

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

September 2014



Strengthening Capacity to Use Research Evidence in Health Policy in Malawi (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 Malawi

This research report has been produced by the  
African Institute for Development Policy (AFIDEP)



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# ABBREVIATIONS AND ACRONYMS

<b>AFIDEP</b>	African Institute for Development Policy
<b>CNHR</b>	Consortium for National Health Research
<b>CoM</b>	College of Medicine
<b>COMREC</b>	College of Medicine Research and Ethics Committee
<b>DHS</b>	Demographic and Health Survey
<b>DFID</b>	United Kingdom's Department for International Development
<b>ECSA-HC</b>	East, Central and Southern Africa Health Community
<b>EVIPNet</b>	Evidence-Informed Policy Network
<b>HMIS</b>	Health Management Information System
<b>KCN</b>	Kamuzu College of Nursing
<b>KTP</b>	Knowledge Translation Platform
<b>MIS</b>	Malaria Indicator Survey
<b>MoH</b>	Ministry of Health
<b>MP</b>	Member of Parliament
<b>PHIM</b>	Public Health Institute of Malawi
<b>SECURE Health</b>	Strengthening Capacity to Use Research Evidence in Health Policy
<b>SMT</b>	Senior Management Team
<b>TWG</b>	Technical Working Group
<b>UK</b>	United Kingdom
<b>UNC</b>	University of North Carolina
<b>WHO</b>	World Health Organization
<b>WT</b>	Wellcome Trust

# DEFINITION OF TERMS AND CONCEPTS

<b>Decision-maker:</b>	A person who decides things, at their level in an organisation
<b>Evidence-based policy:</b>	Any public policy informed by rigorously established objective-evidence
<b>Evidence-informed:</b>	An approach to policy decisions that aims to ensure that decision-making is well informed by the best available research evidence
<b>Health system:</b>	The sum total of all the organisations, institutions and resources whose primary purpose is to improve health
<b>Knowledge translation:</b>	A dynamic and iterative process that includes synthesis, dissemination, exchanges and ethically sound application of knowledge to improve the health of people
<b>Policymakers:</b>	Personnel involved in the formulation of policies
<b>National Assembly:</b>	The National Assembly is used synonymously with Parliament

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# EXECUTIVE SUMMARY

This study was undertaken to understand the current level of capacity of the Malawi Ministry of Health (MoH) and Parliament to use research evidence in decision-making and the factors that influence capacity to use research evidence in decision-making. This information helped in the design of appropriate interventions to achieve the objectives of the SECURE Health programme (Appendix III). The SECURE Health programme seeks to optimise individual and institutional capacity in accessing and utilising data and research evidence in decision-making for health in Malawi and Kenya. The programme has two main objectives, namely:

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

The programme is being implemented by a consortium led by the African Institute for Development Policy (AFIDEP), in collaboration with the College of Medicine, University of Malawi; the Consortium for National Health Research (CNHR); ECSA-Health Community and FHI 360. On the ground, the programme is being implemented in partnership with MoH and Parliament. It is funded by the UK's Department for International Development (DFID).

During the programme's inception phase, consultations were held to generate buy-in from policymakers as well as get a good understanding of the capacity gaps with regard to evidence use in order to refine programme interventions. In addition to these consultations, a comprehensive needs assessment was conducted with top- and mid-level policymakers in the MoH and Parliament in Malawi.

The study adopted a mixed methods approach involving collection of both qualitative and quantitative data. Data was collected through consultations, including one-on-one meetings and group sessions, online surveys, as well as through in-depth, face-to-face interviews. A semi-structured interview survey instrument was used for the in-depth interviews and for the online survey. The instrument employed both structured and open-ended questions.

The study revealed that policymakers in Malawi 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, including:

1. Lack of a mechanism for accessing research evidence and poor dissemination of the research evidence;
2. Little interest in using research evidence among top-level decision-makers;
3. Weak institutional linkages with research institutions;
4. Poor quality of the available evidence especially the routine data;
5. Inadequate funding to support generation and use of research evidence in decision-making;
6. Inadequate staffing;
7. Staff lacking technical skills to:
  - a. Analyse routine data;
  - b. Access research;
  - c. Interpret & synthesise research; and
  - d. Summarise research into clear policy messages.
8. Time constraints resulting from high workloads and inadequate personnel.

The respondents in the study recommended a number of interventions to address the identified challenges namely:

- MoH and Parliament subscribing to journals and online databases;
- Sensitising both top-level and mid-level policymakers to demystify research;
- Strengthening of linkages with research organisations;
- Putting in place a policymakers and researcher pairing scheme;
- Packaging research evidence in user-friendly formats;
- Re-establishing the annual health conference, which used to be there and was coordinated by MoH;
- Strengthening the capacity of policymakers to be able to source, appraise, synthesise and use evidence in decision-making; and

- Developing guidelines on sourcing, appraising, synthesising and using evidence.

The identified opportunities and the emerging institutional and technical capacity needs have informed refinements to the proposed SECURE Health programme, as summarised below.

1. High-level national meetings and engagement of evidence champions in the initial programme have been refined to focus on existing MoH and Parliament forums.
2. The policy science cafes have been maintained.
3. Strengthening effective linkages between MoH/ Parliament and research institutions will now become facilitating meetings between these organisations.
4. The policymakers – researcher pairing scheme in the initial proposal will now be implemented as part of the strengthening of linkages between MoH and research institutions.
5. The UK POST Internship for Parliamentary clerks and research officers has been maintained.

6. Developing guidelines for sourcing, assessing and using research evidence has been changed to support the MoH in developing guidelines for application of research evidence.
7. Skills training is now tailored trainings to emphasise topics rated high, follow-up support and review workshops.

The findings of the study confirmed the results of the scoping study undertaken in 2013 at proposal development stage, and mirrored the broader literature on the main challenges and constraints to application of research evidence use by government officials and Parliamentarians. The suggestions/recommendations made are anchored on proven approaches of working with the officials and as such the conclusions reached will contribute to the existing knowledge base on these issues and will inform future interventions aimed at strengthening individual and institutional level capacities in health.

# I. INTRODUCTION

The use of evidence, which includes research findings and rigorous data can help improve health outcomes and reduce the high disease burden in Africa by informing the formulation of robust policies and implementation plans, resource allocation and the design of effective health interventions. Evidence can help reveal which health issues should be prioritised and also in identifying the most effective intervention strategies. Evidence also helps decision-makers monitor and evaluate the effectiveness 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 recognises 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.

The utilisation of evidence in decision-making processes in the health sector is limited in many African countries due to bottlenecks that operate at individual, system and institutional levels. Research on how to improve evidence-informed policymaking in low-income countries is inadequate. A number of facilitating factors catalyse the application of evidence in policymaking: good networks between users and producers; locally-generated evidence; alignment to national research and programme priorities; and interaction and trust between researchers and policymakers. Broader institutional leadership and organisational support for evidence use in policymaking, including incentives, are documented as strong motivational factors.

By contrast, the likelihood of research being used decreases when policymakers lack both a good appreciation of the value of research evidence as well as relevant skills and expertise in accessing, appraising, interpreting, and using available evidence in decision-making processes. There is commonly a disconnect between when research is produced and when it is most needed or most relevant, which also undermines research uptake in decision-making. Finally, the non-linear and multi-faceted nature of the policymaking 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. The shift in language from striving for 'evidence-based' to evidence-

informed' policymaking reflects this complex reality.

In the last few decades, significant efforts have 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 of research through efforts to raise the priority placed on research in decision-making, or by supporting end-users with 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.

Globally, there have been several studies focussing on the bottlenecks to research uptake. The studies reveal that the most frequently reported barriers to evidence uptake were poor access to good quality relevant research, and lack of timely research output. The most frequently reported facilitators were collaboration between researchers and policymakers, and improved relationships and skills. A few studies have examined bottlenecks of access and use of evidence in decision-making in Malawi and other countries, and came to the same conclusion that main barriers to use of research evidence include competing priorities within the (health) sector and lack or poor opportunities of sharing and deliberating about research findings, lack of well-packaged 'best practices' that highlight the benefits of using research evidence, low motivation to use research evidence by middle level policymakers, inadequate capacity and poor or absent systems to enforce evidence use. In general, there is often a disconnect between the work of policymakers, researchers and frontline clinicians. Without institutionalised exchange and collaboration, researchers are often unable to meet the needs of policymakers, who in turn miss key opportunities to utilise research evidence in policy discussions and incorporate best practices.

Over the last decade or so, there has been increasing attention at the international level on increasing the utilisation of research evidence in policy and programme formulation and implementation in the health sector. In 2005, the World Health Assembly summit called on the World Health Organization (WHO) director-general "to assist in the development of more effective mechanisms to bridge the divide between ways in which knowledge

is generated and ways in which it is used, including the transformation of health research findings into policy and dialogue.” During the same summit, a call was made on the global scientific community, international development partners, the private sector, civil society and other relevant stakeholders “to strengthen or establish the transfer of knowledge in order to communicate, improve access to and promote use of reliable, relevant, unbiased and timely health information.” These efforts led to the establishment of EVIPnet, which is a network sponsored by WHO with the objective of assisting country teams in the formation of knowledge translation platforms. EVIPnet uses a systems approach to strengthening health systems in low-income countries in order to improve the links between policy and scientific research for health.

In Malawi, the Ministry of Health’s (MoH) commitment to promote uptake of research evidence has been demonstrated by the establishment of the Research Unit and the recent institutionalisation of the Malawi Knowledge Translation Platform (KTP). Under the KTP, key stakeholders, including policymakers, researchers and representatives from other sectors (such as education, science and technology, civil society organisations, topic experts, among others.) are brought together to identify and address priority topics where a supposed need to strengthen the systematic use of research evidence to inform decisions about policies for the health sector has been identified.

A ‘scoping study’ using key informant interviews with high- and mid-level policymakers conducted in Malawi and Kenya in 2013 revealed an absence, or ineffective prioritisation of, evidence use by government leadership, insufficient resource allocation to enable research utilisation and low capacity among mid-level policymaking staff to source, appraise, interpret, and use relevant evidence. These challenges are exacerbated by weak institutional support systems to facilitate the use of research evidence, such as a well-equipped library,

reliable Internet access, a functional health management information system (HMIS) and protocols or practical guidelines for data demand and use. These findings mirror other recent assessments of the capacity for evidence use within government institutions in developing countries. Assessments supported by DFID and the Wellcome Trust (WT) revealed that the capacity of the MoH in Malawi and Kenya to use research evidence is weak.

The SECURE Health Programme needs assessment study is one of the few country-specific studies to contribute to the scarce knowledge on the specific individual and infrastructural gaps that need to be filled in order to improve evidence uptake in Malawi’s health sector. The purpose of the study was to assess the current level of capacity of the MoH and Parliament to use research evidence in Decision-Making and the factors that influence capacity. This report presents the results of a comprehensive needs assessment conducted among policymakers in Malawi’s MoH, Parliament and researchers.

#### ***Specific objectives included:***

- Identifying gaps in knowledge, skills and their application to the use of evidence to inform policymaking;
- Assessing the interrelationships between researchers and policymakers;
- Identifying the barriers to use of evidence in policy and decision-making; and
- Soliciting input from beneficiaries on potential solutions and interventions for addressing the bottlenecks.

The study identified specific interventions that policymakers recommended for the programme to implement and evaluate in collaboration with the MoH and Parliament. It is envisioned that through study recommendations, the programme will strengthen the activities of existing programmes like the KTP.

## II. METHODOLOGY

### 1.0 Study Design

This was a cross-sectional descriptive study. The study adopted a mixed methods approach consisting of both qualitative and quantitative data. Data were collected through consultations, which included one-on-one meetings and group sessions as well as in-depth, face-to-face interviews. 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 the existing opportunities for supporting MoH and Parliament. A semi-structured interview guide was used for the in-depth interviews and employed both quantitative and qualitative questions. The tool sought to answer the following research questions.

- Do policymakers in Malawi recognise the importance of using research evidence in decision-making?
- To what extent are policymakers using research evidence and data to inform their decisions?
- What is the status of institutional support mechanisms for enabling use of research evidence in decision-making processes?
- What are the main challenges and constraints policymakers face in using research evidence and data to inform policy and programme decisions?
- How do the challenges and constraints reported by policymakers align to those highlighted by researchers?
- What are policymakers' recommendations on how these challenges and constraints can be addressed?
- How do their recommendations align to those highlighted by researchers?

### 2.0 Target Population

The study interviewed top-level and mid-level decision-makers from the MoH and the Parliament as well as health researchers. Top-level decision-makers at the MoH were comprised of principal secretaries, the directors and deputy directors of various directorates, directors of central hospitals and national programme managers. Mid-level policymakers at the MoH were defined as persons heading divisions, units and programme officers. For Parliament, top-level respondents included the Speaker of

the National Assembly, the Clerk of the National Assembly and heads of various sections. Health researchers, drawn from both public and private institutions, were also interviewed.

### 3.0 Development and Pre-testing of the Survey Instrument

The survey instrument was initially prepared by AFIDEP and discussed in-house and at later stages it was distributed to all SECURE Health Consortium partners for their comments. The draft was pre-tested with three staff from the MoH. Feedback from partners and the pre-test informed the finalisation of the tool.

