 to 5 with 1 being the lowest and 5 the highest. Mid-level policymakers from the Ministry gave an average rating of around 3 for both research evidence and routine data. The rating for prioritisation of research evidence relative to routine data was marginally lower (Figure 3). Top-level decision-makers were more optimistic and provided higher ratings for the level of prioritisation of both research evidence and routine data. Their ratings, though higher, mirrored the same trend seen with mid-level policymakers, implying that routine data is given more attention than research evidence.

Interestingly, even though all parliament respondents noted that they routinely use evidence in their work, their rating closely mirrored that of their mid-level counterparts in the Ministry. On the other hand, the ratings given by County policymakers for prioritisation of both research evidence and routine data were relatively high in comparison to the other end-users from national level.

Figure 3: Rating for Institutional Level of Prioritisation of Use of Research Evidence and Data in Decision-Making



The average rating given by respondents for the Ministry's/Parliament' level of prioritisation of use of research evidence/data in decision-making, using a 1-5 Likert Scale

Inadequate Institutional Incentives for Promoting Evidence Use in Decision-Making

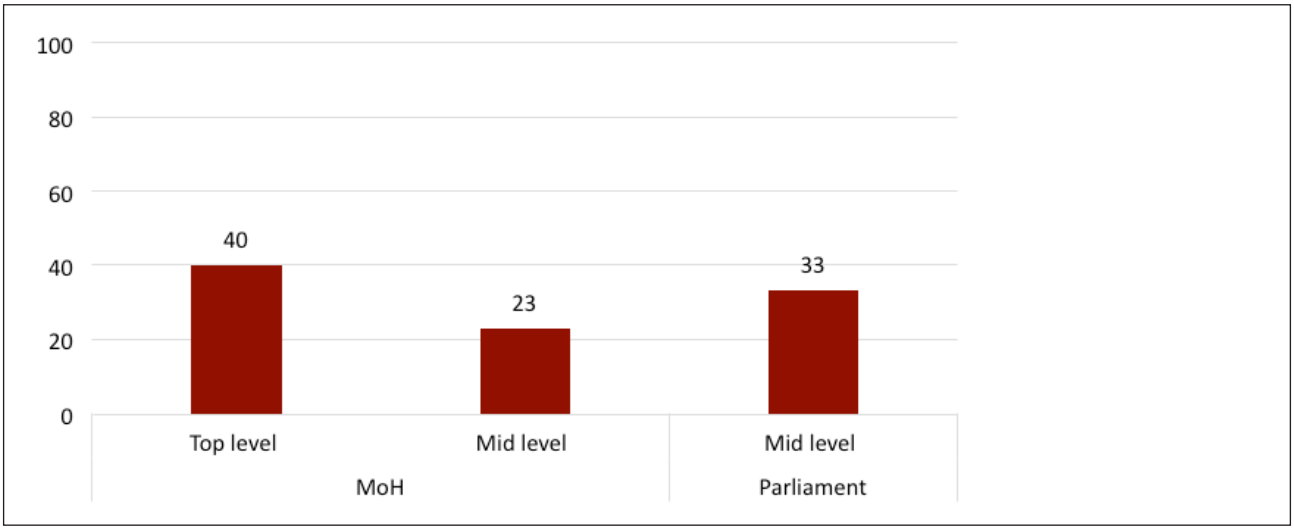
In addition to assessing institutions' prioritisation of evidence use in policy and practice, the availability of incentives to motivate evidence use was also assessed. When asked to rate this on the same Likert Scale, only 2 out of 10 and 3 out of 10 (33 percent) of the mid-level policymakers from the Ministry and Parliament, respectively, stated that there were incentives (Figure 4). One mid-level policymaker explained that:

> *"There are no incentives currently. Some suggested incentives would include promotion from one grade to another, support for conference presentations by the Ministry. Usually staff have to be supported by partners and yet they are presenting evidence from their work."* - Mid-level policymaker, MoH.

Top-level policymakers from the Ministry tended to be more optimistic on this issue though their response rate for this question was low and therefore should be interpreted with caution (only 5 respondents).

Policymakers' views on the availability of incentives to motivate staff on the use of research evidence and data in decision-making appears to be consistent with the lower rating given to prioritisation of research evidence and data.

Figure 4: Existence of Institutional Incentives for Use of Research Evidence and Data in Decision-Making

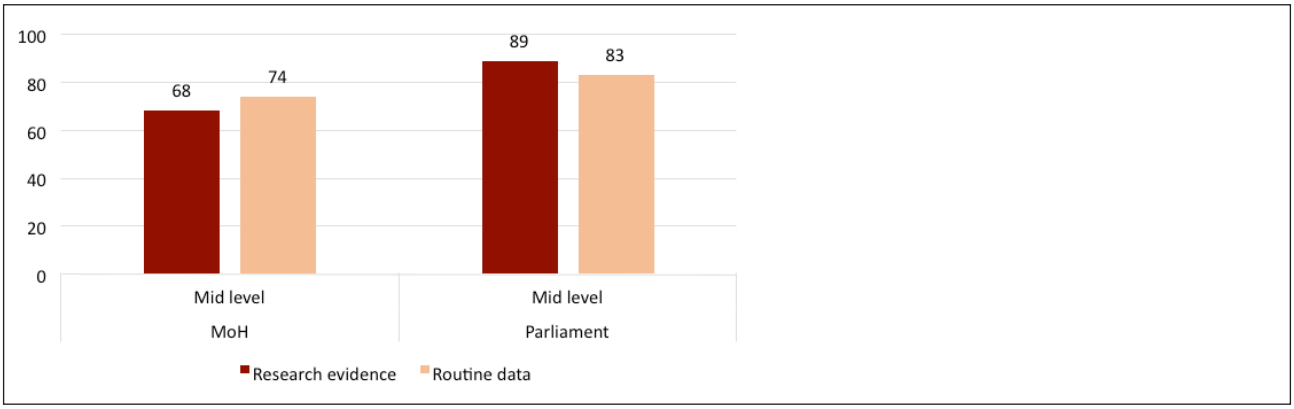


Proportion of respondents who reported that the Ministry/Parliament has put in place incentives to motivate the use research evidence/data in their work (%)

Despite the general view among policymakers that there are inadequate incentives, most respondents from the Ministry and Parliament reported that their departments have instilled a culture of using research evidence and data for decision-making (Figure 5). Top-level MoH policymakers' responses to this question were too few to draw useful inferences. and are therefore not presented in this report. Only 3 respondents provided views to this question.

The views elicited from all respondents point to a need to increase institutional prioritisation and use of research evidence and data in decision-making and the need to put in place incentives to encourage the culture of research evidence use.

Figure 5: Existence of Institutional Culture of Utilisation of Research Evidence and Data in Decision-Making



Proportion of respodents who reported that their directorate/division/unit (or their previous division within the Ministry) has instilled a culture of utilisation of research evidence/data in decision-making (%)

Inadequate Funding to Support the Generation and Use of Research Evidence in Decision-Making

Inadequate funding was frequently cited by respondents from the MoH, Parliament and County as a major institutional barrier to promoting use of research evidence and data in decision-making processes. MoH respondents noted that while government allocates some funding to KEMRI for research, most of it is used to pay salaries, whereas research activities at KEMRI are largely funded by development partners. Competing priorities and lack of prioritisation of research evidence generation were the main reasons cited to explain this, as illustrated below.

> *"There is low resource allocation for research, for example, the budget allocated to KEMRI by the government predominantly funds staff salaries. Partners fund 90% of its research activities."* - Top-level policymaker, MoH.

> *"Priority is not given to research evidence and data. KEMRI gets a very small budget and this goes to pay salaries for staff."* - Top-level policymaker, MoH.

> *"Traditionally, research has not received big budget allocation at all in MoH and this is still the situation."* - Mid-level policymaker, MoH.

> *"Even though the HIV programme sets aside money for research, all the support comes from partners. The Ministry does not see the urgency to allocate money; they say there is a lot of support from partners. There is a certain percentage in the strategic plan which should go to health information but only a fraction of this is actually given."* - Mid-level policymaker, MoH.

Among the respondents from Parliament, inadequate funding was rarely highlighted as a challenge, rather, inadequate staffing, particularly the small number of research officers, emerged as the main challenge. But, as noted elsewhere, all respondents reported that at the time of the study more research officers were being hired to support work in Parliament.

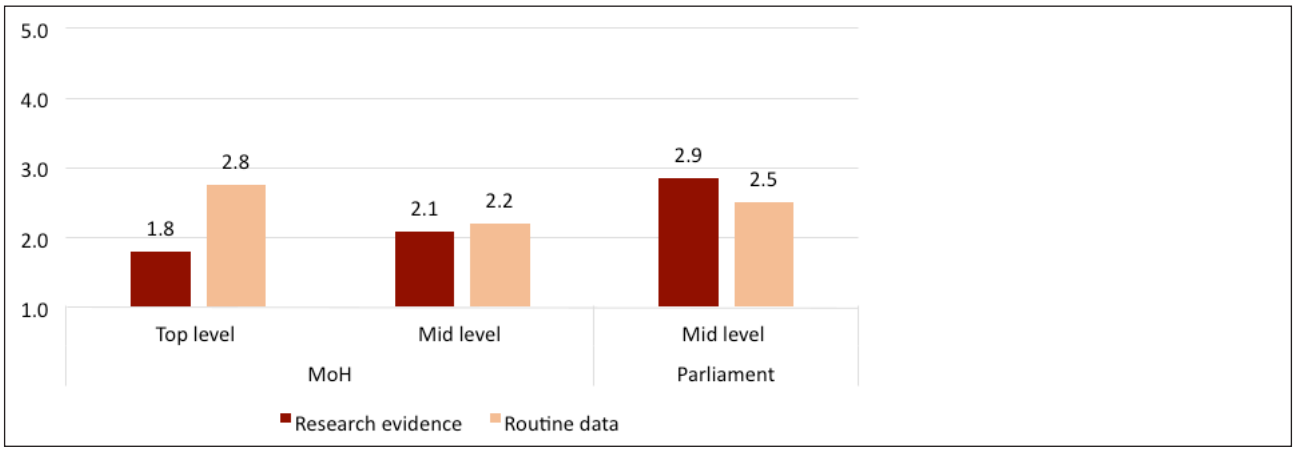
While MoH respondents lauded the establishment of the Division of Health Research and Development, they noted the need to allocate funding to the Division as it currently lacks funding to undertake its responsibilities. Some respondents also noted that

the mandate of the new division is not clear to them and recommended that the Division should lead the coordination of health research activities being undertaken country-wide.

To obtain a more objective measure of respondents' views on budget allocation to evidence use in decision-making processes, respondents were asked to rate the budget allocation on a scale of 1 to 5. The ratings varied by type of evidence and user but was generally below 3 (Figure 6). Top-level policymakers from the Ministry rated the budget allocation to research evidence much lower than the rating for the budget allocation to routine data (1.8 compared to 2.8).

Mid-level policymakers from the Ministry rated the budget allocation to research evidence and routine data the same (2.1 compared to 2.2), while their Parliament counterparts rated the budget allocation to research evidence much higher than that to routine data (2.9 compared to 2.5). Top-level policymakers from the Ministry also gave the lowest rating for the budget allocation to research evidence relative to their mid-level counterparts from both the Ministry and Parliament.

