ehpsa
EVIDENCE FOR HIV PREVENTION IN SOUTHERN AFRICA

EHPSA CRITICAL REVIEW
NOVEMBER 2017

Knowledge Synthesis Report

Factors affecting evidence use in health policymaking institutions in southern and eastern Africa

Author: Emily Hayter

research and knowledge at the heart of development

inasp

Contents

Acronyms

ABC- “abstience, be faithful, use a condom”

ARV- anti-retroviral

CPT- cotrimoxazole prophylaxis treatment

EHPSA- Evidence for HIV Prevention in Southern Africa

EIDM- evidence informed decision making

EIPM- evidence informed policy making

KP- key population

LMICs- low and middle income countries

MDA- ministries, departments and agencies

MSM- men who have sex with men

NCG- Nordic Consulting Group

PEPFAR- President’s Emergency Plan for AIDS Relief

RCT- randomised control trial

SRH- sexual and reproductive health

TWG- technical working group

Glossary of key terms

Evidence: this report follows Jones et al. (2013) in taking a broad view of evidence including research evidence, citizen knowledge, routine data, and practice informed knowledge. This synthesis focuses as far as possible on research evidence.

Policymakers: political, strategic and operational actors within government institutions (including both the executive and the legislative branch). This includes a wide variety of public servants.

- Ø In recognition of the key role that multilaterals and donors play in health policymaking in the region, this report also draws out findings about evidence demand and use in those bodies where possible.

Institutions: the main focus of the project is on the policymaking ‘demand side’ ie government institutions (such as National AIDS Commission or Ministry of Health). However, this report also recognises the role that funding institutions and multilateral bodies play in this sector, and the project aims to draw out findings about evidence demand and use in those bodies where possible.

Meso level: this report uses the term ‘meso’ to refer to issues *within* the institutions described above. It does not use ‘meso’ in the sense of a larger system of multiple institutions.

EIDM: the literature varies between the terms ‘evidence informed policy making’ and ‘evidence informed decision making’. This report follows EHPSA terminology in using the term ‘EIDM’

Use: this report follows Newman, Fisher and Shaxson (2012) and others who emphasise that evidence ‘use’ goes beyond uptake of a single study and instead can be understood as the processes, relationships and structures that systematically gather, appraise and use a wide range of evidence to inform decision making

Executive Summary

This Knowledge Synthesis identifies the key organisational factors affecting evidence use in health policymaking institutions in sub-Saharan Africa. This report constitutes the first stage in a three-stage process which will also involve a survey and interviews. Overall, there is consistency in the literature about the fundamental roles of organisational capacity; organisational processes and systems; organisational culture and relationships, as major factors shaping evidence use in health policymaking in southern and eastern Africa.

The Knowledge Synthesis contributes mainly to EHPSA's Guiding Question 1 *What key meso level factors affect evidence use for HIV prevention policy in policymaking and influencing agencies?* The Knowledge Synthesis also provides some initial findings for EHPSA's other guiding questions around supply and use of evidence, but the surveys (Stage 2) and interviews (Stage 3) will remain the main sources of data for unpacking matters related to the supply and use of evidence.

Key findings:

- **Key aspects of organisational capacity which influence evidence use** include human, financial and IT capacity, as well as access to research.
- Important aspects of **organisational culture** include beliefs and values, leadership, and staff relationships and hierarchies. Organisational culture shapes how available capacities are deployed, and which capacities are prioritised.
- **Evidence is valued by policymakers in the sector** and examples illustrate a range of different ways that health research evidence has contributed to **agenda setting, policy content development, and policy implementation** in east and southern Africa
- Evidence used for policymaking can be divided into **four main types: routine data, research, citizen knowledge, and practice informed knowledge.** The literature contains a number of examples of how these types have been used in health policymaking in the region.
- However, there are competing understandings among various stakeholders about **what constitutes 'good evidence'** which emerge from the particular history of the health sector
- **Relationships within and between government agencies, as well as with external evidence providers**, are fundamental, particularly in contested or sensitive areas such as HIV prevention.
- Two main **outstanding areas for further investigation in Stages 2 and 3** are:
    - How the factors identified manifest in the specific area of HIV prevention policy for EHPSA's KPs and vulnerable groups, and which ones are most relevant. No case studies on evidence use for HIV prevention policy for MSM, prisoners or adolescent girls were found.
    - The degree to which the factors affecting evidence use in government institutions are also present in other key policymaking and influencing organisations (eg donors, regional stakeholders), which do not feature prominently in the literature consulted.

I. Introduction

Evidence use in health policymaking in developing countries is a fraught terrain which draws out some of the most fundamental questions about the relationship between research and policy. Many health issues, particularly those connected to sexuality, represent the intersection of a wide range of disciplines, values and beliefs. This makes HIV prevention policy a particularly complex area involving diverse stakeholders from academic, legal, civil society and media backgrounds. There is also an international dimension, as in the health sector the official recommendations from the WHO, UNAIDS and other multilaterals carry significant weight in national policy making. Related to this is the question of ownership over policy and research agendas, which is potent for sub-Saharan Africa where donors are closely involved in the framing of health policy challenges as well as the implementation of interventions to address them. In a sector which has been heavily influenced by the history of evidence based medicine, which has resulted in a favouring of biomedical approaches, there are also strong and at times contrasting beliefs about what constitutes 'good evidence'.

As a sector, health has been slow to transition from the idea of 'evidence based' to 'evidence informed' decision making, and from the corresponding understanding of a linear transfer of knowledge to a more nuanced understanding of the role of evidence as one part of a complex and political policymaking process (Hawkins and Parkhurst., 2016:580; see also Head, 2016). Hunsmann (2012) offers a detailed examination of the political economy of evidence use for HIV prevention in Tanzania, where the verticality of an overwhelmingly donor-influenced HIV sector as well as the short timescales of donor and political cycles are factors which disincentivise longer-term, holistic structural interventions for HIV prevention.

There is growing literature on the key factors shaping the demand and use of evidence within policymaking institutions in developing countries. Drawing on the work of ODI-RAPID (see Shaxson et al., 2016) as well as the principle of the 'good governance of evidence' (Hawkins & Parkhurst 2016), an institutional approach enables us to understand evidence use "not in terms of the substantive policy decisions reached, but rather how those policy decisions are taken and the ways in which evidence is identified, interpreted and deployed to inform those decisions" (Hawkins and Parkhurst 2016:576). This means a focus not on the policy content but on the organisational systems and processes that shape how a public institution identifies its evidence needs, gathers and synthesises evidence, and considers it in decision making.

II. About this report

This report is a rapid knowledge synthesis providing an overview of the key organisational or 'demand-side' factors affecting evidence use within health policymaking institutions in sub-Saharan Africa. In line with EHPSA's interest areas, there is a particular focus where possible on HIV prevention and sexual and reproductive health. The report focuses on Anglophone African contexts, mainly in the southern and eastern regions of the continent.

This report draws on literature including:

- EIDM synthesis literature on meso level barriers and opportunities for evidence use in policymaking in developing countries (eg. systematic reviews and literature reviews)
- Literature on frameworks for assessing institutional level factors shaping evidence use in policymaking

- Specific case studies related to HIV prevention and other public health issues in the region
- EHPSA's programme documentation including policy windows analysis, symposia reports, and research uptake plans
- Programme documentation from other recent EIDM programmes in the health sector in southern and eastern Africa

EHPSA's critical reviews, policy windows analyses, and stakeholder engagement plans contain detailed pictures of the important macro level social and political environment around HIV prevention for vulnerable groups in eastern and southern Africa. This report does not cover these areas.