### 4.0 Sampling Strategy

Sample size was determined purposefully for each category of the study subjects. The purposive sampling method allowed the researchers to select participants willing to provide information by virtue of their knowledge and experience on policymaking processes in the health sector and how evidence has been utilised in the past. The researchers therefore narrowed our sample selection to individuals who fitted this description. Due to time and financial constraints, we limited the study 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 to participate in planned training workshops during implementation of the SECURE Health programme could be drawn.

At the top level, the researchers aimed to interview at least 15 decision-makers in the MoH. At mid-level, the aim was to interview at least 45 key staff representatives from different departments, directorates and units within the MoH. For Parliament, the researchers planned to interview at least 15 officers in the Clerking and Reporting, Legal Services, Research, Library and Civic Education, Policy and Planning and Human resources units. With regard to health researchers, the aim was to interview at least 30.

From the target populations, the sample drawn was:

- 46 staff from the MoH;
- 14 staff from Parliament; and
- 15 researchers.

## Ministry of Health

All the seven all the seven directorates of the MoH and all the divisions under each directorate including: Planning and Policy Development; Health Technical Support Services; Reproductive Health; Nursing Services; Preventive Health Services; Clinical Services; and Finance and Administration were sampled. This was done in consultation with MoH officials, specifically officials from the Health Research Unit.

A second phase of sampling involved the selection of a limited number of staff per directorate, division and unit with oversampling of those prioritised in consultation with Research Unit officials. Oversampling included about three staff (the Head and two officers) at the division or

unit level in the sample relative to one in other divisions or units. Oversampled groups included directorates, divisions and units that handle matters related with illnesses, diseases and conditions (e.g. Preventive Health Services) as well as the Directorate of Policy, Planning and Development, which deal directly with production of routine data and coordination of health research.

## The National Assembly

In consultation with the Chief Researcher, 14 technical staff from the Parliament were selected. This included clerks of committees, researchers, library staff and legal service staff. Table 1 below summarises the sampling frame and the samples drawn and interviewed.

**Table 1: Secure Health Programme Sampling Frame and Samples**

	Sampling frame	Planned survey sample (% of sampling frame)	Response rate (% of sample)	Top-level	Mid-level
Technical staff at the MoH headquarters	105	60 (57.14%)	46 (76.67%)	21	25
Technical staff - National Assembly	28	15 (53.57%)	14 (93%)	6	8
Researchers	41	30 (73.17%)	16 (53.33%)	-	-
<b>TOTAL</b>	<b>174</b>	<b>105 (60.34%)</b>	<b>76 (72.38 %)</b>	<b>27</b>	<b>33</b>

### Procedures for Informed Consent

Prior to the study, the sampled interviewees were informed of the intention to interview them. Before the actual interview, the interviewers explained to the participants the purpose of the study and got consent by signing the consent form to proceed with the interview. All declines to interviews were largely due to busy schedules.

## 5.0 Data Collection

Appointments were sought through letters and followed up with email messages, phone calls, mobile phone text messages as well as physical appearances in some instances to confirm availability of respondents. The data collection instruments used in the study are attached in Appendix I. There are three types of data tools for this study. The first is a questionnaire for the top-level decision-makers in the MoH and Parliament. The second tool is for mid-level policymakers in the MoH and Parliament. The third is a questionnaire intended for the researchers. For the in-depth, face-to-face interviews, a letter of authority introducing the programme, informing the potential

respondents of the activity and requesting the MoH staff to participate was sought (see Appendix II). This authorised AFIDEP to carry out the interviews among the relevant MoH technical staff. For the National Assembly, a letter of request was written directly to the Clerk of Parliament to request permission to conduct the needs assessment study for their staff. For the researchers, a mix of face-to-face interviews (which took an average of 45 minutes) and an online survey was carried out.

## 6.0 Data Management and Analysis

The data were either collected directly (from researchers) or entered into a Survey Monkey online database (for policymakers and National Assembly study participants). Data entry took place as soon as possible and by the same person who conducted the interview. Where the interview was recorded, the written notes were compared with the audio records as data quality checks.

Internet-based Survey Monkey software was used to capture data from interviews, analyse the quantitative data and generate charts and tables for quantitative data.



The qualitative data from the interviews and consultations was analysed using manual thematic coding and content analysis. This report presents a synthesis of the emergent themes from the consultations and interviews and analysis of the quantitative information.

## **7.0 Ethics**

The study was conducted in accordance with the ethical principles in the country. Ethical clearance was obtained from the Ethical Committee of the College of Medicine Research and Ethics Committee (COMREC), University of Malawi. Consent was requested from each individual and they were asked to read and sign a consent form which explained the purpose of the study, that there were no effects on the respondent's health, no direct cost, measures for protection of privacy. Each participant was assigned a code number that was used on all information collected. Participation was voluntary and anonymous and confidentiality assured. Participants were told they would be kept informed of any important new findings.

## **8.0 Strengths and Limitations of the Study**

This study has several strengths. Enrolling a cross-section of researchers and policymakers in the study elicited a wide range of views and experiences. The use of both quantitative and qualitative (through open-ended questions) methods generated rich, first-hand insights into the experiences of professionals who use research evidence in decision-making in the health sector. Finally, a moderately large representative sample was drawn from various directorates, divisions and units. The study also had several limitations. Sampling was purposive and therefore the findings of this study may not be generalised to the wider researcher and policymaker populations and we were constrained by time to the extent that we did not interview all the potential respondents.

### III. RESULTS

The study sought to assess the current level of capacity of the MoH and Parliament to use research evidence in decision-making and the factors that influence this. The study targeted officials from MoH, Parliament and researchers, with a focus on the topics discussed below.

#### 1.0 Policymakers’ Views on the Importance of Using Research Evidence in Decision-Making

Policymakers’ perceptions on the importance of using evidence in policy and decision-making form a vital part of determining the decision-making context. To discover the extent to which policymakers in health sectors and

parliaments comprehend the relevance and importance of using research evidence and data in decision-making, policymakers were asked to explain what the use of research evidence and data in decision-making means in relation to their job. Policymakers were asked about their use of research evidence and routine data separately in order to discern the differences in the use of the two types of information.

The survey results indicate that policymakers, both top- and mid-level in the MoH and Parliament recognise the importance of using research evidence and data to inform policy, legislative and programme decisions. Some responses are presented in Table 2 below.

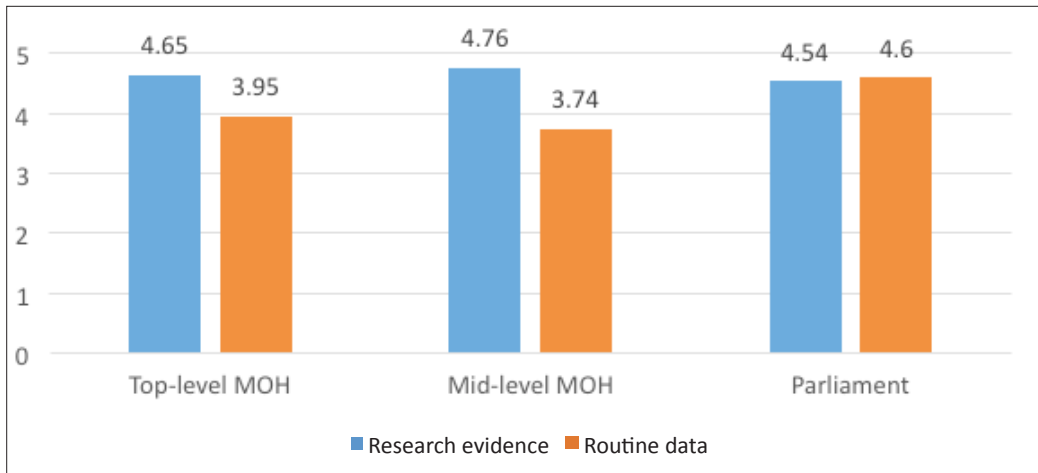
**Table 2: Views of Policymakers on What Use of Research Evidence and Data Means in their Work**

<b>Ministry of Health</b>	<i>“Informed decision-making [is] based on the best available evidence. However we usually don’t have much access to research reports, and in the event that the reports are there, we do not have time to read and conduct a proper analysis; on the other hand, the available routine data is of poor quality.” - MoH, Mid-level Policymaker</i>	<i>“It is extremely important to utilise research evidence - how else can we provide improved health services? It is also important to use routine data for Decision-Making in order to improve on treatment in specific areas. Routine data takes care of the fact that health problems are sometimes defined by geographic settings. Unless, as policymakers we utilise research evidence [and] data, we might end up making ineffective decisions.” -Top-level policymakers</i>	<i>“It is important to use research evidence for decision-making purposes because in the medicine field, it is very expensive to use the trial and error for treatment. Routine data is there just to guide programme planning. For instance in 1973 cholera killed a lot of people but after a research was done, we found a way to curb the disease.” -Top-level policymakers</i>
<b>Parliament</b>	<i>“It is important because MPs need guidance to enrich their debates. It gives confidence, conviction and authority in the policies made. The risk is that if the House does not utilise evidence, they may end up passing bills not in tune with existing problems and challenges on the ground.” - Clerk, Parliament</i>	<i>“It is very important as it helps the MPs to make decisions from an informed point of view. But also we use research evidence as reference material to formulate policies, programmes and projects for the National Assembly.” - Clerk, Parliament</i>	<i>It is imperative that we use research evidence to inform decision-making to have effective policies and programmes on the ground.” - Clerk, Parliament</i>

The respondents were also asked to rate the importance of using research evidence and data for decision-making using the 1 to 5 Likert Scale, with 1 being the lowest and 5 the highest. Regarding the importance of using research evidence, mid-level policymakers in the MoH

ranked this highest at an average of 4.76 while the top-level policymakers rated it at 4.65. The Parliamentary staff gave an average rating of 4.54 for the importance of using research evidence in decision-making

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



On a scale of 1-5 with 1 being lowest and 5 being highest, how would you rate the importance of using research evidence and data in decision making?

On the other hand, the average rating of the importance of using routine data in decision-making varied across policymakers. On the same scale, Ministry decision-makers rated the importance of using routine data in decision-making lower than their counterparts in the Parliament. The officials in the MoH indicated that even though they use routine data, the data are not reliable and the Health Management Information System (HMIS) usually captures only a few indicators, which are often not well analysed and not provided at the right time.

*“We usually use routine data for programming, monitoring and evaluating programmes, however, we have challenges with the source point for the data. Usually, routine data is collected at facility level and in most cases the data are not collected properly since officers are tied up with other activities.” - MoH, Top-level policymakers*

## 2.0 Policymakers’ Use of Research Evidence and Data in Decision-Making Processes

Policymakers were asked about the most recent experience in utilising evidence in their decisions or policy development activities. The responses indicate that policymakers are in fact using evidence in programming and decision-making, as presented in Table 3.

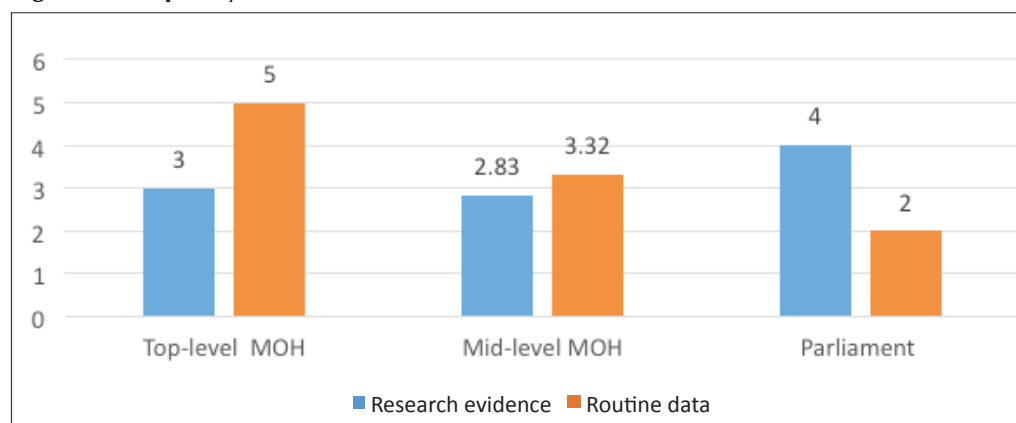
**Table 3: Some Views on the Most Recent Experience Using Research Evidence and Data**

<b>MoH</b>	<i>"I cannot remember the last time I used research evidence, however when it comes to routine data, we use it on monthly basis planning for the procurement and distribution of commodities and medicines."</i> - Top-level policymakers	<i>"Two months ago, working on Dengue Fever, we used the WHO data and research papers from neighbouring countries like Tanzania [and] Mozambique. This was done to inform the Ministry on what alternatives are available when dealing with the fever."</i> - Mid-level policymakers	<i>"This year, we were writing a new proposal. We used the annual assessment reports – the programme's multi-year plans are also informed by assessment and survey results as well as the routine data."</i> - Mid-level policymakers
<b>Parliament</b>	<i>"Recently, when I was preparing speeches, background papers and proposals for the MPs."</i> - Clerk	<i>"When coming up with advocacy materials for the creation of [the] FP [family planning] budget line in 2012 and 2013. The research evidence was used to lobby with different members of Parliament in the National Assembly and other policymakers ."</i> - Researcher	<i>"When writing committee reports and also when preparing talking points for the MPs."</i> - Clerk

Use of research evidence and data among policymakers is inconsistent and varies across end users, despite the recognised importance of using research evidence and data. The respondents were asked to rate the frequency of using research evidence and data in decision-making on the Likert Scale. Use of research evidence in comparison to routine data is rated lower among Ministry decision-makers and higher among Parliament staff (Figure 2).

