



# Chapter 7

## Enhancing capacity to use HPSR evidence in policy-making processes

# Key messages

- Surprising few data exist regarding the real capacity constraints facing the use of evidence in policy. Policy-makers' capacity to understand and use research has been neglected, both as a research topic and as an area of investment in terms of promoting evidence-informed policy.
- Research evidence may play different roles at different stages of the policy formulation cycle. Since evidence can come from many different sources, in many different forms and with varying degrees of quality (and transferability), significant capacities are required to draw upon research evidence in policy-making.
- There are many contextual factors, outside the direct control of policy-makers, which affect how research evidence is likely to be used in policy. However, the government itself has a role to play in terms of influencing the overall context and incentives for using evidence.
- Policy-makers and their advisers, wherever they are located, need a set of skills to enable them to use research in their decision-making. In particular, policy-makers need to be able to:
  - identify situations where research can help;
  - articulate research questions for topics of policy-relevant research; and
  - access and assess research findings and incorporate them in decision-making.
- Discrete interventions may have somewhat limited effect unless accompanied by broader structural reforms that bring about change in civil service culture, and which are potentially supported by stronger demands from civil society groups in terms of enhancing transparency and accountability in policy processes.



## Introduction

We have now reached the final and most critical of the functions that make up our conceptual framework – policy-making itself. No matter how well the previous three functions are working, they are all means to an end – to improve the degree to which policies are informed by evidence. And yet very little is known about how policy is made in practice or the forces that impinge on it. Examples abound of policies that fail to take account of available evidence; the frustrations that causes are familiar to everyone in the field. But why does it happen? If there are gaps in understanding how policy is decided, even less is known about the capacity needs of policy-makers and the institutions in which they work. Other chapters have dealt with the functions further up the chain of interaction – priority-setting; generation of research knowledge; and mediation of research evidence through filtering and amplification. But all these steps ultimately come together in policy-making. Building on Chapter 2, we first outline the typical stages and processes of policy-making and the factors that influence how national policy-makers use research evidence. We then consider the key institutions involved in national policy-making processes and their capacity needs. We review strategies for enhancing capacity of key players for using research-based evidence. Because governments clearly have a role in overseeing all the steps in the policy-making process, we end by summarizing and reflecting on the previous chapters and their implications for policy-makers.

## Policy processes and the use of evidence by national policy-makers

### The policy process

Chapter 2 described how policy-making is a complex, non-linear, incremental and messy process. Many factors influence policy-making, including context (e.g. political election cycles, the state of the government's finances, health systems and governance structures, as well as media hype and political crises) and the ideologies and values of the policy-makers themselves (Trossle et al. 1999; Black 2001; Bowen & Zwi 2005).

Indeed, although the 'engineering' model of how knowledge is incorporated into policy suggests a linear progression from identifying a problem that requires a policy solution, ranking the objectives a solution should achieve and weighing alternative policy options to maximize objectives, in reality, this approach is rarely pursued. The actual steps of the policy process depend on the country and its particular policy structures and mechanisms. However, as noted in Chapter 2, stages in the policy process typically identified are:

- agenda setting – drawing attention to particular problems and issues;
- policy formulation – participating in the development of policy strategies and design;
- implementation – facilitating the execution of agreed policies; and
- evaluation – providing feedback on the implementation and effects of the policy.

Evidence can be used at any of these stages. The resulting policies can be expressed in various ways from internal ministry goals and targets to formal regulations or legal directives. Box 7.1 indicates different expressions of health policies from Ghana.

## BOX 7.1 EXPRESSIONS OF HEALTH POLICIES: EXAMPLES FROM GHANA

Health policies may be expressed in multiple forms. In Ghana these include the following.

- **Visions** – By the year 2000, all people will attain a level of health that will permit them to lead a socially and economically productive life (Alma Ata Declaration WHO/UNICEF, 1978).
- **Goals and objectives** – The basic goal and objectives of Ghana’s health policy will be to maximize the total healthy life of the Ghanaian people and, by 1990, achieve basic primary health care for 80% of the population, and effectively attack 80% of the unnecessary death and disability among Ghanaians (Ministry of Health, Ghana 1978).
- **Organizational strategies** – The proposed primary health care system will have services provided at three levels (Ministry of Health, Ghana 1978).
- **Programme strategies** – Maternal and child health services will be integrated and made accessible to all women and children in Ghana, within the context of primary health care.
- **Targets** – Ghana will attain full childhood immunization coverage of 80% by 4 June 1990 (Policy statement made by the Head of State to Mr James Grant, Executive Director, UNICEF).
- **Implementation plan** – The policy of the Ministry is to implement the primary health care strategy in phases. It is recommended to start with 5–10 districts (Ministry of Health, Ghana 1978).
- **Minuted decision** – District health management teams should introduce community registers in all communities (Regional Directors and Divisional Heads Conference, Accra, 1989).
- **Regulation or guideline** – All government health institutions will charge patients the full cost of drugs. The poor are to be exempt from paying hospital fees (Hospital Fees Legislative Instrument 1313, 1985).
- **Directive** – No Ministry of Health official should drive a Ministry vehicle without having a driving license (Circular from the Director of Health Services, Ministry of Health, November 1991).

Source: Asamoah-Baah (1992).