Aims

The aims of the Knowledge Synthesis are to:

1. Identify the main factors shaping policymakers' demand for HIV prevention evidence, in response to EHPSA's Guiding Question 1 *What key meso level factors affect evidence use for HIV prevention policy in policymaking and influencing agencies?*
2. Identify initial insights into EHPSA's other two areas of enquiry, around supply and use of evidence
3. Identify gaps for further investigation in the next stages of the project (Stage 2- survey and Stage 3- interviews)

III. Factors affecting demand for evidence

Several large synthesis papers and frameworks (eg Court and Cotterell, 2006; Sumner at al., 2011, Punton, 2016; Weyrauch et al., 2016; Taddese and Anderson 2017) have conceptualised the complex and interrelated factors within institutions that shape how formal and informal processes, human relationships, incentives, resources and power structures intersect at multiple levels to create enabling or disabling environments for evidence use. Overall there are a mix of attitudinal, behavioural and operational issues which combine to result in this situation described in EHPSA's first symposium report as "lack of capacity and willingness to convert evidence to policy" (EHPSA, 2015:3). Following the INASP/Politics & Ideas 'Context Matters' framework (Weyrauch et al., 2016), this section groups these and related factors into three main dimensions: organisational capacity; processes and management; and organisational culture[1].

i. Organisational capacity

Capacity constraints are one of the most commonly cited sets of factors affecting evidence use in policymaking institutions in developing countries (see Newman et al., 2012; Weyrauch et.al, 2016; Punton, 2016). Public agencies are often underfunded and overstretched, and it is no surprise that human, financial, infrastructural and administrative capacity issues are fundamental factors shaping evidence use in decision making. Key aspects of organisational capacity include human, financial, and infrastructural resources.

[1] The full 'Context Matters' framework presents these as four dimensions and seventeen subdimensions, but the scope of this report does not permit full investigation of each of these here.

Of particular relevance is the **human resource capacity** of staff who are involved in day-to-day evidence gathering, synthesis and analysis—typically researchers, policy analysts, or staff of policy planning or M&E units. Many of these units are new or recent—for example, Kenya's Ministry of Health had 'recently' established a research unit in 2014 (Murunga et al., 2014:26). They produce a range of reports, policy briefs, fact sheets and presentations to inform decision making. The numbers and educational backgrounds of these staff vary across institutions, and staff turnover can mean that this fluctuates considerably. The degree to which staff capacity issues are related to staff skills, or numbers of staff, or both, therefore also varies between institutions (see Murunga et al., 2014). One overarching issue which is consistent across the literature on evidence use is the fact that staff in policymaking institutions do not have **time to gather, read and synthesise evidence**. This is a factor both of capacity (for instance if there are not enough staff, or they do not have infrastructure or skills to quickly and easily find evidence) and also of culture, which is explored below.

"Capacity to process evidence", as Sumner et al (2011:4) call it, can be broken down into a number of specific skill areas which affect how staff within a policymaking institution use evidence[2]:

- *Capacity to find evidence***:** taking a strategic approach to search strategies and deploying search techniques (eg. using search techniques to effectively find relevant results in databases)
- *Capacity to analyse/appraise evidence:* understanding how to critically judge the relevance and quality of a range of types of evidence
- *Capacity to synthesize evidence:* the ability to synthesize multiple different types of evidence while maintaining accuracy and objectivity
- *Capacity to communicate evidence:* assessing the appropriate audience, messages and channels for evidence
- *Capacity to use IT***:** this is a key cross-cutting issue affecting all the other skills—for example navigating the internet effectively, using file storage and sharing systems and data analysis tools

In many cases, lack of capacity within institutions means that commissioning and synthesizing evidence is simply outsourced, either to technical assistants based within the institution or to external consultants. In their study of evaluation use in Africa, Porter and Feinstein (2014) found that in some cases, including Rwanda and Ethiopia, evaluations are outsourced to development partners entirely because staff are not able to manage them. Murunga et al (2014:11) found that technical assistants funded by donors within the Ministry of Health in Malawi have been "critical in enabling evidence use" because of the "inadequate technical staff in the ministry…[and]weak capacity to find, analyse, interpret and use evidence". Murunga and colleagues further found that when the government of Malawi reviewed its 2002 SRH policy, the review process as well as the actual drafting of the new policy was led by a consultant hired by the Ministry of Health with funding from UNFPA. However as Barugahara and Harber warn (2017:377), drawing on their experience in three ministries in Uganda, "the skills gaps in MDAs…have led to an over-reliance on consultants, who are not typically incentivized to share their expertise and capacity with the MDAs". While consultants can and do play an important role as evidence providers, therefore, in situations where there is limited government capacity and/or significant aid dependence (as in the case with the HIV sector), there is a risk that this can result in undue influence of consultants on decision making. It is important therefore that commissioning agencies have the time and

[2] This section draws on training experience from the VakaYiko programme and related BCURE-funded work in Africa (SECURE Health Consortium, UJ-BCURE, HIV_SA). There is an extensive literature on what methods work to strengthen this capacity (see in particular Langer, Tripney and Gough, 2016; Punton, 2016; Murthy et al., 2012)

capacity to absorb the evidence provided by consultants and other external agencies, and that final decision making rests with the government agency.

Financial resources available for evidence are a fundamental aspect of an organisation's capacity to assess and systematically address its evidence needs. Shaxson et al. (2016:28) note that as a 'spending' department, Health often has a larger budget and more direct control over the structures that deliver its policy than 'influencing' departments. These cross-cutting departments such as Environmental Affairs typically have fewer resources and have to influence spending departments, such as Agriculture or Transport, in order to achieve their goals.. Health therefore may have more financial capacity and influence on evidence than other sectors.

However, as the background reviews by NCG show, in many southern and eastern African countries, health remains a largely donor-dependent sector, and funding for research in health is often over 90% provided by donors (NCG undated:66). Limited national funding for commissioning or conducting research is a common concern, as are the implications for ownership of externally commissioned or funded research (see NCG, undated; Porter and Feinstein, 2014; Murunga et al., 2014). Donors have heavy influence both over the actual gathering and synthesis of research as well as its funding, which can limit the space for national governments to define and explore their own research questions.

A second key resource influencing evidence use within policymaking institutions is **IT infrastructure**. Poor internet connection is a common complaint, and in contexts where staff often rely heavily on internet-based sources of external evidence and do not have access to a library, this can make gathering evidence cumbersome and time-consuming. However, there is considerable variation across institutions, as Murunga et al's report on Kenya (2014) illustrates. Internal storage systems are also important as they enable an institution to learn from its own evidence—without common storage systems, repositories and databases, individual reports can remain on each researcher's personal computer and the institution can duplicate research efforts (Hayter and Liebnitzky, 2015; Uneke et al., 2017b; Murunga et al 2014). However, as Porter and Feinstein (2014) note, poor information management can also be symptomatic of organisational culture, representing a strategy to avoid accountability rather than a lack of capacity.

> *"Even though the HIV programme sets aside money for research, all the support comes from partners. The Ministry does not see the urgency to allocate money; they say there is a lot of support from partners. There is a certain percentage in the strategic plan which should go to health information but only a fraction of this is actually given."*
>
> Mid-level policymaker, Kenya Ministry of Health quoted in Murunga et al (2014, p29)

Access to research remains a very significant factor affecting evidence use, which is related to IT infrastructure and to human and financial capacity. This is of particular relevance to the health sector, where as noted below, evidence from academic research carries particular weight. Access and availability of research is a concern both in terms of a lack of national repositories which enable policymakers to find out what HIV research is ongoing in the country, and in terms of lack of access to global published research through journal subscriptions. NCG's Synthesis Report finds that Kenya is the only EHPSA country that currently has a national repository in place; South Africa and Malawi are developing them. (NCG 2017:10).

