MINISTRY OF HEALTH

Report of the Baseline Survey on the Context and Status of Research Use in Policy Formulation at the Ministry of Health in Kenya

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Executive Summary

This study was conducted collaboratively by the African Institute for Development Policy (AFIDEP) and the Ministry of Health (MoH) to assess both the extent and context of research evidence use in the formulation of policies at the Ministry of Health in Kenya. A team of eight researchers drawn from both AFIDEP and MoH were involved in the design, data collection, analysis and write-up of the report. The study was conducted as part of the SECURE Health (Strengthening Capacity to Use Research Evidence in Health Policy) programme in Kenya, whose overall objective is to optimise access and use of research evidence in health sector decision-making, planning and programming. Decision-makers in public health policy worldwide recognise and believe that the inclusion of evidence in public policy-making is both a desirable and attainable policy goal. Conducted with the aim of strengthening the use of evidence in policy formulation at the MoH, this baseline policy analysis study examined the status of research use, capacity, barriers and facilitators of research use within the MoH in order to provide an information base against which to measure the progress and effectiveness of the SECURE Health interventions.

A qualitative research methodology was employed for this study. The methods used included document analysis, key informant interviews, and a literature review, whose results were triangulated during the analysis and used to write the report. Data collection was conducted over a period of three months between October and December 2015. The study examined both the individual and institutional capacities for evidence use within the MoH mainly because policy processes are organised and driven by people who discuss, negotiate, disagree, co-operate and come to decisions within specific institutional contexts. The MoH was thus considered as the unit of analysis and the individuals were selected on account of their involvement in the policy formulation processes at the MoH. Three policies were selected as case studies for this project: the Kenya Health Policy 2014 - 2030, the National Adolescent Sexual and reproductive Health Policy of 2015 and the Kenya National Malaria Policy of 2010.

One of the key findings of this study is that the MoH considers the use of evidence in policy formulation as critical to the success of its policies and programmes. Consequently it has put in place ad-hoc mechanisms that enable it to access and utilise various forms of the evidence in its policy formulation process. A closer look at these processes and mechanisms, however, reveal a number of glaring inefficiencies and incapacities that need to be addressed. There is severe shortage of capacity both in numbers and levels of expertise at the MoH with regard to policy formulation. At the same time, the MoH does not allocate any budget line for the policy formulation processes. Starved of funding and lacking in capacity, policy formulators at the MoH are forced to turn to their 'partners' for support in accessing relevant evidence as well as in funding the processes involved in the policy formulation. This support is often massive since policy formulation process often takes long, and sometimes like in the Kenya Health policy, up to 5 years. Such support is rarely without forms of covert and overt influence to the direction that the policies eventually take. Most of the evidence required for health policy formulation derives from MoH data Health Management Information System (HMIS) etc and other vital statistics from government agencies. Our findings show that these important sources of evidence were either missing or incomplete - in some cases missing up to 40% of the data. There was also the absence of a central portal where all policy-relevant government data could be archived and accessed, as well as lack of a mechanism by which the MoH could regularly access evidence from other institutions that conduct policy-relevant research in the country.

This study makes a number of recommendations that, if adopted, could strengthen institutional and individual capacity for increased demand and use of research evidence in Kenya's health sector. At the individual level, there is a need for capacity building to equip the staff at MoH involved in policy formulation with the necessary skills required at every step of policy formulation. This capacity building should be both in quantity (in terms of numbers) as well as in quality or technical competence. There is also a need for the establishment of a research evidence portal or health observatory where all evidence collected that is relevant to policy formulation can be stored and accessed by anyone interested in health policy formulation – be they MoH personnel or consultants hired by MoH. This study also recommends that the MoH needs to allocate a budget that is specifically earmarked for the policy formulation process. This budget should address not just the end point of evidence search and policy formulation, but the entire process that generates the relevant data that is analysed by policy formulators. The MoH must thus fund the process of generating the evidence whether through sponsoring policy relevant research or investing in the improvement of data collection by all government institutions that collect policy-relevant data. Finally, there is a need for the institutionalisation of a culture within government that values and consequently invests in research evidence generation and use processes from the start point of the data collectors to the end point of data user and/or policy-makers.

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Acronyms

AFIDEP	African Institute for Development Policy
APHRC	Africa Population and Health Research Center
ASFR	Age Specific Fertility Rate
ARHD	Adolescent Reproductive Health and Development
CD	Communicable Diseases
CNHR	Consortium for National Health Research
DFH	Division of Family Health
DFID	Department for International Development
DOMC	Division of Malaria Control
DPHK	Development Partners in Health Kenya
EBM	Evidence-based Medicine
EBPM	Evidence-based Policy-making
EIPM	Evidence Informed Policy-making
ECSA-HC	Eastern, Central and Southern Africa Health Community
FHI	Family Health International
FGM	Female Genital Mutilation
GDP	Gross Domestic Products
HENET	Health NGOS Network
HMIS	Health Management Information System
HPP	Health Policy Project
IPTp	Intermittent Prophylactic Treatment in Pregnancy
IRS	Indoor Residual Spraying
ITN	Insecticide Treated Nets
KAIS	Kenya AIDS Impact Survey
KDHS	Kenya Demographic and Health Impact Survey
KEMRI	Kenya Medical Research Institute
KEPSA	Kenya Private Sector Alliance
KHP	Kenya Health Policy
KIPPRA	Kenya Institute Public Policy Research and Analysis
KNBS	Kenya National Bureau of Statistics
KNHA	Kenya National Health Accounts
LE	Life Expectancy
LGBTs	Lesbians, Gay, Bisexual and Transgender Persons
MDG	Millennium Development Goals
MOH	Ministry of Health
MOYA	Ministry of Youth Affairs
NACADA	National Authority for the Campaign against Alcohol and Drug Abuse
NASRHP	National Adolescent Sexual and Reproductive Health Policy
NCDS	Non-communicable Disease
NCPD	National Council for Population and Development
NTFR	National Total Fertility Rate
OOP	Out-Of-Pocket
RCTs	Randomised Control Trials
RDTs	Rapid Diagnostic Test
SAGAS	Semi-autonomous Government Agencies
SDGs	Sustainable Development Goals
SECURE	Strengthening Capacity to Use Research
THE	Total Health Expenditure
TWG	Technical Working Groups
UNDP	United Nations Development Programme
UNFPA	United Nations Population Fund
UNICEF	United Nations Children Fund
WHO	World Health Organisation

CHAPTER 1

Introduction

This project report derives from a baseline policy analysis study to assess the status of research use in the formulation of policies by the Ministry of Health in Kenya (MoH). The study was conducted as part of the SECURE Health (Strengthening Capacity to Use Research Evidence in Health Policy) programme in Kenya, whose overall objective is to optimise access and use of research evidence in health sector decision-making, planning and programming. The SECURE Health programme is funded by the UK's Department for International Development (DFID) to implement and evaluate interventions aimed at addressing individual and institutional bottlenecks that prevent policy-makers from effectively accessing and using research evidence in their work. It (SECURE Health) is a three-year project implemented through a partnership of the MoH, parliament and the SECURE Health Consortium led by the African Institute of Development Policy (AFIDEP). Other partners in the Consortium include the Consortium for National Health Research (CNHR), FHI 360 and the Eastern, Central and Southern Africa Health Community (ECSA-HC).

SECURE Health's primary focus is to strengthen institutional and individual capacity for increased demand and use of research evidence in Kenya's health sector. The focus on both the institutional and individual capacity considers the fact that policy processes are organised and driven by people who discuss, negotiate, disagree, co-operate and come to decisions within specific institutional contexts (Eittelt et al 2014). Institutions tend to endure over time, setting the norms, rules and procedures that future individuals will need to adhere to when engaging in policy processes. A baseline study is thus an important aspect for this intervention process to examine the status of research use, capacity, barriers and facilitators of research use within the MoH and to provide an information base against which to measure the progress and effectiveness of the SECURE Health interventions both during and after the implementation. The baseline study was conducted by a research team comprising personnel from AFIDEP and the MoH.

This study employed a qualitative research methodology involving document analysis, key informant interviews, and a literature review, whose results were triangulated during the analysis and used to write the report. The focus of this study was the MoH, which is the steward of health policy in Kenya while the unit of analysis was the policy-making process in its broadest sense which included the contextual factors influencing decision-making processes, especially those rules, norms and procedures that shape decision-making in policy-making processes. It is important to note here that although the MoH was the unit of analysis, actors in the policy-making process were not restricted to the MoH employees. As will become evident in the findings section, policy-making processes involved multiple stakeholders from other government ministries, semi-autonomous government agencies (SAGAS) and non-governmental actors including members of the multilateral and bilateral institutions collaborating with the government. As such, representatives from these institutions were also included in the sampling frame. Three policies were identified as case studies: the Kenya Health Policy 2014–2030 (KHP); the National Adolescent, Sexual and Reproductive Health Policy (NASRHP), and the National Malaria Policy 2010. The report that follows therefore provides an overview of the policy-making process using these three policies as illustrations.

1.1 Background

1.1.2. Evidence-based policy-making

Public health policy literature has identified that numerous key decision-makers believe evidence-based policy and the inclusion of evidence in public policy-making is both a desirable and attainable policy goal (McCaughey and Bruning 2010). Consequently, many expect that policy development should be fully informed by research evidence (Eitelt et al 2014, Nutley et al 2007, Lomas and Brown 2009, Lavis et al 2009). Although the term 'evidence-based' policy-making discourse is popular among a wide range of policy communities (Marston and Watts 2003), finding a clear definition of evidence-based policy is difficult. In much of the policy literature, the meaning is considered self-explanatory or defined simply as the systematic appraisal of and review of empirical research findings (Marston and Watts 2003). Several other terms have interchangeably or simultaneously been used in the same context as evidence-based policy and include knowledge transfer, knowledge exchange, knowledge translation and research utilisation (Graham et al 2006, Lavis et al 2003).

The term evidence-based policy (EBP) has evolved from the concept of evidence-based practice both of which were preceded by evidence-based medicine (EBM) movement of the 1990s (Marston and Watts 2003). According to this movement (i.e. EBM), the strategy to be employed in solving a clinical problem required a clear delineation of

the relevant questions, a thorough search of the literature regarding the said question, a critical appraisal of the said evidence and its applicability to the clinical situation and a balanced application of the conclusion (Guyatt and Renne 2002). As the prominence of this movement grew, and a body of literature began to emerge, it was soon recognised that evidence-based medicine approaches could be applied to other fields, including public health. In spite of the differences between public health and clinical practice, among them the fact that clinical practice concentrated at the individual level while public health operated at the population level, an evidence-based policy and practice orientation emerged based on the logics and principles of evidence-based medicine. Evidence-based policy and practice explores the processes of systematically finding, appraising and using scientific research as the basis for developing sound practices. The knowledge gleaned from this research is used to develop policies and practices that improve health outcomes and performance as well as allowing for more efficient use of resources. Policy-makers are also provided with a better understanding of the science, ensuring that policy decisions are based on the best information available.

The prominence and spread of the evidence-based policy movement is a relatively new phenomenon (Dutoit 2012). Originally associated with the rise of the new Labour Party in Britain (Greenhalgh and Russel 2009), it has since entered other fields such as development and poverty studies. Increasingly, this initiative is linked to a specific push for rigorous scientific approaches to evidence, specifically advocating for systematic reviews and the resurgence of the Randomised Control Trials (RCTs) of social policy initiatives (Dutoit 2012, Wallace et al 2004, Barret and Carter 2010, Schaffer 2011). As evidence-based policy development ideology and practice moved from the UK to the US and eventually to other parts of the world including sub-Saharan Africa, the concern became about making policies based on a sober assessment of scientific evidence (Powel 2000) and the creation of a desirable relationship between evidence and policy in order to enhance the use of evidence in policy-making. Policy-making should accordingly adopt an instrumental rationality based on the 'what works' mantra and avoid value laden or ideological adjudication between ends (Dutoit 2012, Sanderson 2002, Bassey 2001). This orientation assumes that in relation to any policy question, there is a right answer; that best practices exist or can be found. More importantly, the EBP perspective posits that the quality of policy decisions depends ultimately on making sure that decision-makers have access to the 'best' or 'right' evidence assessed and interpreted in a rigorous way (Dutoit 2012:3). A corollary of this assumption is that this evidence does exist or can be generated (found) through appropriately designed research. Much research has therefore concentrated on efforts to catalyse the application of evidence in policy-making, including proper networking between users (policy-makers) and producers (researchers), generating local evidence, aligning national research and programme priorities, creating trust between researchers and policy-makers, as well as supporting and incentivising policy-makers to use evidence in the policy-making process (WHO 2007, Invaer et al 2002, Newman 2012, Oliver et al 2014).

1.1.2. Moving from evidence-based policy (EBP) to evidence-informed policy-making (EIPM)

The key argument in the EBP framework is that the design of policies and interventions should be based on good scientific evidence. Critics have, however, labelled the basic tenets of this framework as empirically naive (Brown 2012, Dutoit 2012). According to Dutoit, the framework makes a number of highly contestable assumptions that include the following: that understanding social reality is about understanding the evidence; that the clarity, adequacy and accuracy of this understanding depends primarily on having enough (or the right) evidence; that the more evidence you have the better (see also Bassey 2001); that valid findings are primarily guaranteed by objective value free analysis; that natural science is the best model for the kind of objectivity and rigour needed, and that informing social policy is ultimately about scientists (or intermediaries who understand the science) presenting and communicating what the evidence 'says' as clearly, simply and as unambiguously as possible (Dutoit, 2012:4).

A more robust criticism of the EBP revolves around its assumption of a linear relationship between evidence and policy decision-making (Young et. al 2002). In this line of argument are critics who posit that the creation and formation of policy is extraordinarily complex and that the evolution of individual policies is heavily influenced by a multitude of factors (Brown 2012). Gough (2004) has, for instance, argued that policy-makers have a number of issues to consider in the development of a policy of which available evidence is just one, while Trowler (2003) concludes by suggesting that the exogenous and endogenous machinations involved in policy-making will often be more instrumental in the formation of policy than rational engagement with available evidence. Consequently, Nowotny et al (2003) and Gibbons (1999) came up with the concept of the 'agora' of the market place in which knowledge is both produced and traded. From the onset, this concept rejects the traditional academic disciplinary based linear modes of production where uses are made of knowledge, which is transferred once it has been produced and proposes a mode where knowledge is produced in a context of application.