In explaining this variability, most MoH policymakers pointed out that access to essential research evidence within or from outside the country is limited due to a lack of culture of evidence use and inadequate capacity to conduct operational research to support decision-making apart from research for academic purposes. Additional reasons mentioned were inadequate capacity to apply research evidence, and poor dissemination of research findings.

**Figure 2: Frequency of Use of Research Evidence and Data**



*On a scale of 1-5 how often do you use research evidence/data in your work?*

When it comes to utilising routine data, Parliament policymakers' rated use of routine data relatively low in comparison to the rating given by Ministry policymakers. Parliamentary officials indicated that they do not generate routine data but have to get this from MoH, which sometimes is not readily available due to poor dissemination mechanisms and protracted bureaucratic processes; as such, they opt to look for research evidence elsewhere. Moreover, the Parliament lacks capacity to

access, analyse and apply it to their work. On the other hand, the Ministry's policymakers indicated that routine data is used frequently but not efficiently. Apart from the HMIS, all the programmes collect their own routine data from the districts on a monthly basis. This data is then compiled into quarterly reports. Table 4 highlights some views explaining the rating of the frequency of using research evidence and data in decision-making.

**Table 4: Some Views on Challenges in Using Research Evidence and Data in Decision-Making**

<p><b>MoH</b></p>	<p><i>“There is unlimited access to data and surveys conducted by government but published research findings are not easily accessible. Even then, usually we need consent from researchers or research institutions to use certain type of work and clinical research is expensive and takes a long time to get results.” – Top-level Policymaker</i></p>	<p><i>“Apart from the lack of interest and orientation on importance of utilising evidence, as well as lack of skills in interpreting, and analysing research, access to research evidence within the country or outside is limited due to poor dissemination of findings. Moreover, we do not have enough researchers and mostly the research being conducted is purely academic and not to inform decision or policy-making. Academic schools do not instill/ promote a culture of research generation to inform policy.” - Mid-level policymaker</i></p>	<p><i>In general, there is this attitude that research is just for academic purposes [...] we also lack resources; for instance internet connectivity to enable us access current research findings.” – Mid-level policymaker</i></p>
<p><b>Parliament</b></p>	<p><i>“We do not have a database of what organisations are conducting research and in what areas, even then we lack capacity within the Parliamentary research section to effectively provide evidence to various committees.... research work is not a clear mandate of Parliament.” - Technical Staff</i></p>	<p><i>“We lack the reading culture due to limited time and capacity for thorough processing of data and evidence.” - Clerk</i></p>	<p><i>“We do not have much demand for research evidence from the Members of Parliament thus we usually do not go out of our way to look for it. Moreover, there is [a] lack of easily accessible research evidence.” - Clerk</i></p>

### 3.0 Policymakers’ Views on the Main Challenges and Constraints to Using Research Evidence and Data in Decision-Making

Both top- and mid-level policymakers were asked to highlight the main barriers, challenges and constraints

they face in using research evidence and data for decision-making. Specifically, they were asked to highlight: i) the general barriers, ii) institutional bottlenecks; and iii) personal constraints. The respondents’ answers have been synthesised and results are presented and organised into these three categories, shown in Table 5. The results from MoH and Parliament are presented together, only differentiating between top- and mid-level policymakers .

**Table 5: Summary of Challenges and Constraints to Research Evidence and Data Use in Decision-Making**

Top-level Policymakers (MoH + Parliament)	Mid-level Policymakers (MoH + Parliament)
<p><b>General Barriers</b></p> <ul style="list-style-type: none"> <li>• *Unreliable / incomplete data sources</li> <li>• *Inadequate funding to support research</li> <li>• *Research evidence is not well disseminated</li> <li>• *Inadequate number of researchers</li> <li>• *Lack of understanding of role of research evidence in decision-making</li> <li>• *Poor coordination between researchers and policy makers</li> <li>• *Lack appropriate expertise to collect, interpret and use data</li> <li>• *No mechanism for conducting, accessing and applying research evidence and data</li> <li>• *Politics – political affiliation and other interests</li> <li>• Suspicious of the motives of research funders and whether the research evidence generated is valid for local situation</li> </ul>	<p><b>General Barriers</b></p> <ul style="list-style-type: none"> <li>• *Unreliable/incomplete data sources</li> <li>• *Inadequate funding to support research</li> <li>• *Research evidence is not well-disseminated</li> <li>• *Strong culture of not reading and relying on past experiences instead</li> <li>• *Little interest in using research evidence among decision-makers</li> <li>• *Inadequate number of researchers</li> <li>• *Lack of understanding of the role of research evidence in decision-making</li> <li>• *Poor coordination between researchers and policy-makers</li> <li>• *Lack of appropriate expertise to collect, interpret and use data</li> <li>• *No mechanism for conducting, accessing and applying research evidence and data</li> <li>• Inadequate orientation on the importance of using research and data for programming especially at high-level</li> <li>• *Politics – usually politicians do not prioritise technical issues</li> </ul>
<p><b>Institutional Challenges</b></p> <ul style="list-style-type: none"> <li>• Lack of guidelines on how to use data and research evidence</li> <li>• *No forum for sharing/disseminating research evidence</li> <li>• *Inadequate funding to support generation and use of research evidence in decision-making</li> <li>• *Time constraints to search and synthesise evidence/data due to high workload</li> <li>• *Politics and personal interest driving decision-making</li> <li>• *Weak institutional linkages between the Ministry, Parliament and research organisations</li> </ul>	<p><b>Institutional Challenges</b></p> <ul style="list-style-type: none"> <li>• *Little interest in using research evidence among decision-makers at high position</li> <li>• *Inadequate funding to support generation and use of research evidence in decision-making</li> <li>• *Politics and personal interest driving decision-making</li> <li>• *Weak institutional linkages between the Ministry and Parliament and research organisations</li> <li>• *Lack of a reading culture</li> <li>• *Time constraints to search and synthesise evidence/data due to high workload</li> <li>• *No forum for research evidence communication</li> <li>• Lack of motivation to use research evidence/data</li> </ul>
<p><b>Individual Constraints</b></p> <ul style="list-style-type: none"> <li>• *Lack of expertise to access, interpret and use evidence and data</li> <li>• *Inadequate funding to support research</li> <li>• *Lack of knowledge of available research evidence</li> <li>• *Time constraints on searching and synthesising evidence and data due to high workloads</li> <li>• *Inadequate personnel</li> <li>• *System has not empowered them to make decisions in civil service</li> </ul>	<p><b>Individual Constraints</b></p> <ul style="list-style-type: none"> <li>• *Lack of knowledge of available research evidence</li> <li>• *Little interest in using research evidence among top-level policymakers</li> <li>• *Time constraints to search and synthesise evidence/data due to high workload</li> <li>• Poor access to Internet</li> <li>• *Inadequate funding to support research</li> <li>• *Lack of appropriate expertise to collect, interpret and use data</li> <li>• *System hinders them from making decisions</li> <li>• *Politics and personal interest driving decision-making</li> </ul>

*\*Areas of convergence across cited challenges and constraints between top-level and mid-level policymakers and / or across general, institutional and individual levels in the Ministry and Parliament*

Observations from the barriers shown in Table 5 indicate an overlap across general and institutional challenges and constraints cited by health policymakers. The following sections, discuss these barriers, challenges and constraints in detail.

### **Little Interest in Using Research Evidence Among Top-level Decision-Makers**

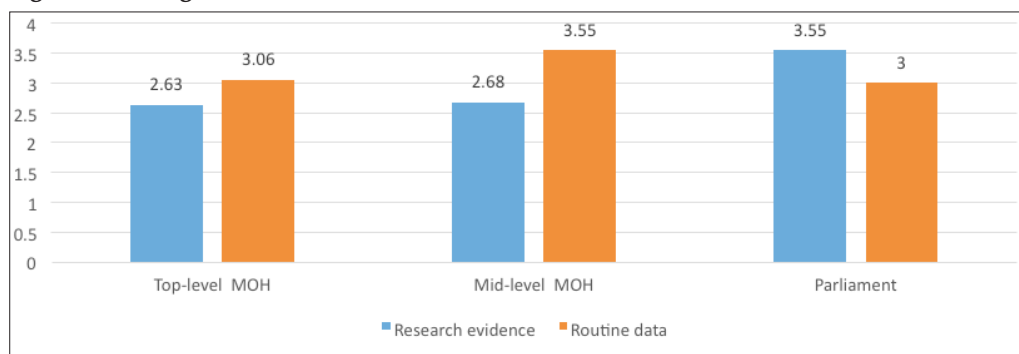
Mid-level policymakers often cited little interest in using research evidence among top-level decision-makers as one of the main barriers to using research evidence in decision-making processes. This was noted as a general, institutional and an individual barrier, evidenced by the quotes presented below.

*“There is just not any demand for research evidence from those in higher authority.”*  
- Mid-level policymaker, MoH

*“The policymakers sometimes don’t appreciate use of evidence and they use experience to make decisions.”* - Mid-level policymaker, MoH

This finding was reinforced when the policymakers were asked to rate the level of prioritisation of use of research evidence and routine data in decision-making. Mid-level policymakers from MoH and Parliament gave higher average ratings for research evidence than top-level policymakers (Figure 3). Regarding prioritisation in using routine data, the same finding was noted between the mid-level and top-level policymakers in the Ministry, who rated the use of data at an average of 3.55 and 3.06, respectively. There was relatively lower prioritisation of use of research evidence compared to use of routine data among MoH policymakers. These results show that there is more consideration of using routine data than research evidence in decision-making processes in the ministry. On the contrary, policymakers from the Parliament reported prioritising use of research evidence in decision-making higher than the policymakers from MoH.

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

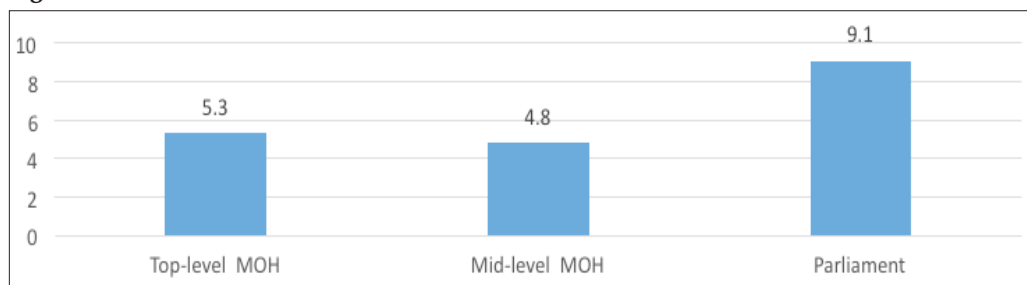


*On a scale of 1-5, how would you rate MoH/Parliament’s level of prioritisation of use of research evidence/data in decision-making?*

The lower rating of prioritisation of evidence use within the Ministry is reinforced by the consistency shown in policymakers’ views on whether their respective institutions have incentives to motivate staff on use of research evidence and data in decision-making. Only about five percent of both top-level and mid-level decision-makers from the MoH said that there were

incentives to motivate staff to use research evidence and routine data in decision-making. Even the Parliament does not really have incentives to motivate technical staff to often use evidence in their day-to-day work or when making decisions (only none percent indicated the existence of such incentives).

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

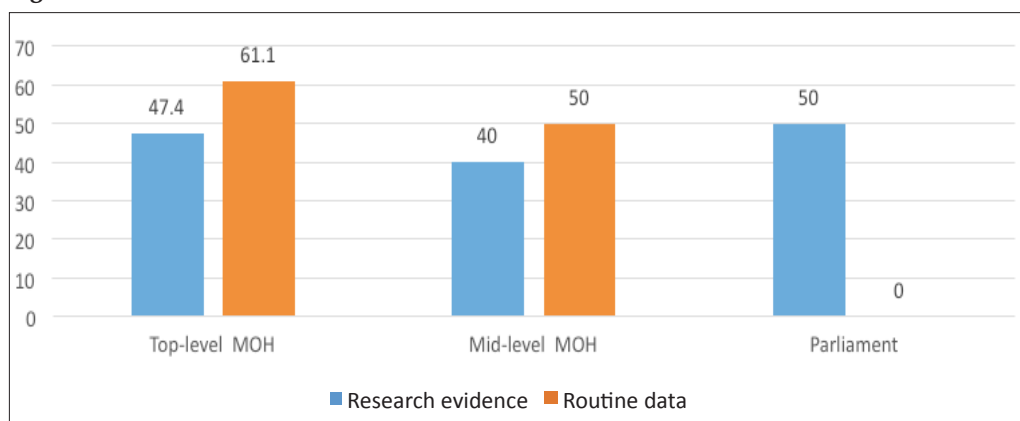


Does MoH/Parliament have any incentives to motivate you to use research evidence/data in your work (% yes)?