Oliver at al.'s systematic review, focusing largely on the health sector, found that lack of access to research was one of the most frequently cited barriers to evidence use in policymaking institutions; conversely, Langer, Tripney and Gough find that access to

research is a key facilitating factor for evidence use (2016:16). Uneke et al. (Nigeria, 2017a and b), Sudhaker and Woldie (Ethiopia, 2016), and Murunga et al. (Kenya, 2014) all illustrate how lack of access to research has constrained evidence-informed-decision making in health policymaking institutions. Murunga et al (2014) describe officials in the Ministry of Health and Parliament paying out of their own pockets for journal articles to use at work. Experience from the VakaYiko programme in Ghana, Uganda and Zimbabwe suggests that most civil servants and parliamentary staff are not aware of the many initiatives that exist to make research accessible and affordable in LMICs, such as the library consortium model which exists across southern, eastern and western Africa and can provide over 90% discounted access to journals through a membership-based system (INASP, 2016; Hussain, 2017). However, as Langer, Tripney and Gough (2016) show, availability of research alone is not sufficient to ensure its use.

A similar observation is made by Uneke et al. (2017b:135), who note that while there are Departments of Planning, Research and Statistics as well as Health Management Information Systems (HMIS) divisions in the federal Ministry of Health and all 36 state Ministries of Health in Nigeria, their "existence … does not guarantee their effective engagement and utilisation by policymakers". The literature is therefore clear that while evidence cannot be used without capacity, capacity alone is not sufficient to drive use. Furthermore, capacity constraints are not static and fixed but are rather linked to dynamic organisational cultures and power structures, which are powerful in shaping evidence use, as well as in making decisions about allocation of the human, financial and infrastructural capacities outlined above.

ii. Processes and management

As Weyrauch et al. (2016) show, the degree of **systematic planning and formal processes to generate and use knowledge** are important factors in shaping evidence use in policymaking. ODI's RAPID team identify four interlinked processes within public institutions: framing the issue, assembling existing evidence, procuring new evidence, and using this to re-frame the issue (Shaxson et al., 2016:19) These structures often exist predominantly at the sector level—for example in HIV a number of key stakeholders collaborate through a National AIDS Strategic Framework, coordinated by the National AIDS Council, and informed by Technical Working Groups. Four of EHPSA's focus countries have Technical Working Groups on HIV Research (Kenya, South Africa, Tanzania and Zambia); only Kenya currently has a National HIV Research Agenda, South Africa and Zambia are currently developing these. All countries have a Key Population Policy and have recently established Technical Working Groups on Key Populations (NCG 2017, also EHPSA undated a, b c and d, Murunga et al., 2014, Longwe-Ngwira et al., 2016). As NCG note, "there is a great difference within the region between well-established institutional structures in Kenya and South Africa for the government to develop HIV policies and set HIV research priorities, and countries such as Zambia that are setting up such institutional structures" (NCG 2017:24).

Within institutions, the literature suggests that there may be more structures and processes in place to shape the management and use of routine data than there are for research (Murunga et al., 2014, Longwe-Ngwira et al., 2016, Ikamari, 2005; MEASURE, 2010). As indicated above, some public agencies have only recently established their own research units, and the question of roles and responsibilities is therefore an important one. The way in which internal researchers liaise with other government agencies as well as external research institutions is likely to have a bearing on the use of evidence within institutions. This is further covered in Section V below.

Processes and structures are not only about the supply of evidence *to* policymakers, but also the communication of decision making *from* policymakers to the public, which is of particular importance in contested areas of health policymaking such as SRH. Hawkins and

Parkhurst (2016) propose the concept of the 'good governance of evidence' in order to address this often under-recognised aspect of evidence-informed decision making. This concept aims to resolve one of the central tensions around evidence in health policymaking by "combin[ing] the desire of health sciences for evidentiary validity with the recognition of the contested nature of the policymaking process" (2016:583). They outline four main criteria for the 'good governance of evidence' in health policymaking agencies:

- *Appropriateness:* judgments of quality to be based on established methodological rigour for the type of research undertaken.
- *Accountability* including clear links back to the public
- *Transparency* in how the evidence base was identified and used
- *Contestability:* need mechanisms in place to challenge the evidence used

An example of the importance of these principles can be found in Broadbent (2012) study of Uganda's HIV/AIDS Prevention and Control Bill, a Private Members' Bill tabled in by the head of the Parliamentary Committee on HIV/AIDS in 2010[3]. The bill included proposals for mandatory disclosure, mandatory testing and criminalisation of HIV transmission. The evidence base for these proposals was not made available to the public or to the author by the Committee, but was reported to consist of study tours to neighbouring countries, consultation with local communities, and a literature review produced by a parliamentary researcher. In her analysis of the ensuing debate, which was conducted largely between civil society activists and the Committee with limited involvement of the national research community, Broadbent observes that while "an awareness, use or undertaking of research-based evidence may exist for the principal actors in the debate –…[it] is often not communicated in public" (2012:26).

The organisational systems which structure how an institution identifies its evidence needs, gathers evidence, and uses that evidence to inform decision making are therefore crucial in shaping demand. They can also contribute to the 'good governance' of evidence by enhancing transparency and accountability around evidence use.

iii. Organisational culture

The literature shows that organisational culture is a very significant factor affecting evidence use. Staff relationships and power structures, attitudes towards evidence and research, and the organisation's flexibility, openness and willingness to change all have a bearing on how available resources and capacity will be deployed and whether they are able to meaningfully inform decision making. Key aspects of organisational culture covered in this section include leadership, beliefs and values, incentives and motivations, and staff relationships and hierarchies. Sumner at al. (2011) show how these factors are particularly relevant for the health sector.

As Weyrauch et al (2016) explain, organisational cultures are influenced by the **leadership**, and the literature confirms that this is an important factor shaping evidence use in health policymaking. For example, Ikamari (2005:4) found after interviewing 40 Nigerian and Kenyan policymakers that "a lack of support from key leadership to promote the availability of data" was a "driving force behind both structural and organizational processes." Hyder at al (2011) found that organizational culture was a consistent factor emerging from interviews with policymakers in six Asian, African and Latin American LMICs.. Also influential at the higher levels of the organisation are the **management personnel and structures** which operationalise the culture set by the leadership. As Weyrauch et al (2016:49) note, "Senior managers often play an important role in terms of interpreting the evidence as well as

[3] This became the HIV Prevention and Control Act 2014 (Government of Uganda, 2014).

deciding who advises them and how. For instance, some opt to form expert advisory committees while others rely more on informal relationships with experts they trust". Such high-level decision makers also have influence over how to budget for and commission evidence, as well as over staff roles and responsibilities, which can affect incentives and motivation. Punton (2016:46) points to evidence from the health sector which found that "collection and appraisal of research was seen to be 'non-work'" in some policymaking institutions, suggesting that "lacking time to appraise research may be linked to an organisational culture that does not prioritise EIPM" (Orton et al.,2011).

Weyrauch et al. (2016) find that **beliefs and values** affect evidence use in policymaking organisations in two main ways: the decision maker's reaction to specific evidence, and the attitudes to evidence within the institution as a whole. Reactions can be influenced by beliefs or values about policy issues, as Weyrauch et al. identify, but also by beliefs and values about types of evidence itself. In the case of HIV prevention policy, both sets of beliefs are at play (see Sumner at al., 2011). Cultural and religious beliefs around sexuality can have a powerful bearing on policymaker attitudes to HIV prevention evidence, as shown by Tulloch et al. (2009) on male circumcision in South Africa and Parkhurst (2012) on PEPFAR's ABC policy in Uganda. The latter case study illustrates the way that national politics and belief systems in a donor country can influence aid policy around HIV prevention.