The scientist is neither on 'top' nor on 'tap' for the policy-makers. Instead, an interactive model is proposed where policy and research mutually influence each other with the agenda for both research and policy decision shaped within policy communities, which contain a range of actors (Young et. al 2002). The agora therefore represents the space where policy-makers and policy-making organisations can set out their stall framing the research priorities that matter to them. The agora hosts numerous evidence experts, both academic and non-academic with whom policy-makers might engage to help find solutions to such problems.

In view of the arguments outlined above, the term evidence-informed policy-making (EIPM) has in recent times replaced evidence-based policy (EBPM) mainly out of the recognition of the non-linear relationship between evidence and policy and the recognition of the wider context that determines whether evidence might be adopted or used within the policy-making process. Davies (2004) describes evidence-informed policy-making as an approach that helps people make well-informed decisions about policies, programmes and projects by putting the best available evidence from research at the heart of policy development and implementation. The evidence-informed policy-making orientation thus argues that the use of research in policy decision-making should not focus on whether evidence is used, but on how evidence is processed to inform decision-making and the contexts within which decision-making occurs. Noting that policy-making is influenced by many factors other than evidence, such as party ideology, personal ambition, opportunism, and cultural beliefs and practices, it is worthwhile adopting a stance that examines policies as 'evidence-informed', 'evidence-influenced' or 'evidence-aware' rather than being 'evidence-based'.

This baseline survey was conducted within the evidence-informed policy-making logic in which the role of evidence was placed in the context of a complex policy-making environment. As such, both the use of evidence and the context within which the evidence was either used or not used were objects of inquiry. By use of multiple research methods, the survey investigated the identification, synthesis and incorporation of evidence, the policy formulation process, the actors involved as well as the external factors (such as the local context, economic factors, legal framework, global influences as well as personal interest and values) that influenced the decisions taken within the policy formulation process.

1.2. Objectives of the Baseline

The main objective of the baseline study was to assess the role of evidence in past policy formulation processes by the MoH and the factors that influenced the use of research evidence in the policy-making processes.

Specific Objectives

The main objective of the study was further subdivided into four specific objectives. These were to:

- Examine the process of evidence selection and context within which the evidence was utilised to inform the policy formulation.
- Provide an understanding of the types of evidence that informed the policy-making process.
- Examine the contributions and influence of different actors and factors in the policy-making process.
- Identify the barriers to research evidence use in policy-making and suggest ways to strengthen the use of evidence.

1.3. Research Questions

The following research questions were set for this study:

i. How was the policy development process initiated and developed?
ii. Who were the main actors in driving the policy-making process?
iii. What kinds of research evidence were sourced, analysed and utilised in the policy-making process?
iv. How did research evidence influence the policy-making process?
v. What other factors shaped and influenced the policy-making process and the decisions made?
vi. What were some of the barriers to the use of evidence in the policy-making process?
vii. In what ways can the use of evidence in the policy-making process be strengthened?

1.4. Methodology

1.4.1 The case study approach

This baseline study employed qualitative approaches to retrospectively examine the role of evidence in policy formulation as well as the process and context within which the evidence was manipulated in the decision-making process at the MoH in Kenya. Three (3) previous policy documents and processes were selected for study. The case study approach was selected as the key qualitative method of inquiry. Yin (2009) defines the case study research approach as an empirical inquiry that investigates a contemporary phenomenon within its real-life context; when the boundaries between phenomenon and context are not clearly evident; and in which multiple sources of evidence are used. The case study method was preferred because it enables a detailed contextual analysis of a limited number of events or conditions and their relationships using

a variety of methods. These in turn generate very detailed information about a particular subject that would not be possible if the researcher was dealing with a larger number of cases with the aim of averaging. The case study is not itself a research method, but researchers select methods of data collection and analysis that will generate material suitable for case studies. This baseline study utilised three methods of data collection and analysis as described in section 1.4.3 below.

1.4.2 Selection of past policy-making case studies

Three policies from different subsectors in the MoH were selected for this baseline study in order to provide an understanding of the influence of evidence in the different sub-sectors. The following three policies were selected for examination:

a) The Malaria Policy 2010

b) The National Adolescent Sexual and Reproductive Health Policy 2015

c) The Kenya Health Policy 2014 - 2030

The selection of the policies for inclusion was done in consultation with the relevant MoH personnel. A deliberate decision was made to select policies developed within the last 5 years so as to avoid the challenge of recall and to enable the tracking down of as many policy actors as possible in view of the high turnover of personnel involved in the policy formulation process. Even with this cautious approach, locating some of the key respondents was, for some cases, impossible because they had moved from their previous work stations, with some of them having left the country all together.

Specifically, the selection of the three policy case studies was purposively guided by two main considerations:

i. To enable an understanding of the role of evidence in the overall health sector in Kenya, we made a deliberate decision to study the Kenya Health Policy 2014 - 2030, which is the overarching policy framework for the health sector in the country, and whose development involved a multitude of different types of actors at the different levels of the policy process.

ii. To enable balanced learning, we made a decision to select a policy from a sub-sector perceived to be largely evidence-driven and another one from a sub-sector perceived to be driven by many other factors and contentions. As such, Malaria Policy of 2010 was selected to represent a sub-sector perceived to be evidence-driven, whereas the National Adolescent Sexual and Reproductive Health Policy 2015 was selected to represent a sub-sector perceived to be influenced by many other factors (culture, religion, politics, etc) and often full of contentious issues. The purpose for this selection was to provide an understanding of how evidence plays out in decision-making within the different sub-sectors of health in order to draw lessons from these sub-sectors.

1.4.3. Data collection methods

The following three interrelated data collection methods were employed in this study.

i. Document analysis of the selected policies

ii. Key informant interviews with policy actors involved in each of the policy case studies

iii. A review of secondary sources of information such as scientific reports, previous policy documents and ministerial assessment reports of policies preceding those under examination.

1.4.3.1. Document analysis of selected policies

All the three policies selected as case studies were read and analysed using a policy analysis framework that included the following sub areas: the policy name; the list of actors involved; the sectors; the policy content or focus area; and evidence usage observed within the policy, whether local or global and the sources of the evidence. The information gathered from this policy audit was considered as data on its own as well as setting the basis for the formulation of questions for the in-depth interviews conducted with the various actors involved in the policy development processes.

1.4.3.2. In-depth interviews

In-depth interviews were conducted with selected informants who were involved in the process of formulating the three policies. The in-depth interview was preferred as a method of inquiry with policy-makers because it can produce very precise and specific answers as well as an exhaustive and varied knowledge about individual determined experiences, opinions and motives. Using this method, the baseline survey explored the role and experience of different actors in the policy-making process, how evidence was sourced, synthesised and included, the barriers encountered in evidence utilisation, the context within which policy-making took place as well as the suggestions from the policy actors on how evidence use in policy-making processes can be strengthened.

a) Key informant selection: purposive and snow ball sampling

A total of 29 key informants were interviewed for this baseline study. The original plan was to select 10 policy actors involved in each of the policy development processes. It was, however, not possible to obtain this balanced number for each of the policy. The Malaria Policy, for instance, was

formulated in 2010 and most of those who were involved in its formulation had moved to other institutions. Only 6 informants were available for interview. For the Kenya Health Policy 2014 - 2030, a total of 13 interviews were conducted, whereas for the National Adolescent Sexual and Reproductive Health Policy (NASRHP), 10 actors were interviewed.

Potential participants were identified in two ways, through purposive sampling and snowball sampling. At the beginning of the data collection, the research team identified key informants on the basis of their role and experience in the formulation of the specific policies selected. For the NASRHP, members of the task force that were critical in its formulation were listed in the policy's addendum. Out of the 26 who were listed in the policy, 10 were selected and interviewed for the study. For the Kenya Health Policy, no task force members were listed and the list of potential respondents was generated through discussions with MoH officials. The same applied for the Malaria Policy. For the latter two policies (especially for the Malaria Policy) snowball sampling (a method of informant selection though suggestions made by interviewed informants for others who might fit the criteria of inclusion) was employed to identify other informants who might have been missed from the initial selection with the MoH officials.

b) The interview guide and interviewing procedures

An interview guide containing 6 questions addressing the broad areas of the baseline study was formulated (see Appendix 1). Appropriate probes were included for each question to enable interviewers to obtain comprehensive responses for each thematic area. As is with most in-depth interviewing procedures, the interview guide provided broad guidelines on the themes to be explored in the interviews as opposed to a strict set of questions to be followed. In most of the interviews, informants were allowed to freely discuss their experiences, allowing for what they considered most relevant and important about their involvement and to give reasons for their opinions and individual points of view. The interviewer used the interview guide only to ensure that all the areas of interest were covered during the interview.

c) Informed consent

Informed consent was obtained for each participant prior to the commencement of the interview. After obtaining the ethics clearance from the Kenya Medical Research Institute (KEMRI) ethics review committee (see Appendix 3), the MoH drafted an introduction letter detailing the study, its objectives and rationale, which was shared with all prospective respondents of the baseline study through e-mail. After the e-mail from the MoH, all prospective respondents were individually contacted by telephone and e-mail to request them to be interviewed for the study. Where a participant agreed to be included in the study, an interview appointment was made and confirmed by a follow up e-mail. In the follow up e-mail, the informed consent form (see Appendix 2) was also dispatched to the respondent. The informed consent form detailed the purpose of the study and emphasised that participation in the study was voluntary and that they could choose not to take part in the study or not to respond to sections of the interview. The prospective respondents were requested to read through the informed consent before the interview. Most of the respondents managed to read through the consent form and agreed to the interviewing procedures including the request for audio-recording of the discussion. Respondents who had not read the consent form requested the interviewers to summarise the content after which they generally acquiesced to be interviewed.

At the beginning of the interview itself, participants were given a broad outline of the scope of the study and were reminded that their responses would remain confidential. The interviewers confirmed that the respondents had read through the informed consent form and that they agreed to have the conversation audio-recorded. The respondents then signed two copies of the consent forms, one of which they retained and the other was retained for records by the interviewer. The interview then began with a number of preliminary questions, to confirm that they were involved in the formulation of the relevant policy and the duration of their engagement. Each interview lasted between 35 minutes to 1 hour. Two interviews, however, lasted approximately one and half hours. All the interview notes were transcribed, summarised and analysed for inclusion in this report.

1.4.3.3 Review of secondary sources of information

The baseline survey attempted to obtain secondary sources of information that were employed by the policy formulating teams at the MoH. Unfortunately not so much of these documents were available for review. The study only managed to obtain the previous policy documents as well as the assessment reports for the policies under review. It was not possible to obtain any minutes of meetings as these were considered confidential documents by the MoH. Other secondary sources of information such a journal articles and books on the general principles of policy formulation processes and the relationships between evidence and policy formulation were reviewed.

The three data sources were independently analysed and together triangulated. The report that follows therefore combines the findings from these three data sources.

1.4.4. Data analysis

Data analysis for this study employed a theme and content approach (also known as thematic) and adopted the five-step qualitative data analytic process as outlined by McCracken (1988). Content analysis involves a process of condensing raw data into categories or themes based on valid interpretations and inferences. Detailed descriptions, direct quotations and direct observations from the interviews are provided as the foundation of the analysis.

The first step of the analysis begun with the reading of all of the 29 transcripts twice: the first time for understanding the contents and the second time for identification of useful comments and observations. In the second stage of the analysis, observations and issues emerging from the interviews were developed into preliminary themes, descriptive and interpretive categories based on the evidence presented in the transcripts, the policy audit and the review of secondary literature identified. The categories employed for the analysis were similar to those used in the in-depth interview guides. Information from the transcripts was thus summarised and typed into the categories already in the guide while new ones were created from the new issues emerging from the interviews. The third stage of the analysis involved a thorough examination of the themes emerging and identifying connections between the groupings or clusters of arguments. Ensuing from and often in combination with the 3rd step was the 4th, which involved the determination of basic themes by examining clusters of comments made by respondents. A theme in this case referred to a statement of meaning that runs throughout all or most of the pertinent data or one in the minority that carries emotional or factual impact (see Ely et.al. 1991). At the end of this stage, several themes were already emerging around which comments could be clustered, such as capacity options, evidence procedures, barriers to evidence use and perspectives for the strengthening of evidence use in policy formulation. These were constructed incrementally from each respective summary with already created themes being discounted or supported while new ones were created as they emerged. The final stage examined the themes from all interviews across the developed categories or groupings and delineated predominant themes contained in the data. These predominant themes are the ones that serve as answers to the research questions, and form the basis for writing up this report.

1.4.5 Challenges and limitations

This baseline survey intended to employ three main methods of data collection techniques, namely a policy audit, in-depth interviews and review of documents such as minutes of meetings of the policy formulation process and research or assessment reports that informed the policy processes. While we were able to obtain the policies for audit and conduct the in-depth interviews, it was not possible to obtain the secondary literature especially those held by the MoH. Among the reasons given was that the MoH considered such documents as confidential and not shareable with non-MoH staff. This study was therefore forced to depend on the abilities of the selected respondents to recall or reconstruct the events of the policy formulation process.

Conducting in-depth interviews with busy MoH officials as well as other non-MoH actors in the policy formulation process was challenging due to their inability to find time for interview. Most of the times, the officials were either out of town or country or in meetings and conferences. In more challenging circumstances, some of the actors had left their previous work stations and either relocated to other institutions in and out of the country. Although Skype call interviewing was an option for interviewing proposed to these informants, none of those who were unavailable for face-to-face interviews were able to set aside time for Skype interviews. A number of key actors (4: one each for the NASRHP and the National Malaria Policy 2010 and two for the KHP 2014 - 2030) in the policy formulation process were thus left out and their views have not been included in this report.