### How do policy-makers use research evidence?

Many types of evidence are available to policy-makers. Moreover, policy-makers create, select, use and interpret evidence in different ways at different stages of the policy process, and depending on the policy context and their personal beliefs and values. Research evidence is only one kind of evidence; policy-makers will also heed other types which may be less robust, for example, ‘expert’ opinions and views or less rigorous ‘think

pieces’ available through the Internet (Bowen & Zwi 2005). Research itself includes outputs from a range of study designs from randomized control trials (providing highly robust data on effectiveness), to systematic reviews, to qualitative and process research, which illuminates feasibility and acceptability issues. Research will be of varying degrees of rigour and quality; for policy-makers who may not be schooled in research it can be challenging to determine what research to trust. In addition, research results, particularly in the field of

HPSR, are often complex and nuanced, and rarely is there clear evidence that a particular policy or strategy is effective under all conditions. Policy-makers in low- and middle-income countries in particular will often have to draw upon research findings from elsewhere, and thus face complex questions regarding the transferability of conclusions from one setting to another. For all these reasons, evidence may be challenged. Significant capacities are therefore required to use research evidence in policy-making.

Results of studies exploring what factors facilitate or hinder the use of research evidence in policy-making are contradictory, making it hard to extract general lessons or conclusions (van den Heuvel, Wieringh & van den Heuvel 1997; Trostle et al. 1999; Gerhardus et al. 2000). A systematic review of decision-makers' perceptions of their use of evidence is somewhat instructive but is limited almost entirely to high-income settings (Innvaer et al. 2002). The authors examined 24 studies looking at facilitators of and barriers to research use, as well as the nature of 'use' reported by decision-makers. They found some striking similarities. Common facilitators include personal contact and timely and relevant research. Also mentioned were the need for clear summary recommendations, quality research that confirmed current policy and data on effectiveness. Community pressure and client demand were mentioned by a handful of studies. Conversely, barriers were cited as lack of personal contact, lack of timeliness and relevance, and mutual mistrust between the two 'communities' of researchers and decision-makers. Power and budgetary struggles, and political instability and high turnover of staff were also mentioned.

The role of research evidence may vary at different times in the policy formulation cycle. For example, the universal coverage policy in Thailand (see Appendix) was informed by evidence at multiple stages. Occasionally, use of evidence may be direct (i.e. the primary basis for policy formulation), but this is rare unless the research

is commissioned by the policy-makers themselves (the arrow linking the policy-making process to research priority-setting in the framework) (Innvaer et al. 2002). But research may often play a role in bringing a particular issue onto the policy-making agenda or in establishing the legitimacy of a particular policy concern. The final policy stage – evaluation – is usually neglected, or is conducted in-house and remains unpublished or inaccessible to the public domain. Interpretation of evidence (including determination of relevance, utility and quality) is often selective and influenced by a range of factors that include interpersonal relations, existing beliefs, political ideologies and institutional structures (Court & Cotterrel 2006). A recent prominent example is the use of evidence by President Thabo Mbeki to support his view on the causes of AIDS (see Box 6.1). Even compelling evidence may fall foul of political ideology and agendas. In the United Kingdom two reports with similar messages, but produced 20 years apart in different political contexts, met very different fates. The Black report (DHSS 1980), which provided extensive evidence of health inequalities in the United Kingdom, was dismissed by the incumbent Conservative government, while its successor, the Acheson report (Department of Health 1998), which was commissioned by the Labour government, reached similar conclusions and led to policy changes (Bowen & Zwi 2005).

In policy institutions that have election or reporting cycles to consider, the selective interpretation of evidence by both national and international policy-makers is partly a function of pressure on them to produce short-term outcomes. For example, pressures to illustrate success can lead to emphasizing the most positive findings, while negative or less positive ones are suppressed. Parkhurst (2002) has shown how the Ugandan government, striving to demonstrate a decline in HIV prevalence to secure donor funding, played up the results of a single district to imply that a nationwide decline in HIV seroprevalence had been achieved between 1989

and 1998. Furthermore, policy-makers dealing with multiple sectors must juggle a hierarchy of issues, which means they will often give greater weight to evidence on issues of security and macroeconomics than to those relating to public health or health systems. Finally, the nature and extent of democratic and political freedoms, including the independence of academic institutions and the media and the strength of civil society institutions, influence the independence of research and whether and how it can be used. There are many examples in which the media and advocacy groups have influenced the course of policy; these are dealt with in Chapter 6.

## How contextual factors affect the use of evidence in policy

As suggested above, there are many contextual factors outside the direct control of policy-makers which affect how research evidence is likely to be used. However, the government also plays a role in influencing the overall context and the incentives to use evidence. At the broadest level, this influence reflects the nature of democratic development and the openness and transparency of decision-making. A recent synthesis of studies suggested that government 'disinterest' in the use of research appeared strongest where the 'accountability gap' is greatest. More discrete measures to promote the use of evidence in policy were unlikely to be successful unless they were "part and parcel of comprehensive civil service and public policy reforms that emphasize professionalism, research-based innovation and participatory decision-making" (Livny, Mehendale & Vanags 2006).

Government regulations and/or traditions are likely to affect the nature of consultative and analytical processes. For example, some countries conduct formal consultations as part of decentralized planning processes, which enable a range of stakeholders to engage in policy development. Such processes may enhance transparency and lead to stronger demands for evidence-informed policy. Specific mechanisms can be put

in place to require that research evidence be reviewed as part of policy development. Guidelines in the United Kingdom, for instance, require departments to publish summaries of the evidence base for policy initiatives (Her Majesty's Government; UK, 2005)

A further contextual factor that affects research use concerns the nature of the broader health research system. Long lead times between identification of a topic worthy of investigation and the conduct and dissemination of the research; the time it takes to secure funding; and the lack of mechanisms for identifying health systems research priorities in the context of national health development may all inhibit the appropriate use of research evidence in policy-making.