Beliefs and opinions about **what counts as 'good' evidence** are also of particular relevance in the health sector, where evidence-based medicine has been deeply influential and certain research methodologies are more highly valued than others (Punton 2016; Hawkins and Parkhurst 2016). As Sumner et al. point out in their review of evidence use in SRH policy, (2011:3) "the public health field has a[n]…established hierarchy of evidence types – with systematic reviews of randomised trials featuring at the top of the hierarchy, and anecdotal or individual cases towards the bottom." Parkhurst points out that "HIV discourses in particular have been historically dominated by a biomedical paradigm" (2012:18). Overall, the literature shows that while the claim to being rooted in evidence is important for all stakeholders in the health sector, understandings about what constitutes good evidence can vary considerably within and between different stakeholder groups, resulting in situations where multiple sides of a debate claim to be 'evidence based'.

In addition to questions of methodological rigour, a clear emerging issue related to beliefs and values around evidence is that **policymakers can be wary of 'external' sources of evidence** (Hutchinson et al., 2011; Murunga et al 2014; Broadbent 2012). This can include external sources of data, as well as published research, and is often rooted in distrust of perceived agendas of international research funders. Drawing on their experience in Kenya, Murunga et al (2014:35) note that "government policymakers often undertake investigations to identify the motives of funders of research evidence being communicated to them, particularly those funded by external agencies". Barugahara and Harber (2017:376) also noted that the three Ugandan ministries they studied "tend… to conduct their own surveys rather than seek existing evidence, thereby wasting valuable resources in duplication". This is of particular relevance for culturally sensitive issues around sexuality and rights, where there may be a perception that 'Western' values around sexual identity, behaviour and relationships are being promoted through local NGOs and research institutions (Broadbent, 2012).

The character of **staff relationships** is also very important in shaping evidence use, especially for mid-level civil servants who are responsible for day-to-day gathering and synthesis of information (see Punton 2016, Murunga et al 2014, Datta 2017). The degree to which staff feel able to use evidence to question institutional practices without damaging relationships is a key factor here (Punton 2016:45). Workshops with the Ministry of Youth in Zimbabwe summarised the working environment for mid-level civil servants as follows: "Directives from 'above' can rarely be questioned. Influencing people more powerful than

you is difficult. Management styles tend to be personality-based. Assertiveness can be interpreted as being oppositional and insubordinate" (Datta 2017). Writing about the Ministry of Health in Kenya, Murunga et al. (2014:33) describe a situation where "whether the evidence is considered at management meetings is at the discretion of the Head of Department and also depends on the level of influence of the staff who provided the evidence". As Weyrauch at al. (2016) demonstrate, the flexibility and openness of staff relationships and behaviours are linked to wider organisational attitudes to change, innovation and learning.

Organisational culture, therefore, is fundamental to the existence and deployment of the capacities and systems the organisation has at its disposal. It also shapes how and when evidence is used, which is explored in the next section.

IV. Using evidence

The preceding sections have shown how organisational capacities and cultures interact to shape evidence use. This section draws on the literature to outline the main types of evidence that policymakers use, and why and how they choose this evidence and at what stages it is used. Overall, the evidence-informed decision making literature tends to follow Jones et al. (2013) in grouping evidence used by policymakers into **four main types: citizen knowledge, routine administrative data, research, and practice-informed knowledge.** There is an emphasis on the need for processes within policymaking institutions that systematically consider and balance a wide range of types of evidence, rather than basing decisions on one set of findings alone (see Newman et al in box at right; also Head, 2016).

> "Evidence-informed policy is that which has considered a broad range of research evidence; evidence from citizens and other stakeholders; and evidence from practice and policy implementation, as part of a process that considers other factors such as political realities and current public debates. We do not see it as a policy that is exclusively based on research, or as being based on one set of findings. We accept that in some cases, research evidence may be considered and rejected; if rejection was based on understanding of the insights that the research offered then we would still consider any resulting policy to be evidence-informed."
>
> Newman, Fisher and Shaxson (2012:17)

The literature suggests that value and use of different types of evidence can vary within and between health policymaking bodies. For example, Murunga et al (2014:21) found that top level policymakers in Kenya's Ministry of Health were more likely to use and value research, whereas mid-level staff in the Ministry and at county level were more likely to be using and valuing routine administrative data. Sumner at al. (2011) also point out that higher level policy makers at the political level often value case studies or anecdotes as they can help influence a public audience in speeches.

The literature contains a number of examples offering insights into health policymakers' selection of types of evidence in health policy in sub-Saharan African countries:

- Broadbent (2012) found that **citizen knowledge** played a fundamental role in the arguments of both civil society opponents, and policymaker proponents, of Uganda's HIV/AIDS Prevention and Control Bill. Encouraging more citizen participation (public opinion, public voice) was seen by policymakers in parliament's HIV/AIDS Committee as a way of creating a 'Ugandan' HIV/AIDS Prevention & Control Bill in a sector which is heavily influenced by donors.
- Longwe-Ngwira et al., (2016) show that Malawi's 2011 Guidelines for Clinical Management of HIV in Children and Adults refers to several specific **published research studies**. They found that there was a particular impetus to back up the Guidelines with research because the proposed policy represented an adaptation of WHO guidelines which policymakers were aware was likely to be challenged.

- Experience from Malawi, Zambia and Uganda (Hutchinson et al, 2011) and Kenya (Murunga et al., 2014) illustrates how **biomedical research** can receive varying levels of acceptance based on national policy and political leadership. For example, Hutchinson et al. (2011) describe how biomedical interventions for CPT were not taken up in HIV policy in Malawi and Zambia in the early 2000s.PTheir interviews found that “Malawian national HIV programming was focused on prevention. Lacking a bio-medical approach, it left staff relatively disinterested in the potential that CPT had to reduce HIV related infections”. However “in marked contrast, the Malawian National Tuberculosis Control Programme was actively seeking bio-medical interventions that could reduce the high numbers of deaths among HIV infected TB patients, which led to CPT being seen as an attractive option” (2011:4). Zambia,. a “highly politicised bio-medical approach to HIV [was] dominated by a campaign to scale up ARVs, and the striking results of the research into CPT…were eclipsed” (2011:9).
- **Operational research** is valued by policymakers, particularly when this is locally led, and offers important opportunities for uptake —for example, in the Hutchinson et al. (2011) case studies in Malawi, Zambia and Uganda, local operational research results were taken up by policymakers much faster than international recommendations for CPT which were not trusted. Theobald et al. (2009) provide insight into operational research which informed policy development in HIV prevention in South Africa, TB testing in Malawi, and community diagnostics for malaria, TB and anaemia in Nigeria.
- **Routine administrative data** has been the subject of a number of investigations. Work from MEASURE Evaluation (Ikamari, 2005; MEASURE 2010) has resulted in a conceptual framework and other tools to assess demand and use of data to inform decision making in the health sector. Longwe-Ngwira et al., (2016) case studies show how routine data on malaria and HIV played a key role in driving the agenda for policy change in Malawi.

Types of Evidence

Taken from INASP EIPM Toolkit (Ademokun et.al, 2016)

Data: information collected to be examined, considered and used to help decision-making (Cambridge English Dictionaries, 1990), for example through Health Management Information Systems (HMIS) or Education Management Information Systems (EMIS). Data is factual information only, without context. Many different stakeholders in the policy-making process produce different kinds of data, and there are complex debates about the process of gathering data and how to ensure quality.

a. Qualitative data describes the nature of answers (evidence) in terms of their verbal, written or other descriptive natures. It asks 'who, which, what, when, where and why?' For example, a feedback form using open-ended written answers would produce qualitative data.

b. Quantitative data is expressed in various measures and indices, and its description and analysis is done by means of statistical methods. It answers 'how many', 'to what extent' or 'how much' questions. For example, a feedback form using tick boxes would produce quantitative data.