Figure 6: Rating for Institutional Budget Allocation for Research Evidence and Data in Making Decisions



The average rating given by respondents for the Ministry's/Parliament' budget allocation to support application of research evidence/data in making decisions (using the 1-5 Likert Scale)

On the other hand, top-level MoH policymakers gave the highest rating for the budget allocation to routine data relative to their mid-level counterparts from both the Ministry and Parliament. Compared to respondents from the Ministry, respondents from parliament gave the highest rating to the budget allocation to research evidence.

Low prioritisation of research evidence use in decision-making processes in the Ministry was cited as the main reason for the low rating on budget allocation to these issues.

Understaffing

Some respondents from the Ministry and Parliament noted that the staff allocated to managing the health information system and activities for generation, synthesis, translation and packaging of research are inadequate. Some felt that there are adequate numbers of staff allocated to support the health information system, but they lack adequate technical skills to do their work. Some views are highlighted below.

> *"We have now a generation of the management of Ministry at national level who are working using science – those at the highest level. We have come to a situation where there is demand for evidence. There is adequate personnel, but what we need to do is build their capacity and for them to use the research skills. We are scientific policymakers."* - Top-level policymaker, MoH.

> *"Priorities of curative services and other areas are considered and not research. KEMRI is delinked from MoH although its is a government department."*- Mid-level policymaker, MoH.

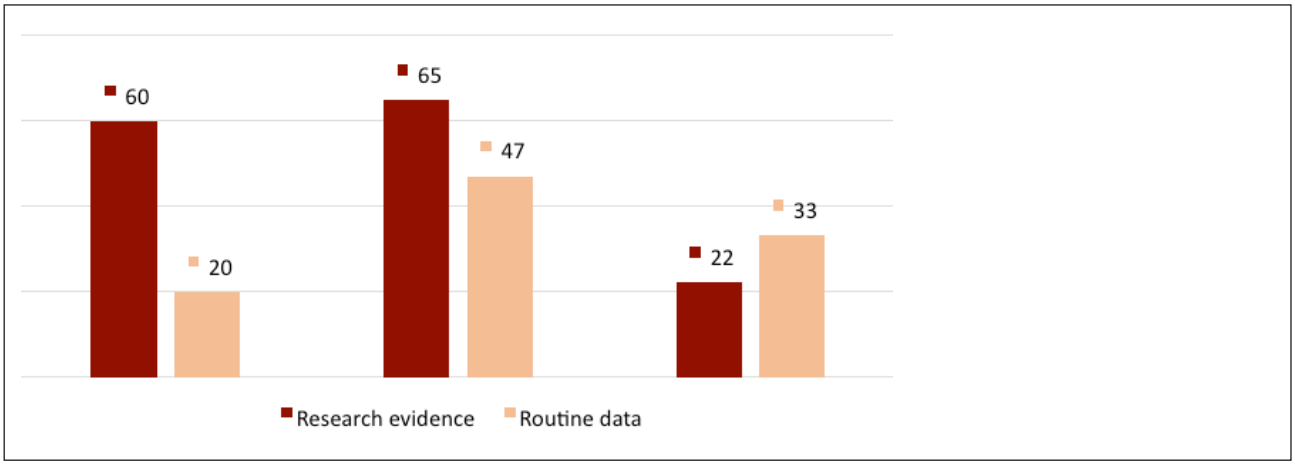
"Health information officers are available only up to district level. At health centre level, it is nurses who are collecting this information. The kind of information they are collecting is limiting because they are not collecting all aspects of health, it is focused on disease yet there are other factors that affect health. It is an area that has been neglected for some time." - Mid-level policymaker, MoH.

"It is not an issue of funding cuts because they employ nurses and doctors."- Mid-level policymaker, MoH.

"The staff for routine data are many; they just need strengthening of the skills needed. Need to put in place incentives for reporting. Some programmes are better than others e.g. HIV data reporting and management is very robust." - Mid-level policymaker, MoH.

To obtain an objective measure of staffing for research evidence and routine data use, respondents were asked whether their institutions have committed adequate personnel to support application of research evidence/data in decision-making. Nearly two thirds of respondents from the Ministry reported that staff allocation to research evidence application is inadequate (Figure 7). On the other hand, the reverse was reported for staff allocation to routine data use. The majority of top-level policymakers (80 percent) felt that there are adequate staff allocated to manage the health information system, while only half of their mid-level counterparts (53 percent) felt the same. Respondents explained that the Ministry focuses on hiring programme staff who are mainly clinicians (nurses and doctors). While there are more staff allocated to manage the health information system, they are still not adequate and at health facility level lack the capacity to undertake their duties, exacerbating the situation.

Figure 7: Existence of Adequate Personnel to Support Application of Research Evidence and Data in Decision-Making



Proportion of respondents who reported that the Ministry/Parliament has not committed adequate personnel to support application of research evidence/data in decision making (%)

Among respondents from Parliament, the extent of the shortage of staff for promoting application of research evidence is less than that noted at the Ministry and the county levels. Most respondents reported that Parliament has committed adequate personnel to supporting research evidence and routine data use in decision-making processes.

Notably, Parliament has recently hired 20 more research officers to address the acute shortage of this cadre that resulted from the introduction of the new bicameral system in 2013 in line with the 2010 Constitution. The introduction of the new parliamentary system resulted in an imbalance between available researchers relative to parliamentarians. The number of parliamentarians increased significantly (from 222 to 349), while that of researchers remained the same (10), making it difficult for researchers to meet the demands for their services. Committee clerks have been filling this gap by adding to their responsibilities the role of undertaking research synthesis and translation. This explains the relatively optimistic views on this issue among respondents from parliament.

Respondents from the County level also cited staff shortage as a major challenge as well as the lack of capacity of existing staff to generate, synthesise and translate research evidence, as captured here:

"Data management is a problem at the county level. You can count the number of health clerks (they are less than 10 for the whole County). We are using nurses and clinical officers at facilities to carry out roles of data clerks." – County Department for Health.

"There is shortage of staff across all cadres." - County Department for Health.

"Counties are new and awareness on the usefulness of research data is low." - County Department for Health.

Weak Linkages with Research Institutions

Related to the challenge of accessing research evidence and data, there was overwhelming agreement among respondents from the Ministry and Parliament that the two institutions have weak linkages with research institutions. Of note, although KEMRI (a para-statal of the Ministry) was frequently described as the research arm of the Ministry, most respondents felt that there is limited collaboration between KEMRI and the Ministry and that KEMRI's research outputs are not meeting the evidence needs of the Ministry. It was frequently cited that KEMRI focuses on clinical research, neglecting research on key social determinants of health that are also important to informing policies and programmes of the Ministry. Respondents recommended strengthening the ways KEMRI and the Ministry communicate and work together, in order to be more mutually-reinforcing. Some of their views are presented below:

"There is no structured mechanism for policy dialogue with KEMRI." – Top-level policymaker, MoH.

"There is need for stronger linkages between KEMRI and other research organisations and the Ministry. KEMRI mostly collaborates with NACOSTI . Its linkage with the Ministry is weak. We do not even get reports on what research KEMRI is undertaking." - Mid-level policymaker, MoH.

"There's need to empower the people who are employed in government to link with researchers outside government. Create the environment where the research information is harnessed. Strengthening linkages with research institutes and policy think tanks. The malaria programme works very well with KEMRI." - Mid-level policymaker, MoH.

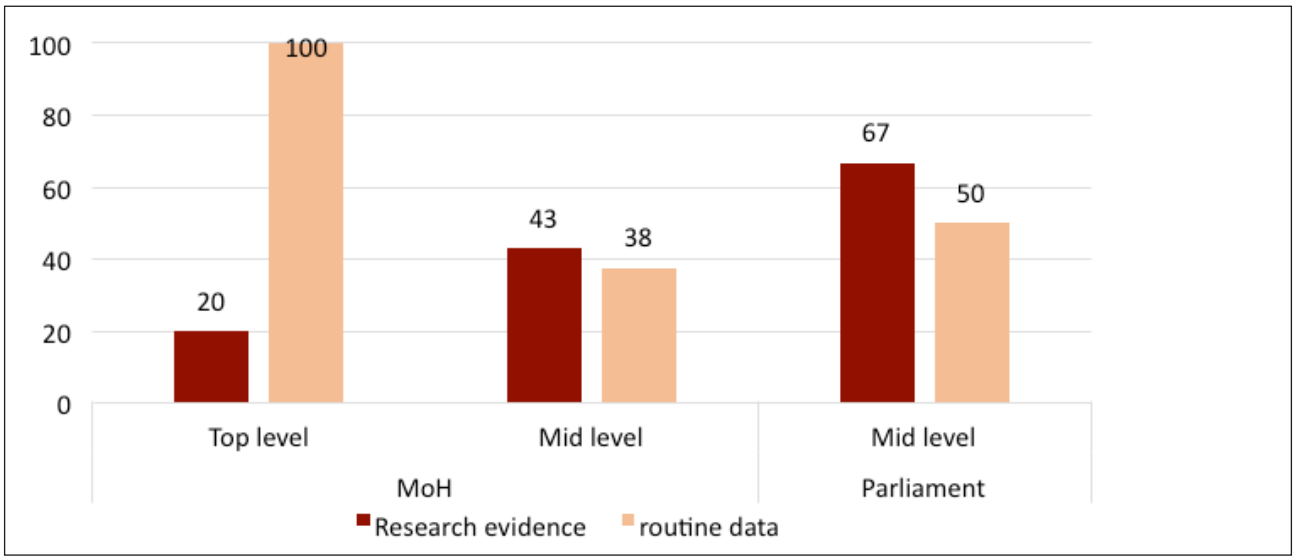
"Researchers need to collaborate with the Ministry so that their research outputs can directly inform policy formulation." - Mid-level policymaker, MoH.

"There is a disconnect between MoH and research organisations and this leads to a challenge in implementing the research evidence that they [research organisations] generate." - Mid-level policymaker, MoH

Parliament has a Research Unit tasked with supporting parliamentarians with research evidence and ideally this unit should establish linkages with research institutions and synthesise and translate it for parliamentarians and committee clerks. However, parliamentary staff indicated that they do not have any linkages with research institutions. Furthermore, the clerks' experiences with working with the Research Unit varied. One clerk noted that, "they [clerks] often source and synthesise research evidence on their own because Parliament's Research Unit does not have the capacity to meet the demand for research evidence." Another noted that, "she frequently sources research evidence from the Unit."

Indeed, more than half of mid-level respondents from the MoH (51 percent) and from parliament (75 percent) reported that there were no structured institutional mechanisms for working with research institutions. Top-level policymakers were not asked this question.

Figure 8: Existence of a Structured Mechanism for Reviewing of Research Evidence and Data in Decision-Making Processes



Proportion of respondents who reported that the Ministry/Parliament has a structured mechanism for reviewing and incorporating the research evidence/data in decision making processes (%)

Lack of Institutional Forums for Communicating Research Evidence to Top-level Decision-Makers

When respondents were asked whether their institutions have structured mechanisms for reviewing and incorporating research evidence and data in decision-making processes, responses varied by end user (Fig 10). Only 20 percent of top-level policymakers from the Ministry felt that there is a structured mechanism for reviewing and incorporating research evidence in decision-making processes, compared to 100 percent with regards to routine data. They explained that there are timelines for reporting, analysis and sharing of routine data. On the other hand, less than half of mid-level policymakers felt that there is a structured mechanism in place for reviewing and considering both research evidence (43 percent) and routine data (38 percent) in decision-making. A Ministry mid-level policymaker illustrates the institutional mechanism for routine data reporting and use as follows:

> *"Decisions made are at the prerogative of the Director. Routine data mechanism is well structured from the lowest level to the highest level. Facilities meet monthly, the district officers present their achievements and they are also updated on policies and guidelines and collect the documents and review their performance. This is collated into a district report. The district performance is reviewed and uploaded to the DHIS. Then quarterly reviews are done. It is well- structured with timelines at each level."* - Mid-level policymaker, MoH.