Even though there is lack of institutional incentives to motivate the use of research evidence in decision-making processes within both the Ministry and Parliament, about 50 percent of the top-level policymakers within MoH and Parliament indicated that their departments have instilled a culture of using research evidence and data for decision-making. This is an interesting finding given that there are no incentives or support systems. It is also noteworthy

because mid-level policymakers indicated that most top-level policymakers do not prioritise evidence use. This was also reported by 40 percent of MoH mid-level policymakers. Just as there is more prioritisation to use routine data than research evidence, there is more instilled culture towards routine data utilisation than research evidence (Figure 5). There was no response regarding routine data from the Parliament.

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



Would you say that your directorate/division/unit (or your previous division) has instilled a culture of utilisation of research evidence/data in decision making (% yes)?

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

Policymakers from the MoH as well as Parliament cited inadequate funding as one of the major institutional barriers to promoting the use of research evidence and data in decision-making processes. The MoH respondents noted that although the government allocates two per cent of the Ministry’s funding to research, much of this allocation is used for other purposes, such as salaries and procuring drugs, among others. Most of research evidence generation and use is funded and carried out by development partners and academic research organisations. The fact that most research is externally-funded and generated also undermines the extent to which the evidence can inform policy and decision-making processes. The same scenario is described by

the respondents from Parliament, who also highlighted inadequate funding as a challenge. Respondents said this was not surprising because research is not considered the main mandate of Parliament’s activities. This response, however, implies that respondents do not appreciate Parliament’s budgetary role, i.e., it influences budgetary allocations to health research in the country. Some respondent’s views are highlighted below.

*“Financial constraints to carry out national surveys regularly, hence national level data, is often outdated or just estimates, making it difficult to apply piecemeal research data to national level policies.” - Mid-level policymaker, MoH*

*“There are not enough resources for research even though there is a percentage for research in*



*the MoH budget. It is usually diverted for core business.” - Top-level policymaker, MoH*

*“Money is allocated as usual with so little going towards research generation and use. However, this is because research is not seen as being part of the main mandate of Parliament activities.” – Mid-level National Assembly official*

Respondents commended the Ministry of Health on establishment of a research unit, the Public Health Institute of Malawi (PHIM) and the Knowledge Translation Platform (KTP) because these would promote the generation, synthesis and application of research evidence in decision-making processes. However, the respondents lamented that these institutions are not operating as expected due to funding problems. The respondents also felt that there is need to allocate more funding to the research unit to undertake its vital responsibilities of generating research and promoting its use. Some of the respondents pointed out that if the unit was adequately funded, it could lead the coordination of health research activities being undertaken by other stakeholders across Malawi.

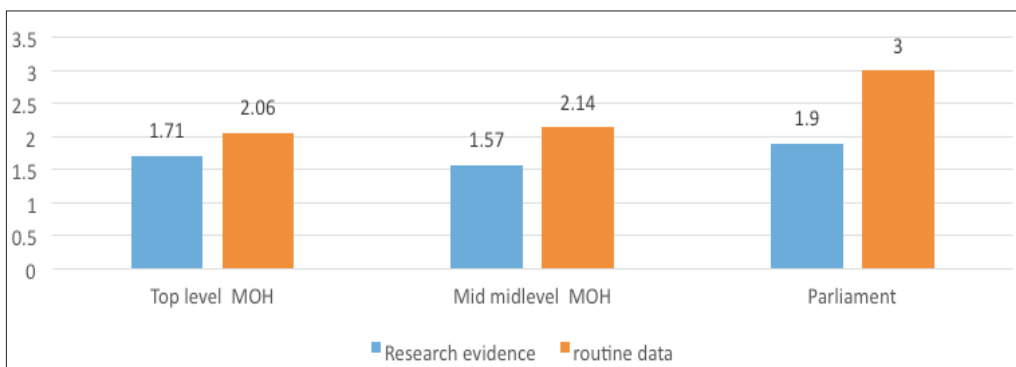
These findings are consistent with the respondents’ views on the MoH’s budget allocation to support the application of research evidence and data in decision-

making processes. When asked to rate budget allocation to research on a scale of 1 to 5, the average rating ranged between 1 and 3 (Figure 6). Top-level respondents from MoH and the Parliament gave higher ratings to budget allocation for research evidence relative to their mid-level counterparts. Top-level policymakers rating for the budget allocation to routine data was lowest compared to their mid-level counterparts from MoH and Parliament. Among respondents from Parliament, the average rating for research evidence was highest relative to all other end users.

Competing priorities and low prioritisation of the use of research evidence in decision-making processes by top management in MoH were cited as the main reasons for the low rating assigned to budget allocation by respondents from MoH. This is reported in the quote below:

*“I rate this low because in MoH we have competing priorities, e.g. we have to buy medicine. But also it is because of declining budget allocation to the MoH; poor capacity of leadership to see the role that research evidence plays in improving health outcomes. ... As a ministry, we really don’t plan or determine our research need per year and the funding required [...]” - Mid-level policymakers, MoH*

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



*On a scale of 1-5, how would you rate the MoH/Parliament’s budget allocation to support application of research evidence and data in making decisions?*

### 3.1 Lack of a Mechanism for Accessing Research Evidence

Regarding mechanism for accessing research evidence, respondents were asked to rate (using a Likert scale 1-5, with one being the least used and 5 the most used) how often they use a number of predetermined sources of information (Table 6). Respondents from both the MoH and Parliament indicated that they mostly source

information, including research evidence and data, from online resources, especially Google searches. Other frequent sources are the library, research organisations, colleagues, conferences and seminars. In addition to the predetermined sources, routinely conducted surveys were also cited frequently as key sources of data. Based on rankings of various sources, we can conclude that the surveys were the main sources of evidence for the mid-level policymakers.

**Table 6: Rating of Frequency of Use of Various Sources of Research Evidence and Data**

	MoH Top-level	MoH Mid-level	Parliament
Health Management Information System (HMIS)	2.50	2.67	1.00
Library	3.50	1.43	4.00
Research organisations	3.00	2.29	2.29
Online resources and databases e.g. Google, PubMed, Medline, Cochrane etc.	4.50	3.76	4.57
Colleagues	2.50	2.35	3.43
List serves	1.00	1.62	2.00
Technical working groups	2.50	2.76	2.40
Conferences and seminars	2.50	2.95	3.14
Surveys		3.80	

*Bold = the first top three sources of evidence for each category*

The top 3 sources of evidence by top-level policymakers are online sources, the library and research organisations. The study showed that mid-level policymakers rely on surveys such as the Demographic and Health Survey (DHS), the Malaria Indicator Survey, online sources and conferences and seminars for information to assist them in decision-making. In Parliament, many technical staff interviewed indicated that their main sources of information and evidence are online sources, the library and colleagues. Only online sources are used across the groups. It is also worth noting that despite the Ministry having a functional Health Management Information System (HMIS), policymakers reported using it infrequently as a source of evidence and data.

Although there is good indication that various sources of evidence exist and are being utilised, respondents mentioned that they usually had challenges in accessing the research evidence and data they needed for decision-making process. Policymakers appreciate that there could be lot of research done on Malawi, but sometimes they do not have access to this evidence because of poor dissemination by researchers. Policymakers feel that most evidence generated is published in journals or disseminated through academic seminars; as such, they have no access to it. There is clearly a need to target the right people when disseminating research, but the evidenced should also be packaged in simple ways that any policymakers can understand and be placed in a central location where it is easily accessible. Moreover, the MoH and Parliament do not have subscriptions to online journals and databases. The quotes below explain this further.

*“There is no conducive environment i.e. deliberate structures and mechanism for conducting, disseminating and applying research.” - Mid-level policymakers, MoH.*

*“Researchers do not share findings – no local dissemination of findings – researchers do not involve policymakers when disseminating research evidence.” - Mid-level policymakers, MoH*

*“There is unlimited access to data and surveys conducted by government but published research findings are not accessible.” - Mid-level policymakers, MoH*

*“Limited access to information - charges applied to access research evidence.” - Mid-level policymakers, MoH*

*“Access to evidence / data is bad due to Internet costs and journal subscriptions are expensive.” - Top-level policymakers, MoH*

*“Research evidence is not readily available. Routine data is mostly centrally kept by CMED (Central Monitoring and Evaluation Division). Some of us do not know what the HMIS is. Data captured from zonal offices is not properly coordinated when consolidating it.” - Top-level policymakers, MoH*

Respondents from Parliament cited the existence of a well-equipped library, but with out-dated resources. Policymakers also lack time to visit the library due to busy schedules. Respondents from the MoH indicated that they have a library, which is lately used mostly for meetings.

This is because it is poorly equipped and not frequently used for its intended purpose. Both libraries do not have online access to resources and this limits their ability to access new information from their offices. An audit of the library to ascertain to what extent it is equipped was not conducted as part of this study.

### 3.2 Poor Data Quality and Inefficient Health Information System

Most policymakers in the ministry cited that they were not using routine data for decision-making because of its flaws. Routine data is usually unreliable for use in decision-making because it is incomplete (reporting rates from health facilities is low), inconsistent (validation of reports sometimes reveals stark differences in results), often not well analysed and not timely. This creates deficiencies in the health information system, which is a disincentive to use it as a source for evidence for decision-making. A number of respondents highlighted that the health information system is inefficient because it is not easily accessed by many mid-level policymakers. The information is also highly summarised, making it difficult to access disaggregated data. Some views on this are highlighted below.

*“Routine data is difficult to interpret due to low expertise in recording data. It is mostly not reliable because of the levels it comes from.”*  
- Mid-level policymaker, MoH

*“[There is a] Lack [of] appropriate expertise to collect and use data. Sometimes routine data is not properly disaggregated according to gender [and] age, hence difficult to use.”* - Mid-level policymaker MoH

*“Research evidence [is] not available, routine data collected do not usually make sense. Those collecting data do not know what they are doing. There are lots of gaps in it.”* - Top-level policymaker, MoH

### 3.3 Weak Institutional Linkages with Research Institutions

Weak linkages between research institutions and MoH and the Parliament was cited as a barrier to research evidence use in decision-making processes. Both the MoH and Parliament have weak linkages with research institutions. For example, the College of Medicine (CoM),

the Kamuzu College of Nursing (KCN), the University of North Carolina Project (UNC) and Johns Hopkins University were mentioned as some of the research organisations that do research in the Malawi health sector. However, many respondents felt that research done by these institutions does not meet the research evidence needs of MoH because the focus of their findings is to get academic recognition. There is also limited collaboration between MoH and Parliamentary policymakers and researchers; hence it is difficult to know what evidence is actually available and how to make use of it. The majority of respondents applauded the Ministry's efforts in establishing the Research Unit, PHIM and the KTP. They thought if these institutions could work effectively and efficiently, some of the challenges could be addressed. The quotes below demonstrate these views.

*“Poor linkages between institutions that carry out research and institutions that need to use it.”*  
- Mid-level policymakers, MoH

*“No existing database of what organisations do research and in what areas... no instilled culture to use research.”* - Mid-level policymakers, MoH

*“Poor coordination and organisation of research processes to share evidence. Poor developed Research Unit and how it links to other programmes. Research unit lacks understanding of research problems in the ministry.”* - Top-level policymakers, MoH

*“There is a disjoint between researchers and policymakers. Most research findings do not enter the decision-making processes but the academia world.”* - Top-level policymakers, MoH

The Parliament has a Research Unit whose mandate is to support clerks and Parliamentarians in various committees with research evidence and ideally this unit should establish linkages with research institutions. The National Assembly staff revealed, however, that these linkages are weak. While some clerks used the research unit whenever they needed evidence, most clerks noted that they often source and synthesise research evidence for their committees on their own, because Parliament's research unit is overstretched and therefore unable to meet everyone's demands.

When respondents were asked whether their institutions have structured mechanisms for working with research

organisations, more than half of the respondents from MoH (63.6 percent), and 90 percent from Parliament stated that there was none.

### 3.4 Suspicion about the Validity of Research Evidence and Motives of Research Funders

Another unexpected barrier to using research evidence in decision-making was the general mistrust of the source of research evidence. The study has shown that some policymakers are cautious using research evidence generated from externally-funded research. As a result, they mostly implement evidence that is in line with the World Health Organization (WHO) recommendations, explaining that information published by WHO is regarded as credible with no hidden agenda.

*“Most research in MoH is funded by stakeholders. Sometimes they run their own agenda rather than prioritising MoH needs.”*  
- Mid-level policymakers, MoH

### 3.5 Politics and Personal Interest Driving Decision-Making

Politics can sometimes influence whether evidence is used. Depending on political priorities and pressure to make decisions, looking for evidence can delay processes, and so decisions are made based on people’s expert opinions. Personal interests and past experiences also influence how research evidence is used.