Trust between researchers and policy-makers also emerges as a key factor bearing on the extent to which research evidence is relied on in policy-making, and case studies demonstrate the importance of personal relationships between policy-makers and researchers (see Box 7.2). Government policy may support the development of close relationships between these groups.

## Organizations involved in national policy-making and their capacity needs

### Organizations involved in policy-making

Institutions involved in policy-making vary widely between countries but include the following:

- Health ministries – These often have special units or departments, such as health policy units or health-planning divisions that have a particular focus on synthesizing evidence and using it to support policy development. In some contexts (as in Ghana) health research units have been established within health ministries as a means to coordinate research agendas and promote research capacity within the ministry.

## BOX 7.2 THE IMPORTANCE OF PERSONAL RELATIONS BETWEEN POLICY-MAKERS AND RESEARCHERS

The successful use of evidence in the development and implementation of Universal Coverage for Health Care Policy in Thailand was supported by a dense network of relations between researchers, policy-makers and politicians. Dr Suraphong Seubwonglee, MD and member of the Thai Rak Thai Party, linked Dr Sanguan Nittayarumphong, a proponent of reform, based within the Ministry of Health, to the leader of the Thai Rak Thai Party in 1999. Based on accumulated research knowledge, Sanguan produced a booklet promoting universal access to health care. After the idea was adopted, Sanguan contacted Viroj Tangcharoensathien, a health economist and researcher, who used to work with him at the Bureau of Policy and Planning, to revise the feasibility analysis previously conducted so that it reflected the newly proposed design of the system. This analysis made the policy look more feasible. Other research conducted by part of the same network of research professionals, including Dr Supasit Pannurunothai and the Health Systems Research Institute Research Committee on Universal Coverage, helped provide comparative evidence from other countries, which also shaped the policy. The shared careers and experiences, in this case, helped ensure trust between researchers and policy-makers.

Source: Pitayarangsarit & Tangcharoensathien (2007), Appendix 1.

- Other central government departments – Many government departments have a role to play in developing health policy, particularly ministries of finance, planning, labour, social welfare and local government. While such ministries have specific technical skills relevant to their mandate, few are likely to have the technical skills to undertake or even interpret health policy and systems research, and commonly have weaker links than health ministries to HPSR organizations.
- Parliamentary and executive bodies – These play critical roles in some political systems. Parliamentary committees provide checks and balances over policies promoted and implemented by health ministries, as well as budgetary oversight and approval. In Southern Africa, parliamentary committees analysed and made input on equity issues in the health budget (in the United Republic of Tanzania, South Africa and Zambia), and raised and promoted debate on issues of migration of health personnel and quality of health

services in Malawi (Equinet 2004). In more affluent countries, parliamentarians serving on such committees have their own research staff who track relevant research findings and liaise with civil society.

- Decentralized levels of government – In some systems, particularly those of larger states such as Brazil, China and India, there are highly decentralized roles, and local government, in various forms, may take major responsibility for health policy.

As discussed in Chapter 5, there are advantages and disadvantages to having research organizations embedded within policy-making bodies. The rationale for locating such units within policy-making bodies is that proximity to research experts encourages policy-makers to access and employ research evidence in decision-making. Also, research units located within policy-making bodies are more likely to undertake policy-relevant studies. However, there appears to be little evidence to support these theories. Furthermore, there are potential dangers

## BOX 7.3 THE IMPORTANCE OF INDEPENDENT RESEARCH

In 2002, after nearly three decades of reform efforts, Nepal's Parliament passed a liberal abortion law. It took a combination of research and human rights advocacy to force a policy change. Local nongovernmental organizations (NGOs), supported by international research agencies, joined forces with health workers and human rights groups to document the impact of unsafe abortion in terms of:

- preventable maternal deaths
- cost to the health sector
- gender-unequal enforcement of the abortion law.

No government-sponsored research programme would have addressed the issue despite the fact that an estimated 50% of maternal deaths were directly attributable to unsafe abortion.

Source: Thapa (2004).

associated with such a strategy. For example, research units established within policy-making organizations that depend on these for their governance and finance may find their research independence curtailed by this relationship. It is also important to maintain research capacities independent of government, as the case of the liberalization of abortion policy in Nepal illustrates (Box 7.3).

As noted in Chapter 5, however, some of the research institutions which appear to have been most successful in terms of providing policy-relevant evidence (such as the Health Systems Research Institute in Thailand and the National Institute for Public Health in Mexico) have roots in health ministries but largely maintain their independence.

### Capacity needs of policy-making institutions

The conceptual framework identified three dimensions of organizational capacity. We use these to consider the capacity needs of health policy institutions with respect to the use of evidence in policy-making.

### Leadership and governance

In order to use evidence in policy-making, ministries and other policy bodies need to have mechanisms and structures to commission research and syntheses from external organizations, and to ensure that the quality of commissioned products is high. Such processes depend on sufficient capacity – skilled staff and established processes for commissioning such products

Perhaps more important, and as highlighted earlier in this chapter, governance structures and accountability for decisions are likely to significantly influence the incentives for using evidence in policy-making. If there are incentives for the organization as a whole to use evidence in policy, then these incentives also need to be translated to individual units and staff members. For example, staff performance assessments could include appraisal of skills and behaviours with respect to evidence use.