1.4.6. Ethics approval

The ethics approval of this survey was obtained from the Kenya Medical Research Institute's ethics review board (see Appendix 3). As required by the MoH, a letter of approval was obtained from MoH that allowed their personnel to participate in the survey (see Appendix 4). This study thus observed the ethical practices regarding the conduct of research with human beings as determined by the KEMRI ethics clearance board and adhered to the protocols required for research with MoH personnel.

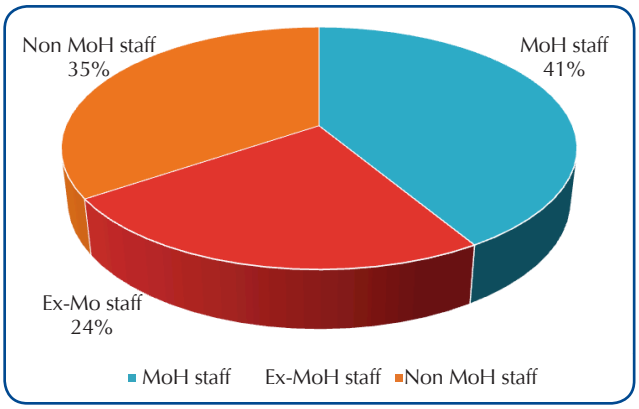
CHAPTER 2

Findings

2.1 Introduction

The findings presented in this section draw from an analysis of the responses provided by the informants and augmented through triangulation with other data sources as listed in the methodology section. A quick note about the informants is in order here to provide a lens with which to interpret the findings. Informants were drawn from the MoH as well as other non-governmental actors involved in the formulation of the policies. In total, 41% of informants were from the MoH, 35% were non-MoH, while 24% were ex-MoH staff (see Figure 1 below). For purposes of confidentiality informants have been broadly classified as MoH, ex-MoH or non-MoH. Where reference to a policy runs the risk of revealing the identity of an informant, these have been omitted all together. The greater majority of the informants interviewed participated in the entire policy formulation process. Only 3 of them did not participate in the entire process: two exited the process before it concluded while one joined when the policy formulation process had commenced.

Figure 1



Generally, most of the informants spoke freely about their experiences and provided valuable, occasionally reflexive and self-critical information about their role and that of their respective institutions in the policy formulation process. However, the MoH informants appeared to be more guarded in their responses, especially where candidly responding to some sensitive questions would appear to cast the operations of their Ministry in bad light. On some occasions, informants asked not to be quoted and occasionally requested that the audio-recorder be turned-off. This is to be expected as responding on the contrary would jeopardise their positions within the Ministry. This report does not consider their opinions to be erroneous or misleading. Instead, these positions are taken to reflect the reality of institutional research and of working within institutional arrangements that require a positive appraisal (especially by officials at the helm of decision-making processes), of the workings, aims, objectives and mandate of the MoH in the policy formulation process. However, there were some in the Ministry, especially those who had moved to other departments, or to other institutions, who were less entangled with the Ministry's management structure who spoke critically about certain aspects of the policy mainly because such performative skills were less required for their positions. The findings from these different sources are presented below categorised according to the themes set for the baseline survey and reflected in the in-depth interview guide.

2.2 The Context of Health Policy-making at the MoH

All policies guiding the health sector in Kenya are formulated at the MoH. The constitution of the MoH, both in terms of structure and personnel is, however, a political process and is often in a state of continuous flux with consequences for the policy formulation process. An example of this flux and its influence to the policy formulation process was evident in the writing of the three policies under study. In the period during which the Malaria policy 2010 was formulated, (roughly between 2009 - 2010) the MoH was broken into two sister ministries: the Ministry of Medical Services and the Ministry of Public Health and Sanitation. The formulation of the KHP 2014 - 2030 was also initiated around the same time. In the course of the formulation of the KHP 2014 - 2030, the MoH was restructured in 2013, and the two sister ministries merged into one Ministry of Health. The restructuring of the MoH was not only at the ministry level, but also at the departments and division levels. At the time where there were two sister ministries, for instance, each one of them had a technical planning department, and the heads of these units were part of the KHP 2014 - 2030 policy formulation. The merging of the two ministries then led to only one of the technical planners completing the policy writing process, as the other was transferred in the restructuring process. The NASRHP was formulated when

the MoH was a single ministry.

MoH Informants observed that the policy formulation process was done at the department level and was rarely affected by the restructuring. As currently structured, the MoH is headed by a Cabinet Secretary assisted by the Principal Secretary and a Director of Medical Services. For its operations, the Ministry is divided into six departments one of which is the department of policy, planning and health care financing. This department is further subdivided into three divisions: Division of Health Policy and Planning, Division of Health Care Financing, and Division of Monitoring and Evaluation and Health Informatics. Ideally, policy formulation should be undertaken by the Division of Policy, Planning and Health Financing. In practice, however, the different departments at the MoH wrote their own policies. The Kenya Malaria Policy 2010 was formulated at the Division of Malaria Control (DOMC) while the NASRHP was formulated at the Division of Family Health (DFH). The KHP 2014 - 2030 was formulated by a team selected by the Principal Secretary (then known as Permanent Secretary) from various departments within the MoH. The MoH does not have a central policy formulating department and neither does it have a ratified code of procedures for policy formulation. For this reason, the Permanent Secretary was forced to select an ad-hoc committee to spearhead the review and formulation of the KHP 2014 - 2030. Policy formulation is undertaken by those working within the different technical planning units as one among the many duties that they perform. One MoH policy writer summarised the situation in this manner:

"There is no health policy formulation framework at the ministry. Policies emanate from the different departments. What happens is the department head takes charge, then assigns one or two staff who now look for help from partners to incorporate as stakeholders. It is important that the Ministry comes up with a policy framework that guides all policies formulated by the different departments at the MoH."

The creation of the Division of Health Policy and Planning is expected to provide a framework and a central portal for the formulation of policies at the MoH. In the absence of such a functioning policy formulation framework, the policy formulation process was independently designed by personnel in each department while the head of the relevant department assumed stewardship of the process. The policy formulation process revolved around assembling a policy formulating team that would provide both the technical as well as financial input. Without exception, this support was sought from development partners as the findings from the following sections exemplify. One drawback emanating from the departmentalisation of the policy-making process at the MoH was that the policies do not seem to speak to each other. An example of this is evident in the KHP 2014 - 2030 document that refers to the reduction of malaria related mortality and provides reasons for this reduction on page 11. The policy does not provide any figures for this and makes no reference to the Kenya National Malaria Policy that would ordinarily have those figures. The NASRHP makes very scanty reference to the KHP 2014 - 2030 that might be assumed to provide the reference point of the rest of the policies in the MoH. This could, however, be attributed to the fact that both the KHP 2014 - 2030 and the National Adolescent Sexual and Reproductive Health Policy (NASRHP) were formulated around the same time in 2013 and 2014.

2.3 Rationale for Policy Review

Analysis of the interviews and a review of the policies showed that the review of two of the three policies was necessitated by among other things the expiry of the period of the policies preceding them. The KHP 2014 - 2030 was preceded by the Kenya Health Policy Framework (KHPF 1994 - 2010), while the NASRHP was preceded by the Adolescent Reproductive Health and Development Policy (ARHD) of 2003. The Malaria Policy 2010 was the first edition of the policy to be written in Kenya. In this case, the rationale for its revision was different. As the policy actors involved observed, the Malaria control programmes in the country were previously guided by strategic plans and implementation programmes without a documented policy framework. Through the advice and support by the WHO, the MoH embarked on a policy formulation process, which incidentally came after the strategic plan had been made. The policy framework is thus dated 2010 while the strategic plan runs from 2009 - 2018. A non-MoH policy actor observed the following:

"After developing the 2009 - 2017 strategy, we realised that actually we need a policy. So the policy came after the strategy. We realised that there was a step missing so we went back and developed the policy to answer the question of what needed to be done."

In its introduction, the Malaria Policy 2010 supports the above statement by also stating that it was developed to put together the various Malaria policies that have hitherto been incorporated into various guidelines and strategic documents. In doing this, the policy drafters revised some of the policies 'in line with new developments and recommendations from the global *Roll Back Malaria* partnership regarding the implementation of Malaria control interventions' (see National Malaria Policy 2010: pg. 1). Informants interviewed for this policy maintained that it would be erroneous to assume that no policy existed prior to the current one. Several policies existed, but in an undocumented state. As one MoH policy informant stated,

"Policies do not have to be written, even a presidential pronouncement is equivalent to a policy. There were several policies in the Malaria programme for example regarding the free supply of mosquito nets."

Yet another informant, who previously worked at the MoH, introduced both the donor's perspective and the need for accountability from the government as a justification for the need to formulate the policy at this time. In his opinion:

"The new way of doing things was that, if it was not in the policy, you could not compel government to do it. And so when you have a policy, it is a tool that commits the government to act in a certain way. The policy also formed the basis for utilising funds from other partners, because without a policy, partners will be wondering, what are they supporting? The policy provides each partner with an idea of where they can fit in their efforts."

The rationale for the revision of the KHP 2014 - 2030 and the NASRHP differed from that of the Malaria Policy because they were not drafted from an empty slate. The main reason given for the review of both policies was the expiry of the period of the previous policy, the need to assess the progress achieved in the previous policy period as well as the need to revise the policy in order to respond to the new developments both in the health and socioeconomic sectors of the country. Moreover, there was the need to align the new policy with the new global trends, demands and commitments. The NASRHP policy observes the following as the rationale for its review:

"Responding to the multifaceted changes of Adolescent Sexual and Reproductive Health requires a clear understanding of their circumstances and issues... Since development of the first Adolescent Reproductive Health and Development Policy (ARHD) in 2003, the international, regional and national legislative and policy landscape has changed with regard to adolescents. Many continuing and emerging issues have come to the fore as a result of advances in information, communication and technology (ICT) and the resultant exposure to materials and practices that influence young people's behaviour. These issues include: high incidence of poverty; early initiation of sex by adolescents; increased Human Immunodeficiency Virus (HIV) incidence and prevalence as well as AIDS-related deaths among adolescents; adolescents affected by HIV; Human Papillomavirus (HPV); drugs and substance use; harmful traditional practices that impact negatively on adolescent health and future well-being; and SRH needs of adolescents with disabilities together with increased ease of access to varied ICT channels among adolescents. These factors together with changing adolescent needs have necessitated revision of the Policy. (pg 5-6)"

Many of the informants interviewed were able to list most of the above as reasons for the review of the NASRHP. The KHP 2014 - 2030 had a similar rationale where informants stated that the review of the previous policy coupled with emerging conditions and threats necessitated the review. A MoH informant listed the following reasons for the review of the policy:

"There were already global discussions looking at the future of global health and definitely Kenya needed to participate in that discussion. At the regional level, there were a lot of political realignments, trade realignments e.g. of SADC, EAC, etc, and some of these have impacts on health and so we needed to realign our policies to fit in these economic global and regional debates. From the local level, our demographic and epidemiologic trends required us to refocus and redefine various interventions. Examples of these were the trend towards a decrease of Communicable Diseases, which had been our area of investment in the previous policy and the emerging trend of Non-Communicable Diseases associated with our improved economic development. There were emerging trends in terms of injuries and these took a significant chunk of the burden of diseases. There was an emerging trend in terms of partnerships – how to engage with both multilaterals and bilaterals. Our policies in terms of resource mobilisation had to be tweaked to respond to these trends. The other is linked to the global debate on the issue of social protection. Health care financing reforms needed to be brought as key agenda for discussion and these needed to be translated in our policies for us to move towards universal health coverage."

2.4 Policy Formulation Processes

Majority of the informants interviewed stated that the MoH was both the steward and custodian of the policy formulation process and therefore was in the driver's seat in initiating and steering the policy formulation process. When asked directly to respond to the question: who was in charge of the policy formulation process, most informants responded, 'Of course it is the MoH!' with some of them, especially those within the MoH finding the question preposterous. However, an examination of the responses on the question of how the policy formulation process was initiated and carried through reveals a continued dependence on the support of other partners for both financial and technical inputs. MoH informants explained that their ministry had no budget lines for policy formulation activities and they depended solely on donor support. Comments from actors

within the policy formulation process of all the three policies exemplified this position.

In one of them as is evident from the two comments below, the policy formulation process was jumpstarted by the partners.

"I am the one who alerted the Ministry about the need to review this policy in view of the changed circumstances, but two years down the line they had not started the review process (Non-MoH policy actor)."

This comment was supported by another non-MoH policy actor who observed the following regarding the same policy:

"I was key in the policy formulation process because (name of donor1) was providing both technical and financial support. I am the one who drafted the initial terms of references for the consultant to work in and basically you know the terms of reference defines the parameters of what needs to be looked at in terms of the evidence that needs to be generated and what kinds of evidence that needed to be utilised2. Of course, we had secondary and primary data and so I was also overseeing the work of the consultant technically. At the TWG, level I was also critical in terms of driving the agenda. I played a critical role in ensuring that we don't just duplicate the old policy."

Similar sentiments admitting to the dependency culture at the MoH were expressed by MoH and non-MoH actors commenting on the other policies. And while majority of those interviewed (both MoH and non-MoH) did not appear to admit to the contradictory nature of this arrangement, a few of the policy formulators questioned this arrangement. Some of the most critical informants pointed out that the Ministry could not claim to own the process if they did not fund it. An ex-MoH informant reflected about the situation at the MoH in this manner:

"I think in the health sector, we have a big problem, because we say we are in charge of it, but we don't pay for it. So that means you follow what you are told and so whoever pays the piper calls the tune. So you might be adopting things that do not work in your interests, they work in the interest of someone else."

Several other informants out of the MoH expressed these sentiments even while admitting to the regrettable state of affairs within the MoH as the comment below shows:

"I don't want to be very hard on them (MoH personnel), but at times it is the donors who drive the evidence searching process. Most of the big meetings that come up with policy directions are always funded by donors. The problem with this is that it ensures that the donors thinking and ideas get into the policy process, which may not be good because you end up implementing a policy that has the interest of some specific donors."