*“Politics can hinder the process, all decisions have to go through the SMT and there is a lot of political interference in the decision-making process.”* - Mid-level policymakers, MoH

*“Systems in place sometimes force one to make decisions without any scientific evidence. Advocacy is not there – the political drive has been weak to audit decisions which are evidence based. And research reports are mainly used to lobby for more money.”* - Top-level policymakers, MoH

The same scenario is observed with the Parliament. Some respondents in the Parliament noted that decisions are made based on political interests and on which grouping in the Parliament one belongs to. A member of Parliament may have an interest in a certain agenda and in as much

as they request for research evidence, if the evidence presented is not supportive of their position they may choose not to use it.

*“As much as we want to use research in decision-making processes, some decisions have to be made without using evidence. Especially if evidence is on the contrary.”*  
- Committee clerk in the National Assembly.

### 3.6 Understaffing and Lack of Time Due to Competing Demands on the Job

Inadequate personnel in various directorates, divisions and units in the Ministry was reported to hinder evidence use in various stages of decision-making process. The personnel at the research unit are not enough to manage activities for research generation, synthesis, translation and packaging to facilitate application. Respondents from Parliament also noted that the staff working in the research section is not enough to support the demand for evidence from the whole Parliament. This is also a general problem in Parliament; even the other sections do not have enough personnel. For example, there are not enough clerks to serve in the various committees. As a result one clerk serves more than one committee. This gives clerks no time to search for evidence for their committees. The other constraint is on the capacity of the clerks to access, synthesise, interpret and use evidence or data. Some views are highlighted below.

*“Lack of training for personnel –, clerks are not even able to conduct pre-budget and post budget analysis”*  
- Top-level policymakers, Parliament

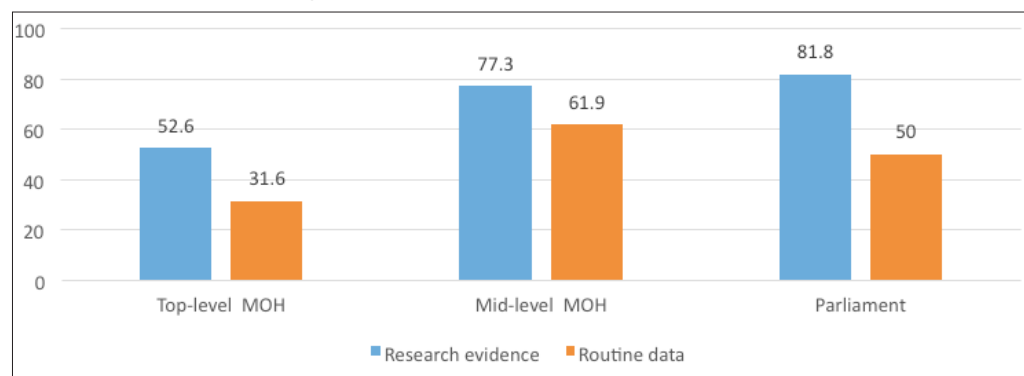
*“Inadequate human resources – we need to increase the human resources on the ground to ease the work load so that we can have time to read.”* - Mid-level policymakers, MoH

We asked respondents whether their institutions have committed adequate personnel to support the application of research evidence and data to decision-making. Most respondents from the MoH stated that this was not the case for staff responsible for application of research evidence. Figure 7 shows that slightly above half (52.6 percent) of top-level policymakers felt that there are not adequate staff, while the great majority of their mid-level counterparts (77.3 percent) felt the same. Although there are seemingly more personnel allocated to manage the

health information system, they are still not adequate and at health facility level, most of the staff lack the capacity

to both undertake their duties and collect data, which makes the situation worse.

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



Has MoH/Parliament committed adequate personnel to support application of research evidence/data in decision making (% no)?

The extent of shortage of staff in the Parliament is even worse, with about 82 percent of respondents citing that there are inadequate personnel allocated to support the application of research. The Parliament is in the process of addressing this challenge by recruiting more people. It was also noted that it would be a good idea to train clerks in research skills so that they double as both clerks and researchers for their committees. Sufficient Parliamentary support staff with appropriate skills is crucial for delivery of Parliamentary services. They provide information services and products and access to sources of information, assist Members of Parliament (MPs) in analysing bills and policies, assist Parliament to monitor and evaluate government programmes, hold government accountable for its activities and conduct legislative research whenever necessary.

Respondents from the MoH and Parliament also indicated that they struggle to find time to source and synthesise research evidence due to time constraints and that this is further aggravated by the difficulty in quickly accessing the research evidence that they need and that is packaged in a simplified manner for their understanding. Time constraints are mainly due to the shortage of staff.

*“One person carrying out too many responsibilities hence no time to consider research evidence.”*

- Mid-level policymakers, MoH

*“The workload is just too much to even find time to read [a] research paper and summarise it.”* - Mid-level policymakers, Parliament

### 3.7 Inadequate Analytical Capacity

Respondents from the Ministry frequently cited inadequate knowledge and skills to collect and analyse data and access, synthesise and translate research evidence as a challenge to using research evidence. This was corroborated among Parliament staff members, who noted that sometimes documents coming from the Ministry do not make adequate reference to research evidence.

Furthermore, there was overwhelming agreement among Ministry policymakers that there is a huge staff capacity gap in data collection, reporting and analysis (at health facility level), which affects the quality and reliability of routine data, of the HMIS and ultimately, its use in decision-making. Many respondents felt that there is a need to sensitise top-level policymakers of the importance of using evidence and data for decision-making. They also noted training mid-level policymakers to enable them generate and apply research evidence.

The same applies to Parliamentary staff, who expressed a need for strengthening their knowledge and skills through continuous on-the-job training in research evidence generation and utilisation. Parliamentary clerks and MoH policymakers also expressed a need for strengthening their knowledge and skills particularly in the development of policy-oriented reports and policy briefs. Some views are presented below.

*“[There is] inadequate knowledge by personnel on how to apply the research evidence / data.”*

- Mid-level policymaker, MoH

*“We do not have training on how to conduct*

and utilise research and this affects our ability to access and appraise and use evidence”.

- Mid-level policymakers, MoH

“[There is a] lack of capacity from the Parliamentary research section to effectively provide evidence to various committees.”

- Clerk in the Parliament

“Most technical staff in MoH do not have research skills, especially in analysing and interpreting data.” -Top-level policymakers, MoH

### 3.8 Lack of Equipment, Software and Systems to Support Sourcing and Using Research Evidence and Data

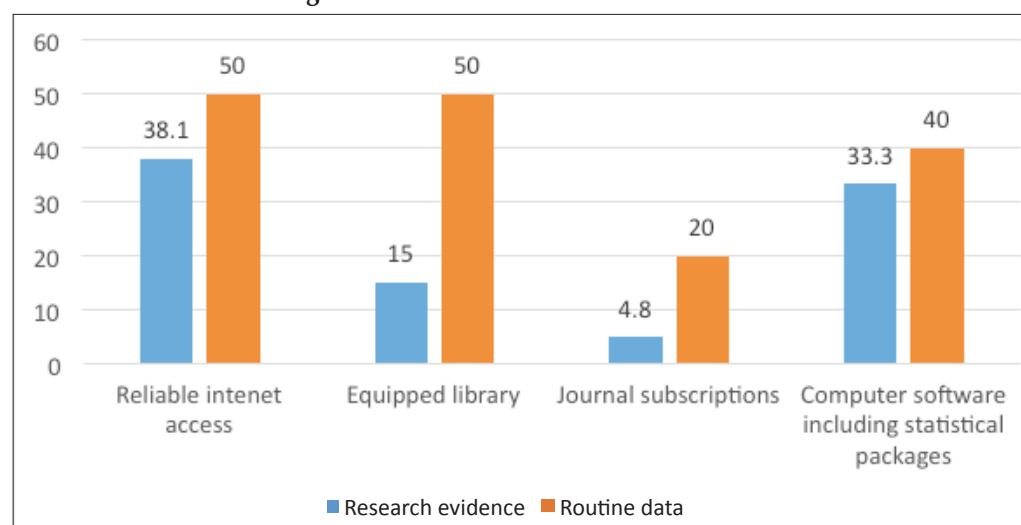
One of the challenges facing the Ministry and Parliament in utilising evidence is lack of proper equipment and software that could support access and synthesis of research evidence from various sources. Respondents from MoH and Parliament expressed the need for MoH and Parliament to support staff with equipment and systems to support sourcing and analysis of research evidence and data. Therefore, apart from strengthening their skills to source and appraise and utilise evidence and data, respondents recommended also that their institutions take care that all necessary systems and software are put in place. Once staff have the necessary systems and software to support application of the skills,

there would be improved uptake and consideration of research evidence in decision-making strategies.

Respondents were asked whether their institutions provided them with reliable Internet, a well-equipped library, journal subscriptions and statistical software; their responses are presented in Figure 8. In general, Parliament is better equipped in terms of systems and software in place to facilitate their job. About 50 percent of respondents in Parliament indicated that they have reliable Internet access compared to only 38 percent from the MoH. Regarding whether their institutions have a well-equipped library, half of the Parliamentary respondents answered yes, compared to only 15 percent from the MoH. MoH respondents noted that there is a library but it has no relevant up-to-date material and there is no librarian. As a result, it is currently being used for meetings and not as a library. The percentage of respondents saying they had journal subscriptions in their institutions was rather low, at 5 percent and 20 percent for MoH and Parliament respectively.

Just about a third of respondents from the MoH indicated that they are provided with statistical packages while 40 percent said the same in Parliament. Respondents from MoH who mentioned that they are provided with statistical packages tended to be staff responsible for the health information system, those in policy and planning and epidemiology – those who require software for their work.

Figure 8: Existence of Systems and Software to Support Research Evidence and Data for Decision-Making



Does MoH/Parliament have the following? (% answering Yes)

Respondents from MoH and Parliament expressed the need for these institutions to put in place equipment and systems that enable sourcing and analysis of research evidence and data. Even if their skills were strengthened, they would not be able to use research evidence in their work without supportive institutional systems and mechanisms. The quotes below elaborate these views.

*“One main challenge is lack of resources such as computers, Internet...so how do you expect people to access research evidence?”*

- Mid-level policymakers, MoH

*“My staff could have some skills to do analysis but the main challenge is that some of the computers they use are old, have no updated analytical software packages.”*

- Top-level policymakers, MoH.

*“In the Parliament here we do have some intermittent connectivity although it is not reliable sometimes. It needs to be improved if we can use it for research purposes.”*

- Parliament staff.

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

Poor dissemination or “lack of a proper dissemination mechanism” of research findings was frequently cited by respondents as something that hinders their ability to source, synthesise and apply research evidence. Respondents from MoH frequently mentioned the absence of a forum where research evidence can be disseminated or communicated to decision-makers. It was also mentioned that sometimes when dissemination takes place, it does not target policymakers and would be in a form that is hard to understand from a layman’s point of view. Some views on this subject are highlighted below.

*“Lack of an institution that can organise dissemination meetings or meetings to sensitise personnel on the importance of research.”*

- Mid-level policymakers, MoH

*“Dissemination is not there. Hence data not available and cannot be used. Example, KCN conducts lots of studies but no dissemination.”*

- Top-level policymakers, MoH

*“Lack of proper communication structure, in other words dissemination does not involve the final Decision-makers.”*

- Mid-level policymakers, MoH

*“Research findings hang at policy level with no dissemination for programming and planning use [...]”* - Mid-level policymakers, MoH

*“Lack of proper dissemination channels to reach policymakers. For instance, CoM has done a lot but the problem is not sharing the research evidence they find.”* - Top-level policymakers, MoH

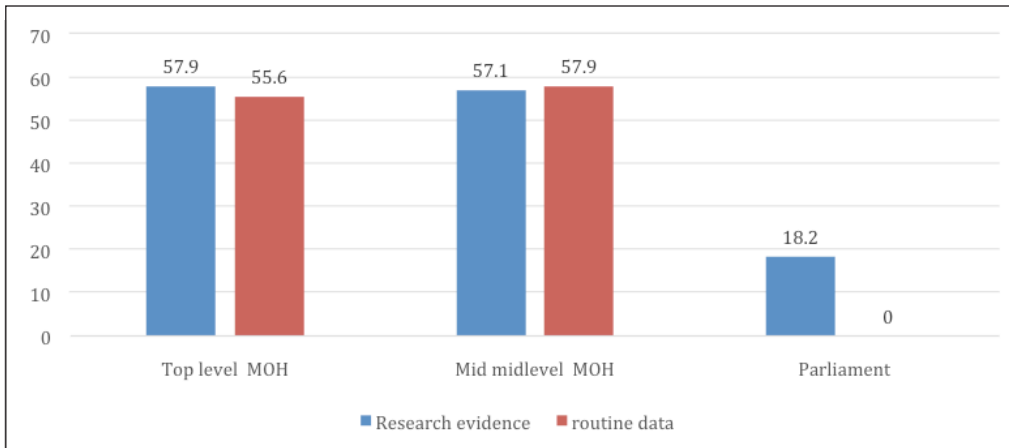
*“There is poor dissemination of research findings such that most people in decision-making positions do not know what researchers are doing.”* - Mid-level policymakers, Parliament.

Respondents were asked whether their institutions have structured mechanism for reviewing and incorporating the research evidence/data in decision-making processes. The results are not so different between top- and mid-level policymakers in MoH. According to Figure 9, about 57 percent indicated that there is a structured mechanism in place for reviewing and considering both research evidence and routine data in decision-making, namely programme and technical working group meetings. Among respondents in Parliament, the trend was the reverse, with only 18 percent reporting that there is a structured mechanism in place. There was no response for routine data.