Less tangible incentives to the use of evidence relate also to the culture of the organization. Case studies of countries that have been successful in creating a culture of evidence-informed decision-making (again,

such as Thailand (see Appendix) and Mexico) often suggest that strong leadership has been a critical factor behind this success. Such leadership can be important in establishing a culture that values evidence and ensuring adequate incentives for staff to use it. Strong leadership within policy-making bodies is also likely to have broader repercussions. As the previous chapters have illustrated, the effective use of evidence in policy requires the coordination of multiple actors; increasingly, policy development occurs through the repeated interaction of policy-makers, civil society organizations and researchers. While leadership for such policy networks could come from multiple sources, its most natural home is within the ministry of health. Strong leadership capacity within the ministry of health might therefore help ensure that research agendas are policy-relevant, that researchers feel motivated to communicate findings in a manner that is accessible to policy-makers and that civil society organizations invest in developing the evidence base behind their advocacy efforts.

At a wider level, government also has a responsibility to ensure that all four functions set out in the framework operate effectively and with due governance and accountability. For example, mechanisms are needed to ensure that research is conducted in an ethical manner; that educational policies incorporate provisions for HPSR training; that public sector pay recognizes the needs of the research community; that aid processes in low-income countries consider research needs, including capacity building; and that national-priority setting receives proper attention.

## Resources

The two key resources required in ensuring adequate capacity within policy processes are human and financial. Policy-makers and their advisers, wherever they are located, need a set of skills to enable them to use research in their policy and decision-making. In particular, policy-makers need to be able to:

- identify situations where research can help;
- articulate research questions for topics of policy-relevant research; and
- access and assess research findings and incorporate them in decision-making.

Capacity to do this may not require research degree qualifications, but it does benefit from a strong grounding in research, including, for example, different research approaches and methods, and issues involved in applying research findings from one context to another.

There is surprisingly little sound evidence about the capacities that policy-makers need in order to do a better job at using research. A self-assessment tool developed by the Canadian Health Services Research Foundation attempts to enable policy-makers to understand and address the organizational barriers to more effective use of research evidence (Box 7.4).

Recent work by the Alliance in Viet Nam has attempted to adapt this self-assessment tool for use by policy-makers in other contexts. Findings from Viet Nam indicate that policy-makers felt they had sufficient skills to employ research in their decision-making processes, but lacked the incentives to do so. Greater evidence is needed from different contexts to understand whether the key obstacles to evidence use are bureaucratic barriers and lack of incentives, or whether inadequate skills is the primary issue facing staff.

In some contexts, salary levels for civil servants compared to other professions are low, and this may cause retention problems for skilled staff. Ministry of health officials with a higher degree (and therefore stronger research skills) may also easily find employment domestically in think tanks or donor agencies, and overseas in international organizations or universities. Retention and motivation of skilled civil servants is a primary challenge for many low-income (and some middle- and higher-income) countries, and is likely to require attention to working conditions, public sector ethos and opportuni-

## BOX 7.4 TOOL FOR SELF-ASSESSING EFFECTIVE USE OF RESEARCH EVIDENCE

The tool focuses on four different aspects of organizational capacity, each with implications for staff skills.

### 1 Acquire research

Can the organization find and obtain the research findings it needs?

### 2 Assess research

Can the organization assess research findings to ensure they are reliable, relevant and applicable to you?

### 3 Adapt its format

Can the organization present the research to decision-makers in a useful way?

### 4 Apply it in decisions

Are there skills, structures, processes and the culture in the organization to promote and use research findings in decision-making?

Source: CHSRF (2005).

ties for career development, as well as better remuneration. These problems are analogous to those discussed in Chapter 5 and may require coordinated solutions.

Effective use of research evidence in policy- and decision-making requires financial resources. For example, resources are required to commission studies on specific topics, organize consultative meetings with civil society organizations and researchers, pay salaries to retain well-trained ministry of health officials and invest in ongoing staff development. Infrastructural development may also be necessary in areas such as Internet access. In least-developed health systems, lack of financial resources can be a significant barrier to being able to manage consultative processes. Further, where support for such processes is predominantly donor-provided, there may be limited government ownership of them (Livny, Mehendale & Vanags 2006).

In low-income country contexts, donors have commonly provided support to the development of research capacity and to strengthening information systems, but appear less likely to support the development of capacity in health ministries to acquire, assess and use evidence

in policy-making. The United Kingdom Department for International Development (DFID)-supported policy advisory units (see Chapter 5) seem to be relatively rare examples of such donor investment.

### Communication and networks

As previous chapters have illustrated, communication capacity and ability to network broadly with researchers and civil society organizations involved in filtering and amplifying work are increasingly core capabilities that health ministries and other policy-making bodies need to develop. Most governments have formal mechanisms to facilitate such communication. For example, government departments often establish ad hoc working groups or committees that allow them to access specific expertise for policy development. Governments may also work with knowledge broker organizations, such as the Regional East African Community Health (REACH) Policy initiative (see Chapter 6). With the development of civil society organizations and their enhanced role in advocacy, government officials also need the capacity to determine which stakeholders to listen to. As discussed

in Chapter 6, civil society organizations derive their legitimacy from different bases, and policy-makers need to understand the source of a particular civil society organization's legitimacy and determine accordingly how seriously to take its arguments. In addition, policy-makers need to be able to communicate effectively with their counterparts in other government bodies and departments in order to share relevant research evidence and knowledge.