2.5 Stakeholder Involvement

An analysis of the policy formulation processes shows that the MoH endeavoured to involve as many stakeholders as possible. This was in recognition of the fact that the health sector adopted a multi-sectoral strategic and implementation approach, which brought together many local and international actors. It was therefore important to bring all of them together to learn from them about their experiences on the best practices in their areas of competence. Moreover as several informants observed, stakeholder involvement was a constitutional requirement and so the MoH had no choice but to include all stakeholders. The selection of stakeholders by the Ministry was made through the several Technical Working Groups (TWGs) comprising local and international partners in health that cover the breadth of all activities at the MoH. The TWGs selected and nominated their members to be part of the taskforces that drafted the policies and shared with the bigger TWGs for review, editing and ratification. Participation in the TWGs and the taskforces was voluntary. The technical support value of the stakeholders was observed by one MoH informant who commented thus,

"Most of our partners have technical advisors with enormous experience and so we always invite them to offer their experiences and views on some of the issues."

Stakeholders, especially the bilateral and multilateral partners, did not just provide the technical advice, but in most cases either provided the evidence from their work or supported the evidence searching process at the MoH. Informants interviewed observed that in most cases, where the partners pointed to a source of evidence, they either provided the evidence or supported consultants to search and synthesise the evidence. Apart from providing or paying for the process that produced the evidence, bilateral partners supported all the meetings that discussed the draft policies. Commenting about the policy formulation process of one of the policies, a non-MoH policy actor expressed her shock at the manner in which the MoH chair of the taskforce openly

[1]Identity of partner withheld for purposes of confidentiality.
[2]Emphasis added

solicited for financial support:

"The chair of the taskforce would say something like, "we need this and that data analysed, who is able to support that"? And actually wait for people to volunteer funding!"

The same chair of task force from the MoH who solicited for support would later comment in this manner regarding the role of the donors,

"I don't think they had any influence, it is only that we had to depend on their timelines because of their funding."

In view of the large number of stakeholders, the MoH often had to group them into categories for ease of engagement. In its annexes, the NASRHP lists 26 members out of which only 7 came from the MoH. The different stakeholders were classified as, government or government agencies, development partners, implementing partners or independent consultants. The KHP on its part classified the stakeholders as government agencies, development partners (who worked through the Development Partners Health Kenya (DPHK[3])), civil societies (operating through Health NGOs Network, HENNET) and the private sector (working through KEPSA). Through these organisations, the different stakeholders engaged with the policy framers at the MoH to produce the policies.

2.6 Stakeholders' Influence and Strategies

Majority of the informants, especially those from the MoH stated that the different stakeholders had no undue influence in the policy formulation process. As one of the MoH policy actor observed,

"There was no undue influence from the partners because we based our policy on the national vision."

This MoH position was supported by a non-MoH policy actor who observed the following when asked about the role of the different stakeholders:

"The most important consideration was if one had the evidence and the MoH was the overall decision maker over what was to be included. So if you had the evidence we all sat down and listened and considered the evidence on its merit."

The position held by the MoH of an objective process primarily influenced by the strength of evidence was, however, contradicted and criticised by other policy formulators, from their experience in the stated policy formulation process as well as from the literature. This criticism came from both within and outside of the MoH. Informants who stated that the partners influenced the policy formulation process observed that the partners used both covert and overt means to ensure that their views were included in the policies. One covert means of influence was through training of the policy-makers. An ex-MoH policy-maker explained that he and two of his colleagues were trained for six months on the process of policy formulation:

"In terms of capacity building, the xxxxxx4 government took us for a six months training course on policy formulation, analysis and implementation, which was done in collaboration with the Kenya School of Government. They used to fly in a professor all the way from their country to offer us that course."

Sponsoring of meetings was yet another strategy employed by the partners to exert influence on the policy-making process both covertly and overtly. A MoH informant who initially observed that the process was primarily driven by objective evidence would later provide a glimpse of the influence of partners through sponsoring meetings.

"If you compare what we finalised then and what is in the current document, you find that they (partner) have sneaked in some new indicators under investment which were not defined. They got back to us (MoH) and we refused to define those variables because they are data elements and therefore not definable. They had promised to support a meeting but when we gave them our point of view, they have said they will not finance it."

The example above illustrates that funders would use their financial power to influence the decision-making process within the policies. In view of the fact that they supported many of the meetings that produced the policies, then the level of influence would be expected to be as high as the number of meetings supported. Another MoH policy actor was categorical in his comments regarding the direct role and influence of the partners:

"Some of them indirectly tried to change the way the ministry operates. It boils down again to the financial muscle of each of those partners, they would compete amongst themselves, who has more power. That fight then comes to the ministry and then within the ministry you find that there are realignments, pro this and pro that. And indeed this ministry was at one point almost split into two. It was there but I do not want to get into

[3]The DPHK is an ad-hoc group of all international partners supporting the health sector, including bilateral and multilateral partners, foundations and global health initiative partners.
[4]Name of country concealed for confidentiality purposes.

the details but this was so evident. And that will definitely affect the content and process of the policy development and also implementation of the policy itself."

This latter position aligns with the literature on the politics of donor support and was supported by other actors outside of the Ministry. A non-MoH actor candidly stated the following,

"Policy making is a power game and those who are strong always end up having their way: it is a game of interests."

In spite of the differing opinions expressed by the informants regarding the role and relationship between the Ministry and the partners, one aspect that is not disputed is that the partners support for the policy developing process is critical. As observed by one of the MoH policy formulators, the policy process often came to a standstill when donor funding was not forthcoming. This scenario is, however, not limited to the policy formulation process alone. Many of the programmes and projects by the Ministry are often supported by partners. Using the example of Malaria programmes, one ex-MoH informant observed that most of the funding came from the partners:

"If you look clearly you will see that over 90% of the funding that goes to Malaria comes from external sources. And that's why sometimes you see the indicators are not changing in spite of all the money going into the sector. It is because you are depending on donors whose funding cycle is always between 3-4 years. And now, how can an NGO that has 3-4 years programme money provide a long-term strategy for the health sector?"

Yet another ex-MoH policy-maker who played a key role in the policy formulation process before moving to his current position stated the following:

"We requested for funding from the xxxxx5 and this came through the yyyyyy6 group because they work in the policy area. In terms of editing and printing of the document it was mainly done through the partners support. They funded all the retreats and data sourcing mechanisms."

2.7 Role of Evidence in the Policy Process

An analysis of the policy documents and the observations from the interview conducted indicate that a deliberate attempt was made by the policy formulators to include as much evidence as could be accessed. All informants stated in their opinions that the policies were adequately informed by evidence and where the evidence was unavailable, the policies expressly stated so. One of the non-MoH policy formulators observed the following regarding the policy that he was involved in reviewing:

"The process was mostly informed by evidence. I have worked around Africa a bit and I would say it was the first time I was seeing such a thorough process. I am not sure if it was because the WHO was involved or what. In fact WHO was so happy with the process that I was sent to Mozambique to do a similar thing there."

In the following sections, a brief analysis and illustrations from the policy and interviews about the extent, nature and content of the evidence used as well as a brief commentary on the gaps in the evidence used for each of the policies is provided. It is not possible to provide an appraisal of each piece of evidence used (or not used) in the policies under study. However, for the KHP 2014 - 2030 and the NASRHP, a critical analysis of the appropriateness of some of the evidences used in the policies is provided.

2.6.1. The Kenya Health Policy 2014 - 2030

This policy lays its foundation mainly from an analysis of the previous policy (the Kenya health policy framework 1994-2010) and focuses on the main health challenges that need to be tackled. These have been enumerated using available evidence as diseases both emerging and re-emerging, complications of pregnancy and child-birth, geographic and climatic conditions. The policy uses various sources of data which include routine data (from the Health Management Information System (HMIS), Kenya National Health Accounts (KNHA) and yearly economic surveys), periodic data including the various Kenya Demographic and Health Surveys (KDHS), Kenya Aids Impact Survey (KAIS) and the Kenya Household Expenditure and Utilisation Survey) and data from reports compiled by multilateral agencies such as the World Health Organisation (WHO) and the United Nations Development Programme (UNDP).

Most of the evidence used in the policy document is enumerated in Chapter 2 of the policy document. Section 2.1 of the policy provides the health profile of Kenyans using available evidences (KDHS 2003, WHO 2010 statistics). Examples of evidence included here are the trends in life expectancy, adult, infant and child mortality, morbidity and mortality, and development indicators such as poverty levels, Gross Domestic Product (GDP) indicators, and literacy levels. Epidemiological data obtained from a review of the KHPF 1994 - 2014 is used to show the leading causes of mortality and disability in Kenya and to depict the inequalities and disparities both geographical

[5]Name of development partner concealed for purposes of confidentiality.
[6]Name of institution associated with funding agency at footnote 5 is concealed for purposes of confidentiality

and by gender. Evidence on the progress on TB case detection and TB treatment success rates is sourced from the WHO Tuberculosis Report 2013. Section 2.2.2 also uses evidence to illustrate the risk factors to good health in Kenya and in section 2.2.3, there is use of evidence to show the determinants of health. In order to depict the levels of health care financing and the trends thereof, the policy has made use of the KNHA evidence to indicate the levels of government expenditure in health as a percentage of total government expenditure, out of pocket (OOP) expenditures by patients and the private sector share of total Health expenditure (THE). This is further strengthened by the human resource evidence (sourced from the Economic Surveys of 2012, 2013 and 2004) used in section 2.3.2 of the policy, which shows the levels of human resources in the country. The policy uses projections from modelling evidence to set targets and show where the country should be if the policy is properly implemented by the end of the period under consideration in 2030 especially with respect to Non-Communicable Diseases (NCDs).

A key element of the KHP 2014 - 2030 is the shift in focus from a concentration on Communicable Diseases (CDs) and to more emphasis on NCDs in the new policy implementation period. The KHP argues that by continuing the current policy direction (i.e. those proposed in the 1994 - 2010 concentrating more on communicable), the overall annual mortality would decline by 14% by 2030. The contribution to the annual mortality by disease domain would be different: CDs would decline to 39% and NCDs and injuries conditions will increase to 47%, and 14%, respectively. This represents a 48% reduction in absolute deaths due to communicable conditions, but a 55% increase in deaths due to NCD conditions and a 25% increase in deaths due to injuries and violence. Current efforts to tackle Malaria, TB, and HIV are expected to bear fruit in the short and medium term. Their contributions to the overall disease burden will be reduced significantly. However, other dormant or emerging conditions, such as dietary-related diseases, will continue to contribute immensely to the overall disease burden, and thus erode out any gains made through existing interventions on communicable diseases. To ensure significant reductions in the overall ill health and mortality in Kenya, continuous availability of resources, healthy lifestyles and minimum population growth should be guaranteed. The Kenya Health Policy 2014 - 2030 therefore seeks to ensure a significant reduction in the general ill health in the Kenyan population by achieving reductions in deaths due to CDs by at least 48% and reducing deaths due to non-communicable conditions and injuries to below levels of public health importance without losing focus on emerging conditions. This would translate to a 31% reduction in the absolute numbers of deaths in the country, as opposed to only a 14% reduction (see KHP pgs 23-25).

Although the KHP makes a deliberate attempt to use evidence, a number of inconsistencies and gaps in evidence sources are visible by reading the policy document. This policy proposes a shift from the earlier policy framework by paying more attention to NCDs as illustrated in the preceding paragraph. The evidence for the need to shift the focus to NCDs is provided on page 11 of the policy document, which states that NCDs represented 50-70% of all in-patient admissions during the previous policy period and up to half of all inpatient mortality. Injuries and violence levels are also placed high at 3.5% of all deaths in 2009. The source of this data is however not provided in this document and no breakdown is provided for the contribution of the different NCDS to the hospital admissions and mortality rates. Most of the informants interviewed for the KHP 2014 - 2030 observed that there were no national data for NCDs incidence. In the absence of national estimates, and the lack of a clear indication of the source of these data, it is difficult to verify how these figures were arrived at.

All informants interviewed for this policy agreed that the policy made this decision even though they had very little evidence to support this claim. They were, however, divided almost halfway as to whether this was a prudent policy decision. Due to the lack of the evidence, modelling was used to make the projections and to suggest the policy direction taken. A key policy formulator at the MoH observed the following:

"Some data required modelling for us to arrive at some of the critical areas. We didn't have much of the data especially in the area of NCDs and so in that area we felt that we needed to model the little data that we had and so since the WHO had the tools and the modelling expertise, they came on the ground and we were able to model the data and helped us to project where we are going in line with the NCDs, e.g. road traffic accidents."

There were, on the other hand, policy actors both within and outside the Ministry who opined that in view of the lack of evidence on NCDs, the modelling was an inaccurate method to arrive at the projections on which to base the policy. One policy actor who was critical on the dearth of evidence on NCDs and on disease conditions in general had the following to say:

"So typically you only use a model so that you can project what will happen in future, and anything that the model tells you should be based on carefully accumulated data from the past. Unfortunately for Africa and Kenya is probably one of the better countries, we are using models for today to decide what happened in the past and what is going to happen in future. The

data we have used in the past is always low quality data. And you know even when you have good data for many years, when you model or project for the future you still make those projections with large amount of uncertainties. Can you imagine when the basis of your estimation for the future is based on inaccurate or poorly collected data?"

Several other discrepancies and inconsistencies can be discerned for other indicators within the KHP 2014 - 2030 policy document. On page 11, Life Expectancy (LE) in Kenya in 1993 is stated at 58 years, and dropped to 50 years in 2000. It, however, rose to 59 years by 2009. Evidence for LE in 1993 and 2000 is sourced from the KDHS 2003, while that at 2009 is obtained from the WHO World Health Statistics. Since the KDHS 2008/9 data is available one would expect the same source to be used consistently to avoid methodological biases between the 2 reports. Further, on page 29 the LE of Kenyans as at 2010 is given as 60 years. The source of this evidence is, however, not provided. The KHP 2014 - 2030 policy document states that there has been an improvement on TB case detection and treatment success rates which stood at 85% and 85.5%, respectively. This evidence is obtained from the WHO Tuberculosis report 2013. The scale of improvement is not provided since the baseline or earlier levels are not provided. Moreover, this information is better sourced from the HMIS data.