Research evidence: evidence produced through a formal, comprehensive and rigorous process that uses primary and secondary literature and adheres to accepted principles of quality. Research evidence varies according to sector (social science research is different from natural science research) but has some key common principles, including literature review, methodological rigour, a specific question or topic, objective treatment of evidence and triangulation of results. Research papers usually combine other kinds of evidence such as data, citizen evidence and practice-informed evidence to build a deep understanding of an issue and explain context and causality. Within this definition, we include peer-reviewed academic work as well as research papers by think tanks, multilaterals and NGOs and evaluations.

Practice-informed evidence is knowledge gained from experience of implementing policy and practice. Often highly tacit in nature, it is held by individuals and organizations with long histories of tackling an issue, and has its roots in work experience and an understanding of what works and what does not in specific contexts. This type of evidence can be found in formal processes such as programme documents, monitoring and evaluation data, and formal evaluations. It can also be found in informal spaces such as in meetings, stakeholder consultations or roundtables. It is held and produced by all stakeholders involved in the policy process.

Citizen (or participatory) evidence is held by citizens, both individually and collectively, drawing on their daily lives. It is knowledge of a place, a culture, people and their challenges, gained through direct experience. It can be difficult for outsiders to access without considerable sensitivity, but is often brokered through representatives, such as civil society organizations or cultural or religious groups. Citizen evidence may be expressed through the democratic process itself, as well as via stakeholder consultations, social audits and community mapping or monitoring exercises. Too often, however, the actual influence of people's expressed voice is minimal or tokenistic, as some actors hold the power to frame and even marginalize it

In terms of conceptualising how health research feeds into policy, the Sumner et al. framework (2011) is instructive. The authors identify three main ways in which sexual and reproductive health research is used in policymaking: **agenda setting, changing policy content, and changing policy implementation**. The process is complex and non-linear, as the methods of use can overlap and can be sequenced in different ways. In their study of three Malawian health policies, Longwe-Ngwira et al., (2016) found that evidence had played varying roles: in the production of national guidelines for HIV and malaria, evidence was most prominent in making the case for policy change and in identifying policy options. In the

case of the national Sexual and Reproductive Health Rights Policy, however, evidence played more of a role in defining the problem and the need for a new policy, and was less prominent in identifying policy options. Broadbent (2012) found a similar situation in Uganda where she observed that HIV-related research had played a more prominent role in informing the diagnosis of problems than in informing solutions. Tulloch et al. (2009), however, found that health research in Ghana (maternal syphilis and legislative change for sexual violence survivors), South Africa (male circumcision for HIV prevention) and Tanzania (male circumcision for HIV prevention) had informed both the design and implementation of policy solutions in the health sector. Theobald et al. (2009) case studies from Malawi, Kenya and Nigeria also demonstrate how operational research can inform policy implementation once the case for policy change has been made and there is existing momentum.

Policymakers and their information needs	
Decision-making level	**Type of information**
Political actors: they set the boundaries within which the strategic actors work, and enable them to act within those boundaries.	· Results and impacts of interventions they support. They usually require indicators that account for the advances in certain areas under their influence. · Design and implementation alternatives when approaching a new policy. Comparative evidence may be required in these cases. · Information about budget execution. · Trends as regards government image, their own image and that of their potential competitors among the electorate.
Strategic actors: they process and communicate part of this information to political actors as well as inform the operating actors about what needs to be done.	· Information related to plans and programmes functioning. · Elements that allow them to innovate as regards specific programmes. · Elements that allow them to innovate at administrative level: monitoring and assessment, information systems etc. · Diagnoses about different situations that allow visualizing public policy problems. · Information to justify new courses of action before different players of the political community (political actors themselves, opposing parties, funding organizations etc.).
Operating actors: they process and communicate part of this information to strategic actors.	· They are in charge of collecting and systematizing the information on indicators from projects developed within their area. · They collect information to justify new courses of action
Taken from INASP (2016) Evidence-Informed Policy Making Toolkit, drawing on Echt and Weyrauch (2015)	

V. Supplying evidence

This section explores the main stakeholders and channels involved in supplying evidence to health policymaking institutions. These encompass both formal and informal structures and relationships with evidence providers within and outside government, the strength of which have been consistently found to have an important influence on the use of evidence (see for example Court and Cotterell, 2006; Mendizabal, 2006; Kok et al., 2016; Shaxson et al, 2016)[4].

> *"For the studies that have been done outside our knowledge, we just see them as academic studies/research those that do not have influence on the national policy. Studies that have influence on national policy, the program manager and the team have to be aware of the protocol, we have to input in the protocol and sometimes we are requested to supervise the actual fieldwork. We have to know the whole process up to the end."*
>
> Malawian health policymaker quoted in Longwe-Ngwira et al. (2016:15)

In their synthesis of factors affecting evidence use in policymaking, Weyrauch et al. (2016) found two main types of relationships that affect a policymaking institution's use of evidence in policymaking: relationships with other government agencies, and relationships with non-state actors. As Hawkins and Parkhurst note, "evidence is unable to resolve policy controversies which revolve around contested and competing value systems or issue frames" (2016:579). These relationships are therefore of particular importance in the area of HIV prevention policy for KPs and vulnerable groups, where there are multiple competing values at play . Importantly, such relationships go beyond the supply of evidence to policy, but also involve the role of policymaking institutions in communicating decision making back to the public.

The literature on evidence use in health policymaking in sub-Saharan Africa confirms the findings of Weyrauch and colleagues. Health policymakers rely heavily on **relationships with other government agencies** for evidence—for example, officials at central government level rely on district or county levels for data, parliamentary staff supporting the health committee rely on evidence from the Ministry, and the Ministry relies on evidence from associated agencies, commissions and institutes including research bodies (for example the Uganda Health Research Organisation). In the case of EHPSA's key populations and vulnerable groups, there are also other relevant stakeholders outside the health sector—for instance the correctional services for prisoners or Ministry of Education for adolescent girls (EHPSA undated c and d).While as Weyrauch et al (2016:36) note, "institutional silos can limit access to research and evidence use" there are suggestions that in the health sector the structures and systems for facilitating these relationships are more developed for routine data than for other kinds of evidence such as research (Murunga et al 2014).

Weyrauch et al (2016) identify the following factors which can affect how these relationships between government agencies contribute to evidence use:

- The flow of information between government agencies, in particular in decentralised systems
- Varying capacity for using research across different government agencies
- A reluctance to use research that has not been commissioned for one's own agency

[4] There is an extensive literature on macro-level research-to-policy systems, networks and communities, which is beyond the scope of this report. As this project focuses on instutions, the focus of this section starts with the institution and considers the main types of external relationships it holds that affect evidence use. Such relationships constitute one part of much broader national and international networks and systems, encompassing many other actors and relationships.

- Level of trust in relationships between policymaking institutions and other government institutions such as national research or science councils, statistics agencies
- Hierarchical vs horizontal relationships
- Degree of coordination between agencies
- Sector (health is often noted as one of those most likely to use evidence)

'Two Communities'? Policymakers and researchers' ideas of evidence *Adapted from Ademokun et al (2016)*	
Policymakers	***Researchers***
Colloquial (narrative)	Scientific
Contextual	Generalisable
Policy relevant	Contributes to existing knowledge
Clear message	Caveats and qualifications
Timely	Take as much time as needed

Relationships with non-state actors are pivotal, but present a number of challenges arising from the differing needs, values and motivations of stakeholders across the research-to-policy system (eg. see table above). Policymakers and researchers were for some time conceptualised as 'two communities' (Caplan, 1979) with fundamentally different motivations, operating systems, and understandings of evidence. Evidence informed policy making was therefore seen as a way to 'bridge the gap' between these separate groups, and this framing continues to be a major theme in the sector (eg. see Hyder et al. 2011). More recent work has begun to add nuance to this conceptualisation by highlighting the varying levels of existing interaction between the groups, as well as unpacking the label 'policymakers' to consider the differences between actors within policy institutions (Newman et al 2015). For example, as Barugahara and Harber (2017:376) note from their experience with three Ugandan ministries, "while a demand for relevant, locally produced research exists among senior government officials", in practice 80% of civil servants who responded to their survey across three ministries had little or no engagement with researchers.