*“This works through the TWG (Technical Working Group) meetings where the research will be critiqued and then this is taken to the senior management meeting which is later on forwarded to the PS or the Minister.”*

- Mid-level policymakers, MoH.

**Figure 9: Existence of a Structured Mechanism for Reviewing Research Evidence and Data in Decision-Making Processes**

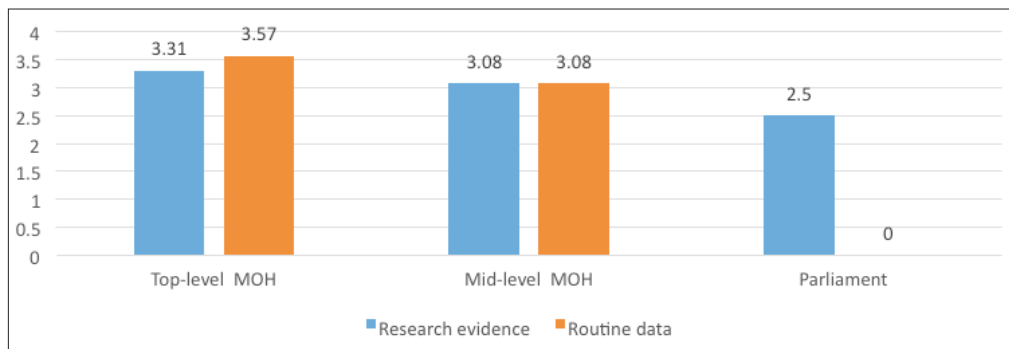


Does MoH/Parliament have a structured mechanism for reviewing and incorporating the research evidence/data in decision making processes? (% answering yes)

Study respondents were asked to rate the mechanism in place for reviewing and considering research evidence and data to inform decisions on a scale of 1 to 5. The average rating across all end-users was 3 for research evidence, while the rating varied for routine data (Figure 10). Top-level policymakers rated the mechanism for reviewing

and considering routine data at an average of 4, while mid-level gave an average rating of 3. Respondents from Parliament rated the mechanism for research evidence at 2.5. This shows that there is at least some mechanism in MoH to consider reviewing and incorporating research evidence in decision-making processes.

**Figure 10: Rating For Mechanism For Reviewing Research Evidence And Data In Decision-Making Processes**



On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate this mechanism

### 3.10 Lack of Guidelines for Research Evidence and Data Use

The lack of guidelines for using data and research evidence came up often as an institutional barrier to utilising evidence in decision-making. Responses showed that there is need for guidelines, although top-level policymakers generally feel that there are existing guidelines as compared to the mid-level counterparts who feel otherwise.

About 40 percent of top-level respondents from MoH reported that there are no guidelines for research evidence and routine data use, while around half of respondents representing mid-level policymakers in MoH reported a lack of guidelines. Over 80 percent of

Parliamentary policymakers reported lack of guidelines for research evidence use (Figure 11). Some views on this are presented below.

- “We have designated forms for collecting data which are in place as part of HMIS.”*  
- Mid-level policymakers, MoH
- “I know that these are in draft form but not sure if those drafts have been signed.”*  
- Mid-level policymaker, MoH

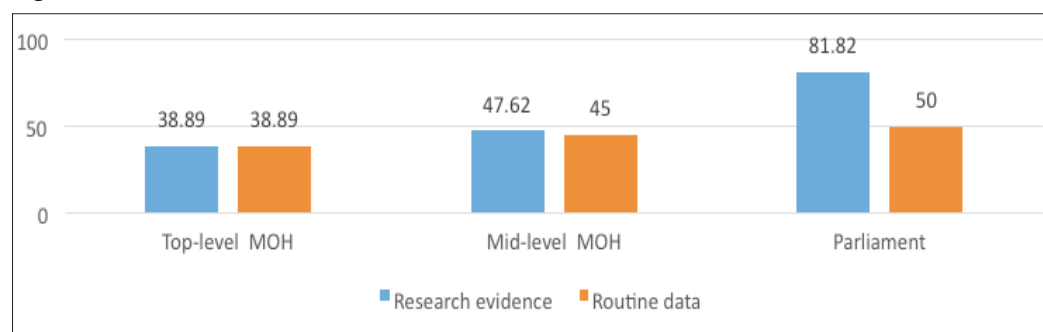
*“I have heard about these guidelines but have never seen a copy. The problem is that when these documents are introduced, there is no proper follow up and coordination with the*



*different programmes to see if they are being utilised.” - Top-level policymaker, MoH*

*“I do not think we have any guidelines on this. Maybe the Research Unit could know better. I do not know about their existence.” - Mid-level policymaker, MoH*

**Figure 11: Existence of Written Guidelines on Research Evidence and Data Use**



*Does MoH/Parliament have written guidelines on research evidence/data use? (% answering No)*

### 3.11 System Not Empowering Mid-level Policymakers to Make Decisions

Most policies and decisions are finalised at the top-level, while most of the drafting of these documents is done at the mid-level and by programme officers. This acts as a disincentive to mid-level policymakers. The quotes below highlight this issue.

*“Sometimes it is not about capacity of people but it is about the system. The system has not empowered the mid-level policymakers to make decisions in civil service”. - Top-level policymaker, MoH*

*“There is inadequate participation in decision-making by us the people at mid-level, yet we are the ones who drive the system.” - Mid-level policymaker, MoH*

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

The study explored the facilitators and constraints faced by researchers in promoting use of research evidence by policymakers and how they align to those highlighted by policymakers. Researchers were asked to rate a predetermined list of challenges and constraints to using research evidence using the 1-5 Likert Scale (Table 7). The highest rating, close to 4, was on poor coordination between researcher institutions and policymaking institutions, followed by insufficient funding, then inadequate participation in knowledge sharing platforms. On the other hand, inadequate technical capacity of researchers to communicate research evidence to policy audiences was rated lowest, at 2.78.

**Table 7: 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	3.22
Inadequate participation in knowledge sharing platforms	3.56
Inadequate interaction between researchers and policymakers	3.11
Inadequate technical capacity of researchers to translate research evidence for policy audiences	3.00
Inadequate technical capacity of researchers to communicate research evidence to policy audiences	2.78
Inadequate technical capacity of policymakers to apply research evidence	3.00
Insufficient funding for translation of research evidence	3.67
Insufficient funding for dissemination of research evidence	3.44
Poor coordination between researcher institutions and policymaking institutions	3.78

These findings are in line with the views expressed by the policymakers. Policymakers highlighted poor dissemination “or lack of a proper dissemination mechanism” for research findings as one main hindrance to their ability to source synthesise and apply research evidence. Respondents from both MoH and Parliament indicated that they mostly source information from online resources, especially Google searches. Respondents from MoH frequently mentioned the lack of a forum where research evidence can be disseminated or for communicating research evidence to decision-makers. They also noted that the research evidence to which they have access usually does not properly link with the programmes. Policymakers also noted that their own poor technical capacity to apply the research evidence was a major challenge.

## 5.0 Recommendations on How Identified Challenges and Constraints can be Addressed

### *Policymakers’ Views*

Policymakers and Parliamentary staff were asked to suggest ways in which the institutional, individual and general constraints, challenges and barriers to the use of research evidence in decision-making 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, summarised in Table 8 below.

**Table 8: Recommendations of Policymakers for Tackling the Constraints and Challenges to Using Research Evidence in Decision-Making**

MoH	Parliament
<b>Enhance Institutional Support</b>	
<ul style="list-style-type: none"> <li>• Sensitise top-level leadership on the benefits of research evidence in decision-making</li> <li>• The Ministry should have journal or online database subscriptions</li> <li>• Establish a research fund, to be used for research and its application</li> <li>• Encourage the KTP idea, let people know it exists</li> <li>• Establish or strengthen regular forums for scientific programme reviews or for discussing research evidence and data with decision-makers</li> <li>• Strengthen the Research Unit so that it can put together research evidence and interpret and disseminate it, including at district level</li> <li>• Hire more staff to address time constraints</li> <li>• Strengthen linkages between the Ministry and research organisations / researchers and policymakers</li> <li>• Develop guidelines on sourcing, appraising, synthesising and using evidence</li> <li>• Invest in functional and updated technology that can facilitate access to research evidence</li> <li>• Re-establish the health annual conference, which used to be coordinated by MoH</li> </ul>	<ul style="list-style-type: none"> <li>• Recruit more staff to address time constraints (the Parliament has plans to address this)</li> <li>• Provide good Internet connectivity, which can be used to search, access and share data</li> <li>• Increase funding for research and its application</li> <li>• Sensitise MPs on the importance of research</li> <li>• Develop guidelines on sourcing, appraising, synthesising and using evidence</li> </ul>
<b>Improve Technical Knowledge and Skills</b>	
<ul style="list-style-type: none"> <li>• Build staff capacity in accessing, appraising, synthesising, translating &amp; communicating research evidence/data</li> <li>• Train staff in research methods and analytical skills</li> </ul>	<ul style="list-style-type: none"> <li>• To address the capacity constraint, train existing clerks in analysing and packaging data and research evidence so that they double as researchers</li> <li>• Attach staff to other parliaments to learn how they source and use evidence</li> </ul>

## Researchers' Views

Researchers were asked to suggest demand-side and supply-side solutions to how the challenges and constraints they highlighted could be addressed. As with those of the policymakers, their recommendations fall into two main categories, interventions to strengthen institutional support and to improve technical knowledge and skills, summarised in Table 9.

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, to translate and package the findings to meet policymakers' needs and to build researcher capacity to do so. Respondents also noted the need to align their research to the national health and health research priorities. Also highlighted is the need to involve policymakers in the design and implementation of research.

**Table 9: Researchers' Recommendations for Addressing Constraints to Using Research Evidence in Decision-Making**

Demand Side	Supply Side
<b>Enhance institutional support</b>	
Increase platforms where researchers can present their work to policymakers	Improve stakeholder engagement
Make efforts to establish committees that identify appropriate stakeholders	Knowledge should emphasise priority issues for policy change
Local collaboration between policymakers and researchers is needed to know how to do this well	MoH and partners to improve engagement with researchers; this should be institutional rather than individualised
Remove conflicting interests of researchers	There should be sessions in conferences that offer these kind of discussions
Put together the right people at the right time	Strengthen linkages between research institutions and policy organisations
Follow up on research findings	Identify alternate sources of funding for conducting and disseminating research
The National Research Committee should be able to remedy these problems	Provide platforms whereby researchers will interact fully with policymakers
<b>Improve technical knowledge and skills</b>	
Train staff to source and use research evidence	Provide training for researchers in packaging of research evidence and effective communication to policy researchers
Improve researchers' capacity to communicate research findings effectively to policymakers	
Too much research for academic advancement; more should be policy-linked	Involve policymakers in conducting research

## 6.0 Policymakers' Views on Proposed SECURE Health Interventions

To inform the SECURE Health programme interventions for the next two and half years (2014-2016), mid-level policymakers were asked to rate, on a scale of 1 to 5, three proposed interventions for strengthening collaboration,

linkages and institutional systems to support research evidence use in the Ministry. Table 10 below shows that the average ratings for all the three interventions range between 4 and 5 for both MoH and Parliament respondents. This simply means that the project interventions are in line with their needs and expectations.

**Table 10: Ratings by Policymakers on Proposed SECURE Health Interventions for Strengthening Collaboration, Linkages and Institutional System**

Proposed Interventions for Strengthening Collaboration, Linkages and Institutional Systems		
Intervention	Average Rating	
	MoH	Parliament
Strengthen effective linkages between your organisation and research institutions	4.33	4.44
Develop guidelines for sourcing, assessing and using research evidence	4.13	4.70
Sensitise of top-level decision-makers	4.54	4.90

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. Table 11 below gives a summary of the topics and their average ratings.

**Table 11: Ratings by Policymakers on Proposed SECURE Health Programme Skills Training Topic**

Proposed Training Topics					
Average rating			Average rating		
Topic	MoH	Parliament	Topic	MoH	Parliament
Defining knowledge gaps that need to be addressed to make policy decisions	3.96	4.10	Adapting findings from other contexts	3.83	4.50
Understanding the basics about various research methodologies (for example, the difference between an experimental and an observational research study)	4.04	4.60	Presenting research results to top-level decision-makers	4.25	4.70
Identifying, and searching for research evidence in relevant journals and online databases	3.88	4.10	Developing charts, tables, graphs etc. from data sets or reports	3.33	4.10
Assessing the relevance and applicability of research evidence to the key issues that concern your work	4.46	4.60	Developing PowerPoint presentations	2.79	3.70
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)	4.54	4.50	Developing policy briefs	4.33	4.40
Synthesising and summarising research evidence from different sources and drawing key messages	4.38	4.70			

The average rating for all proposed topics ranged between 2.79 and 4.54 among respondents from MoH and between 3.70 and 4.70 among respondents from Parliament. The following four topics (highlighted in bold) rated slightly higher than the rest (Table 11):

- Assessing the strength or quality of evidence that you find (or, knowing how to determine what is credible versus what is poor quality or weak);
- Assessing the relevance and applicability of research evidence to the key issues that concern your work (just among respondents from MoH);
- Synthesising and summarising research evidence from different sources and drawing key messages; and
- Developing policy briefs.