Evidence on unsafe sexual practices, breast feeding and the use of tobacco is provided on page 12 of the KHP 2014 - 2030 policy document. The source of this evidence is not provided. On the same page, there is evidence on social determinants of health and whose source is equally not provided. These include data on access to safe water, women literacy levels, malnutrition, stunting and wasting, (un)employment levels, rural urban migration and housing conditions. Data on malnutrition in pregnancy and early childhood is provided from a website known as the www.thousanddays.org. It is not possible to determine the reliability of the evidence provided from this website as it has no information about the studies conducted to support its findings.

2.6.3. The National Adolescent Sexual and Reproductive Health Policy (NASRHP)

In formulating this policy, the MoH made use of a consultant and three research organisations to source and synthesise the evidence. As a result, the policy formulation process was supported by available data except for areas where the data was unavailable. The policy document lists a total of 62 reference documents as providing the evidence for the policy observations and directions. These comprised mainly of data from reports commissioned by the MoH, periodic data, from reports by multilateral agencies, literature sources for definitions and data from published research papers. Up to 25 research papers were used as a source of evidence. Periodically collected data included that from the KDHS (2010, 2014), the Kenya National Housing and Population Census, and the Kenya Aids Indicator Survey - KAIS (2012). Research conducted by multilateral development partners and implementing agencies equally contributed lots of evidence included in the policy. The WHO provided 4 research publications while the UNFPA and UNICEF provided 2 each. Other evidences were sourced from research conducted within the MoH as well as by other ministries and government agencies such as the Ministry of Devolution and Planning, Ministry of Youth affairs, Kenya National Bureau of Statistics, National Authority for the Campaign Against Alcohol and Drug Abuse (NACADA), and the National Council for Population and Development (NCPD).

A reading of the policy document reveals the use of the following data and data sources: section 2.2 on the rationale for the policy uses evidence from the Kenya National Housing and Population Census to show the magnitude of the adolescent population which cannot be ignored; section 4 of the policy on the sexual and reproductive health status of adolescents in Kenya has utilised various available evidence ranging from KDHS 2009, performance monitoring and accountability 2020, family planning indicator brief and other operations research data to present the scenario in the country; evidence is utilised in demonstrating the various factors associated with adolescent pregnancies and the association with other major challenges like HIV and AIDS, sexual abuse and violence, drug and substance abuse and other harmful social and cultural practices like FGM and child marriages; in pages 13-15 data and evidence is used to illustrate the state of marginalised and vulnerable adolescents living in informal settlements, in child labour, with disabilities, orphaned, in emergency situations and living with HIV.

Like in the KHP 2014 - 2030 several gaps in evidence, inconsistencies and inaccuracies appear in the policy document. In the first instance, even through the NASRHP observes that a review of the previous policy (Adolescent Reproductive Health and Development – ARHD 2003) was conducted before its formulation, evidence from that policy period on the achievements of this policy is not cited anywhere in the current policy, even while observing that the 'landscape had changed with regard to adolescents' in the duration between the previous and the present policy periods (see NASRHP pg. 5).

The NASRHP provides several data and evidences on the Age-specific fertility rate (ASFR) for adolescents in Kenya that are inconsistent on page 9. The ASFR for women in Kenya aged 15-19 is given as 96 births per 1000 women according to the 2014 KDHS. The policy further observed

that more recent estimates have increased it to 121 births per 1000 women. This second figure is sourced from the Performance Monitoring and Accountability 2020 Family Planning indicator brief dated 2014 by the KNBS. Since both reports are dated 2014, one cannot be more recent than the other. Furthermore, the differences between the figures might imply a difference in the methodology used for the two studies as opposed to a real difference in the figures fertility rates observed. The NASRHP provides more data regarding the contribution of adolescents to the National Total Fertility Rate (NTFR), which is shown to increase from 32% in 1975 to 37% in 2008. This information is sourced from a Ministry of Youth Affairs (MOYA), Youth Dialogue 2011 report. A reading of the Youth Dialogue report reveals two inaccuracies in the NASRHP that are not mentioned in the NAHRSP document. First, the MOYAs Youth Dialogue report reports on the youth ages 15-24 years and not adolescents aged 10-19 years. Second, the contribution of youth to the overall TFR is provided as increasing from 30% to 40% between 1975 and 2008. These inconsistencies can be remedied if the policy document used the Kenya Population Situation Analysis report by the UNDP that provided consistent figures using the 1977/78 Kenya Fertility Survey and consistently collates figures from the various KDHS in 1998/1999,1993, 1998, 2003, and 2008/2009.

More discrepancies in the NASRHP are evident in the evidence on maternal mortality rates section. A position paper by the WHO on mainstreaming adolescent pregnancy observes that there is evidence of association between adolescence and adverse neonatal outcomes such as infant mortality pre-term birth, low birth weight and malformations among adolescent mothers. This observation is concretised by evidence of high maternal mortality rates at 260 per 100,000 among adolescents of ages 15-19 years compared to 190 per 100,000 years among older adolescents (20 – 24 years). There are two major discrepancies in this evidence: one, the adolescent ages as rightly observed by the NASRHP are between 10-19 years so the case for older adolescents between 20-24 years should not arise as a comparison; and two, the evidence cited here is for a study conducted in Mali. There is no indication in the NASRHP document how evidence from Mali relates to the situation in Kenya.

Several other inconsistencies appear in the section dealing with HIV and AIDs among adolescents. This section reports that adolescents between the ages of 10-19 years represented 9% of persons living with HIV/AIDS and 13% of all HIV-related deaths in Kenya. It further states that HIV testing rates for Kenya were the lowest for adolescents 15-19 years with only 23.5% reporting awareness of status. These figures are attributed to a study by McKinnon et al 2014 conducted with a cohort of male sex workers in Nairobi. This is probably a referencing error as it is unlikely that a study amongst a key population in Nairobi would generate nationwide data on adolescent HIV prevalence and knowledge of HIV status.

While acknowledging that maximum efforts were put in accessing and including the relevant data and evidence, a number of policy actors complained of the lack of evidence in several aspects of adolescent matters. There was a general dearth of evidence regarding the younger adolescents between ages 10-14 years. Most of the data sources like the KDHS collected information from the age of 15 years, occasionally combining the data to the age of 24 years. There was therefore a lack of information disaggregated according to the adolescents aged of 10-19 years. There was also a lack of evidence on vulnerable groups such as the Lesbians Gay Bisexual and Transgender (LGBTs), adolescents in the labour market and adolescents in emergency situations.

2.6.3 The Malaria Policy 2010

Malaria is one of the diseases that has consistently received enormous amounts of funding compared to other disease conditions and consequently attracted lots of research in Kenya. The availability of research and a vibrant malaria research environment meant that the policy benefitted from most of the locally and internationally available research evidence. An analysis of the policy document and the interviews conducted point to the use of most of the evidence available for the indicators of interest. There is an attempt to use vector evidence in section 1.4.4 of the policy. However, the evidence may be outdated as it refers to a study done in 1974. Section 1.3 of the policy cites epidemiological data from sentinel and demographic surveys of Malaria showing the effects of Malaria on morbidity and mortality. This epi-data is utilised to classify the country into various eco-epidemiological strata. There is also mention of modelling and Malaria transmission data being utilised in classifying the country into different Malaria risk/endemic zones in the policy. In estimating the population at risk of Malaria, census data is used in sections 1.4.2. Sections 1.4.3 & 4 of the policy-make reference to evidence on the species of plasmodium found in Kenya and the respective vectors that are the main culprits for the epidemic. In section 1.5.2, evidence from the Kenya Demographic and Health Survey (KDHS) is used to demonstrate the progress made in relation to malaria prevention through the use of insecticide treated nets (ITNs) and intermittent preventive treatment of Malaria in pregnancy (IPTp). Section 3.3 envisages Malaria control programmes that are targeted and based on epidemiological evidence of the various regions in the country, while section 4.2.1 suggests using of evidence generated from the Malaria interventions to inform programming.

Overall, a few gaps in evidence use and opportunities can be observed by reading through the documents. In section 1.5.4, the policy-makes an attempt to link Indoor

Residual Spraying (IRS) to Malaria prevention, but falls short of presenting the hard evidence to support the claim. Such efficacy evidence would have been very useful if adduced in the policy to lay claim for further investments or otherwise in the method. Section 3.3 on targeting of Malaria control interventions is a missed opportunity to identify and prescribe some of the epidemiological evidence-based interventions that the Ministry intends to roll out.

All the informants interviewed for the policy indicated that they made use of all the available evidence in formulating the policy. One of the informants, however, identified the lack of evidence on the efficacy of Rapid Diagnostic Test kits (RDTs) compared to the use of microscopy as one of the evidence gaps in this policy.

2.8 Data Sourcing and Synthesis

The policy formulation process employed independent consultants and research firms to assist the researchers based at the MoH to analyse, synthesise and input the data in the policies formulated. The evidence search and synthesis was therefore a collaborative effort between the MoH and various research institutions. Among the institutions involved as members of the task force for this purpose include the African Population and Health Research Center (APHRC), the African Institute of Development Policy (AFIDEP), the Kenya Medical Research Institute (KEMRI), Health Policy Project (HPP), Population Council, and Kenya Institute of Public Policy Research and Analysis (KIPPRA). Several independent consultants were hired mainly on a needs basis to conduct research on specific sections of the policy. As already observed, these were often hired by partners as part of their support for the Ministry. While most of the MoH officials lauded the efforts of their partners in ensuring that evidence was utilised in the policy formulation process, a few critical policy formulators observed that the use of non-MoH policy actors, coupled by MoH's weak capacity in finding, appraising and applying research, compromised the objectivity of the policy. These criticisms came from within and outside of the MoH as the comment below exemplifies.

"If you are running a system and you have ceded the thought process of that system to someone else, how do you function properly and you are relying on someone else, to let's say, to fund a DHS and you need to know how many people are dying in your country, you see how absurd it is?"

- non-MoH policy actor

2.9. Barriers to Using Evidence in Policy Analysis

Informants interviewed for this study identified several barriers to using evidence in policy formulation. This section examines these barriers.

2.8.1. Lack of consistently assembled data sources

Most of the informants identified lack of adequate data – data that is complete in terms of the number and range of variables of interest as well as the details within those variables – as one of the biggest impediments to the use of data. As one of the non-MoH informants observed, most of the information required for policy formulation should come from routine data held by the government or the MoH. Yet, this is where the biggest problem lay since data collection by the government agencies was rarely complete. Another non-MoH policy formulator hired to analyse part of the data held within the government civil registry commented thus:

"In some years, for the data that we required to work with, especially in the trend analysis, there was only about 30-40% of the data available. So we wonder what happened in those years, I don't remember which ones, in some cases they had explanations for the gaps but in some others they simply had no explanation."

An MoH actor familiar with the data collecting process attributed the poor quality of the data to the data collecting process and the training of the data collectors by the MoH. Using the example of injuries and accidents, he observed that the MoH expects to collect adequate complete data yet health care providers have not been trained on the level of details required.

"We had little information (on NCDs) because not all facilities were reporting on them. E.g. for road accidents we had to look for information from the police, and add up with the little information that we had. Because most of the evidence we get from the health facilities are very scanty in terms of reporting road traffic accidents. Our clinicians for instance do not follow the international standards of detailing the information. We have that challenge with the clinicians. An accident is for instance just reported as road traffic accident. That does not help in terms of narrowing to the area that you need to take a prevention action."

One of the critical data missing in the policy formulation processes identified by the policy actors concerned the burden of disease. This was mainly because the data used for the burden of disease was collected at the health facilities, which gave incidences of disease as opposed to the burden of disease. Informants for instance, observed that not all fevers or diseases were reported to the facilities, and so using the health facilities data, even if it was complete could

not accurately determine the magnitude of the disease. As one of the MoH policy actors lamented, *'the problem in this country is that since independence, we don't know what is killing our people'*.

2.8.2. Lack of capacity at the MoH

All the informants interviewed (MoH and non-MoH actors) observed that the MoH lacked capacity both quantitatively and qualitatively to spearhead the policy formulation process. There were far too few people charged with the responsibility of policy formulation and even those few lacked the requisite skills. This lack of skills was recognised by both MoH and non-MoH actors as is evidenced by the following two quotes:

"Since we did not have the expertise in this area, the WHO helped us in formulating it. They provided us with a template that is used in many of the countries, not just in Kenya."

- ex-MoH policy actor.

"The other barrier is like everybody not having the same understanding of the research, the kind of research we need and why certain indicators may be better than others. This was especially a problem with our MoH colleagues so we had to spend a lot of time educating them first before continuing with the policy writing."

- non-MoH actor

The view by those who attested to the lack of skilled personnel at the MoH was that there were two types of expertise required in the policy formulation process. There is at the first level, a basic analytic skill that everyone tasked with the responsibility of policy analysis should possess to enable them run analysis and derive basic conclusions. At the second level is highly technical policy analysis skills that a special group of people in government and/or MoH should possess to enable them understand concepts such as modeling and econometric costing. These do not necessarily have to be MoH or government employees, but simply experts that the government can momentarily turn to when such high level analyses are required to be done or where done by hired experts, to objectively analyse the findings and advise the government. In the absence of such a mechanism, one non-MoH policy actor observed thus:

"In the absence of such a system, an expert from some big city in the West puts together some fairly crude pieces of information about a country and they will tell you this is an eradication feasibility, if you invest some 10 billion dollars for a period of 15 years you will have eradicated disease x. And you believe him because you cannot independently verify what the 'expert' says."

2.8.3 Lack of synergy between the researchers and policy formulators

Most of the informants observed that there was a lack of synergy or coordination between the policy formulators and the researchers in the country. This resulted in a blame game and a vicious cycle of wastage. On the one hand, the researchers complained that they produced lots of research but the policy-makers failed to use their findings. The policy-makers, on the other hand, complained that the researchers conducted research without involving them and more often than not failed to address policy questions in their research. A policy actor from the MoH observed thus:

"I am analysing a report of publications by xxxxx for last year. They produced 287 publications, so I ask them, out of these 287 publications, how many policy briefs did you derive to inform policy-makers?"