## Strategies to enhance capacity to use evidence in policy-making

Ultimately, the use of evidence in policy-making requires the coming together of multiple different processes; accordingly, strategies to promote the use of evidence in policy can operate at different levels. Box 7.5 groups and summarizes the main strategies identified and the key actors likely to be responsible for them. The following sections of this chapter are grouped by these sets of interventions.

In advance of embarking upon capacity development strategies, a country-wide assessment of existing capacities and constraints might enable the identification of key problems and the wise targeting of resources. A framework such as that presented in Chapter 3 could help guide such an assessment.

### Enhance supply of policy-relevant research products

As described earlier, a number of factors associated with the overarching health research system prevent the effective use of evidence. Improvement is brought about by strengthening priority-setting processes, particularly for health policy and systems research, and ensuring that funding follows identified priorities. Policy-makers, researchers and research funders need to commit to participating jointly in priority-setting processes and to

abiding by the results. The particular challenges around priority-setting were discussed in Chapter 4.

In many instances, however, policy-makers are unlikely to act on a single research study; multiple sources of research evidence need to be brought together. In light of this, the current trend of requiring researchers working on a particular study to produce policy briefs and engage policy-makers may be misplaced. While occasionally policy positions will be influenced by a single study, far greater investment needs to be made in the development of transparent and short research syntheses for policy-makers. While the evidence-based medicine movement has brought major changes to how clinical decision-making is approached (Rosenberg & Donald 1995), policy-making has not kept pace. As noted in Chapter 5 further methodological development is needed in this field.

In addition, systematic reviews and policy briefs need to be made easily accessible – ideally, at least for those with Internet access, via the World Wide Web. There is currently a proliferation of Web portals providing evidence relating to health systems (for example, see Eldis health systems dossier,<sup>1</sup> World Bank online resource centre<sup>2</sup>). While these Web sites can provide a useful service, the criteria used to select research articles, and the methods used to create briefs and dossiers, are not always apparent. Consequently, policy-makers are hard put to assess the reliability and generalizability of the findings presented. One study, of government-run Web portals which link to websites on health, concluded that information available via such portals was unlikely to be based on systematic reviews and was often unclear, incomplete and misleading (Glenton, Paulsen & Oxman 2005).

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<sup>1</sup> <http://www.eldis.ids.ac.uk/go/topics/resource-guides/health-systems> (last accessed 22 August 2007).

<sup>2</sup> <http://web.worldbank.org/WBSITE/EXTERNAL/TOPICS/EXTHEALTHNUTRITIONANDPOPULATION/EXTHSD/0,,menuPK:376799~pagePK:149018~piPK:149093~theSitePK:376793,00.html> (last accessed 22 August 2007).

## BOX 7.5 SUMMARY OF STRATEGIES TO ENHANCE CAPACITY TO USE EVIDENCE IN POLICY-MAKING

| Area of intervention   | Types of interventions   | Key actors |        |            |
|--|--|------------|--------|------------|
|  |  | Government | Funder | Researcher |
| <b>Enhance supply of policy-relevant research products</b>                       |  |            |        |            |
| Ensure relevance of HPSR research  | Promote joint priority-setting exercises   | ■          | ■      | ■          |
| Increase production and accessibility of evidence-based briefs                   | Support development of policy briefs   | ■          | ■      | ■          |
|  | Support development of systematic reviews  | ■          | ■      | ■          |
|  | Archive briefs, evidence syntheses and research summaries in an easily accessible form (e.g. on-line databases)  | ■          | ■      | ■          |
| <b>Enhance capacity of policy-making organizations to use evidence</b>           |  |            |        |            |
| Strengthen individual staff skills and institutional behaviours                  | Provide training or mentoring in use of research evidence, commissioning of research studies and briefs  | ■          | ■      |            |
|  | Create stronger incentives for evidence use (e.g. through performance assessments, staff appraisals and leadership programmes)   | ■          |        |            |
| Increase financing for functions related to evidence use                         | Secure donor funding or raise government revenues to support development of policy analysis units, or perhaps research units within government bodies                        | ■          | ■      |            |
| Enhance access to evidence   | Improve access to research resources through improved Internet access, development of low-cost databases of research evidence (such as HINARI)                               |            | ■      |            |
| <b>Establish new organizational mechanisms to support evidence use in policy</b> |  |            |        |            |
| Develop and support knowledge broker capacity                                    | Establish knowledge broker organizations in or outside of government, such as NICE (United Kingdom), REACH (East Africa), health technology assessment units, CHSRF (Canada) | ■          | ■      |            |
|  | Establish networks (such as EVIPNet) to support knowledge broker-type functions through training and exchange of experience  | ■          | ■      |            |
| Build health research capacity in, or close to policy organizations              | Establish health systems research units in health ministries or in organizations with links to ministries  | ■          | ■      |            |