Respondents from the Ministry explained that reviewing and considering research evidence is often ad hoc, and existing well-structured mechanisms needed by Researcher programme-specific. There there are no similar institution-wide forums, which many felt would be useful. Within the programme structures, specific information flows from Technical Working Groups (TWGs) through Task Forces often created to undertake more in-depth reviews and assessments, through programme Interagency Committees (ICCs) and finally to the Health Sector Joint Forum. Some views are highlighted below.

"Right now it is ad hoc. There is no formal mechanism. It works well through the programme structures. Since a research committee has been established, this will be a good structure to embed this mechanism." – Mid-level Policymaker, MoH.

"No integrated or institution-wide mechanism exists. The one in place is mainly through the programme structures. We want a unified one. Let everyone be included." – Mid-level policymaker, MoH.

When a Head of Department wants to take a decision, they may request research evidence from staff in order to inform the decision. Others noted that if one finds compelling evidence they often share it with the Head of Department. However, whether the evidence is considered at MoH management meetings in which heads of departments participant is at the discretion of the Head of Department and also depends on the level of influence of the staff who provided the evidence. Others noted that bureaucracy is a bottleneck to getting evidence to be considered by decision-makers. Some of the views provided are presented below.

"The mechanism is ad hoc. One may prepare a cabinet memo, concept note and analysed data with policy option." - Top-level policymaker, MoH.

"We used to have a management committee where Heads of Units were participating, but this is not there anymore. With the new Ministry structure right now, Heads of Units take issues they would like addressed to the Directorate. They have a meeting with other heads of directorates where issues could be presented. Top management may call upon heads of units to present on specific information that they are interested in." – Mid-level policymaker, MoH.

Two-thirds (67 percent) of respondents from Parliament reported that there is a structured mechanism in place for reviewing and considering research evidence in decision-making, compared to half who reported the same for routine data. In Parliament, research evidence and routine data are sourced and used concurrently and are considered using the same mechanism. The marginal difference stems from the external forces , which are out of the control of parliamentary staff, but affect sourcing of routine data.

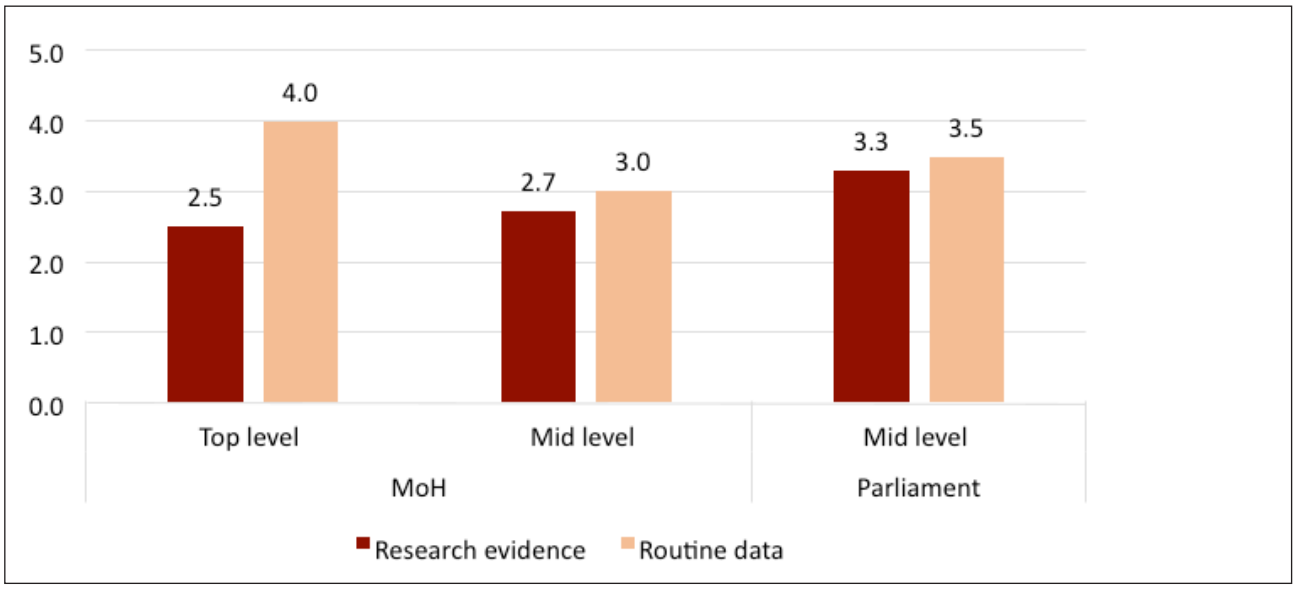
Respondents from parliament referred to the sector committee structure as the mechanism used to review and consider research evidence in decisions. The Research Unit helps Committee members gather evidence on an issue being reviewed and produces a report. The report is shared with the Clerk of the Committee for discussion by Committee members. If accepted, it is tabled in Parliament for debate and adoption.

"Researchers produce a report which is then sent to the Clerk of the Committee, this is discussed at committee level and if accepted it is sent to the chamber where it is either approved or rejected. In the event that it is rejected, a redraft may be requested." – Research Officer, Parliament.

To obtain a more objective measure of the existence of a mechanism in place for reviewing and considering research evidence in decision-making processes, respondents were asked to rate the performance of the existing mechanism using the Likert Scale. The average ratings varied across all end-users (Figure 11).

Top-level policymakers from the Ministry rated the mechanism for reviewing and considering routine data much higher than that for research evidence (4 relative to 2.5). Mid-level policymakers from the Ministry and Parliament rated the mechanisms for research evidence and routine data at around the same levels, with Parliament assigning slightly higher ratings.

Figure 9: Rating for Mechanism for Reviewing Research Evidence and Data in Decision-Making Processes



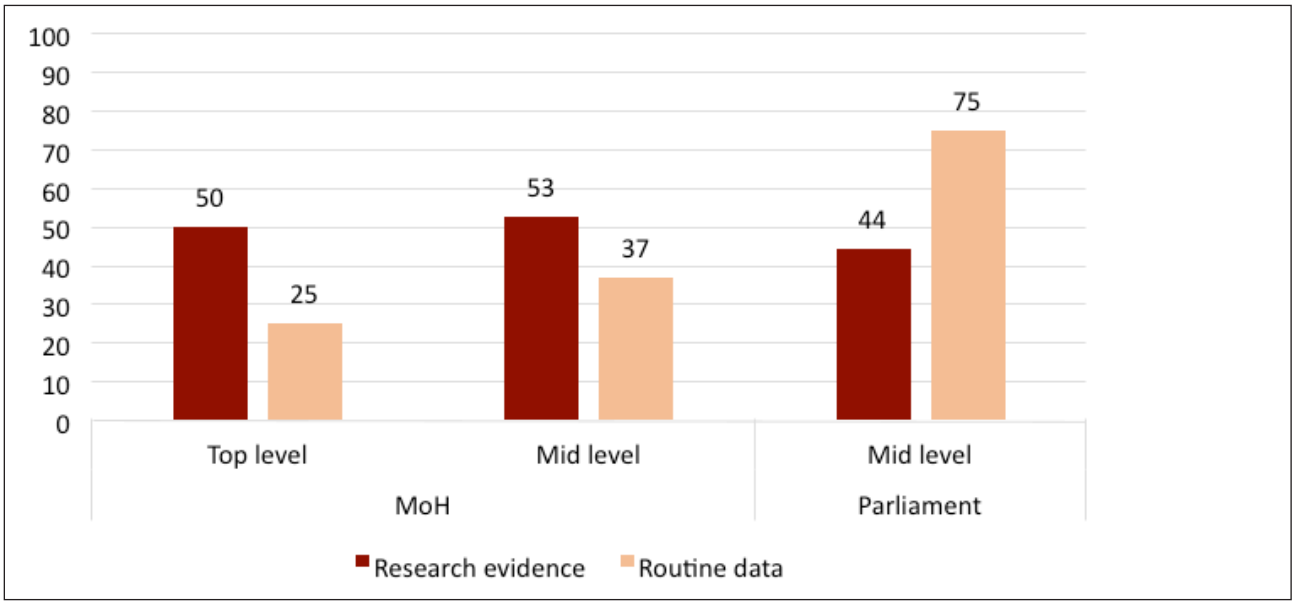
The average rating given by respondents for the mechanism for reviewing research evidence and data in decision-making process using the 1-5 Likert Scale

Lack of Guidelines for Research Evidence and Data use

Quite often respondents cited the lack of guidelines for the application of research evidence and data as a key challenge. When asked whether their institutions have written guidelines on research evidence use, half of the respondents both from the Ministry and Parliament indicated that there were none (Figure 10).

Regarding the existence of guidelines on routine data use, about 25 percent of top-level MoH respondents and 37 percent of their mid-level counterparts reported that these were lacking, whereas 75 percent of mid-level respondents from Parliament reported the same. Ministry officials explained that the guidelines are in the form of Standard Operating Procedures that outline how to access and use the routine data from the Health Management Information System (HMIS).

Figure 10: Existence of Written Guidelines on Research Evidence and Data Use



Proportion of respondents who reported that the Ministry/Parliament does not have written guidelines on research evidence/data use (%)

These findings are consistent with the views of respondents on the existence of a structured mechanism for reviewing and considering research evidence and data to inform decisions, where more respondents tended to believe that there is a structured mechanism for use of routine data and rated its performance higher than that for research evidence. Of note, given that Parliament uses the same mechanism for reviewing and considering research evidence and routine data, it is interesting that more respondents felt that there are guidelines to support research evidence use relative to routine data use.

> *"We do not have Standard Operating Procedures (SOPs) and guidelines for use of evidence for decision-making. The development of the research agenda is ongoing. Directorates have been asked to identify their research priorities for incorporation in the research agenda."* - Top-level policymaker, MoH.

> *"I have not seen any guidelines. If they exist they are probably programme-focused e.g. guidelines for disease surveillance exist. Guidelines for routine data are in draft form. They may be finalised or are in the process of finalisation."* - Mid-level policymaker, MoH. *"There is need for a policy on a Health Records System to support evidence based decision-making."* - Mid-level policymaker, MoH.

Suspicion About Motives of Research Funders and the Validity of their Research Evidence

A major barrier to using research evidence in decision-making in the Ministry and parliament is the general mistrust of research evidence funded by external or foreign agencies. It was frequently cited that Ministry policymakers consume research evidence with caution because "they mistrust external sources of data". Government policymakers often undertake investigations to identify the motives of the funders of research evidence being communicated to them, particularly those funded by external agencies. Consequently, "most decisions in the Ministry are based solely on WHO recommendations".

In Parliament, one respondent explained that committee members often ask the question: "Who funded the research and among which community was it conducted?" and proceed to try and investigate any political ties and interests linked to the research.

The fact that the government allocates very few resources to research activities and yet policymakers do not want to use research funded by external sources points to the need for government to increase its funding for research, as well as collaborate more closely with external research funders in order to co-own the research generated. Respondents from the Ministry of Health noted that there are opportunities for the Ministry to access more funding to support research through the 2 percent of GDP government commitment in the NACOSTI Act.