## 7.0 Recommendations from the Validation Meeting

During the launch of the validation of the needs assessment results, which was also the launch of the SECURE Health programme, the Secretary for Health in Malawi, Mr Chris Kang'ombe emphasised how the Ministry will benefit from the programme. Below is the extract from his speech.

“It is to the advantage of the Ministry to have the SECURE Health Programme, which will add value to the Knowledge Transformation Platform. I am very excited to learn that the SECURE Health Programme will optimise leadership and technical and institutional capacity for increased use of research evidence in decision-making. This is one of the areas that the MoH is lacking and it is good that this programme has come at the right time. I hope that by the end of the three-year programme, use of research evidence will be a culture within us.”

The Secretary for Health also encouraged his staff to apply the lessons from the results shared, so that by improving use of research evidence in decision-making, the Ministry can achieve efficient and effective health delivery systems that will conserve limited resources.

### *Other Key Points Emanating from the Discussion of the Needs Assessment Results Parliament*

- Concurrence with some of the constraints the KTP identified, which shows the urgency of solving these existing barriers to evidence use.
- Satisfaction that Parliament was involved in the SECURE health programme, but the programme should involve Parliamentarians themselves so legislators are facilitated to enact laws after consideration of research evidence.
- Commendation of the training workshops and follow-ups because these were unique and will ensure skills/knowledge acquired in the training are retained.
- The challenge of making the project relevant at sub-national levels (especially involvement of councillors).
- The need for a national repository or clearing house for research evidence to facilitate access, and, although this is too big an investment for the SECURE programme, it can facilitate and support the process by coming up with a strategy to lobby for the repository.

## IV. DISCUSSION AND CONCLUSION

This study sought to understand the institutional and technical capacity needs of policymakers for the application of research evidence and data in policy and programme decisions as well as to inform the refinement of the proposed SECURE Health programme interventions. While the proposed interventions were initially informed by a scoping study conducted in 2013, there was a need to collect more representative views through an in-depth study. The respondents of the study were drawn from the Malawi MoH and the Parliament.

In general, the study revealed that policymakers in Malawi recognise the importance of using research evidence in decision-making but the actual use of research evidence and data in decision-making is inhibited by a number of institutional challenges and individual constraints.

This study's findings on the challenges and constraints to use of research evidence and data largely confirm those of the scoping study conducted in Malawi in 2013 and also what the broader literature presents on this issue. Utilisation of research evidence and data in decision-making is curtailed by a number of institutional and individual challenges and constraints including:

### Institutional constraints

- Lack of a mechanism for accessing research evidence and poor dissemination of the research evidence
- Little interest in using research evidence among top level decision-makers
- Weak institutional linkages with research institutions
- Inadequate funding to support generation and use of research evidence in decision-making

- Lack of incentives for staff to encourage the use of evidence in decision-making

### Individual Constraints

- Inadequate staffing
- Lack of technical skills to:
  - Analyse routine data
  - Access research
  - Interpret & synthesise research
  - Summarise research into clear policy messages
- Time constraints resulting from high workloads and inadequate personnel.

### Access Barriers

- No national repository for health research
- No subscriptions to journals by both MoH and the Parliament
- Poor packaging & dissemination of research evidence
- Lack of relevant research evidence to improve services – Research is seen as an academic output and not for informing policy and programming
- Poor quality of data - routine data is incomplete, untimely and not well analysed

This study further found that the SECURE Health Programme was conceptualised at an opportune time as the policy environment for enhancing application of research evidence in decision-making is ripe and receptive to its strengthening.

The consultations with decision-makers in MoH and Parliament with policymakers revealed that there are ongoing processes that the SECURE Health Programme can support and build on, which are presented in Table 12.

**Table 12: Opportunities for the SECURE Health Programme**

<b>Ministry of Health</b>
<ul style="list-style-type: none"> <li>• The Ministry of Health recently established the Knowledge Translation Platform (KTP-Malawi), whose main objective is to strengthen linkages between policymakers, researchers and health workers to better coordinate the generation and application of health-sector research</li> <li>• The recent establishment of the Public Health Institute of Malawi (PHIM), whose mission is to provide leadership in disease surveillance, research, prevention and control as well as to generate information that informs policy and practice in public health service delivery</li> <li>• Malawi is mid-way through the lifespan of the Health Research Agenda (2012-2016), leaving ample time to review its effectiveness in promoting research evidence generation and utilisation</li> </ul>
<b>Parliament</b>
<ul style="list-style-type: none"> <li>• Parliament is embarking on a restructuring process, which includes strengthening its research unit and the committee section by hiring more research officers and clerks, as well as providing them with training opportunities</li> </ul>

These opportunities and the emerging institutional and technical capacity needs have informed minor refinements to the proposed SECURE Health Programme, which are summarised in Table 13 below. The main

tenets of the programme have been maintained, with refinements mainly focused on content and approaches suggested or emphasised as important by the respondents.

**Table 13: SECURE Health Programme Proposed Intervention and Refinements**

Proposed Interventions	Refinements
High-level national meetings and engagement of evidence champions	Focus on existing MoH and Parliament forums
Policy Science Cafés	Focus on existing MoH and Parliament forums
Strengthen effective linkages between MoH/Parliament and research institutions	Maintained
Policymaker – researcher pairing scheme	Facilitate structured linkages between MoH/Parliament and research organisations
UK POST internship for parliamentary clerks and research officers	Implemented as part of the strengthening of linkages between MoH and Research Institutions
Develop guidelines for sourcing, assessing and using research evidence	Maintained
Skills training	Support the MoH to develop guidelines for application of research evidence
	Tailor trainings to emphasise highly rated topics, follow-up support and review workshops. Topics highly-rated and endorsed are as follows: <ul style="list-style-type: none"> <li>• Interpretation of research evidence</li> <li>• Synthesis and translation of research evidence</li> <li>• Packaging of research evidence including development of policy briefs</li> <li>• Communication of research evidence to top decision-makers</li> </ul>

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 will also be used to inform the work plan and to strengthen the activities of the Research Unit in the Ministry of Health.

In conclusion, the findings confirm the results of the scoping study of 2013. They 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 and contribute to the existing knowledge base on these issues.

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# APPENDIX I: Data Collection Tools Used



## Assessment of Decision makers' Capacity to use research evidence in policy formulation and programme design and implementation

### Informed Consent

Date of interview:

Start time:

Name of interviewee (optional):

Name of organisation:

Position of interviewee:

Hello. My name is \_\_\_\_\_ and I work for the [Name of Organization]. The African Institute for Development Policy (AFIDEP), in collaboration with the College of Medicine, Malawi (CoM), ECSA-Health Community, and FHI 360, is implementing a programme of work on strengthening capacity for data and research evidence use in health sector decision-making in Malawi – SECURE Health. The project 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 optimize access and use of data and research evidence in health-related policy decision-making, planning and programming in Malawi.

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.

### 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 organization?	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

9. 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?	
10. 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

17. What do you see as the main barriers to the use of research evidence/data in decision-making and practice in the health sector in Malawi? Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	
18. What are the 3 main personal capacity constraints that impede effective utilisation of research evidence/data in decision-making? Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	1. _____ 2. _____ 3. _____
19. How can these be addressed?	1. _____ 2. _____ 3. _____
22. What are the 3 main capacity constraints your staff have that impede them from effective utilisation of research evidence/data in decision-making? Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	1. _____ 2. _____ 3. _____
23. How can these be addressed?	1. _____ 2. _____ 3. _____
24. What are MOH/Parliament's 3 major challenges that hinder the utilisation of research evidence/data in decision-making?	1. _____ 2. _____ 3. _____
25. How can these be addressed?	1. _____ 2. _____ 3. _____

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

Issue	Rating
26. What policies are you putting in place to ensure that research evidence is used for decision making in MOH?	
27. How are you prepared to fund the research component at MOH? Probe: <ul style="list-style-type: none"> <li>• Conducting research versus application of research evidence</li> <li>• Are there available partners/stakeholders who would like to support research at MoH?</li> </ul>	

<p>28. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate MOH/Parliament's level of prioritization of use of research evidence/data in decision making? Please explain.</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<p>1 - lowest 2 3 4 5 - highest</p>
<p>29. Has MOH/Parliament committed adequate personnel to support application of research evidence/data in decision making? Please explain.</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul> <p>30. What do you think could be the contributing factor?</p>	
<p>31. 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.</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> <li>• We are interested in the budget allocation to application of research evidence/data?</li> </ul> <p>32. What do you think could be the contributing factor?</p> <p>Additional probes if one can provide information:</p> <ul style="list-style-type: none"> <li>• Do you know how much MOH allocates or what proportion of the research budget?</li> <li>• Has there been an increase in the budget allocation for research over the past 1 – 3 years?</li> <li>• Who else supports MOH's research budget?</li> </ul>	<p>1 - lowest 2 3 4 5 - highest</p>
<p>41. Does MOH/Parliament have written guidelines on research evidence/data use? Please explain</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<ul style="list-style-type: none"> <li>• No</li> <li>• Yes</li> <li>• I don't know</li> </ul>
<p>42. Do you think it is useful to have this in place?</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	
<p>42.b. Are you aware of the existing Research Agenda?</p>	<p>0. No – Skip to Q43 1. Yes – proceed to Q 42.c</p>
<p>42.c. On a scale of 1 to 5, with 1 being the lowest and 5 the highest, how would you rate what effect the Research Agenda has had on</p> <p>1. generation of research evidence</p> <p>2. use of research evidence</p> <p>Please explain your rating</p>	<p>1 - lowest 2 3 4 5 - highest</p>

<p>43. Does MOH/Parliament have a structured mechanism for reviewing and incorporating the research evidence/data in decision making processes? Please explain</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Organization level</li> <li>• Directorate/division level</li> <li>• Research evidence</li> <li>• Routine data</li> <li>• If you came across relevant research, how would you present it to decision makers?</li> <li>• When major decisions are made, do top-level decision-makers allow time on the agenda for considering research evidence? Please explain</li> </ul>	<ul style="list-style-type: none"> <li>• No – Skip to Q46</li> <li>• Yes - proceed to Q44</li> <li>• I don't know – Skip to Q46</li> </ul>
<p>44. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate this mechanism?</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<p>1 - lowest</p> <p>2</p> <p>3</p> <p>4</p> <p>5 - highest</p>
<p>46. Would you say that your division/unit has (or your previous division) instilled a culture of utilization of research evidence/data in decision making? Please explain</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<p>0. No</p> <p>1. Yes</p> <p>2. I don't know</p>
<p>47. Does MOH/Parliament have any incentives to motivate you to use research evidence /data in your work?</p> <p>48. If yes, please list the incentives</p> <p>49. If no, what incentives would motivate you to use research evidence/data in your work?</p>	<p>0. No – Skip to Q 50</p> <p>1. Yes</p> <p>2. I don't know</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>

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

50. What interventions would strengthen the use of research evidence by individuals and institutions in Malawi?	
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### G. MoH's current Program Priorities

Finally, the planned MOH-SECURE Health capacity building program cannot focus on all program areas within the MOH/Parliament. Thus, which program 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 utilize 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

\*Glossary of terms to be included



## Assessment of Decision makers' Capacity to use research evidence in policy formulation and programme design and implementation

### Informed Consent

Date of interview:

Start time:

Name of interviewee (optional):

Name of organisation:

Position of interviewee:

Hello. My name is \_\_\_\_\_ and I work for the [Name of Organization]. The African Institute for Development Policy (AFIDEP), in collaboration with the College of Medicine, Malawi (CoM), ECSA-Health Community, and FHI 360, is implementing a programme of work on strengthening capacity for data and research evidence use in health sector decision-making in Malawi – SECURE Health. The project 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 optimize access and use of data and research evidence in health-related policy decision-making, planning and programming in Malawi.

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.