## BOX 7.5 SUMMARY OF STRATEGIES TO ENHANCE CAPACITY TO USE EVIDENCE IN POLICY-MAKING

| Area of intervention  | Types of interventions   | Key actors |        |            |
|---|--|------------|--------|------------|
|   |  | Government | Funder | Researcher |
| <b>Promote networking</b>   |  |            |        |            |
| Establish institutional mechanisms that promote exchange between research and policy worlds | Revolving door mechanisms whereby policy-makers spend time in research organizations and think tanks   | ■          |        |            |
|   | 'Shadowing' [i.e. observing a professional researcher or policy maker at work] and job swaps   | ■          |        |            |
|   | Develop databases of researchers active within the country, including their skills and areas of interest   |            |        | ■          |
|   | Encourage regional networks such as Equinet  | ■          | ■      |            |
| Encourage mechanisms that bring technical expertise into government                         | Encourage the establishment of special commissions or technical advisory groups  | ■          |        |            |
| Conduct special events or meetings that bring key actors together                           | Run 'safe harbour fora' or other policy-oriented events that bring policy-makers, researchers and civil society together to discuss evidence and policy issues |            | ■      |            |
| Require policy-maker participation in research  | Ensure that recipients of major research grants are required to engage regularly with policy-makers  | ■          |        |            |
| Establish norms and regulations   | Support legislation that requires publication of evidence base for new policies  | ■          |        |            |
|   | Mandate evaluation of new social and health programmes   | ■          |        |            |
|   | Integrate operational research and evaluation into existing processes and programmes   | ■          | ■      |            |

### Acronyms:

|         |   |
|---------|---|
| CHSRF   | Canadian Health Services Research Foundation              |
| EVIPNet | Evidence-Informed Policy Networks                         |
| HINARI  | Health InterNetwork Access to Research Initiative         |
| NICE    | National Institute for Health and Clinical Excellence     |
| REACH   | Regional East African Community Health Policy Initiative. |

■ A square indicates the actors with primary responsibility for pursuing the intervention, but successful interventions may require collaboration between governments, funders and researchers.

## Enhance capacity of policy-making organizations to use evidence

Skills in using evidence may be improved through training and development programmes for policy-makers and other policy agents. For example, in Ghana in the 1990s there was recognition that, despite a long tradition of health research in the country, policy-makers were generally unaware of its usefulness. The then Director of Medical Services set up a programme to sensitize and motivate policy-makers and programme managers to the importance of studies. A series of 'consultative meetings' were held to demonstrate relevance by showcasing examples of operational research conducted by universities, research institutions and the ministry of health that had helped to solve problems and inform policy. For example, one study (Dovlo et al. 1990), addressed issues regarding clients' dissatisfaction with government health services. This study and subsequent discussion led to client perspectives of quality of care becoming one of the main pillars of health reforms in Ghana. Surprisingly, the review of capacity development initiatives in Chapter 3 found relatively few initiatives targeted at developing skills in using evidence. Training courses on health system issues, such as the World Bank Flagship course, typically aim to enhance knowledge rather than build skills in using research.

It is also important that policy-makers feel they can request short and accessible research summaries rather than long, detailed reports which are likely to remain unread. In the United Republic of Tanzania, policy on malaria only changed after evidence was made available to policy-makers in an accessible way. While the increase in chloroquine-resistant malaria had been documented by researchers for 10 years, the lengthy periodic reports submitted to the Ministry of Health were routinely ignored. Eventually researchers produced a short, snappy policy brief, and the result was almost immediate action (de Savigny, personal communication, 2007). In this case

it was the researchers who acted, but policy-makers can proactively demand such briefs.

Building on the discussion in Chapter 6, policy-makers also need skills to manage advocacy and civil society groups and determine which groups to listen to.

Competence in using evidence needs to be complemented by availability of relevant evidence; this cannot be taken for granted in all countries, particularly those with poor Internet access. In Viet Nam, for example, policy-makers' self-assessment was that, although they had access to studies and evidence via the Internet, the quality of access was poor.

Finally, as observed earlier, enhancing skills and organizational capacity to obtain and use evidence in policy may be of limited value without incentives. While many incentives operate in the broader environment (and not at the organizational level), there are specific things that organizations can do to encourage evidence use. These include using evidence as a dimension in staff performance assessments and providing resources to policy units to enable them to draw on evidence.

## Establish new organizational mechanisms to support use of evidence in policy

Some of the best examples of cultivating organizations dedicated to supporting evidence use in policy come from high-income countries. In the United Kingdom, the government established the National Institute for Health and Clinical Excellence (NICE), which has been seen as a "policy embodiment of evidence-based medicine" (Sheldon et al. 2004, p. 1). NICE's mandate and processes are described in Box 7.6. There is increasing interest in the development of such mechanisms in other countries. For example, the REACH initiative in East Africa (see Chapter 6) aims to establish a new organization with a mandate to collate, summarize and package research evidence relevant to policy concerns

## BOX 7.6 NATIONAL INSTITUTE FOR HEALTH AND CLINICAL EXCELLENCE, UNITED KINGDOM

The National Institute for Health and Clinical Excellence (NICE) was established by the United Kingdom's Department of Health in 1999 to improve standards of care and to reduce inequalities in access to new treatments. It was established partly from pressure to make better use of research evidence generated both by the national health system's own Research and Development Programme, as well as internationally. Specifically, NICE's objectives are to identify best practice and advise health professionals on which treatments work best and are cost-effective. NICE produces 30–50 guidance publications each year for health providers. Its procedures for developing guidance on public health interventions or programmes involve a wide range of stakeholders and a systematic review of published evidence. The steps are shown below.

### 1 Topic selected

The intervention/programme topic is referred to NICE by the Department of Health.