Politics and Personal Interest Driving Decision-Making

Decisions made in the Ministry and Parliament are often perceived to be driven by political and personal interests.. A number of respondents from the Ministry highlighted that decision-making in the Ministry is usually "unilateral" in nature or is based on political considerations, as noted in some views below.

> *"Many times top decision-makers give priority to issues of interest to them. Heads of Departments are often asked to take a position on an issue and they do not usually have time or the capacity to consider evidence, and often the decision is needed urgently."* Mid-level policymaker, MoH.

> *"Decisions are not based on evidence rather on political considerations."* - Mid-level policymaker, MoH.

Similarly, some respondents from Parliament noted that decisions are made based on political interests. A Member of Parliament may have an interest in a certain agenda and in as much as they request research evidence, if the evidence presented is not supportive of their position, they will often choose not to use the evidence.

> *"Research evidence is not taken seriously. In addition, the quality of evidence is wanting. No adequate funding is provided for research and its utilisation. Although the research team in*

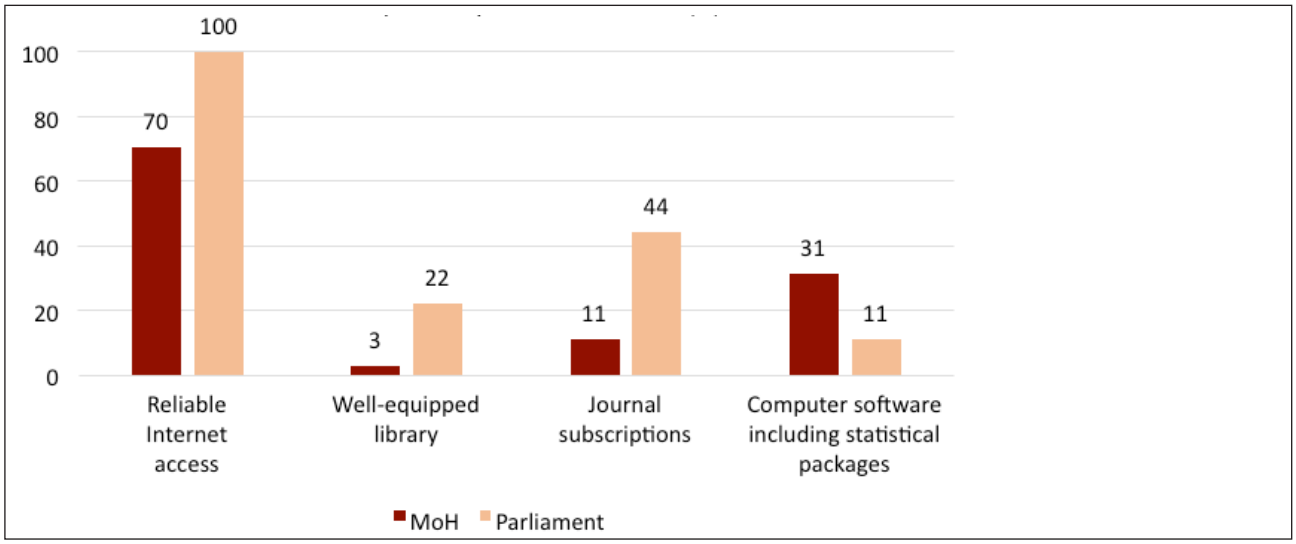
Parliament plays an important role, most decisions are made based on political considerations." - Research Officer, Parliament.

A respondent from the County also cited decision-making based on political interests as a challenge stating that, "I operate with politicians who often do not care about things to do with research."

Lack of equipment, software and systems to support sourcing and using research evidence and data Respondents from the Ministry and Parliament emphasised that it is important that once staff are trained in the skills to source, analyse and apply research evidence and data, the institution should ensure that staff have the necessary systems and software to support application of the skills learnt.

When mid-level policymakers were asked for their views on whether their institutions provided them with reliable internet connection, a well-equipped library, journal subscriptions and statistical software, responses varied by institution (Figure 11). The majority of respondents from the Ministry and all from Parliament reported that they have reliable internet access.

Figure 11: Existence of Systems and Software to Support Research Evidence and Data for Decision-Making



Proportion of respondents interviewed who reported that the Ministry/Parliament provide systems and software (%)

All except one respondent from the Ministry reported that they have no library. They explained that there used to be a library, but it was reorganised into a meeting room. Respondents from Parliament reported that a library exists, but they felt that it is not well equipped. Only 1 in 10 respondents from the Ministry reported that they are provided with journal subscriptions, while nearly half (44.4 percent) of the respondents from Parliament said the same. Respondents from the Ministry noted that journal subscriptions are offered only at the Unit level rather than at institutional level. Less than a third (31 percent) of respondents from the Ministry indicated that they are provided with statistical packages while only 11 percent from Parliament reported the same. Respondents from the Ministry who are provided with statistical packages tended to be staff in the Health Information and Policy and Planning units. Some views are highlighted below.

"Statistical packages are probably just for the staff working in the HMIS Unit. Other staff have to work with partners to get what they want." - Mid-level policymaker, MoH.

"Subscriptions for journal articles are not offered at organisational level. Staff get individual journal subscriptions if they [staff] can afford it." - Mid-level policymaker, MoH.

The County-level appears to be worse off than the national level. All respondents from the Counties reported no access to a library, journal subscriptions or computer software.

3.3.3 Individual Barriers

Inadequate Technical Skills to Gather, Analyse, Interpret, Synthesise and Translate Research Evidence

Respondents from the Ministry frequently cited inadequate knowledge and skills to collect and analyse data and access, synthesise and translate research evidence as a major barrier to using research evidence. Parliament staff also noted that they find it difficult to interrogate bills drafted by the Ministry because often the bills do not refer to research evidence.

Furthermore, there was overwhelming agreement among Ministry policymakers that there is a huge staff capacity gap in data collection, reporting and on-site analysis (at health facility level), which affects the quality and reliability of routine data and ultimately lowers its usefulness in decision-making. Many respondents felt that there is a need to sensitise health workers about the importance of data for decision-making as well as train them in basic data analysis for them to appreciate its importance in decision-making.

Even though accessing, synthesising and translating research evidence is the core responsibility of research staff in Parliament, they expressed a need for strengthening their knowledge and skills through continuous learning in this field. Parliamentary clerks also expressed a need for strengthening their knowledge and skills particularly in policy analysis and the development of reports and policy briefs. Some views are highlighted below.

> *"Staff who collect data have no capacity to analyse it. Data collectors must be skilled and knowledgeable in data collection."* - Top-level policymaker, MoH.

> *"Health facility managers are incapable of analysing it and therefore they do not use it for decision-making."* - Top-level policymaker, MoH.

> *"Operational research is not institutionalised due to inadequate capacity and lack of mentors."*- Mid-level policymaker, MoH.

> *"There is inadequate information to plan with in the Ministry, under-reporting and inadequate capacity to generate reliable information."* - Mid-level policymaker, MoH.

Lack of Time Due to Competing Demands on the Job

Respondents from the Ministry and Parliament frequently noted that they struggle to find time to source and synthesise research evidence due to competing tasks. This is further aggravated by the difficulty in quickly accessing the research evidence that they need in a simply packaged form for their consumption. They noted that most research papers that they find or are given are usually too scientific and difficult to interpret and therefore they are unable to use the evidence.

> *"Our scientists need to know how to package their research into a palatable language for policymakers…Most of the research in Kenya is academic. It is published and not used beyond that. It is not translated to inform policies. Policy briefs are not generated." - Top-level policymaker, MoH.*

> *"Research evidence is not always translated for use by policymakers."* - Mid-level policymaker, MoH.

> *"Available research evidence is not simplified. It uses scientific jargon making it difficult to use especially by those making decisions."* - Mid-level policymaker, MoH.

> *"It is not packaged in a way that it can be used by policymakers and it takes too much time to access the research."* - Mid-level policymaker, MoH.

> *"Researchers need to package their research evidence to make it easier to understand. They should highlight the cost implications of the research or its socio-economic impact for the community."* - Mid-level policymaker, MoH.

3.4 Researchers' Views on the Main Challenges and Constraints to the Uptake of Research Evidence and Data by Policymakers

We sought to understand the challenges and constraints faced by researchers in promoting use of their research output and how they align to those mentioned by policymakers. Researchers were asked to rate a predetermined list of challenges and constraints to using research evidence using the 1 to 5 Likert Scale. They were also asked to highlight others not listed (Table 5).

They gave the highest average rating (over 4) to poor coordination between research and policymaking institutions, inadequate interaction between researchers and policymakers and insufficient funding for translation of research evidence. Inadequate technical capacity of policymakers to apply research evidence and insufficient funding for dissemination of research evidence both received an average rating of close to 4.

Table 5: Ratings by Researchers on Challenges and Constraints to Uptake of Research Evidence and Data by Policymakers

Challenges and constraints	*Rating
Lack of prioritisation of use of research evidence in decision-making	3.63
Inadequate participation of researchers in knowledge sharing platforms	3.70
Inadequate interaction between researchers and policymakers	4.11
Inadequate technical capacity of researchers to translate research evidence for policy audiences	3.22
Inadequate technical capacity of researchers to communicate research evidence to policy audiences	3.30
Inadequate technical capacity of policymakers to apply research evidence	3.85
Insufficient funding for translation of research evidence	4.11
Insufficient funding for dissemination of research evidence	3.96
Poor coordination between researcher institutions and policymaking institutions	4.26

These findings mirror those highlighted by policymakers.

3.5 Recommendations on How Identified Challenges and Constraints can be Addressed

3.5.1 Policymakers' Views

Policymakers were asked to recommend ways in which the challenges and barriers to the use of research evidence in decision-making that they faced could be addressed. Their recommendations fall into two main categories: interventions to strengthen institutional support and interventions to improve technical knowledge and skills of individual staff, as summarised in Table 6.

Table 6: Recommendations from Policymakers for Tackling the Constraints and Challenges to Using Research Evidence in Decision-Making

MoH	Parliament	County
Enhance Institutional Support		
• Sensitise the top-level leadership on the benefits of research evidence in decision-making • Inculcate institutional culture of research evidence use • Allocate funding to research and its application, including funding for the new Division of Health Research and Development • Establish a repository for health research • Establish or strengthen forums for discussing research evidence/data with decision-makers • Provide statistical software to programme staff to use for analysis of data • Strengthen linkages between the Ministry and research institutions	• Hire more staff to address time constraint; it was indicated that this is now being addressed • Provide equipment and software to support analysis and packaging of research evidence • Strengthen linkages with research producers including subscribing to publications and establish in-house mechanisms for sharing and discussing research evidence • Develop guidelines on sourcing, appraising, synthesising and using evidence to support parliamentary decision-making	• Increase resource allocation to research evidence use • Prioritise research evidence use in decision-making • Strengthen linkages with research institutions • Hire staff skilled in research generation and use
Improve Technical Knowledge and Skills		
• Train staff in accessing, appraising, synthesising, translating and communicating research evidence/data • Better time management	• Train researchers and committee clerks in analysis and packaging data and research evidence to address the capacity constraint	• Train staff in research generation and use particularly translation and packaging of research evidence • Better management of politicians

3.5.2 Researchers' Recommendations

Researchers were asked to suggest demand-side and supply-side solutions on how the challenges and constraints they highlighted could be addressed. Like the recommendations offered by policymakers, their recommendations fall into two main categories: interventions to strengthen institutional support and improve technical knowledge and skills. These are summarised in Table 7.