The literature is therefore increasingly examining the dynamic ways that multiple types and levels of policymakers and researchers engage, rather than approaching relationships as a linear model of 'dissemination' of research from one distinct group to another. Some of the factors that affect the strength and impact of such engagements are identified by Weyrauch et al. (2016) as follows:

- Existence and types of policy forums and epistemic communities. Institutionalised, regular policy forums[5] can help to build trust, and epistemic communities can be particularly effective when they involve influential leaders
- Degree of citizen participation in policymaking processes, and the extent to which citizen knowledge reinforces research findings. Notably, research was found to be more likely to be used where it was complemented by citizens' views.

[5] The literature reviewed confirms that Technical Working Groups are the key formal structures that health policymaking institutions have in place to facilitate stakeholder dialogue and input to policymaking. As Murunga et al. 2014 (p32) note, "information flows from Technical Working Groups (TWGs) through Task Forces often created to undertake more in-depth reviews and assessments, through programme Interagency Committees (ICCs) and finally to the Health Sector Joint Forum." These formal structures are explored in more depth in the NCG reports and are not covered here.

- The role of international experts and the degree to which this influences country ownership over framing and addressing policy problems
- Relationships with donors, which in aid-dependent sectors can strongly influence agenda setting, policy content and implementation. This is linked with relationships with international experts and has similar potential considerations for country ownership (see Hunsmann 2012 for a detailed study of how such relationships affect Tanzanian HIV prevention policy)

In practice, engagements between evidence producers and users take many forms.Some are institutionalised within policymaking organisations, while others rest with individuals and networks. In their review of knowledge transfer and exchange mechanisms in the health sector, Mitton et al. (2007:744) identified the following specific mechanisms for engagement between researchers and policymakers:

- Face-to-face exchange between decision makers and researchers (consultation or meetings)
- Education sessions for decision makers
- Networks and communities of practice
- Facilitated meetings between decision makers and researchers
- Interactive, multidisciplinary workshops
- Capacity building within health services and health delivery organizations
- Web-based information, electronic communications
- Steering committees

Where relationships do exist, the quality of these, including timing and elements of trust and reciprocity, are important, as EHPSA stakeholders identified in the first symposium (EHPSA, 2015; see also Oliver at al., 2014)The literature illustrate many cases where such trustful and reciprocal relationships—both formal and informal— between health policymaking institutions and external research bodies have resulted in research informing policy (see for example Burris et al., (2011) on HSV 2 treatment in Ghana; Tulloch et al. (2009) on sexual violence in Ghana and male circumcision in South Africa and Tanzania; and Longwe-Ngwira et al. (2016) on Malawi's Guidelines for Clinical Management of HIV in Children and Adults. Examples of specific pairing schemes, mentoring and fellowship initiatives which have connected researchers and policymakers can be found in Langlois et al. (2016); Sudhaker and Woldie (2016); and Barugahara and Harber (2017).Broadbent's 2012 case study of Uganda's controversial HIV/AIDS Prevention and Control Bill is illustrative of the consequences when such relationships have not been in place.

Health research for policy and practice in Ghana

Kok et al. (2016) profile the uptake and use of 30 health research studies conducted in Ghana. 20 of the 30 studies, all of which were initiated and led by Ghanaians, had some form of policy/practice impact in 6-12 months after closing. The following factors were found to influence the uptake of the research:

- Studies that were aligned with the national health research agenda
- If the studies were initiated by people who were important decision makers in public health policy
- Involving key users during the formulation of the study and also during implementation—if the investigators were not themselves potential key users, then involvement of key users throughout is important
- Introducing new practices as part of the research
- Involving potential key users in developing recommendations
- Targeted distribution of printed results (beyond the scientific domain)

Communicating Evidence

The different types of evidence that feed into policy and the various channels through which they are supplied, mean that evidence is communicated in multiple ways. Communication is a significant theme in the literature. In reflection of the increasingly complex view of researcher-policymaker relationships, understandings of communication for research impact have moved beyond simple, one-off 'dissemination' models to long-term, multi-layered models. Researchers' capacity to identify their audiences and translate complex technical information in a clear and compelling way, either in written form (eg policy briefs, infographics) or through verbal means (presentations) is important (Hyder, 2011; Ademokun et al 2016). There is an extensive area of research and practice concerned with how research should best be communicated to policymakers.

Given the fact that many of the most effective and popular channels for evidence supply are in-person, 'soft' communications skills such as influencing and storytelling are also crucial (see Datta, 2017 for experience from Zimbabwe). Such communications skills are not only relevant for researchers aiming to influence policymakers, but also for different types of policymakers to influence each other—for example, technical staff providing briefings to their superiors, or parliamentary researchers providing evidence to a committee of MPs. As shown above, organisational cultures, hierarchies and politics are crucial factors affecting evidence use on the 'demand side', and strategic and effective communication is fundamental to navigating these dynamics. Communication can therefore be thought of as a cross-cutting theme affecting not only how evidence is supplied by researchers to policymakers, but also how it is used within policymaking institutions.

VI. Areas for exploration in Stages 2 and 3

The Knowledge Synthesis has outlined a number of gaps for further exploration in the next stages of this project. In the delivery framework outlined in the Inception Report, the Knowledge Synthesis was envisaged to contribute mainly to Guiding Question 1, while the surveys and interviews would provide most of the data for the other Guiding Questions. The Knowledge Synthesis does provide some initial findings for some of the other Guiding Questions, but the surveys (Stage 2) and interviews (Stage 3) will remain the main sources of data for those themes, especially around how they relate to HIV prevention for KPs and vulnerable groups, which was the main gap in the Knowledge Synthesis. Appendix 2 summarises the status of EHPSA's Guiding Questions at the end of the Knowledge Synthesis.

The key main areas for further exploration are:

- How the factors identified manifest in the specific area of HIV prevention policy for EHPSA's KPs/vulnerable groups, and which ones are most relevant. No case studies on evidence use for HIV prevention policy for MSM, prisoners or adolescent girls were found.
- To what degree the issues the literature identifies regarding evidence use in government institutions are also present in other key policymaking and influencing organisations (eg donors, regional stakeholders)
- The extent to which the broader social/cultural attitudes around EHPSA's KPs and vulnerable groups are also present within policymaking bodies in this sector, or whether policymaking institutions are 'going against the grain' in terms of attitudes to these groups.
- The role of evidence in the recently emerged structures and systems around KPs and vulnerable groups (eg the TWGs identified by NCG report). The literature

confirms that these structures will be key channels in evidence provision and consideration for KPs and vulnerable groups.

VII. Conclusion

There is an extensive literature on the relationship between research and policy in developing countries. A growing strand of this focuses on the 'demand side', exploring how evidence is used in decision making within policymaking institutions. This report has identified the main factors that affect evidence use within policymaking institutions, and illustrated how these manifest in the health sector in southern and eastern Africa. The most influential factors emerging from the literature are organisational capacity (including human, financial and infrastructural resources); organisational culture (including leadership, beliefs and values, and relationships) and relationships within and between institutions. The literature provides a range of examples of how these factors have influenced evidence use in health policymaking in the region. It also confirms the main types of evidence used (research, routine data, practice informed knowledge, and citizen knowledge) as well as illustrating how health evidence has contributed to policymaking at different stages of the policy process, from agenda setting to implementation. Key remaining issues for exploration in the next stages of the project are around how these factors manifest for HIV prevention policy for KPs and vulnerable groups, and to what degree the factors present in government institutions are also present in other policy influencing institutions such as donors and multilaterals.