## 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 organization?	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: Policy makers' views and understanding of and capacity to use of research evidence/data in decision making

8. What does “use of research evidence/data in decision-making” mean in relation to your job? Probe: Research evidence Routine data	
10. 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
11. 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
12. 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	

12.b. On a scale of 1-5, with 1 being the lowest and 5 the highest, what is the extent to which 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
13. 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
14. 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 Organizations d) Online resources and databases e.g. Google, PubMed etc. e) Colleagues f) List servs (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
15. Have you received any training on Research Methods and when (year)? Please describe.	0. No 1. Yes
16. Can you use statistical packages to analyse data? Please list which one	0. No 1. Yes
16.b. 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

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

24. What are MOH/Parliament's 3 major challenges that impede utilisation of research evidence/data in decision-making?	1. _____ 2. _____ 3. _____
25. How can these be addressed?	1. _____ 2. _____ 3. _____

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

Issue	Rating
28. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate would MOH/Parliament's level of prioritization of use of research evidence/data in decision making? Please explain. Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	1 – lowest 2 3 4 5 – highest
29. Has MOH/Parliament committed adequate personnel to support application of research evidence/data in decision making? Please explain. Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No 1. Yes 2. I don't know
30. What do you think could be the contributing factor?	
31. 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: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> <li>• We are more interested in budget allocation to support for application of research?</li> </ul>	1 - lowest 2 3 4 5 - highest
32. What do you think could be the contributing factor? Additional probes if one can provide information: <ul style="list-style-type: none"> <li>• Do you know how much MOH allocates or what proportion of the research budget?</li> <li>• Has there been an increase in the budget allocation for research over the past 1 – 3 years?</li> <li>• Who else supports MOH's research budget?</li> </ul>	
33. Do you have a performance contract or workplan against which your performance is assessed? Please explain	0. No – contract – Skip to Q 35 1. No - workplan– Skip to Q 35 2. Yes – contract proceed to Q 34b 3. Yes -workplan proceed to Q 34b

34.b. Does it assess the extent to which you or the team apply research evidence in your work? Please explain Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No 1. Yes 2. Not explicit
35. Are there institutional led fora where staff and invitees present and discuss research evidence/data related to your organisation's main goals? Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No – Skip to Q 38 1. Yes proceed to Q36 2. I don't know – Skip to Q 38
36. How often does it/do they meet?	0. Annually 1. Quarterly 2. Monthly 3. Weekly 4. Other
37. How useful do you think it is/ they are?	
38. 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: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No – Skip to Q 41 1. Yes proceed to Q 39 2. I don't know – Skip to Q 41
39. How often do/did (if referring to previous division) they meet?	0. Annually 1. Quarterly 2. Monthly 3. Weekly 4. Other
40. How useful do/did (if referring to previous division) you think it is?	
41. Does MOH/Parliament have written guidelines on research evidence/data use? Please explain Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No 1. Yes 2. I don't know
42. Do you think it is useful to have this in place? Probe: <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	0. No 1. Yes 2. I don't know
42.b. Are you aware of the existing National Health Research Agenda?	0. No – Skip to Q 43 Yes – proceed to Q 42.c
42.c. On a scale of 1 to 5, with 1 being the lowest and 5 the highest, how would you rate what effect the National Health Research Agenda has had on 1. generation of research evidence 2. use of research evidence Please explain your rating	1 - lowest 2 3 4 5 - highest

<p>43. Does MOH/Parliament have a structured mechanism for reviewing and incorporating the research evidence/data in decision making processes? Please explain</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> <li>• If you came across relevant research, how would you present it to decision makers?</li> <li>• When major decisions are made, do top-level decision-makers allow time on the agenda for considering research evidence? Please explain</li> </ul>	<p>0. No – Skip to Q45</p> <p>1. Yes - proceed to Q44</p> <p>2. I don't know – Skip to Q45</p>
<p>44. On a scale of 1-5, with one being the lowest and 5 the highest, how would you rate this mechanism?</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<p>1 - lowest</p> <p>2</p> <p>3</p> <p>4</p> <p>5 - highest</p>
<p>45. Does your MOH/Parliament have:</p> <p>a) Reliable Internet access?</p> <p>b) Well-equipped library?</p> <p>c) Journal subscriptions?</p> <p>d) Computer software including statistical packages</p>	<p>0. No</p> <p>1. Yes</p> <p>2. I don't know</p>
<p>46. Would you say that your division/unit has (or your previous division) instilled a culture of utilization of research evidence/data in decision making? Please explain</p> <p>Probe:</p> <ul style="list-style-type: none"> <li>• Research evidence</li> <li>• Routine data</li> </ul>	<p>0. No</p> <p>1. Yes</p> <p>2. I don't know</p>
<p>47. 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)</p> <p>48. If yes, please list the incentives</p> <p>49. If no, what incentives would motivate you to use research evidence/data in your work?</p>	<p>0. No – Skip to Q 51</p> <p>1. Yes</p> <p>2. I don't know</p> <p>1. _____</p> <p>2. _____</p> <p>3. _____</p>

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

<p>51. 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 that you attend?</p> <p>a) Defining knowledge gaps that need to be addressed to make policy decisions</p> <p>b) Understanding the basics about various research methodologies? (for example, the difference between an experimental and an observational research study)</p> <p>c) Identifying, and searching for research evidence in relevant journals and online databases?</p> <p>d) Assessing the relevance and applicability of research evidence to the key issues that concern your work?</p> <p>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)?</p> <p>f) Synthesising and summarising research evidence from different sources and drawing key messages?</p> <p>g) Adapting findings from other contexts?</p> <p>h) Presenting research results to top-level decision-makers?</p> <p>i) Developing charts, tables, graphs etc. from data sets or reports?</p> <p>j) Developing PowerPoint presentations?</p> <p>k) Developing policy briefs?</p> <p>l) Other? Please list them.</p>	<p>1 - lowest</p> <p>2</p> <p>3</p> <p>4</p> <p>5- highest</p>
<p>51. b. If you are to pick one, which of these skills would be most critical to cover in a training?</p>	
<p>52. 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?</p>	<p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
<p>53. Please provide examples of some current “hot” policy topics or questions in your division that we could use to develop training materials?</p>	<p>1. _____</p> <p>2. _____</p> <p>3. _____</p>
<p>54. 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?</p> <p>b) Strengthen effective linkages between your organization and research institutions</p> <p>d) Develop guidelines for sourcing, assessing and using research evidence</p> <p>e) Sensitization of top level decision makers</p>	<p>1 – lowest</p> <p>2</p> <p>3</p> <p>4</p> <p>5- highest</p>
<p>55. Is there a structured mechanism through which your division works with research organizations to access research evidence?</p> <p>55.b. Are there challenges or constraints faced with this mechanism?</p> <p>56. How can this mechanism be improved?</p>	<p>0. No – Skip to Q 57</p> <p>1. Yes- proceed to Q55</p> <p>0. No – Skip to Q 57</p> <p>1. Yes - proceed to Q56</p>
<p>57. Do you participate in any technical working groups (TWGs)/committees?</p> <p>58. If yes, which one? What is its mandate?</p>	<p>0. No – Skip to Conclusions</p> <p>1. Yes</p>

59. How can health researchers interested in participating in these forums become involved?	
60. 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 the MoH/ Parliament's capacity to utilize 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.

\*Glossary of terms to be included

## APPENDIX II: Letter of Authority

<p><b>Telephone No.:</b> <b>Lilongwe – 789 400</b> <b>Fax No.: 789 431</b> <b>Communications should be addressed to Secretary for Health</b></p>		<p><i>In reply please quote No:.....</i></p> <p><b>Ministry of Health</b> <b>P.O. Box 30377</b> <b>Capital City</b> <b>Lilongwe 3</b></p>
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**REF:**

**28 April 2014**

To: DIRECTORATE OF PLANNING AND POLICY DEVELOPMENT  
DIRECTORATE OF HEALTH TECHNICAL SUPPORT SERVICES  
DIRECTORATE OF REPRODUCTIVE HEALTH  
DIRECTORATE OF NURSING SERVICES  
DIRECTORATE OF PREVENTIVE HEALTH SERVICES  
DIRECTORATE OF CLINICAL SERVICES  
DIRECTORATE OF FINANCE AND ADMINISTRATION  
HEADS OF UNITS  
PROGRAMME MANAGERS

### **RE: SECURE Health Program: Needs Assessment Interviews**

The Ministry of Health (MoH) through the Research Unit is collaborating with a consortium of four organizations in implementing 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 Malawi.

The SECURE Health Consortium comprises of the African Institute for Development Policy (AFIDEP), College of Medicine-Research Support Centre, 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 Malawi and Kenya. Currently, 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 utilizing 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: Heads of Directorates, Heads of Technical Divisions, Mid-level Policy Makers and Programme Staff in this Ministry from **Wednesday August 27, 2014** through **Friday 16th September 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 the implementation phase for the Secure-Health Programme.

Chris Kang'ombe

**SECRETARY for HEALTH**





## NATIONAL ASSEMBLY

Parliament Building, Private Bag B362, Capital City, Lilongwe 3

Ref: NA/PC/08

Telephone: 01 773 566/01 773 208/01 773 740

Fax: 01 774 196/01 771 340

E-mail: [parliament@malawi.net](mailto:parliament@malawi.net)

22<sup>nd</sup> May, 2014

The Director  
AFIDEP  
P.O Box 3093  
Lilongwe 3

Dear Sir/Madam

**RE: REQUEST FOR PERMISSION TO CONDUCT A STUDY ON THE  
SECURE HEALTH CAPACITY STRENGTHENING PROGRAM' NEEDS  
ASSESSMENT**

I refer to your letter dated 6<sup>th</sup> May, 2013, requesting for a written permission and names of Parliament officials to be interviewed on Capacity Needs Gap in using research evidence in policy formulation, programme design and implementation. I wish to advise that the following National Assembly staff will participate in the study:-

**Table Office Section**

1. Mr. J. Manzi
2. Mr. L. Chitseko
3. Mr. M. Makande

**Committee Section**

4. Mr. M. Chiusiwa
5. Mr. F. Kamwani
6. Ms. M. Musukwa

**Library Section**

7. Mr. K. Kazembe
8. Mr. M. S. Banda

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All correspondence to be addressed to the Clerk of Parliament

**Research Section**

- 9. Ms. V. Manyonga
- 10. Mr. L. Tilingamawa

**Civic Education Section**

- 11. Ms. S. Dambe
- 12. Mr. K. Banda

**Policy and Planning**

- 13. Mr. J. Mdala
- 14. Mr. L. Nyongo
- 15. Mrs. E. Kuyeri

You will be required to come to have a briefing meeting of about 30 minutes to inform the officials on the aim of the study. Thereafter, officials should be given the questionnaires to fill at their own time.

You may wish to note that the coordinator for this exercise is Ms. V. Manyonga, Chief Research Officer. You can contact her on 0999 591 488 and [vmayonga@yahoo.co.uk](mailto:vmayonga@yahoo.co.uk)

Yours faithfully,



H. H. Njolomole

For: **CLERK OF PARLIAMENT**

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All correspondence to be addressed to the Clerk of Parliament

Telephone No.:  
Lilongwe – 789 400  
Fax No.: 789 431  
Communications should be addressed  
to Secretary for Health



In reply please quote No. ....

Ministry of Health  
P.O. Box 30377  
Capital City  
Lilongwe 3

TO:

**RE: SECURE Health Program: Needs Assessment Interviews**

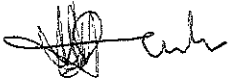
The Ministry of Health (MoH) through the Research Unit is collaborating with a consortium of four organizations in implementing a new program, the SECURE Health Program, whose aim is to optimize leadership, technical and institutional capacity for increased use of research evidence in decision-making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

The SECURE Health Consortium comprises of the African Institute for Development Policy (AFIDEP), College of Medicine-Research Support Centre, 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 Malawi and Kenya. Currently, 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 utilizing 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: Heads of Directorates, Heads of Technical Divisions, Mid-level Policy Makers and Programme Staff in this Ministry from **Wednesday August 27, 2014** through **Friday 16th September 2014**.

The purpose of this letter therefore is to ask you to participate in the interviews and to book an appointment with you for the interviews. We are looking forward to the findings of the survey, which will inform the implementation, planning and programming, and inform the implementation phase for the Secure-Health Programme.

I look forward to your participation and should be grateful if you can confirm your participation by emailing or calling Dr C. Mitambo (MOH) on [cmitambo@gmail.com](mailto:cmitambo@gmail.com) 0881001539/0999397913) or Nissily Mushani (AFIDEP) on [nissily.mushani@afidep.org](mailto:nissily.mushani@afidep.org) (0991690934/0881690934)

  
pp: Dr. Damson Kathyola  
**Director of Research**

Telephone No.:  
Lilongwe – 789 400  
Fax No.: 789 431  
Communications should be addressed to  
Secretary for Health



In reply please quote No. ....

Ministry of Health  
P.O. Box 30377  
Capital City  
Lilongwe 3

7 May 2014

To whom it may concern

**Letter of Support for Conducting the Needs Assessment Exercise in the Ministry of Health**

The African Institute for Development Policy (AFIDEP), in collaboration with the College of Medicine, Malawi (CoM), ECSA-Health Community, FHI 360, and Ministry of Health, is implementing a programme of work on strengthening capacity for data and research evidence use in health sector decision-making in Malawi – *SECURE Health*. The project 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 optimize access and use of data and research evidence in health-related policy decision-making, planning and programming in Malawi.

The programme seeks to conduct a rapid Needs Assessment study on Decision-makers' Capacity to apply research evidence in policy formulation and programme design and implementation. This letter serves to indicate that the Ministry of Health fully supports the assessment exercise. The exercise will generate important information needed to refine the *SECURE Health* program's proposed interventions for addressing capacity gaps and bottlenecks that hinder increased use of health research evidence in decision making within the MoH and parliament.

I should be grateful for your assistance on this matter.

M.C Msasata  
**For: SECRETARY for HEALTH**

# APPENDIX III: Secure Health Programme Summary

## 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 Legislatures 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 policymaking 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



African Institute for Development Policy

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SECURE Health is implemented by the African Institute for Development Policy (AFIDEP), University of Malawi: College of Medicine, East, Central and Southern Africa Health Community (ECSA-HC), FHI 360 and the Malawi Government

**African Institute for Development Policy**

**Nairobi**

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