### 2 Stakeholders register interest

Potential stakeholders are asked to register an interest. Stakeholders may include national organizations representing professionals, research and academic institutions, industry and special interest groups from the general public. Stakeholders are consulted throughout the guidance development process.

### 3 Scope prepared

The scope sets out what the guidance will – and will not – cover, and outlines the review process. After a consultation period the scope is finalized.

### 4 Evidence reviewed

A synopsis is prepared, with an evidence review and economic appraisal of the intervention/ programme. The evidence review may be done by NICE or by a contracted research body. Stakeholders comment on the synopsis.

### 5 Draft intervention guidance prepared

The Public Health Interventions Advisory Committee (PHIAC) reviews the synopsis and produces draft intervention/programme guidance.

### 6 Consultation on the draft guidance

There is a one-month consultation period on the draft guidance.

### 7 Fieldwork carried out

The draft guidance is also field-tested. A series of fieldwork meetings are held with practitioners not previously involved in developing the guidance. The meeting reports are combined into a technical report which is submitted to PHIAC.

### 8 Final guidance produced

PHIAC reviews the technical report and comments from the consultation, and produces the final guidance.

### 9 Guidance issued

After peer review, NICE formally approves the final guidance and issues it to the national health system.

Although the actual implementation of NICE guidance notes is variable (depending on the environment in which they are being implemented, the support given to providers and costs), NICE's role is considered critical in synthesizing medical research evidence to directly guide policy and practice.

Source: Sheldon et al. (2004); NICE website: <http://www.nice.org.uk> (last accessed 22 August 2007).

## BOX 7.7 GOVERNMENT COMMITTEE AND RESEARCHER INTERACTION: EXAMPLES FROM THE UNITED KINGDOM

In the United Kingdom, academics are frequently called to give evidence to a range of government committees – either through ad hoc meetings with ministers or policy advisors, or more formally through presentations to select committees or parliamentary hearings. These usually take place at the policy formulation stage when government is consulting and asking for ‘expert opinions’, though they can also occur when an existing policy is being reviewed. Formal requests to present at select committees are government-initiated, but it is possible for other actors to initiate other types of public consultations.

Another example involves a coalition of NGOs and academics wanting to increase the United Kingdom Government’s commitment to expenditure on family planning commodities in support of the Millennium Development Goals. The coalition suggested and secured a parliamentary hearing on ‘The Impact of Population Growth on the MDGs’, which resulted in subsequent amendments to Department for International Development policy documents and mention of the importance of supporting population policies, particularly in Africa, in parliamentary debates and speeches.

Source: Mayhew, Personal communication, 2007.

and present this in a timely fashion to policy-makers (van Kammen, de Savigny & Sewankambo 2006). Such knowledge brokers are primarily intended to act as bridges between policy- and decision-makers on the one hand, and researchers on the other; they are discussed more fully in Chapter 6. Knowledge brokers may be embedded within government offices or be more independent. For example a recent survey of more than 400 knowledge brokers in Canada found that 30% were working in universities, 10% in foundations or research funding agencies, and the remaining 60% in different levels of the health system (Lomas 2007).

### Promote networking

In many countries, the border between the research and policy sectors is a fluid one. In South Africa, leading academic health research institutions, such as the Centre for Health Policy at the University of Witswatersrand in Johannesburg, train students who then go on to assume

posts in health-related ministries and departments. Similarly, specialist institutions like the London School of Hygiene and Tropical Medicine in the United Kingdom have alumni throughout DFID and other government health agencies. This enhances research-related capacities of government institutions and can facilitate academics’ access to policy processes. A study in the Lao People’s Democratic Republic noted that at the national level, the “blurred line between researchers and administrators” could work to the advantage of efforts to promote the use of evidence in policy (Jonsson et al. 2006).

Some international programmes promote networks between researchers and policy-makers. For example, the International Health Policy Programme (see chapter 3) required that each research team identify a local policy advisor to advise the project; while partly aimed at ensuring policy relevance, this strategy had the added advantage of strengthening policy-maker/researcher

networks. Simple initiatives that governments in low-income countries can take to encourage the development of such networks include policies that support secondments, job swaps and shadowing between the two communities.

Too often interaction between researchers and policy-makers depends on personal relationships. Establishing formal processes of exchange and communication between researchers and policy-makers may help to mainstream the role of research evidence in policy processes and promote the sustainability of interactions. While developed countries typically have a number of expert committees at parliamentary, department or ministry levels that call on or commission research (see Box 7.7 for an example), in less developed (or less democratic) countries few such mechanisms may exist.

Standing committees or advisory groups may also be established in less-developed countries; for example, the Bill & Melinda Gates Foundation is supporting the development of capacity at the country level to provide independent, scientific advice on vaccines and immunization programmes through the development of expert advisory bodies.<sup>3</sup>

While there are a range of alternative advisory models that could be employed by policy-makers, it is not clear whether one model is more effective than others or which models suit which decisions.

### Establish norms and regulations regarding evidence use in policy-making

Some agencies and low- and middle-income countries have tried to incorporate research formally into policy processes. In Ghana, for example, the annual 'partners meeting' (of government bodies, donors and imple-

menting NGOs) was used as a vehicle within which to develop a formal entry point for research evidence from both routine ministry sources and independent sources, to become part of the health policy process. Its structure is shown in Box 7.8, which also summarizes the experience of Mexico in requiring evaluative evidence of the effects of social programmes.