The findings illustrate that researchers' and policymakers' views on how to address the highlighted constraints are well aligned. In addition to the need to strengthen linkages between policy and legislative institutions and research institutions, respondents acknowledge that there is need to make their research available locally and easily accessible to policymakers, translate and package the findings to meet policymakers' needs and build researcher capacity to do so.

Researchers also noted the need to align their research to national health and health research priorities. Also highlighted is the need to involve policymakers in the design and implementation of research.

Table 7: Researchers' Recommendations for Addressing Constraints to Using Research Evidence in Decision-Making

Demand-side	Supply-side
Enhance Institutional Support	
Establish a single national repository of all research being undertaken	Increase access to relevant research including making them available locally
Collaborate with research institutions	Strengthen linkages between research and policy institutions
Policy institutions to employ research-competent staff	Research organisations should hire policy-minded/ trained personnel
The newly introduced research division in the MoH should organise regular consultative forums with researchers	Hold regular forums for dialogue and sharing research evidence with policymakers
Participatory formulation of health sector policy to involve researchers	Align research to the national health and health research priorities
	Allocate funding for translation and dissemination
	Synthesise and package research evidence for use by policymakers
Improve Technical Knowledge and Skills	
Train staff to source and use research evidence	Train researchers in packaging of research evidence and its communication
Sensitize of policymakers on the importance of research evidence in decision-making	
Actively engage scientists in policymaking forums	Collaborate with policymakers in conducting research
Participate in scientific workshops and conferences	

3.6 Policymakers' Views on Proposed SECURE Health Programme Interventions

To inform the SECURE Health programme interventions for the next two and half years (2014-2016), mid-level policymakers were asked to rate four proposed interventions for strengthening collaboration, linkages and institutional systems to support research evidence use in the Ministry on a Likert Scale of 1 to 5. Table 8 summarises these findings.

Table 8: Policymakers' Rating on Proposed SECURE Health Interventions for Strengthening Collaboration, Linkages and Institutional Systems

Proposed Interventions for Strengthening Collaboration, Linkages and Institutional Systems			
	***Average Rating**		
Intervention	**MoH**	**Parliament**	**County**
Policymaker-researcher pairing scheme	4.69	4.56	2.50
Strengthen effective linkages between your organisation and research institutions	4.83	4.78	4.50
Develop an institutional research agenda in order to communicate evidence gaps and guide research activities	4.81	4.78	4.50
Develop guidelines for sourcing, assessing and using research evidence	4.83	4.56	3.00

While the average rating for all four interventions ranged between 4 and 5, policymakers rated the following 3 interventions highest (Table 8):

- Strengthen effective linkages between policymaking and research institutions
- Develop an institutional research agenda in order to communicate evidence gaps and guide research activities
- Develop guidelines for sourcing, assessing and using research evidence

Mid-level policymakers were also asked to rate a number of proposed training topics to improve their knowledge and skills in sourcing, appraising, translating, communicating and applying research evidence. These findings are captured below in Table 9.

County respondents rated these topics lower than their counterparts in MoH and Parliament. The average rating for all proposed topics ranged between 3.5 and 5 among respondents from MoH and between 2.5 and 5 among respondents from the County. The following 3 topics rated slightly higher than the rest (Table 9):

- Developing policy briefs;
- Presenting research results to top-level decision-makers;
- Assessing the relevance and applicability of research evidence to the key issues that concern your work (only among respondents from MoH);
- Developing PowerPoint presentations (only among respondents from the County).

Table 9: Ratings by Policymakers on Proposed SECURE Health Programme Skills Training Topics

Proposed Topics							
	*Average Rating				*Average Rating		
Topic	MoH	Parliament	County	Topic	MoH	Parliament	County
Defining knowledge gaps that need to be addressed to make policy decisions	4.47	4.11	2.50	Adapting findings from other contexts	4.35	4.22	4.00
Understanding the basics about various research methodologies (for example, the difference between an experimental and an observational research study)	4.47	3.89	2.50	Presenting research results to top-level decision-makers	4.68	4.78	4.50
Identifying and searching for research evidence in relevant journals and online databases	4.35	3.78	3.00	Developing charts, tables, graphs etc. from data sets or reports	4.56	4.00	3.50
Assessing the relevance and applicability of research evidence to the key issues that concern your work	4.68	4.00	3.50	Developing PowerPoint presentations	4.12	4.00	4.50
Assessing the strength or quality of evidence that you find (or knowing how to determine what is credible vs what is poor quality or weak)	4.57	4.11	4.50	Developing policy briefs	4.71	4.67	4.50
Synthesising and summarising research evidence from different sources and drawing key messages	4.51	4.11	2.50				

** Average rating using the 1 to 5 Likert Scale, figures highlighted in red signify the highest ratings*

3.7 Outcome of the Validation Meeting

The results of the needs assessment study were largely accepted as reflecting the status and challenges linked to evidence use in decision-making processes in Kenya's health sector. An overarching sentiment was that *"a lot of research evidence is generated, but very little is used to inform decision-making in the health sector in Kenya"*. The Director of Medical Services (DMS) at the Ministry of Health officiated the meeting and committed to steward the following initiatives to address the barriers to evidence use in the Ministry in collaboration with partners such as the SECURE Health programme.

- Increase access and utilisation of research evidence
    - Form advisory teams that will synthesise emerging research evidence on different health policy issues and advise him on the policy options that the Ministry needs to take in order to tackle the issues.
    - Establish a Health Observatory, a one-stop shop for all health research evidence produced in the country.
    - Put in place incentives to encourage a reading culture among Ministry policymakers and health workers and use of research evidence in drafting of policies and programme design, e.g. revamp the Ministry library and writing retreats for staff to write papers for publication.
- Improve skills in synthesis, translation and application of research evidence.
    - Promote training of policymakers in research evidence synthesis and translation, e.g. development of before policy briefs.
- Promote evidence informed decision-making
    - Initiate a review of existing policies developed by the Ministry to assess whether they are evidence informed, cost-effective and efficient. The Free Maternity Services policy was highlighted as an ideal policy to start this assessment.
    - Promote allocation of funding based on evidence of burden of disease and health conditions.
- Promote collaboration between health researchers and policymakers at the Ministry

4. DISCUSSION AND CONCLUSION

The main aim of the study was to understand the institutional and technical capacity needs of policymakers that should be addressed in order to realise increased demand for and use of research evidence and data in decision-making processes. The purpose was to use the information generated by the study to refine the proposed interventions of the SECURE Health programme. While the proposed interventions were initially informed by a scoping study conducted in 2013, there was need to collect more representative views through a comprehensive and in-depth study.

Overall, our study revealed that policymakers in Kenya recognise the importance of using research evidence in decision-making, but in practice use of research evidence and data in decision-making is curtailed by a number of challenges and constraints.

Our findings on the challenges and constraints to use of research evidence and data largely confirm those of the scoping study conducted in Kenya in 2013 and also what the broader literature presents on this issue.

The study also revealed that the SECURE Health programme was conceptualised at an opportune time, as the policy environment in Kenya is ripe and receptive to efforts that seek to strengthen the role of research in decision-making.

Indeed, our consultations and interviews with top-level and mid-level decision-makers in MoH, Parliament and the three County Health Departments have revealed that there are ongoing processes aimed at increasing research use in decision-making and which the SECURE Health programme can support and build on as presented in Table 10 below.

Table 10: Opportunities for the SECURE Health Programme

MoH
• Recently established the Division of Health Research and Development mandated to provide leadership in three result areas: coordination and partnerships, research for health and capacity building, and technical support to Counties, among other activities as assigned by the MoH. The division is currently working with academic institutions to establish a coordination mechanism for health research country-wide. • Currently the Division is developing a National Health Research agenda and priorities.
Parliament
• Has a Research Unit that is currently being strengthened through hiring more Research Officers. The Research Unit is also in the process of creating linkages with Research Institutions. • Has a training institute, the Centre for Parliamentary Studies and Training (The CPST) mandated to empower all staff of Parliament, including parliamentarians with knowledge and skills to enable them to carry out their responsibilities.
Counties
• Most health responsibilities have been devolved to the Counties and there is a great need to build both individual and institutional capacity at County level to enable research use in decision-making.

These identified opportunities and the emerging institutional and technical capacity needs have informed minor refinements to the proposed SECURE Health Programme. The main tenets of the programme have been maintained with changes mainly focused on content and approaches suggested or emphasized as important by the respondents. Objectives 1 and 2 were merged because they were found to be very strongly interconnected and interdependent. In addition, two interventions were dropped: 1) under objective 1, the activity "convening high-level meetings" was dropped because the project team noted that there were existing high level meetings in the Ministry and Parliament on which the project could leverage; and (2) under objective 2, the activity "pairing researchers and policymakers to promote uptake of research evidence" because it emerged that the extent of support that would be required for this

intervention to work was beyond the scope of the programme.

It is worth noting that the assessment used a participatory approach, which lends itself to the success of implementation of the needs assessment. The assessment was incorporated as part of the work plan of the Division of Health Research and Development.

In conclusion, despite the limitations of the study, the fact that the findings confirmed the results of the scoping study of 2013 and mirrored the broader literature on the main challenges and constraints to application of research evidence by government officials and parliamentarians and proven approaches of working with them.

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APPENDICES

- APPENDIX I: SECURE Health Baseline/Needs Assessment Tools
- APPENDIX II: Sampled Ministry of Health Directorates, Divisions and Units
- APPENDIX III: SECURE Health introduction and interviews request letter to the Principal Secretary, Ministry of Health
- APPENDIX IV: SECURE Health introduction and interviews request letter to Parliament SECURE Health introduction and interviews request letter
- APPENDIX V: SECURE Health programme summary

APPENDIX I: SECURE Health Baseline/Needs Assessment Tools

MINISTRY OF HEALTH

Assessment of top-level Decision-makers' capacity to use research evidence in policy formulation and programmeme design and implementation

Informed Consent

Date of interview:

Start time:

Name of interviewee (optional):

Name of organisation:

Name of Directorate:

Level of Parliament:

Position of interviewee:

Hello. My name is _____ and I work for the African Institute for Development Policy. The African Institute for Development Policy (AFIDEP), in collaboration with the Consortium for National Health Research (CNHR), ECSA-Health Community, and FHI 360, is implementing a programmeme of work with the Ministry of Health on strengthening capacity for data and research evidence use in health sector decision-making in Kenya – SECURE Health. The programmeme is funded by the UK Division for International Development (DFID).

The programmeme entails working collaboratively with the Ministry of Health and Parliament to design and implement interventions that optimise access and use of data and research evidence in health-related policy decision-making, planning and programmeming in Kenya.
This survey will help us understand the current level of capacity of the Ministry of Health/Parliament to use research evidence in decision-making and the factors that influence capacity to use research evidence in decision-making. The information will guide the design of appropriate interventions to enhance capacity, in consultation with Ministry of Health/Parliament Officials. The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.
Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey since your views are important.
Will you participate in this survey? Yes/No

RESPONDENT AGREES TO BE INTERVIEWED

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us produce a detailed transcript of our conversation since it is not possible for me to write everything that you will say during the interview. We will ONLY use the audio-recording to transcribe the interview and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose, and if the answer is still NO, then continue with the interview, recording as much detail as possible and type-up the full transcript of the interview within 24 hours.

RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED

0 No

1 Yes

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____ Date:_____

Development of the survey instrument

This survey instrument is adapted from *"Is research working for you? A self- assessment tool and discussion guide for health services management and policy organisations"* developed by the Canadian Health Services Research Foundation (undated) and *"Operational Manual for Strengthening Institutional Capacity to Employ Evidence in Health Policymaking for Developing Countries: The Nigeria Experience"* developed by Uneke C. J. et al, 2010 . The present instrument was developed and reviewed by the Secure Health programmeme partners including the Kenya Ministry of Health.

A: Background

1. [Interviewer, please note sex of respondent]	1. Male 0. Female
2. How many years have you been working in your current position?	0. < 1 year 1. 1-5 years 2. 6-10 years 3. >10 years
3. How many years have you worked in this organisation?	0. <1 year 1. 1-5 years 2. 6-10 years 3. >10 years
4. How many technical staff work in this division/unit? # _____ I don't know _____	

B. Policy-makers' research needs

5. What do you consider to be the key research needs in the health sector?
6. Why are these research needs a priority to the health sector?
7. Describe the health research that your directorate is undertaking?

C. Policy-makers' views and understanding of use of research evidence/data in decision-making

8. Do you think the use of research evidence to inform decision-making is important? To what extent is this so, in your view? Probe: • What are the risks of not using research evidence?	1. Male 0. Female
9. On a scale of 1-5 with 1 being lowest and 5 being highest, how would you rate the importance of using research evidence/data in decision-making? Probe: • Research evidence • Routine data	1 - lowest 2 3 4 5 - highest

D. Barriers and capacity constraints to application of research evidence in decision-making and potential solutions & interventions

10. What do you see as the main barriers to the use of research evidence/data in decision-making and practice in the heath sector in Kenya? Probe: • Research evidence • Routine data	
11. What are the 3 main personal capacity constraints that impede effective utilisation of research evidence/data in decision-making? Probe: • Research evidence • Routine data	1. _____ 2. _____ 3. _____
12. How can these be addressed?	1. _____ 2. _____ 3. _____

13. What are the 3 main capacity constraints your staff have that impede them from effective utilisation of research evidence/data in decision-making? Probe: • Research evidence • Routine data	1. _____ 2. _____ 3. _____
14. How can these be addressed?	1. _____ 2. _____ 3. _____
15.What are MoH/Parliament's 3 major challenges that hinder the utilisation of research evidence/data in decision-making?	1. _____ 2. _____ 3. _____
16.How can these be addressed?	1. _____ 2. _____ 3. _____

E: Management and institutional support for use of research evidence/data in decision-making

Issue	Rating
17.What policies are you putting in place to ensure that research evidence is used for decision-making in MoH?	
18. How are you prepared to fund the research component at MoH? Probe: • Conducting research versus application of research evidence • Are there available partners/stakeholders who would like to support research at MoH?	
19.On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate MoH/Parliament's level of prioritisation of use of research evidence/data in decision-making? Please explain. Probe: • Research evidence • Routine data	
20. Has MoH/Parliament committed adequate personnel to support application of research evidence/data in decision-making? Please explain. Probe: • Research evidence • Routine data 21.What do you think could be the contributing factor?	
22. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate the MoH/ Parliament's budget allocation to support application of research evidence/data in making decisions? Please explain. Probe: • Research evidence • Routine data • We are interested in the budget allocation to application of research evidence/data? 23. What do you think could be the contributing factor? Additional probes if one can provide information: • Do you know how much MoH allocates or what proportion of the research budget? • Has there been an increase in the budget allocation for research over the past 1 – 3 years? • Who else supports MoH's research budget?	
24. Does MoH/Parliament have written guidelines on research evidence/data use? Please explain Probe: • Research evidence • Routine data	

25. Do you think it is useful to have this in place? Probe: • Research evidence • Routine data
26. Does MoH/Parliament have a structured mechanism for reviewing and incorporating the research evidence/data in decision-making processes? Please explain Probe: • Organisation level • Directorate/division level • Research evidence • Routine data • If you came across relevant research, how would you present it to decision-makers? • When major decisions are made, do top-level decision-makers allow time on the agenda for considering research evidence? Please explain
27. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate this mechanism? Probe: • Research evidence • Routine data
28. Would you say that your division/unit has (or your previous division) instilled a culture of utilisation of research evidence/data in decision-making? Please explain Probe: • Research evidence • Routine data
29. Does MoH/Parliament have any incentives to motivate you to use research evidence /data in your work? 30. If yes, please list the incentives 31. If no, what incentives would motivate you to use research evidence/data in your work?

F. Potential solutions & interventions for improving staff and institutional capacity to use research evidence/data

32. What interventions would strengthen the use of research evidence by individuals and institutions in Kenya?	

G. MoH's current programme priorities

Finally, the planned MoH-SECURE Health capacity building programme cannot focus on all programme areas within the MoH/Parliament. Thus, which programme areas are a priority for the MoH?

Conclusion

Given the focus of this interview, is there any other information that you think will be useful in strengthening the Ministry of Health/Parliaments capacity to utilise research evidence, which you would like to share with me?
Thank you so much for your invaluable insights on this issue and for your time.
The results of this assessment will be shared with you and other stakeholders through a formal stakeholder validation meeting.

MINISTRY OF HEALTH

Assessment of mid-level decision-makers' capacity to use research evidence in policy formulation and programme design and implementation Date of interview:

Informed Consent

Start time:

Name of interviewee (optional):

Name of organisation:

Name of Division/Unit:

Level of Parliament:

Position of interviewee:

Hello. My name is _____ and I work for the African Institute for Development Policy. The African Institute for Development Policy (AFIDEP), in collaboration with the Consortium for National Health Research (CNHR), ECSA-Health Community, and FHI 360, is implementing a programme of work with the Ministry of Health on strengthening capacity for data and research evidence use in health sector decision-making in Kenya – *SECURE Health*. The programme is funded by the UK Department for International Development (DFID).

The programme entails working collaboratively with the Ministry of Health and Parliament to design and implement interventions that optimise access and use of data and research evidence in health-related policy decision-making, planning and programming in Kenya.

This survey will help us understand the current level of capacity of the Ministry of Health/Parliament to use research evidence in decision-making and the factors that influence capacity to use research evidence in decision-making. The information will guide the design of appropriate interventions to enhance capacity, in consultation with Ministry of Health/Parliament Officials. The survey usually takes 60 minutes to complete. You will not be identified by name in any reports or analyses of the results of these interviews.

Participation in this survey is voluntary and you can choose not to answer any individual question or all of the questions. You can stop the survey at any time. However, we hope that you will participate in this survey since your views are important.

Will you participate in this survey? Yes/No

RESPONDENT AGREES TO BE INTERVIEWED

0 No

1 Yes

I would also like to ask for your permission to record the interview. The purpose of recording is to enable us produce a detailed transcript of our conversation since it is not possible for me to write everything that you will say during the interview. We will ONLY use the audio recording to transcribe the interview and we will delete the audio file soon after the transcription.

Is it fine for me to record the interview?

IF YES – Go ahead to record the Interview

IF NO – Try to explain again the purpose, and if the answer is still NO, then continue with the interview, recording as much detail as possible and type-up the full transcript of the interview within 24 hours.

RESPONDENT AGREES FOR INTERVIEW TO BE RECORDED

0 No

1 Yes

At this time, do you want to ask me anything about the survey?

Signature of interviewee: _____ Date:_____

Development of the Survey Instrument

This survey instrument is adapted from *"Is research working for you? A self- assessment tool and discussion guide for health services management and policy organisations"* developed by the Canadian Health Services Research Foundation (undated) and *"Operational Manual for Strengthening Institutional Capacity to Employ Evidence in Health Policymaking for Developing Countries: The Nigeria Experience"* developed by Uneke C. J. et al, 2010. The present instrument was developed and reviewed by the Secure Health project partners including the Kenya Ministry of Health.

A: Background

1. [Interviewer, please note sex of respondent]	0. Male 1. Female
2. How many years have you been working in your current position?	0. <1 year 1. 1-5 years 2. 6-10 years 3. >10 years
3. How many years have you worked in this organisation?	0. <1 year 1. 1-5 years 2. 6-10 years 3. >10 years
4. How many technical staff work in this directorate/division/unit? # _____ I don't know _____	

B. Policymakers' Views and Understanding of and Capacity to Use of Research Evidence / Data in Decision-making

5. What does "use of research evidence/data in decision-making" mean in relation to your job? Probe: • Research evidence • Routine data	
6. On a scale of 1-5, with 1 being the lowest and 5 being the highest, how would you rate the importance of using research evidence/data in decision-making? Probe: • Research evidence • Routine data	1 - lowest 2 3 4 5 - highest
7. Does your job description require you to use research evidence/data in your work? Probe: • Research evidence • Routine data	0. No 1. Yes 2. Not explicit
8. Tell me about the most recent time when you used research evidence/data in your work. Probe: • Research evidence • Routine data • What, why, when, how, where	
9. On a scale of 1-5, with 1 being the lowest and 5 the highest, how often do you use research evidence/data in your work? Probe: • Research evidence • Routine data If never or rarely, Please explain why	1 - lowest 2 3 4 5 - highest
10. On a scale of 1-5, with one being the lowest and 5 the highest, how often do you use the following sources of research evidence/data? Please explain a) Health Management Information System (HMIS) b) Library c) Research Organisations d) Online resources and databases e.g. Google, PubMed etc. e) Colleagues f) List serves (online knowledge exchange platforms) g) Technical working groups h) Conferences & seminars i) Others (please specify)– note as mentioned _____	1 - lowest 2 3 4 5 - highest
11. Have you received any training on Research Methods and when (year)? Please describe.	0. No 1. Yes
12. Can you use statistical packages to analyse data? Please list which one	0. No 1. Yes
13. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate your competence in using those statistical packages?	