Part of the blame on the researchers is attributed to the complicated language used in their publications mainly because they target an academic audience. Yet some policy-makers also observed that the research churned out by most of the research institutions was always funded by foreign institutions who ended up consuming the findings as this comment from an MoH policy actor attests:

"Of course the person who pays for the data is the one who receives it."

2.8.4 Other barriers

Other barriers to research use mentioned included lack of access to publications and a lack of government commitment and funding for regular research. One MoH actor observed the following regarding the lack of funding:

"We have neglected area of research so where will we get the evidence? And when we do this, who fills up this gap? The interested parties. And when they are interested, the results must favour them. The government must progressively allocate funds for research."

2.10 Suggestions for Strengthening the Use of Evidence in Policy Formulation

All informants were asked to suggest ways in which the use of evidence in policy formulation can be strengthened. The following section looks at some of the suggestions proffered by the informants.

2.9.1 Institutionalisation of a culture that values evidence in decision-making

Most informants interviewed were of the opinion that the

quality of the data was a critical component of evidence generation. And since most of the data or the evidence required in policy-making came from government sources, there was a need to institute a culture within government that values data and invests in ensuring that the data generation process is diligent. This culture that primes the use of evidence ought to permeate the entire system of evidence gathering to the final policy formulation level. One non-MoH policy actor summarised the argument thus:

"People need to understand that the same way they use information in their personal decisions is the same way policy formulation works. There has to be a genuine acceptance of the need for evidence for every policy decision made. It should not just be a matter of responding to the WHO, IMF or World Bank requirement. Information must be produced and must be used for policy and for me it boils down to governance. There has to be a president, a minister, a principal secretary and all the way down to the health worker who understands and values the collection of data relevant to decision-making."

In advancing this line of thought, informants argued that once the culture of using information is institutionalised and valued, most of the barriers to use evidence will be overcome: it means then the government will invest both time and funds to generate quality data, systems will be put in place to collate the data while the eventual health worker or government worker in charge of collecting the actual data will be trained and motivated to produce quality data. Once the government employees in charge of collecting the data are trained on the value of the data they collect and how important the data is in the decision-making process, and a proper system is in place to collect and collate this data, then it will only require a little motivation to ensure the data they collect is of good quality.

2.9.2. Creation of a research portal or health observatory

Most of the informants suggested the creation of a portal or health observatory where all the research relevant to health policy formulation conducted either within the Ministry or by any other research organisation could be stored and routinely analysed to inform policy. In this case, as some of the informants observed, any new information will be available to MoH personnel as and when it is generated to inform policy. While agreeing that periodic data was ill-equipped to advise on policy, many informants suggested that having such a portal or observatory would assist in timely decision-making regarding the need to review policy.

2.9.3. Forging closer collaboration between researchers and policy-makers

Most informants suggested the forging of closer ties between the MoH and the different research institutions that would partially resolve the problem of the absence of a portal or health observatory. This will strengthen the research to evidence linkage in two ways. On the one hand, the MoH will come up with a research agenda that it can share with the research community regarding their need for research. On the other hand, the researchers will conduct research that responds to the policy questions of interest to the MoH. This will eventually break the cycle of blame and wastage alluded to under the barriers to evidence use section.

2.9.4 Capacity building at the MoH

All informants agreed that there was a need to invest in improving the capacity of MoH staff both in terms of numbers and in their expertise to engage in analysis and use of evidence in policy formulation. Improving the capacity at the MoH will not only enable them to analyse the evidence they generate, but to also understand and critically evaluate the evidence and policy advice generated by their partners. Addressing himself to the problem of capacity at MoH, one ex-MoH policy actor observed the following:

"So, combinations of having someone in the ministry who is not qualified and then is not given money, what can you expect? That is why I said, we should have someone at the ministry who is qualified, even if he does not have the money, then he can articulate the issues. We need to start training people to be in charge of these dockets."

2.9.5. Expertise sharing within institutions

In the absence of relevant capacity within the MoH, several informants suggested the creation of a system where experts can be easily shared between the institutions to assist in carrying out specific tasks. Experts would be loaned for a specified period from institutions such as the universities and/or other research institutions like KEMRI to work in the MoH during critical moments in the process of policy formulation and revert back to their work stations once their tasks are completed. Such a system seemed to have worked in the formulation of the Malaria policy where a KEMRI researcher was seconded to the MoH to assist in formulating the first edition of the policy. However there was no evidence that such an arrangement was ever done for other policies.

2.9.6. Creation of a pool of 'super' experts to advise government on policy

In view of the large number of stakeholders involved in the policy formulation process, informants suggested

the creation of a virtual pool of experts to advise the government on the different policy options suggested. This pool of experts would objectively look at the policy options suggested by the MoH as well those suggested by their partners and independently offer their expert opinion. Such a pool of experts need not necessarily be employed by the government, but could be tapped on whenever the government needed to make an important policy decision. This suggestion responds to the observation by most of the respondents about the enormous support and vested interest of the bilateral and multilateral partners of the MoH.

2.11 Other Factors Influencing the Policy Decisions

Most of the informants provided examples of factors beyond the use of evidence that impacted on the decisions made in the framing of their respective policies. This finding agrees with observations in the literature that policy decisions are often responsive to more than available evidence. Considerations that influenced decisions made within the policies were contextual, personal interest and values and/or global processes.

One of the contextual factors that was considered in the formulation of the policies was the new constitution that not only introduced a new governance structure, but also provided the overarching framework to ensure a comprehensive rights-based approach to health-based strategy. According to the constitution, every person has a right to the highest attainable standard of health, which includes reproductive health (see KHP pg 1). Most of the respondents interviewed observed that they had to input this spirit of the new constitution in all decisions made with respect to the policies they formulated, especially for the KHP 2014 - 2030 and the NASRHP that were written at a time when the new constitution was already in operation.

The performance of the economy was also mentioned among the factors influencing the decisions. As one of the MoH actors mentioned,

"We always had to consult the treasury because we could not input into the policy an aspect that neither they nor the development partners could fund."

But perhaps one of the key economic considerations that had a bearing on the decisions made especially with respect to the KHP 2014 - 2030 was the re-categorisation of Kenya as a middle income country by the World Bank. This had implications on resource mobilisation especially the ability of the country to attract foreign support and investment. It also raised the expectations for the provision of health services in line with a middle-income economy. As part of the policy formulation process, MoH policy actors organised visits to other middle income countries to enable them to align the policies with those of similar middle income countries in order to attain the level of care and standards of service provision expected of their new status.

Other contextual factors considered included the laws of the country, which for instance outlawed female genital mutilation for adolescents. Cultural and religious factors were also considered in the NASRHP. Informants interviewed observed that they had to tone down sections of the policy especially with respect to abortion and use of contraceptives so that the policy could be accepted across all cultures and religions.

All policies drafted had to consider global processes and agreements that the country had ratified with respect to certain disease conditions. The Malaria Policy 2010, for instance, had to revise some of the policies in line with the new developments and recommendations from the global Roll Back Malaria Partnership. The NAHRSP equally observed that the review process had to be aligned to the African Youth Charter (2006) and the post-2015 development Agenda through the Sustainable Development Goals (SDGs).

Informants interviewed for the KHP (2014 - 2030) observed that the policy was written at a time when global attention had moved towards the policy of universal coverage and this influenced the decisions made for the policy. Many of the informants interviewed argued that personal interests and values were never allowed to affect the decisions on the policy directions taken. There were, however, considerable differences among them with respect to the decision to shift the focus of the KHP towards the NCDs, even though the CDs contributed a higher burden of disease than the NCDs. Although the informants agreed to a dearth of evidence with respect to the NCDs, there was on the one hand informants who stated that this scanty evidence was sufficient to make the shift. According to them, even though the evidence was scanty, projections made by the modelling done was sufficient ground to make the decision. On the other hand were informants both within and out of the MoH who felt that the modelling did not provide any ground for this decision and that the decision responded more to personal interest and global pressure than to the felt need. In a candid observation about the shift, a non-MoH policy actor stated the following:

"I think it was because of the efforts of an individual or a group of individuals because it was not really based on evidence, because the evidence was not there. There was no national survey on risk factors for NCDs. It was more of someone who was visionary, who has seen projections who said, this was going to be a problem in the future so let us include it now. Pushing of an agenda by an individual however can be a double edged sword

because it means if it was something else, this individual would have still managed to push it through, it is only that this time I think he got it right. What if it was something not so important? This individual would have still pushed it through!"

The sentiments above expressed by a non-MoH policy actor were supported by another MoH policy actor who observed that the push towards NCDs responded to the global agenda where the focus had shifted towards NCDS. At the same time, the push was spearheaded by the two ministers of health who were personally affected by NCDs then. So according to him, the policy shift was as a result of a conflation of personal interests and circumstances with the prevailing global shift of attention to NCDs.

"Globally there is much more focus on NCD conditions because that is what majorly affects the developed nations. Of course they have the financial capability to push that agenda. For our case it is an issue, but the trumpet has been overblown politically. Such a move is strategic because the country also wants to have access to some of the funds available globally in the fight against NCDs."

These observations are supported by the KHP policy write-up that states in its introduction that it was 'developed at 'a time when the global development efforts towards the attainment of the MDGs were coming to a close and other global initiatives, such as those targeting NCDs, social determinants of health and managing emerging and re-emerging health threats were gaining momentum' (see KHP 2014-2030: page 6). The policy document equally mentions the need to conform to internationally ratified obligations such as the declarations in Rome of 2003, Paris 2005, Accra 2008, and Busan 2011, among the global influences on the policy formulation process.

This chapter has presented the major findings of the baseline study from the three key data sources. The following chapter discusses these findings and provides the conclusions and recommendations from this study.

CHAPTER 3

Discussion

3.1. The Importance of Evidence in Policy-making

The findings from this baseline study show that all those tasked with the responsibility to formulate policy both within and outside of the MoH considered the search, appraisal and use of evidence to be an integral aspect of the policy formulation process. A thorough review of the three policies and an analysis of the interviews reveal a deliberate and conscious attempt to include evidence in most if not all aspects of decision-making of the policies under review. All those interviewed concluded that in their opinion the policies were adequately informed by available evidence. Where evidence was not available, the policies acknowledged and documented it in their narratives. An examination of the policy formulation processes further revealed a careful attempt to bring together a wide range of actors aimed at providing the technical and financial assistance to the process of collecting, collating, synthesizing and including multiple sources of evidence into policy. This was done through the Technical Working Groups (TWGs) within the Ministry that brought together an array of actors, local and international for the sole purpose of ensuring an all-inclusive and evidence supported process. As explained by the MoH policy conveners, membership in the TWG was voluntary and was based on an interest and what was considered as an institution's 'area competence'. In that case, an institution that conducted surveillance programmes would be included in the TWG or the taskforce that writes the policy specifically to contribute their experience and evidence in this area. A closer look at the ways in which evidence is sourced synthesized and incorporated in decision-making for policy exposes several weaknesses and practices that compromise the rigour required and expected for an evidence informed policy-making process.

3.2 Evidence, Rigour and the Role of Partners at the MoH

Most of the informants in this baseline survey agreed that the bulk of the evidence required for the policy revisions and formulation should be obtained from routine data collected by the government through its various ministries. The data mining process for the three policies under study benefitted from an analysis of routine data from government sources such as the MoH's HMIS, a review of the previous policy documents, vital statistics from the KNBS and the KNHA. As observed by both MoH and non-MoH policy-makers, the status of the data collected through the government systems was suboptimal and in some cases missing up to 40% of the data required for analysis. This essentially meant that the evidence generated from such data required several assumptions and projections to be made in place of the missing data. The case of NCDs as highlighted in the findings is pertinent in this discussion. Informants interviewed stated that there was no sufficient data for NCDs in the country to make any assessments on the magnitude of the NCDs problem in the country. Yet the KHP 2014 - 2030 provides figures for the national hospitals admissions and mortality rate from NCDs in the country. The source and mode of generation of these figures in the policy document was not stated and remained unknown to most of the MoH informants during the interviews. Most of them stated that a consultant was hired by the 'WHO that has the expertise to model and come up with the figures'. Evidence that leads to such an important shift in policy formulation required to be more rigorous and with a stronger input from the MoH personnel. Findings from this research show that this was not the case. The MoH should be in charge and in control of the process that generates the evidence including the politics that enables such evidence to matter in the policy-making process.

In order to strengthen the use of evidence in policy-making, efforts should be made to improve the quality of all policy relevant data collected by all government institutions. This problem is not restricted to NCDs alone. Data collected for accidents and other injuries were also described by the informants to be inadequate. It is therefore important that the government recognises that operational data collected as part of the day-to-day activities for the primary purpose of tracking and managing the operational aspects of an area or unit constitutes the core of the data required for policy review and revision. In that case, the government should ensure that: a) all government staff take reasonable steps to ensure information created, collected, stored, accessed and used within their working environment is accurate, timely, comparable, useable and relevant; b) data custodians are trained and incentivised for the day-to-day management of data; c) a data repository is instituted which includes data that is collected from various sources, including operational data collected for the primary purpose of monitoring, evaluation, reporting and research; d) people in charge of data management have delegated responsibility for setting the overall strategic direction of the specific data collection

to ensure the process of data collection is developed, maintained and utilised in accordance with the strategic goals of the MoH; d) that there is a metadata that describes, explains, locates or otherwise makes it easier to retrieve, use or manage an information resource. A good example for a process that optimises the quality of data used in health research is the data quality policy adopted by the Western Australian department of health that can be easily adopted for use by the MoH (see http://www.health.wa.gov.au/CircularsNew/attachments/662).