Bibliography

Ademokun et.al (2016) Evidence-Informed Policy Making Toolkit. Oxford: INASP. Available online at: http://www.inasp.info/en/training-resources/courses/229/

Barugahara, I. & Harber, T. (2017) 'Complexities of linking researchers with policymakers in Africa', *Research for All*, 1(2): 375–86.

Broadbent, E. (2012) *Research-based evidence in African Policy debates: Case Study 2—Uganda's HIV Prevention and Control Bill.* London: Overseas Development Institute.

Burris, H., Parkhurst, J., Adu-Sarkodie, Y. & Mayaud, P. (2011) 'Getting research into policy - Herpes simplex virus type-2 (HSV-2) treatment and HIV infection: international guidelines formulation and the case of Ghana', *Health Research Policy and Systems,* 9(Supp 1): S5.

Caplan, N., (1979) 'The Two Communities Theory'. *American Behavioural Scientist* Vol 22 No 3 459-470. Thousand Oaks, CA : Sage.

Court, J. & Cotterrell, L. (2006) *What Political and Institutional Context Issues Matter for Bridging Research and Policy? A Literature Review and Discussion of Data Collection Approaches.* London: Overseas Development Institute.

Court, J., and Young., J (2003) Bridging Research and Policy: Insights from 50 Case Studies. ODI Working Paper 213. London: Overseas Development Institute.

Datta, A. (2017) *Improving Effectiveness of Evidence Use to Support Zimbabwe's Youth.* Oxford: INASP. Available online at http://www.inasp.info/en/publications/details/290/

Echt, L. and Weyrauch, V. (2015). Leaders of Change: Developing Latin American Policymakers' Capacity to Promote the Use of Knowledge in Policy. Politics & Ideas: unpublished training material.

EHPSA (2015) Synthesis of proceeding and outcomes of the 1st EHPSA Symposium. Available online at http://www.ehpsa.org/all-documents/general/14-first-ehpsa-symposium/file

EHPSA (undated a) Country Context and Policy Influence Opportunities Reports: Malawi—Adolescent and Young Women.

EHPSA (undated b) Country Context and Policy Influence Opportunities Reports: Namibia—MSM.

EHPSA (undated c) Stakeholder Engagement Plan for the uptake and acceptability of a combination HIV prevention package among young people in Zambia and South Africa (PopART for Youth [P-ART-Y] Study.

EHPSA (undated d) Stakeholder Engagement Plan for Treatment as Prevention (TasP) in Correctional Facilities in South Africa and Zambia.

Ettelt, S, Hawkins, B & Alvarez-Roset, A. (2013) *Analysing evidence use in national health policy-making - an institutional approach.* London: London School of Hygiene and Tropical Medicine.

Government of Kenya Ministry of Health (2016) *Guidelines for Evidence Use in Policy-Making.* Nairobi: Ministry of Health.

Government of Uganda (2014) *HIV/AIDS Prevention and Control Bill.* Kampala: Parliament of Uganda. Available online at: http://www.parliament.go.ug/images/stories/acts/2014/HIV%20and%20AIDS%20prevention%20and%20control%20act%202014.pdf

Harrison, T. & Nutley, T. (2010) *A Review of Constraints to Using Data for Decision Making: Recommendations to Inform the Design of Interventions.* Chapel Hill: MEASURE Evaluation.

Hawkins, B. & Parkhurst, J. (2016) 'The 'good governance' of evidence in health policy', *Evidence & Policy*, 12(4): 575–592.

Hayter, E. & Liebnitzky, J. (2015) *Needs Assessment Parliament of Uganda: Capacity Building in the Department for Research Services and Institute of Parliamentary Studies* [unpublished]

Head, B., (2016) 'Toward More 'Evidence-Informed Policymaking?'. *Public Administration Review,* Vol 76, Issue 3 :472-484. Washington, DC: American Society for Public Administration.

Hunsmann, M., (2012) 'Limits to evidence-based health policymaking: policy hurdles to structural HIV prevention in Tanzania'. *Social Science & Medicine* 74: 1477-1485.

Hussain, F. (2017) 'Enabling access to research in public institutions: emerging insights'. INASP Blog, 14 June. Oxford: INASP. (www.blog.inasp.info/enabling-access-researchpublic-institutions-emerging)

Hutchinson, E., Parkhurst, J., Phiri, P., Gibb, D., Chishinga, N., Droti, B. & Hoskins, S. (2011) 'National policy development for cotrimoxazole prophylaxis in Malawi, Uganda and Zambia: the relationship between Context, Evidence and Links', *Health Research Policy and Systems,* 9(Suppl 1): S6.

Hyder, A., Corluka, A., Winch, P., El-Shinnawy, A., Ghassany, H., Malekafzali, H., Lim, MK., Mfutso-Bengo, J., Segura, E., and Ghaffar, A., (2011) 'National Policymakers speak out: are researchers giving them what they need?'. Health Policy & Planning 26:73-82. London and Oxford: London School of Hygiene and Tropical Medicine and Oxford University Press.

Ikamari, L. (2005) *Decision Maker Perceptions in Kenya and Nigeria: An Assessment of Data Use Constraints*. Chapel Hill: MEASURE Evaluation.

INASP (2016) *Approaches to Developing Capacity for the Use of Evidence in Policy Making.* Oxford: INASP. Jones, H., Jones, N., Shaxson, L. & Walker, D. (2013) *Knowledge, Policy and Power in International Development.* London: Overseas Development Institute.

Jessani, N., Kennedy, C. & Bennett, S. (2017) 'Enhancing evidence-informed decision making: strategies for engagement between public health faculty and policymakers in Kenya', *Evidence & Policy*, 13(2): 225–253.

Kok, M. O., Gyapong, J. O., Wolffers, I., Ofori-Adjei, D. & Ruitenberg, J. (2016) 'Which health research gets used and why? An empirical analysis of 30 cases', *Health Research Policy and Systems,* 14:36.

Langer, L., Tripney, J. & Gough, D. (2016) *The Science of Using Science: Researching the Use of Research Evidence in Decision Making*. London: Institute of Education, University College London.

Langlois, E., Becerreil Montekio, V., Young, T., Song, K., Alcalde-Rabanal, J. & Tran, N. (2016) 'Enhancing evidence informed policymaking in complex health systems: lessons from multi-site collaborative approaches', *Health Research Policy and Systems,* 14:20.

Liverani, M., Hawkins, B. & Parkhurst, J. (2013) 'Political and Institutional Influences on the Use of Evidence in Public Health Policy. A Systematic Review', *PLoS* ONE 8(10): e77404.

Longwe-Ngwira, A., Ngwira, B., Oronje, R., Mushani, N., Nkhata, M. J., Muula, A. & Zulu, E. (2016) *Status of Evidence Use in Health Policy Formulation in Malawi: Results from three policy analysis case studies*. Nairobi: African Institute for Development Policy.

Longwe-Ngwira, A., Oronje, R., Mushani, N., Singini, K., Nsaliwa, T., Muula, A. (2016b) *Mid Term Review of the Performance of the National Health Research Agenda in Malawi.* Nairobi: African Institute for Development Policy

Mendizabal, E., (2006) 'Understanding networks: the functions of research-policy networks'. ODI Workking Paper 271. London: Overseas Development Institute.