C. Barriers and Capacity Constraints to application of research evidence in decision making

14.Generally, what do you see as the main barriers to the use of research evidence/ data in decision-making and practice in the heath sector in this country?	
15. What are the 3 main personal capacity constraints that impede you from effective utilisation of research evidence/data in decision-making?	1. _____ 2. _____ 3. _____
16.How can these be addressed?	1. _____ 2. _____ 3. _____
17. Over the past year, have there been any institution initiatives to address these constraints? 18. If yes, please describe	0. No 1. Yes 2. I don't know
19. What are MoH / Parliament's 3 major challenges that impede utilisation of research evidence/data in decision-making?	1. _____ 2. _____ 3. _____
20.How can these be addressed?	1. _____ 2. _____ 3. _____

D: Management and institutional support for use of research evidence/data in decision-making

Issue	**Rating**
21.On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate MOH/Parliament's level of prioritisation of use of research evidence/data in decision making? Please explain. Probe: • Research evidence • Routine data	1 – lowest 2 3 4 5 – highest
22.Has MOH/Parliament committed adequate personnel to support application of research evidence/data in decision making? Please explain. Probe: • Research evidence • Routine data 23.What do you think could be the contributing factor?	0. No 1. Yes 2. I don't know
24.On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate the MOH/Parliament's budget allocation to support application of research evidence/data in making decisions? Please explain. Probe: • Research evidence • Routine data • We are more interested in budget allocation to support for application of research? 25.What do you think could be the contributing factor? Additional probes if one can provide information: • Do you know how much MOH allocates or what proportion of the research budget? • Has there been an increase in the budget allocation for research over the past 1 – 3 years? • Who else supports MOH's research budget?	1 - lowest 2 3 4 5 - highest
26.Do you have a performance contract or workplan against which your performance is assessed? Please explain	0. No – contract – Skip to Q 40 1. No - workplan– Skip to Q 40 2. Yes - contract 3. Yes -workplan

27. Does it assess the extent to which you or the team apply research evidence in your work? Please explain Probe: • Research evidence • Routine data	0. No 1. Yes 2. Not explicit
28.Are there institutional led fora where staff and invitees present and discuss research evidence/data related to your organisation's main goals? Probe: • Research evidence • Routine data	0. No – Skip to Q 38 1. Yes 2. I don't know – Skip to Q 38
29.How often does it/do they meet?	0. Annually 1. Quarterly 2. Monthly 3. Weekly 4. Other
30.How useful do you think it is/ they are?	
31.Has your division (or did your previous division, if current one is new) institutionalise(d) any technical working groups that review emerging research evidence/data on key issues of concern to your organisations? Please explain Probe: • Research evidence • Routine data	0. No – Skip to Q 41 1. Yes 2. I don't know – Skip to Q 31
32.How often do/did (if referring to previous division) they meet?	0. Annually 1. Quarterly 2. Monthly 3. Weekly 4. Other
33.How useful do/did (if referring to previous division) you think it is?	
34.Does MOH/Parliament have written guidelines on research evidence/data use? Please explain Probe: • Research evidence • Routine data	0. No – Skip to Q 43 1. Yes 2. I don't know
35.Do you think it is useful to have this in place? Probe: • Research evidence • Routine data	0. No 1. Yes 2. I don't know
36.Does MOH/Parliament have a structured mechanism for reviewing and incorporating the research evidence/data in decision making processes? Please explainProbe: • Research evidence • Routine data • If you came across relevant research, how would you present it to decision makers? • When major decisions are made, do top-level decision-makers allow time on the agenda for considering research evidence? Please explain	0. No – Skip to Q45 1. Yes 2. I don't know
37.On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate this mechanism? Probe: • Research evidence • Routine data	1 - lowest 2 3 4 5 - highest
38.Does your MOH/Parliament have: a) Reliable Internet access? b) Well-equipped library? c) Journal subscriptions? d) Computer software including statistical packages	0. No 1. Yes 2. I don't know

39. Would you say that your division/unit has (or your previous division) instilled a culture of utilisation of research evidence/data in decision making? Please explain Probe: • Research evidence • Routine data	0. No 1. Yes 2. I don't know
40. Does MOH/Parliament have any incentives to motivate you to use research evidence /data in your work? (e.g. Training; Recognition/Award; Sponsorship for conferences)	0. No – Skip to Q 51 1. Yes 2. I don't know
41. If yes, please list the incentives 42. If no, what incentives would motivate you to use research evidence/data in your work?	1. _____ 2. _____ 3. _____

E. Potential solutions & interventions for improving staff and institutional capacity to use research evidence/ data

43. Using a scale of 1-5 with 1 being the lowest and 5 the highest, what skills would you see as most important to cover in a training of your staff? a) Defining knowledge gaps that need to be addressed to make policy decisions b) Understanding the basics about various research methodologies? (for example, the difference between an experimental and an observational research study) c) Identifying, and searching for research evidence in relevant journals and online databases? d) Assessing the relevance and applicability of research evidence to the key issues that concern your work? e) Assessing the strength or quality of evidence that you find (or, knowing how to determine what is credible vs. what is poor quality or weak)? f) Synthesising and summarising research evidence from different sources and drawing key messages? g) Adapting findings from other contexts? h) Presenting research results to top-level decision-makers? i) Developing charts, tables, graphs etc. from data sets or reports? j) Developing PowerPoint presentations? k) Developing policy briefs? l) Other? Please list them.	1 - lowest 2 3 4 5- highest
44. If you are to pick one, which of these skills would be most critical to cover in a training?	
45. What actions might be needed in the post-training period to ensure that you are supported to use the newly acquired skills or knowledge about evidence use?	1._____ 2. _____ 3. _____
46. Please provide examples of some current "hot" policy topics or questions in your division that we could use to develop training materials?	1._____ 2. _____ 3. _____
47. On a scale of 1-5, with 1 being the lowest and 5 the highest, how would you rate your interest in the following interventions and strategies to improve your capacity to use research evidence in your work? a) Policy maker-researcher pairing in order to provide support to policymaker evidence needs and improve their capacity in accessing, appraising, synthesising and using research evidence b) Strengthen effective linkages between your organisation and research institutions c) Develop an institutional research agenda in order to communicate evidence gaps and guide research activities d) Develop guidelines for sourcing, assessing and using research evidence	1 – lowest 2 3 4 5- highest
48. If you were to pick one, which of these interventions would be most critical in addressing the barriers and constraints in using research evidence in decision making?	

49. Is there a structured mechanism through which your division works with research organisations to access research evidence? 50. How can this mechanism be improved?	0. No – Skip to Q 57 1. Yes
51. Do you participate in any technical working groups (TWGs)/committees? 52. If yes, which one? What is its mandate?	0. No – Skip to Conclusions 1. Yes
53. How can health researchers interested in participating in these forums become involved?	
54. Can you provide me with contact information for staff managing the TWGs/ committees?	

Conclusion

Given the focus of this interview, is there any other information that you think will be useful in strengthening theMoH/Parliament's capacity to utilise research evidence, which you would like to share with me?

Thank you so much for your invaluable insights on this issue and for your time.

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

This scoping study is a collaboration activity under the SECURE Health Programme: Optimising the Utilisation of Research Evidence in Decision-making for Health in Kenya.

The Ministry of Health and Kenya Parliament is working with a Consortium led by the African Institute for Development Policy (AFIDEP), in collaboration with the Consortium for National Health Research (CNHR), ECSA-Health Community, and FHI 360, to implement a programme of work aimed at strengthening capacity for data and research evidence use in health sector decision-making in Kenya – SECURE Health. The project is funded by the UK Department for International Development (DFID).

The partnership will design and implement interventions that optimize access and use of data and research evidence in health-related policy decision-making, planning and programming in Kenya.

The aim of the scoping study is to gather insights from researchers on the kinds of health research they undertake, how it aligns to the national health goals and how they interact with policymakers in the health sector to contribute to the development of evidence informed policies.

The information gathered will help us understand the current level of engagement and interaction between researchers and policy makers in the health sector. The information will also guide the development of interventions aimed at improving collaboration and interaction of researchers and policy makers to bolster the uptake of research evidence in decision making processes.

Participation in the survey is voluntary but we hope that you will choose to do so as your input will be valuable to the program. Please complete based on your experience.

The survey should take no more than 30 minutes to complete. The deadline for completion of the survey is 4th July 2014.

Thank you for your participation!

(All information provided will be treated with the strictest confidence. Prior permission will be sought from respondents to publish any considered sensitive information)

BACKGROUND INFORMATION ON THE RESEARCH ORGANIZATION

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***1. Please describe the type of organization you work for.**

- ○ Academic or University
- ○ Research institution (international/regional)
- ○ Research institution (local)
- ○ Multilateral organisation
- ○ Bilateral donor agency
- ○ Regional/International NGO
- ○ National NGO
- ○ Government dep't/agency/commission
- ○ Private foundation
- ○ Private company/organisation
- ○ Other (please specify)

***2. How long ago was the organization established?**

- ○ <1 year
- ○ 1-5 years
- ○ 6-10 years
- ○ >10 years

***3. Does your organization conduct or commission (or both, if applicable) health research that informs policy? please tick appropriate one.**

- ○ Conduct
- ○ Commission
- ○ Both

***4. What are the rationale, mandate and objectives of the organization as far as undertaking research for policy development and practice is concerned?**

Rationale

Mandate

Objectives

***5. What are your main research focus areas?**

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***6. What proportion of the health research your organization conducts and/or commissions informs policy?**

	<10%	10-19%	20-29%	30-39%	40-49%	50% or more
Health research conducted	○	○	○	○	○	○
Health research commissioned	○	○	○	○	○	○

Please explain

***7. Please list up to 3 current research programmes/activities being undertaken by your organization that are likely to have outcomes that inform policy and practice in the health sector in Kenya?**

***8. On a scale of 1 to 5, with 1 being the lowest and 5 the highest, in general, to what extent are your research priorities identified in relation to the ones in the national health strategy?**

1	2	3	4	5
○	○	○	○	○

Please explain

***9. Which of the national health strategy priorities are they aligned to? (Please tick those that apply)**

- ☐ Eliminate Communicable Conditions
- ☐ Halt and reverse rising burden on non-communicable conditions
- ☐ Reduce the burden of violence and injuries
- ☐ Provide essential health services
- ☐ Minimize exposure to health risk factors
- ☐ Strengthen collaboration with health related sectors

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***10. If not aligned to the national health strategy, please describe how they were identified?**

***11. Does your organization have a policy, strategy or guidelines to ensure that the research you conduct or commission aligns to the priorities in the national health strategy and informs policy and practice in the health sector?**

	Yes	No	I don't know
Policy	○	○	○
Strategy	○	○	○
Guidelines	○	○	○

12. If yes, please quote the relevant section of your organization's policy, guidelines or strategy.

Policy

Strategy

Guidelines

13. When was the policy, strategy or guidelines developed? (enter 4-digit year; for example 2006)

Policy

Strategy

Guidelines

***14. What mechanisms does your organization have in place that ensure that research undertaken will ultimately inform policy and practice in Kenya?**

***15. On a scale of 1-5, with 1 being the lowest and 5 the highest, how would you rate how your mechanisms work?**

	1 - lowest	2	3	4	5 - highest
Rating mechanism	○	○	○	○	○

SECTION 3: ASSESSMENTS OF SPECIFIC PROJECTS/PROGRAMMES UNDERTAKEN

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***16. Provide details on the subject, targeted end-users and mode of dissemination of research findings of the most recent research project with relevant policy implications you undertook.**

Disciplinary Area	
Target end users	
Mode of dissemination of research findings	
State the policy or practice influence they have had	

SECTION 4: EXPERIENCE IN IMPLEMENTING HEALTH RESEARCH WITH POLICY IMPLICATI...