Apart from the quality of data, the implications for policy formulation structure and process at MoH need to be evaluated within the context of discourse on the nature of evidence and of the workings of social science and/or of socially-informed policy-making. In all policies reviewed in this study, MoH personnel appeared to be far removed from the process that produces the evidence. As Dutoit (2012) and others have argued, evidence never speaks for itself. Rather evidence is made to speak through discursive practices that imbue particular findings, observations, experiences and events or records with significance and consequence allowing them to function as evidence (see also Latour and Woolgar 1997). Importantly these same practices and institutions also allow other records, data givens, and observations to be dismissed as irrelevant, inconsequential, wrongly interpreted or simply unscientific. In a world where evidence appeals to policy-makers as it does to MoH policy actors, the important thing to note is that what is decisive is not simply the evidence on its own, but the frameworks of assumptions and the underlying narratives which render particular pieces of evidence salient and imbue them with consequence while other considerations are excluded, marginalised, left out of view or considered irrelevant. The MoH policy-making structure allows for the production of evidence by partners, either from their own sources or through the analysis of MoH data. The modelling of data by consultants hired by the WHO produced figures for the NCDs and projections that were used to advice the new focus of the KHP 2014 - 2030. The MoH lacks the capacity to vigorously evaluate the evidence produced by the consultant and therefore have to accept the figures provided. By so doing they elide the crucial questions of politically and ideologically loaded policy narratives.

Several inaccuracies and discrepancies were identified in the evidence used in sections of the policies. One of the most glaring discrepancies in the policy documents was when evidence is adduced and the source of the evidence is not provided. The relevance of these data and its sources could therefore not be ascertained. In other aspects of evidence use already presented in the findings, an examination of trends is provided from different data sources. For example, LE expectancy data provided in the KHP 2014 - 2030 compares KDHS data in 1993 with WHO data in 2009. Another example is to be found in the NASRHP where the age-specific fertility rates were compared from the KDHS 2014, with those from the Performance Monitoring and Accountability 2020 Family planning indicator brief of 2014. In this latter case both studies are dated 2014 and provide different figures. Such discrepancies might imply that the evidence sourcing and use within the policy documents may not be as rigorous and accurate as most of the policy formulators believed it to be. Inaccuracies in figures and inappropriateness of the source of data were also detected within the policy documents. As exemplified by the NASRHP document, the figures quoted in the policy for the contributions of adolescents to the overall total fertility i.e. 32% - 37%, are different from those quoted in the original source - the MOYAs Youth dialogue tool (2011) – i.e. 30% - 40%. Moreover, the MOYAs youth dialogue index reports on youth of ages 15-24 and not adolescents of ages 10-19 years. It is neither possible nor desirable to report on each piece of evidence used in the policy documents, but the examples cited here suggest that a more rigorous and thorough evidence sourcing and evaluation process would have weeded out such discrepancies. A rigorous process ought for instance to notice and make a comment on the use of maternal mortality figures from Mali. Was data for Kenya absent and how does the Malian data compare to the situation in Kenya?

Most of the stakeholders incorporated in the policy writing process were invited because they were 'experts in their fields' of competence and were expected to contribute evidence for the policy. As one of the non-MoH policy writers commented, 'we were the evidence guys'. The policy formulation process was therefore beholden to the evidence available to or availed by the partners. The MoH did not have an independent way of sourcing the evidence or verifying the objectivity of the evidence provided by the stakeholders. Even where the review or analysis of MoH data was contracted to partners, the MoH did not have a system nor the capacity to verify the findings from the evidence mined from its own sources. As one of the informants observed, the MoH had ceded key aspects of the policy formulation process to outsiders and cannot therefore claim to be in charge of the policy writing process.

There are obvious disadvantages that accrue to the MoH policy-making process when they are not in charge of the evidence sourcing process. In the first instance the stakeholders will only provide evidence they are aware of and in most cases, this is evidence that supports their programmes. Evidence use in policy formulation requires policy makers and institutions in which they work to have the capacity and incentives to routinely consider a range of research evidence when making policy decisions. Bassey

(2001) points us to the fact at the core of all evidence is the preoccupation with the question of 'what works'. He argues that social sciences must grapple with the problem that because it is social then it inevitably embraces a multitude of variables. In social circumstances, what works may not be a foregone conclusion, but one that depends on contexts and that research only produces a fuzzy prediction. While natural scientists usually feel able to say x in y circumstances produces z social scientists may be wise to say x in y circumstances may produce z. In this case, all evidence is always about what may work and should always show under what circumstances x may produces z and under which ones x may not produce z. In depending on partners for evidence, the MoH may not access contrary evidence to what is provided as expert evidence by its partners which compromises the evidence evaluation process in which policy-makers need to evaluate a range of evidences. Finding out that a given piece of research has had an impact does not necessarily mean that policy is evidence-informed. It could potentially mean that those availing and communicating the research are only aware of this source from their work or they have lobbied more effectively than others. In that case, a different cast of partners or consultants with different evidence and evaluative frameworks or with more powers could easily sway the policy in a different direction.

3.3 Policy Formulation and Partners' Influence

An examination of the policy formulation practice at the MoH reveals a process that is highly dependent on the support of bilateral and multilateral partners. The partners were part of the TWG of the MoH and were present in all taskforces that formulated the different policies. They provided funding for the search of evidence even where that evidence was to be found in the MoH's HMIS. All the policies under study were preceded by a review of the previous policies periods, processes that were paid for by the bilateral partners. In one of the policies described, the partners actually drafted the terms of reference and supervised the consultant who carried out the review and sourced the evidence. Bilateral and multilateral partners funded all the seminars and workshops that drafted the policies. However, when asked about the role and influence of the different actors many of the policy actors interviewed alluded to an evidence-led process devoid of any forms of power, a democratic process in which all views were tabled, debated and assessed on their merit and veracity of evidential claims.

The relationship between the MoH and its partners and the influence that this brings to the policy formulation process merits a further reflection. The notion and language of partnerships is the new terminology employed to characterise relationships of support for less developed countries by the developed countries (see Samoff and Carol 2003). It replaces earlier terms such as charity, aid or technical support. The term partnership is meant to confer notions of independence, equality and autonomy between partners and to detach current structures and practices from the legacy of postcolonial dependency (Crane 2010). These changing phraseology has, however, not been accompanied by a change in the funding mechanisms. Developing countries still depend heavily on the support from the developed countries and their agencies as described in the findings of this study. For the MoH, many of its programmes including the policy formulation processes, depended on the support of the developed partners. From the processes described by informants in this study, one could conclude that the policy formulation process would not be carried out if the donor support was not forthcoming. As one stakeholder observed, the policy formulation process halted when the funding from the partners was not available.

In an ideal context of partner support in health care processes, the MoH should set the policy framework identifying the priority areas and the partners come in to support the programmes. In the MoH cases, partners joined right from the policy formulation stage and offered their support in the writing of the policy itself. Although many of the MoH policy formulators stated that the policy-making process was free of stakeholder influence, this is unlikely to be the case. Several other MoH and non-MoH policy-makers observed that partners exerted both overt and covert influence on the directions taken by the different policies. A retrospective baseline survey may not be the best method to document partner influence on the policy formulation. However, several of our informants both within and out of the MoH engaged in self reflexivity and provided candid evidence of partner influence in the policy formulation process. Forms of covert influence could be discerned through the funding of meetings, hiring and paying for consultants and consulting firms, providing evidence sources and training policy-makers. As already observed, three critical members of the policy-making team from the MoH were trained for six months by one of the partners. Such processes would obviously influence the policy directions in the directions favoured by the supporting partners.

Several of our informants were unequivocal that some of the partners deliberately sought to sway the policies in a direction favoured by them. According to this group of policy formulators, all partners had an interest in the policy-making process and often introduced their thinking in the policies. Some of the tactics employed by the partners included attempts to influence individual policy- makers, sneaking in indicators of interest to them and in worst

case scenarios as described by one of our interlocutors, arm-twisting the MoH by withholding funds for the policy-making process. All partners to the MoH were expected to speak with one voice and channel their support through the DPHK. But as explained by some of our informants, development partners dissatisfied with the position taken by the DPHK often approached members of the taskforce to impress upon them to support their views and as one of our informants observed,

"...at some point this ministry was almost split into two."

These examples as reflected upon by the informants show that the policy-making processes by the MoH were influenced by the direction of the most powerful partners and as eloquently observed by one of the informants ended up formulating and implementing policies as dictated to them by the funders. It is therefore important as some of the informants observed that the MoH invests in capacity building for the policy formulation process to insulate it against influence by its partners.

3.4 Policy Formulation Process and its Implications for Capacity Building

Questions about capacity and the role of routine data collected by the MoH were prominently discussed by majority of the respondents interviewed for this study resulting in one conclusion: the need (in some interviews stressed as urgent) for capacity building in the MoH to enable the policy-makers effectively engage in the policy formulation process. The question of lack of capacity at the MoH was also identified in a previous needs assessment study conducted by AFIDEP (See Murunga et al 2014). In view of MoH's policy-making structure and processes discussed in the findings, this will involve a number of key features and dynamics (see also Peierson 2012). It needs a vision and strong leadership to move it forward and will involve many different staff as well as positioning staff in new working relationships. It should create proficiencies in Evidence-Informed-Decision-Making (EIDM) skills and necessitate the provision of training opportunities. Furthermore, it requires significant fiscal and technological resources. It induces a shift in the culture of the organisation from "doer" to "thinker doer". It demands a knowledge management strategy to ensure evidence and decision-making information is current, comprehensive, accessible, usable and evaluable. It necessitates a communications strategy to raise awareness, develop shared vocabulary, provide updates, and maintain clarity and transparency. And, it compels careful monitoring, management, and evaluation of the mechanistic and humanistic aspects and outcomes of change. This is what one of the informants in the baseline survey referred to as the institutionalisation of a culture that values the use of evidence at all levels of policy development.

A look at the policy formulation structure and personnel at MoH reveals massive shortages and capacity gaps both in quality and numbers of policy formulating personnel. There was no clear delineation of who the policy-makers were and no central institution in charge of policy-making. Rather, as one of the informants explained, policy-makers were selected from individuals working in departments that required a policy. Policy-making was in most cases neither their strongest points nor their only responsibility. For them policy-making for the most part, was about assembling a taskforce and ensuring proper representation both in terms of expertise and in the ability to raise funding for the process. Their work was thus reduced to collating evidence from different stakeholders, ensuring funds were available from partners, and coordinating and managing relationships between the different stakeholders as opposed to a critical engagement with evidence and policy directions. This has implications for capacity building efforts within the ministry. Efforts at policy-making must therefore initially decide on whose capacity is to be built, what levels of capacity building need to be imparted and consider the chances that those whose capacities they build are or will be sufficiently involved in the actual policy-making processes.

Evidence use in policy-making depends on the ability to access, appraise and synthesise the sources of evidence. Evidence generation, on the other hand, depends on good quality data. As already observed by informants in the study, the bulk of the evidence required for policy review emanates from government records and the quality of the data from government sources, where available, was found to be suboptimal. Capacity building efforts should therefore not only concentrate at the top level of enabling the policy-makers to access and appraise readymade evidence, but equally concentrate at the lower levels of data collection and analysis. Ensuring availability of good quality data and evidence from within government sources will not only resolve the problem of data availability and access, but more importantly stop the blame game between researchers and policy-makers.

CHAPTER 4

Conclusion

This baseline study has provided the context within which evidence is used in policy formulation process within the MoH in Kenya employing a qualitative methodology. The baseline survey reviewed three policies formulated in the past five years and interviewed policy-makers involved in the policy-making process. For some of the variables of interest, such as the discussions around what evidence to use and what to discard and the influence of partners, a retrospective study might not have been the best method to capture such data. For such an examination, participant observation of an on-going policy formulation process would be most appropriate. A better picture will emerge from the prospective study of the policy formulation processes currently in progress as part of the SECURE Health programme.

Nevertheless, the qualitative methodology employed by the retrospective baseline survey generated useful data that provided an understanding of the policy-making processes at the MoH. Most of the policy-makers recognised the importance of using evidence in the policy-making process and were equally conscious of the fact that occasionally, policies were made at the MoH without any recourse to documented evidence. There was also a shortage of personnel equipped with the abilities to source, synthesise, critically evaluate and incorporate evidence into policy formulation. The absence of requisite capacity is compounded by the fact that the MoH does not allocate any funding for the policy formulation process and has not fully operationalised the recently constituted central policy-making structure. The resultant gap is readily filled up by partners who provide both the funding and effectively control the data mining and policy formulating process. In policies studied for this baseline survey, the MoH was beholden to the support of partners and occasionally appeared to be under siege from the partners. Efforts to strengthen the capacity of the MoH to use evidence in policy formulating process at the MoH must therefore address these gaps in data quality and evidence synthesis while being cognisant of the fact that the policy formulation process was heavily dependent on the MoH 'partners'. Capacity building will involve a restructuring of the process of collecting and synthesising routine data from the MoH's HMIS while encouraging the MoH to lobby the government for funding for the policy formulation process. A structure in which partners initiate policy review and reformulation, pay for the workshops and retreats, including per diems for MoH policy writers, train policy-makers and pay for every bit of the policy-making process such as printing and editing of drafts to be presented to cabinet, is not ideal for an objective MoH guided policy-making process. Improving the capacity of the MoH personnel to not only control the data collection, mining analysis and synthesis process has a high chance of extricating the policy formulation process from such external control and influence.

CHAPTER 5

Recommendations

This study makes the following recommendations:

a) The MOH needs to invest in capacity building both in terms of the numbers of personnel involved in policy formulation and the level of technical expertise required in the formulation of its policies. There is a need for a careful evaluation within the MoH regarding the numbers and levels of expertise required for policy formulation followed by training and a deliberate redeployment of such expertise to the appropriate levels of need.

b) The MoH should set aside funding for all aspects of the policy formulation process in order to shield it from the influence of partners.

c) In view of the fact that most of the data and evidence required for policy formulation is to be found within the government records, there is a need for the government to ensure that all policy-relevant data created, collected and stored is complete, accurate, timely, comparable, useable and relevant. This might involve a retraining and reorientation of all those in charge of these processes within government. A standard template needs to be developed for the collection of all policy-relevant data and all data collectors must complete it in full as part of their routine work

d) The MoH needs to establish a portal or health observatory where all the research relevant to health policy formulation conducted either within the Ministry or by any other research organisation could be stored and routinely analysed to inform policy.

e) Due to the shortage of trained personnel in policy formulation, the MoH should in the interim explore the possibility of expertise sharing through secondment arrangements from other institutions until such a time when the MoH is fully equipped with its own experts in policy formulation.

f) The MoH must establish a central department or unit in charge of policy formulation and guidelines for policy formulation to be adopted for all policies formulated at the MoH. This unit does not necessarily have to write all the policies. Instead the unit should oversee the process, appraise all policies formulated and store the final policy documents enacted. The guidelines for policy formulation currently under preparations should be concluded and implemented to streamline the policy formulation process at the MoH.