Mitton, C., Adair, C., McKenzie, E., Patten, S., and Brenda Perry, B., (2007). Knowledge Transfer and Exchange: Review and Synthesis of the Literature. *Milbank Quarterly* 85(4): 729–68.
Murunga, V., Abisi, J., Oronje, R. & Zulu, E. (2014) *An Assessment of Capacity Needs for Application of Research Evidence in Decision-making in the Health Sector in Kenya.* Nairobi: African Institute of Development Policy.

Murthy, L., Shepperd, S., Clarke, M. J., Garner, S. E., Lavis, J. N., Perrier, L., Roberts, N. W. & Straus, S. E. (2012) 'Interventions to improve the use of systematic reviews in decision-making by health system managers, policy makers and clinicians (Review)'*, Cochrane Database of Systematic Reviews,* Issue 9.

Newman, J., Cherney, C., and Head, B. (2015). 'Do Policymakers Use Academic Research?: Reexamining the 'Two Communities' Theory of Research Utilization'. *Public Administration Review* Vol 76, Issue 1: 24:32. Washington, DC: American Society for Public Administration.

Newman, K., Fisher, C. & Shaxson, L. (2012) 'Stimulating Demand for Research Evidence: What Role for Capacity Building?' *IDS Bulletin* 43(5).

Nordic Consulting Group (undated) Draft Baseline Report—EHPSA Critical Reviews, Cluster 1, Cross Cutting Topics, Review 2.

Nordic Consulting Group (2017) Draft Synthesis Report—EHPSA Critical review, Cluster 1, Cross Cutting Topics, Review 2.

Okwaro, F. (2016) *Report of the Baseline Survey on the Context and Status of Research Use in Policy Formulation at the Ministry of Health in Kenya*. Nairobi: African Institute for Development Policy.

Oliver, K., Innvar, S., Lorenc, T., Woodman, J. & Thomas, J. (2014) 'A systematic review of barriers to and facilitators of the use of evidence by policymakers', *BMC Health Services Research,* 14:2.
Parkhurst, J. (2012) 'Framing, ideology and evidence: Uganda's HIV success and the development of PEPFAR's 'ABC' policy for HIV prevention', *Evidence & Policy* 8(1): 17-36(20).

Porter, S. & Feinstein, O. (2014) *Demand for and Supply of Evaluations in Selected Sub-Saharan African Countries.*. Johannesburg: University of the Witwatersrand Centre for Learning on Evaluation and Results—Anglophone Africa.

Punton, M. (2016) *How can capacity development promote evidence-informed policy making? Literature Review for the Building Capacity to Use Research Evidence (BCURE) Programme*. Brighton: ITAD

Shaxson, L., Datta, A., Tshangela, M. & Matomela, B. (2016) *Understanding the organisational context for evidence-informed policy-making.* Pretoria: Department of Environmental Affairs; and London: Overseas Development Institute.

Stewart, R., Wiggins, M., Thomas, J., Oliver, S., Brunton, G. & Ellison, G. (2005) *Exploring the Evidence-Practice Gap: Mixed and Participatory Training for HIV Prevention in Southern Africa.* London: Institute of Education.

Sudhaker, M. & Woldie, M. (2016) *Increasing Evidence Use Among Ethiopia's Health Planners and Policymakers.* Oxford: INASP.

Sumner, A., Crichton, J., Theobald, S., Zulu, E. & Parkhurst, J. (2011) 'What shapes research impact on policy? Understanding research uptake in sexual and reproductive health policy processes in resource poor contexts', *Health Research Policy and Systems,* 9(Supp 1): S3.

Taddese, A. & Anderson, A. (2017) *100+ Government Mechanisms to Advance the Use of Data and Evidence in Policymaking: A Landscape Review.* Washington, DC: Results for All.

Theobald, S., Taegtmeyer, M., Squire, S. B., Crichton, J., Simwaka, B. N., Thomson, R., Makwiza, I., Tolhurst, R., Martineau, T. & Bates, I. (2009) 'Towards building equitable health systems in Sub-

Saharan Africa: lessons from case studies on operational research', *Health Research Policy and Systems,* 7:26.

Tulloch, O., Mayaud, P., Adu-Sarkodie, Y., Opoku, B. K., Lithur, N. O., Sickle, E., Delany-Moretlwe, S., Wambura, M., Changalucha, J. & Theobald, S. (2009) 'Using research to influence sexual and reproductive health practice and implementation in Sub-Saharan Africa: a case-study analysis', *Health Research Policy and Systems,* 9(Supp 1): S10.

Uneke, C. J., Sombie, I., Keita, N., Lokossou, V., Johnson, E. & Ongolo-Zogo, P. (2017a) 'An assessment of policymakers' engagement initiatives to promote evidence informed health policymaking in Nigeria', *Pan African Medical Journal,* 27(1).

Uneke, C.J., Sombie, I., Keita, N., Lokossou, V., Johnson, E., Ongolo-Zogo, P (2017b) 'Improving Maternal and Child Health Policymaking Processes in Nigeria: an assessment of policymakers' needs, barriers and facilitators of evidence-informed policy making', *Health Research Policy and Systems,* 15(Supp 1): 48.

Weyrauch, V., Echt, L. & Suliman, S. (2016) *Knowledge Into Policy: Going Beyond 'Context Matters'*. Buenos Aires: Politics & Ideas.

Wills, A., Tshangela, M., Shaxson, L., Datta, A. & Matomela, B. (2016) *Guidelines and good practices for evidence informed policy making in a government department.* London: Overseas Development Institute.

Young, T., Garner, P., Clarke, M. & Volmink, J. (2017) 'Evidence-based health care and policy in Africa: past, present and future', *Journal of Clinical Epidemiology,* (83): 24-30.

Young, J., Shaxson, L., Jones, H., Datta, A., Cassidy, C., and Hearn, S. (2014) *ROMA: A Guide to Policy Engagement and Influence*. London: Overseas Development Institute.

Appendix 1: Case studies: evidence in health policy in Africa

Country	*Policy*	*Author*
Malawi	Guide for Management of Malaria (2007)	Longwe-Ngwira et al. (2016)
Malawi	Guidelines for Clinical Management of HIV in Children and Adults (2011)	
Malawi	National Sexual and Reproductive Health and Rights Policy (2009)	
South Africa	Male circumcision for HIV prevention	Tulloch at al. (2009)
Tanzania	Male circumcision for HIV prevention	
Ghana	Maternal syphilis screening	
Ghana	Legislative change for sexual violence survivors	
Ghana	Herpes simplex treatment and HIV infection	Burris at al. (2011)
Kenya	Voluntary counselling and testing for HIV	Theobald et al. (2009)
Malawi	Provision of TB testing in grocery stores	
Nigeria	Community diagnostics for anaemia, TB and malaria	
USA/Uganda	PEPFAR's ABC approach to HIV prevention	Parkhurst (2012)
Uganda	HIV/Aids Prevention & Control Bill (2010; became an Act 2014)	Broadbent (2012)

research and knowledge at the heart of development

2/3 Cambridge Terrace,
Oxford
United Kingdom
OX1 1RR

t +44 (0)1865 249909
f +44 (0)1865 251060
inasp@inasp.info
www.inasp.info

Company registration number 04919576
Registered charity number 1106349

International Network for the Availability of Scientific Publications Limited is a company limited by guarantee and registered in England and Wales. INASP works with partners across the research-to-policy system to support the production, sharing and use of research to inform national development.

This document has been prepared as part of the Evidence for HIV Prevention in Southern Africa (EHPSA) programme which is supported by UK aid from the Department for International Development (DFID) and Sweden, through the Swedish International Development Agency (Sida) - mandated to represent the Norwegian Agency for Development Cooperation (NORAD)

The content and opinions as expressed within this document are those of the authors and do not necessarily reflect the opinion of UK aid, DFID, Sida, NORAD or that of the programme managers, Mott MacDonald.