While national governments can do much to establish norms and regulations that support the development and use of research evidence, this is also an area where international actors need to be more active. There is increasing recognition of how health system constraints impede progress in scaling-up service delivery, and several agencies, such as GAVI and the Global Fund to Fight AIDS, Tuberculosis and Malaria, have begun to focus on this area; rarely has such investment in health system-strengthening programmes been routinely accompanied by research and evaluation both to document the effects of the strategies supported and to learn lessons. Support for evaluative and operational research should be part of the norm for funders of health systems.

## Conclusions

While multiple strategies to strengthen capacity for use of evidence in policy-making have been outlined in this chapter, discrete interventions may have somewhat limited effect unless accompanied by broader reforms in civil service culture, and potentially supported by stronger demands from civil society groups, in terms of enhancing transparency and accountability in policy processes. The strategies pursued in any particular country to promote evidence use need to be rooted in an understanding of the broader political context. For example, there may be limited returns to investing in skill-building for policy-makers or improving policy-maker access to resources, if in the end evidence is not valued and politics will always trump efforts to increase capacity. In such contexts, twin strategies may be necessary, involving enhancing civil

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<sup>3</sup> [http://www.gatesfoundation.org/GlobalHealth/Grantseekers/RFP/RFP\\_Vaccines.htm](http://www.gatesfoundation.org/GlobalHealth/Grantseekers/RFP/RFP_Vaccines.htm) (last accessed 22 August 2007).

## **BOX 7.8 ESTABLISHING NORMS AND REGULATIONS REGARDING EVIDENCE USE IN GHANA AND MEXICO**

### **Incorporating research into health sector review processes in Ghana**

In Ghana, the Ministry of Health and Partners Summit is the main policy-determining platform where decisions affecting the health sector are jointly made by the MoH and its agencies, such as the Ghana Health Service and other stakeholders. Two summits are held each year. The first receives and discusses a report from an independent review team on the performance of the sector in the previous year. At the second, stakeholders discuss performance for the first half of the current year and pledge financial support for planning and budgeting. A summary 'aide-memoire' of discussions and recommendations is produced. Reports and aide-memoires are available on the Internet.<sup>4</sup>

The summit has created a demand for information for decision-making. The process brings together information needed to assess implementation of MoH policies and strategic plans as well as identifying issues requiring the development of new policies and guidelines.

### **Mandating evaluations in Mexico**

The large-scale Mexican conditional cash transfer programme Progresa was designed in 1997 during the Zedillo administration as a part of a poverty reduction agenda. The programme's sustainability was a concern. Previously, it was common for each new administration to establish its own social programmes. Thus, it was likely that the change of administration in 2000 meant that Progresa would be cut. To ensure the programme's survival through political changes, it needed to demonstrate positive impact. What followed was an impressive and rigorous randomized controlled effectiveness evaluation of the large-scale social welfare programme that initiated important changes in the design of social policy. The evidence of its positive impact was strong and contributed to the new administration's decision to expand rather than curtail the programme.

Moreover, after release of the external evaluation to the public, the Mexican Congress issued a law in 1999 requiring social programmes to carry out annual impact evaluations, preferably by external evaluators. This set in motion important changes to the design of social policy in Mexico from being driven by individual and political interests to being driven by evidence. Furthermore, substantial financial resources were dedicated to back the mandate, and the evaluation results were used to allocate resources. This provided incentives for programme managers to design innovative but conceptually sound programmes, which would be evaluated to determine whether they merited expansion. The law and funding effectively built evaluation into the management, planning and resource allocation processes for large-scale social welfare programmes – and provided incentives for innovation and effectiveness. Evaluation became an opportunity for learning and benefit, rather than a threat or judgment.

Sources: Ministry of Health, Ghana (1999); Barber (2007).

<sup>4</sup> <http://www.danida-health-ghana.org> (last accessed 22 August 2007).

society organizations' access to information, while at the same time working with policy-makers to convince them of the advantages of using evidence to inform policy.

Other things being equal, policy-makers are likely to accord more trust to research evidence coming from national institutes, and country-specific research findings are likely to be better tailored to the country's own needs and take into account the country context. These observations underline the importance of investing in capacity to generate health policy and systems knowledge at the country level. However, it is unlikely that all policy questions can be addressed through locally conducted research (especially for HPSR, where the existing evidence base is limited); and in most cases policy-makers seem to prefer to rely on multiple sources of evidence – coming from their own country, but supported by evidence from elsewhere. This suggests that, in addition to developing local capacity for HPSR, we need to invest in syntheses of the global research literature. Increasing policy-makers' access to and use of research from other countries requires a better understanding of the generalizability of that research; and multicountry studies are required to analyse how context influences the effectiveness of different policy options.

Policy-makers' capacity to understand and use research has been neglected, both as a research topic and as an area of investment in terms of promoting evidence-informed policy. For example, in terms of research, more evidence is needed on how organizational distance from government affects the relevance of research conducted, the independence of such research and trust between policy-makers and researchers. Similarly, a variety of technical advisory mechanisms are available to governments seeking to draw evidence into policy-making in a more formalized manner, but there is limited information about their comparative advantages. Finally, but perhaps most critically, there is a surprising lack of data as to the real capacity constraints facing the use of evidence in policy: to what extent is the lack of incentives the most critical barrier (versus lack of skills or lack of organizational capacity)? To develop effective programmes in this area, ensure wise investment in promoting evidence-informed policy, and ultimately sound policy choices, a great deal more sound data are required.