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Appendix 1: In-depth Interview Guide

In-depth interview guide

Name of policy: **National adolescent sexual and reproductive health policy**

Name and title of respondent:_____ Name of interviewer:_____

Date of interview_____ start time_____end time _____

Introduction

Hello, good day to you, my name is _____ I am from an organisation called AFIDEP or MOH (select as appropriate) We are conducting a study on the role of evidence in policy formulation in the Ministry of Health of Kenya. I would like to speak to you for approximately 45 minutes. Your participation in this study is voluntary and would be appreciated. The in-depth guide is only accessible to the study team and your answers are confidential. Before starting with the interview, I would like to take you through the informed consent procedures which I can quickly summarise or you may read if you prefer to.

Background information

Q1. What was your role in the policy formulation process?

Probe:

a) For how long did you work on this policy formulation process?

b) Did your engagement last the entire policy formulation duration?

Q2. Why was the policy needed?

Probe on the use of evidence?

Q3. What did the government seek to achieve with the policy reform?

Q4. How was the policy development process initiated?

Probe:

a) Who was in charge of the policy development process?

b) Was evidence needed or used at this stage?

Q5. Which actors were involved in the policy development process and why

Probes:

a) Obtain a comprehensive list of actors and for each actor probe, why/how?

b) What were the interests of the different actors in the policy-making process?

c) What influence did the different actors have on the policy development process and the decisions made?

d) What strategies did the different actors use in getting their interests addressed in the policy development process?

Q6. What was the role of evidence in the whole policy development process?

Probe:

a) What evidence was needed to inform the policy

b) How was this evidence sourced?

c) How was evidence synthesized (i.e. made sense of/interpreted)and used?

d) Who played what roles in evidence use?

e) How did/Did evidence inform or influence the initial agenda setting stage where the decision to develop the policy was made?

f) How did/Did evidence inform the selection of the policy or the policy options made?

g) Which specific researchers influenced this stage?

h) How did science/researchers influence the policy development process?

Probe: which specific research/researchers were involved and what were their roles or influence in the policy development process?

i) In your opinion, was the policy-making process adequately informed by evidence?

j) In your opinion were all stakeholders involved? Were some left out and why?

k) Were there any specific barriers to using evidence to formulate this policy?

l) In your opinion, what ways can the role of evidence in health making be strengthened in future processes?

Q7. What other factors influenced the decisions made in this policy?

If not mentioned, probe for

a) Contextual factors – religious and cultural beliefs and interests, interests of the political establishment, existing laws, economic status?

b) Personal interests and values and/or beliefs, political interests, financial interests?

c) Global and regional health processes or decisions?

d) Who/what institutions played what roles in tabling such factors and what process was followed in deciding which factors were more important?

Wrap up

Snowball sampling question.

Do you know of someone else who was involved in the policy formulation and who you would recommend to us to speak with?

Thank informant and inform them about the dissemination/validation meeting

Appendix 2: Informed Consent Forms

MINISTRY OF HEALTH

Consent from for tape recorded in-depth interviews for the Retrospective Policy Analysis Study

Title: Strengthening Capacity to Use Research Evidence in Health Policy in Kenya

Investigators and Affiliations

NAME	INSTITUTIONAL AFFILIATION
Dr. Charles Nzioka, Head Dr. James Mwitari Dr. Esther Ogara	Ministry of Health, Afya house cathedral road, P.O. Box 30016 – 00100 Nairobi, Kenya
Dr. Eliya Zulu Dr. Rose Oronje Ms. Violet Murunga Mr. Jones Abisi Dr. Ferdinand Okwaro	African Institute for Development Policy (AFIDEP), Suite #25, Royal Offices, Mogotio Road off Chiromo Lane, Westlands, Nairobi, P.O. Box 14688-00800, Westlands, Kenya

Introduction

The Strengthening Capacity to use Research Evidence in Health Policy (SECURE Health) Project in Kenya has the overall goal of optimising access and use of research evidence in health sector decision-making, planning and programming. The project's primary focus is strengthening institutional and individual capacity for increased demand and use of research evidence in Kenya's health sector. The project has two overarching objectives:

- Optimize institutional leadership and capacity to enhance evidence use
- Enhance individual skills and capacity of policy-makers in the ministry of health and the legislature in accessing, appraising and using evidence

SECURE Health is three-year project (Nov 2013-Nov 2016) funded by UK's Department for International Development (DFID). The project is a collaboration between the Ministry of Health and four organisations led by the African Institute for Development Policy (AFIDEP) and which form the SECURE Health Consortium. The other three organisations are the Consortium for National Health Research (CNHR), FHI 360, and the Eastern, Central and Southern Africa Health Community (ECSA-HC). The project is implemented in partnership with the Ministry of Health and the Parliament of Kenya.

As part of project monitoring and evaluation, the project is conducting a retrospective policy analysis study on the role of research evidence in past policy-making processes within the MoH. The findings of the study will be used for project evaluation comparing with findings of a prospective policy analysis study to measure the difference that the project makes on the role of research in policy-making processes. We would like to request your participation in this project because we think your knowledge and experience will contribute to our understanding of this topic

Purpose

This study is about strengthening capacity to use research evidence in health policy. We intend to conduct interviews with MoH staff and external policy actors involved in selected policy-making processes within the MoH. As one of the policy actors involved in the development of the Kenya Health Policy 2014 – 2030 we would like to request for your participation in the study interviews.

Voluntariness

Your participation in this study is voluntary and you can choose either to take part in the study or not to take part in the study. You can also choose not to answer any individual question or all of the questions. You are also free to stop

the interviews at any time. Your views are however very important for our study and we would appreciate your participation

If you choose to take part,

Your participation in the study will involve a 45-minute interview, during which you will be asked a few questions regarding your experiences in the policy-making process. I will pose the questions, one-by-one, and you will provide answers as necessary. We would like to tape-record the interview if you allow us for purposes of note taking only. If at any time you would like the recorder switched off, please let us know and we will do so.

If you choose not to take part

If you choose not to take part, you will not have any disadvantage from this, and your name and your decision will not be taken forward to your employers or anybody else. Your decision not to take part in this study will not influence your present or future career prospects or employment status with the MOH.

Confidentiality

All the data gathered through this interview shall be used only for the purposes of the study. The data shall be handled with highest levels of confidentiality to eliminate any risks of it getting into the hands of people not involved in this study. Gathered data will be stored on a password-protected computer and interview forms with responses as well as the tape recordings shall be locked up in a cabinet. All tape recordings will be destroyed after the analysis is completed. The use of interview responses in any of our study reports or publications will not disclose the names of respondents or the names of their institutions. We therefore commit to ensuring that all the responses provided in this study remain anonymous.

Risks

This study presents no known risks to your health or wellbeing. If any parts of this study make you uncomfortable, you can skip questions or stop the conversation. You can stop this interview at any time.

Benefits

There are no direct benefits to you as an individual for participating in this study. However, the information gathered from this study will enable us to assess the effectiveness of the SECURE Health project in improving the role of research use in policy-making processes in the MoH. You might however find that participating in this study accords you an opportunity to reflect on your work and offer your views on how evidence use can be improved in policy formulation and hopefully lead to better policies in the future.

Costs to you

Taking part in this study will not result in any costs to you. We shall only require a little of your time and we will avoid interfering with your work schedules. If you have to use public transport to meet with us, your expenses will be refunded based on standard public transport rates

Persons to contact if you have further questions

If you would like to ask questions regarding this study, you could call the researcher, Dr. Ferdinand Okwaro on Tel 020 – 2039510 or 0707187951 (e-mail: Ferdinand.okwaro@afidep.org) or Dr. Rose N. Oronje, Tel. 020-2039510, 0727-935-844 (email: rose.oronje@afidep.org) or Dr. Charles Nzioka, Tel. 0721234904 (e-mail: nziokacm2003@yahoo.com)

If you wish to contact someone else not directly involved in the project please contact

The Secretary to the KEMRI ethics review committee on, Tel: 020-272-2541, 0722-205-901 or 0733-400-003

If you have any immediate questions about the study, please ask them right away

Consent Form Signature

I, Dr/Mr/Mrs/Ms ……., agree/decline (tick or cross response appropriately) to take part in the retrospective policy analysis study on the role of research in policy-making under the Strengthening Capacity to Use Research Evidence in Health Policy (SECURE Health) project in Kenya. I have been briefed about the project and study and understand its focus and importance. I understand that information gathered from the interview will be treated as strictly confidential. I also agree that this interview can be tape recorded for notes taking purposes only.

Informant's signature: ……Date: …….

Interviewer's signature: .....Date: .....

Appendix 3: Ethics Approval from KEMRI

KENYA MEDICAL RESEARCH INSTITUTE

P.O. Box 54840-00200 NAIROBI - Kenya
Tel: (254) (020) 2722541, 254 (020) 2713349, 0722-205901, 0733-400003 Fax (254) (020) 2720030
Email: director@kemri.org info@kemri.org Website: www.kemri.org

KEMRI/RES/7/3/1 **September 1, 2015**

TO: **DR. ELIYA MSIYAPHAZI ZULU,**
PRINCIPAL INVESTIGATOR, SECURE HEALTH POJECT,
EXECUTIVE DIRECTOR, AFIDEP,
P.O BOX 14688-00800, WESTLANDS
NAIOBI, KENYA

Dear Sir,

RE: NON SSC PROTOCOL 495 (*RESUBMITTED INITIAL SUBMISSION*): STRENGTHENING CAPACITY TO USE RESEARCH EVIDENCE IN HEALTH POLICY IN KENYA (SECURE HEALTH). (*VERSION 1.2 DATED 27TH AUGUST 2015*)

Reference is made to your letter dated 26th August, 2015. KEMRI/Scientific and Ethics Review Unit (SERU) acknowledges receipt of the revised documents on 27th August 2015.

This is to inform you that the Committee determines that the issues raised at the 241st A of the KEMRI/SERU meeting held on 14th July, 2015 have been adequately addressed.

Consequently, the study is granted approval for implementation effective this day, **1st September, 2015** for a period of one year. Please note that authorization to conduct this study will automatically expire on **1st September, 2016**. If you plan to continue data collection or analysis beyond this date, please submit an application for continuation approval by **21st July, 2016.**

You are required to submit any proposed changes to this study to SERU for review and the changes should not be initiated until a written approval from SERU is received. Please note that any unanticipated problems resulting from the implementation of this study should be brought to the attention of SERU and you should advice SERU when the study is completed or discontinued.

You may embark on the study

Yours faithfully,

For:
PROF. ELIZABETH BUKUSI,
ACTING HEAD,
KEMRI SCIENTIFIC AND ETHICS REVIEW UNIT

Appendix 4: MOH Letter of Approval

MINISTRY OF HEALTH

Office of the Principal Secretary

Telephone: Nairobi 254-020-2717077
Fax: 2719008
Email ps@health.go.ke

Afya House
Cathedral Road
P.O. Box 30016 - 00100
NAIROBI

When replying please quote:

Ref: MOH/ADM/1/2/45

18th September 2015

To:.....

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.....

.....

RE: STUDY TO EXAMINE THE ROLE OF RESEARCH EVIDENCE IN HEALTH POLICYMAKING IN KENYA

Reference is made to the ongoing collaboration between the Ministry of Health and African Institute for Development Policy (AFIDEP) in implementing the "Strengthening Capacity to Use Research Evidence in Health Policy" (SECURE Health) Programme. The aim of SECURE Health is to optimize leadership, institutional, and technical capacity for increased use of research evidence in decision-making within the Ministry of Health and Parliament in Kenya. SECURE Health is a three-year programme that started in November 2013 and it is funded by the UK Department for International Development (DFID). The SECURE Health Consortium is led by AFIDEP and includes the Consortium for National Health Research (CNHR), FHI 360, and the East, Central and Southern Africa Health Community (ECSA-HC).

The Ministry of Health through the Health Research & Development Unit and the SECURE Health programme are conducting a policy analysis study to examine the extent to which research evidence has informed policy decisions in past health policymaking processes in Kenya. This study has adopted a case study design through which three policymaking processes have been carefully selected for this study. These include:

1. The Kenya Health Policy 2014-2030
2. The National Malaria Policy 2010
3. The National Adolescent Sexual and Reproductive Health Policy 2015

The Ministry of Health and SECURE Health programme will concurrently conduct a prospective tracking of two on-going policy-making processes to monitor the role that research evidence will play in informing the processes as well as strengthen the use of evidence in these processes. The two policies selected for the prospective studies are:

1. Health financing policy
2. Research for health policy

The purpose of this letter is to request for your participation in this study and to accord any other support related to this exercise that the representatives of the Ministry and AFIDEP will request. Within the Ministry of Health, the study is led by Dr. Charles M. Nzioka, Deputy Director of Medical Services and Head of Health Research and Development (HR&D), who is the Co-Principal Investigator. Other (HR&D) staff will also be involved in the study (including Dr. James Mwitari, Dr. Esther Ogara and Robert Wathondu). Within the SECURE Health Consortium the study is led by Dr. Eliya Zulu, the Executive Director of AFIDEP, who is the Principal Investigator. Other AFIDEP staff who will be involved in the study include Dr. Rose Oronje, Dr. Ferdinand Okwaro, Ms Violet Murunga and Mr. Jones Abisi. Please find more details on the study in the attached study information sheet as well as the ethical clearance certificate.

The Ministry is looking forward to the findings of the study, which will provide baseline information on the role that research is playing in informing policy decisions in the health sector and what needs to be done by various stakeholders to increase the use of research for more effective decision-making practice and programming. The retrospective and prospective studies will be conducted as from the 23rd September 2015 to 30th November 2015 and 23rd September 2015 to November 2016 respectively.

Dr. Khadija Kasachoon
PRINCIPAL SECRETARY