***17. In your opinion, what are the best ways of influencing the health policy and practice in Kenya? Please limit to up to 3 ways.**

1	
2	
3	

***18. Which one is the most impactful approach of ensuring that health research results or outputs that inform policy and practice are actively provided to Government/private sector?**

***19. What is/are your reasons for why this is the most impactful approach?**

***20. In your experience, what have been the key factors facilitating the delivery of relevant research outputs that inform national policy and practice?**

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***21. On a scale of 1 to 5, with 1 being lowest and 5 highest, how would you rate the extent to which the following constraints hinder your ability to deliver research outputs that inform policy development and practice?**

	1	2	3	4	5
Lack of prioritization of use of research evidence in decision making	○	○	○	○	○
Inadequate participation in knowledge sharing platforms	○	○	○	○	○
Inadequate interaction between researchers and policy makers	○	○	○	○	○
Inadequate technical capacity of researchers to translate research evidence for policy audiences	○	○	○	○	○
Inadequate technical capacity of researchers to communicate research evidence to policy audiences	○	○	○	○	○
Inadequate technical capacity of policy makers to apply research evidence	○	○	○	○	○
Insufficient funding for translation of research evidence	○	○	○	○	○
Insufficient funding for dissemination of research evidence	○	○	○	○	○
Poor coordination between researcher institutions and policy making institutions	○	○	○	○	○

Other (please specify)

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***22. Briefly suggest strategies that can be used to mitigate each of the constrains that you ranked above.**

Lack of prioritization of use of research evidence in decision making	
Inadequate participation in knowledge sharing platforms	
Inadequate interaction between researchers and policy makers	
Inadequate technical capacity of researchers to translate research evidence for policy audiences	
Inadequate technical capacity of researchers to communicate research evidence to policy audiences	
Inadequate technical capacity of policy makers to apply research evidence	
Insufficient funding for translation of research evidence	
Insufficient funding for dissemination of research evidence	
Poor coordination between researcher institutions and policy making institutions	
Others	

***23. How can you as a researcher participate in implementing the suggestions you have noted above?**

***24. Please give examples of research outcomes either from your organization or other organization that have played a big role in informing policy or practice in Kenya? Give details.**

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***25. Do you participate on any networks engaged in knowledge production and sharing of health research outcomes?**

- ○ Yes
- ○ No
- ○ I don't know

26. If so, please describe up to 3 networks that you are involved in.

1 _____

2 _____

3 _____

27. Do you directly engage with policy makers at the Ministry of Health?

- ○ Yes
- ○ No

28. If, yes, how do you engage with them?

- ☐ I do not engage with policy makers at the Ministry of Health
- ☐ Ministry Technical Working Groups/Interagencies Coordinating Committees [ICCs]
- ☐ Ministry Task Forces
- ☐ Other (please specify)

***29. Please identify up to 3 key interventions that could help researchers more effectively facilitate uptake of their research evidence in decision making processes.**

1 _____

2 _____

3 _____

***30. Likewise, identify up to 3 key interventions that could help policymakers more easily access the research evidence they need to inform their decisions?**

1 _____

2 _____

3 _____

SECURE HEALTH PROGRAMME KENYA RESEARCHER SURVEY

***31. Are there any other relevant issues to which you want to draw the attention of the scoping study? Please limit to up to 3 key issues.**

1
2
3

APPENDIX II. Sampled Ministry of Health Directorates, Divisions and Units

Directorates	Divisions	Units
1. Directorate of health Standards, Quality Assurance and Regulation 2. Directorate of Clinical Services 3. Directorate of Health Policy, Planning and Finance 4. Directorate of Preventive and Promotive Health Services 5. National Quality Control Laboratories 6. Administration	1. Health Standards & Assurance 2. Curative and Rehabilitative Services 3. Emergency and Disaster Risk Management 4. Health Sector Policy, Planning and Finance 5. Health Informatics, Monitoring and Evaluation 6. Health Research and Development 7. Non Communicable Diseases and Injuries 8. Family Health 9. National Health Laboratories 10. Environmental Health and Sanitation 11. Communicable Disease prevention and Control 12. Health Sector Policy and Planning 13. Administration	1. Nursing Unit 2. General clinical services 3. Oncology Unit 4. Pharmaceutical Services Unit 5. Laboratory Diagnostic Unit 6. Medical Engineering and Technologies Unit 7. National Health Research Strategy Unit 8. Health Research & Coordination Unit 9. Non Communicable Diseases Unit 10. Reproductive and Maternal Health Unit 11. Neonatal, Child and Adolescent Health unit 12. Vaccine and Immunization Program 13. Nutrition Unit 14. Community Strategy Unit 15. Health Promotion Unit 16. NASCOP Unit 17. Disease Surveillance and Response Unit 18. Malaria Control Program 19. Field Epidemiology Training Program 20. TB & Leprosy and Lung Diseases Unit 21. Public Private Partnerships 22. Human Resources Management 23. Information & Communications Technology

APPENDIX III. SECURE Health Introduction and Interviews request letter to the Principal Secretary, Ministry of Health

MINISTRY OF HEALTH
OFFICE OF THE PRINCIPAL SECRETARY

From: PRINCIPAL SECRETARY

To: Director of Medical Services
Heads of Directorates
Heads of Technical Divisions
Heads of Divisions
Heads of Units
Programme Staff

REF: MOH/ADM/ADM/1/2/45/(17)

DATE: April 28, 2014

RE: SECURE Health Program: Needs Assessment Interviews

The Ministry of Health (MoH) through the Division of Health Research and Development is collaborating with a consortium of four organisations to implement a new program, the SECURE Health Program, whose aim is to optimize leadership, technical and institutional capacity for increased use of research evidence in decision-making within the MoH and Parliament in Kenya.

The SECURE Health Consortium comprises of the African Institute for Development Policy (AFIDEP), Consortium for National Health Research (CNHR), FHI 360, and the East, Central and Southern Africa Health Community (ECSA-HC). SECURE Health is a **three-year Program (Nov. 2013 – Nov. 2016)** funded by the UK's Department for International Development **(DFID)** and is being implemented in **Kenya** and **Malawi**. Currently, the program is in its Inception Phase through June 2014 during which one of the key activities is to conduct a comprehensive needs assessment study in the Ministry of Health and Parliament to understand challenges and opportunities for enhancing capacity in accessing and utilising data and research evidence in policy formulation, planning and programming.

In view of the above, the program will be carrying out needs assessment interviews with Top Level Policy Makers comprising of Director of Medical

Services, Heads of Directorates, Heads of Technical Divisions, and Mid-level Policy Makers comprising of Heads of Divisions, Heads of Units and Programme Staff respectively in this Ministry from **Wednesday April 30, 2014** through **Friday 16th May 2014.**

The purpose of this letter therefore is to ask you to participate in the interviews and to accord any other support related to this exercise that the representatives of the Ministry and our partners may request. We are looking forward to the findings of the survey, which will inform the implementation, planning and programming, and inform implementation phase for the Secure-Health Programme that is planned to start in **July 2014.**

Prof. Fred H.K. Segor
PRINCIPAL SECRETARY

Copy to: **Cabinet Secretary**

APPENDIX IV. SECURE Health Introduction and Interviews Request Letter to Parliament

AFIDEP
African Institute for Development Policy
Bridging Development Research, Policy and Practice

CNHR
Consortium for National Health Research

East, Central and Southern African Health Community (ECSA-HC)

fhi360
THE SCIENCE OF IMPROVING LIVES

19th May, 2014
Director General,
Parliamentary Joint services
Parliament of Kenya

Dear Sir,

RE: SECURE HEALTH PROGRAM: NEEDS ASSESSMENT

The African Institute for Development Policy (AFIDEP) in collaboration with the Consortium for National Health Research (CNHR), the East, Central and Southern Africa Health Community (ECSA-HC) and FHI 360 is implementing a new program, SECURE Health Program in Kenya and Malawi. SECURE Health is a three-year program running from Nov 2013-Oct 2016, funded by the UK's Department for International Development (DFID). The program seeks to optimize leadership, technical and institutional capacity for increased use of research evidence in decision-making within Parliament and the Ministry of Health in both Kenya and Malawi.

In Kenya, the program is built on the premise that rigorous data and research evidence are central to Kenya's attainment of the health aspirations and goals set out in the country's 2012-2030 Health Policy, the Vision 2030, and the 2010 Constitution. To support the realization of these aspirations and goals, SECURE Health is working with both top-level and mid-level policymakers in identifying capacity gaps, challenges, and designing and implementing responsive interventions. Such support includes strengthening leadership, motivation, and skills needed to enable the use of data and research evidence in health sector policy formulation, planning and programming. The program also aims to enhance capacity of mid-level policymakers in the legislature and the health ministry in accessing, appraising, adapting, synthesising, presenting and using evidence.

On behalf of the SECURE Health Program partners, AFIDEP requests your office to grant us permission to conduct a needs assessment from the 26th May 2014 to 13th June 2014 with members of the Health Committee of both the National Assembly and the Senate as well as the research unit in both houses of parliament. The needs assessment will help us identify capacity gaps and challenges in optimizing use of data and research evidence in order to design and implement responsive interventions. Please find attached the SECURE Health Program summary and the needs assessment tool. I look forward to working with you and your office in implementing this program.

Yours sincerely,

Dr. Eliya M. Zulu, PhD
Executive Director, AFIDEP

Appendix V: SECURE Health Programme in Brief

Introduction

The use of rigorous data and research evidence can help improve health outcomes and reduce the high disease burden in Africa by informing formulation of robust policies and implementation plans, and design of effective health interventions. However, utilisation of evidence in decision-making processes in the health sector is limited in due to bottlenecks that operate at individual, system and institutional levels.

The Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) programme was set up to optimise individual and institutional capacity in accessing and utilising health data and research evidence in decision-making in Kenya. Not much is known on what works and what does not in strengthening the capacity of policymakers to use research evidence, and so the SECURE Health programme will generate important information to fill this knowledge gap. SECURE Health is a three-year programme running from November 2013 to November 2016. The programme is being implemented in both Kenya and Malawi. Lessons from Kenya and Malawi will be shared through the annual platforms of the East, Central and Southern Africa Health Community (ECSA-HC) in order to provide learning opportunities for other countries in sub-Saharan Africa.

Objectives and Interventions

The primary aim of the SECURE Health programme is to strengthen the capacity of health policymakers and legislators in accessing, interpreting, and using research evidence in decision-making processes. The programme has two overarching objectives under which various interventions are implemented:

1. **Optimising institutional leadership and capacity to enhance evidence use**
   (i). Engaging with leaders in the Ministry of Health (MoH) and Parliament, and evidence champions to strengthen their active role in promoting evidence use in decision-making
   (ii). Hosting and supporting sessions on prioritisation of research evidence and addressing bottlenecks to its use at existing high-level forums, seminars and conferences
   (iii). Engaging ministers of health, directors of health services, national health research organisations and deans of medical teaching institutions from ECSA-HC's ten member countries to promote access and use of research evidence in decision-making in their countries
   (iv). Supporting the development of the national health research agenda and establishment of a Kenya health knowledge translation platform to galvanise networking and coordination of knowledge translation activities
   (v). Supporting the development of evidence-informed decision-making toolkit/guidelines for policymakers
   (vi). Facilitating interaction between policymakers and researchers through science policy cafes, and other linkages between MoH, parliament, and research institutions

2. **Enhancing individual skills and capacity of policymakers in the Ministry of Health and the Legislature in accessing, appraising and using evidence**
   i. Training workshops and follow-up support for mid-level policymakers
   ii. Hands-on support on selected case studies of policymaking processes
   iii. Internships for parliamentary staff with the UK Parliamentary Office of Science and Technology (POST).

The Consortium and Funding

The SECURE Health Programme is implemented by a consortium led by the African Institute for Development Policy (AFIDEP) in partnership with the MoH and Parliament in both Kenya and Malawi. The consortium partners include ECSA-HC, FHI 360, the Consortium for National Health Research (CNHR) in Kenya, and College of Medicine at the University of Malawi. UK POST is a collaborator on the programme.

The SECURE Health Programme is funded by the UK's Department for International Development (DFID) under its Building Capacity to Use Research Evidence (BCURE) programme for three years.

MINISTRY OF HEALTH

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SECURE Health is implemented by the African Institute for Development Policy (AFIDEP), East, Central and Southern Africa Health Community (ECSA-HC), FHI 360, the Consortium for National Health Research (CNHR) and the Kenya Government.

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East, Central and Southern African Health Community (ECSA-HC)

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