Review of Local and Global Practices On Evidence-Informed Health Policy: Recommendations for Ethiopia

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Summary

This report outlines recommendations to inform evidence-informed health policymaking in Ethiopia. Recommendations were identified through key informant interviews in Ethiopia and based on literature review, and case studies from Thailand, Rwanda, Mexico, Kyrgyzstan, and Ethiopia’s Agricultural Transformation Agency. The cases represent environments, institutions, or both in support of evidence generation and use for policy.

There are a number of different ways the Federal Ministry of Health (FMoH) can build capacity for policy analysis and evidence use in creating health policy. Developing functional knowledge management will facilitate using existing evidence, and help with understanding the current scope and state of research. This is essential, but it will not facilitate evidence use on its own. Creating a Health Policy Analysis Unit (PAU) is key. The institutional arrangements of the PAU are critical to ensuring establishment of a capable unit that proactively generates and reviews evidence and health policy. The unit should be formed based on a comprehensive long-term strategic plan that includes sustainable funding mechanisms. There are advantages to creating this unit as an independent institute, but this could also be created within the Minister’s office of the Ministry of Health, under the direct oversight of the Minister, with the long-term strategic goal of becoming an independent institute.

Inclusive research coordination and priority setting mechanisms will help to meet the FMoH’s research needs, limit research duplication, and improve resource use. Using existing mechanisms to more effectively link universities and the FMoH, such as FMoH staff training programs within universities, engaging academics in existing programs and forums, and promoting academicians to take positions in FMoH, are some important means to improve academic – policymaker links.

Direct access and close relationship between researchers and policy analysis unit staff and the Minister, State Ministers, and other high-level officials will help to facilitate evidence use.

Finally, commitment of leaders is critically important to developing policy analysis and knowledge management functions, and to fostering a practice of evidence use in updating existing health policies and developing new policies moving forward.
I. Introduction

Evidence use in health policy helps to support proven methods to maximize health benefits and minimize costs. Using evidence in health policy is a complex process. This is reflected in the Ethiopian context, where a number of different challenges influence evidence use in health policy. Improving use of evidence in health policymaking requires improvements in multiple areas to build structures and an environment supportive of evidence-informed health policymaking.


Policymaking depends on multiple factors including political, historical, cultural, and other context specific factors (1,2,3). Due to this complexity, the presence of high quality evidence does not necessarily result in direct translation of the evidence into health policy (4,5). Because of this, evidence-informed health policy (rather than evidence-based health policy) is considered as a more appropriate description of how evidence is used in health policy (6,7).

This document outlines a framework for structures and capacities supportive of evidence-informed health policy. This is followed by analysis of challenges constraining evidence use for health policymaking in the Ethiopian context and their root causes. It also reviews lessons from case studies on evidence use for health policymaking. The central section of the document presents recommendations for functional evidence-informed health policymaking processes and practices for Ethiopia, and concludes with a summary of key messages.

What is evidence?
“Evidence: The available body of facts or information indicating whether a belief or proposition is true or valid”
(Oxford English Dictionary)

Evidence is usually understood as research or analysis, but can be based on other forms of facts: observations, knowledge, and information (9). Expert opinions, may be based on

What is health policy?
“Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society.”
(World Health Organization)

Health policy is inclusive of health-related directives beyond those entitled ‘policy’ that aim to achieve healthcare goals. Other definitions specify that health policy is primarily a role of government in the health system (9).
II. Methods

This research relied on in-depth interviews, review of published and grey literature, and documentation of lessons from selected countries. Sections on Ethiopia and country case studies are based on in-depth interviews. Interviews were conducted in June and August of 2015 by researchers from the Harvard T.H. Chan School of Public Health. Twenty-three in-depth interviews were conducted in Ethiopia. In-depth interviews were based on a semi-structured interview guide. No names were collected, but institutional affiliation was recorded. Interviews were hand-written instead of recorded to increase key informants’ comfort. In hand writing notes, articles and conjunctions were removed. These were added back into quotes within the text. No additional changes were made. Interviews were conducted in-person in Ethiopia and Rwanda and by phone and Skype in the cases of Mexico, Thailand, and Kyrgyzstan. The reports on Mexico, Thailand, and Kyrgyzstan are based on interviews complemented by information extracted from review of published and grey literature.
III. Framework for Evidence-Informed Health Policy

Because of the complexities in using evidence in health policy, the ability to generate evidence-informed health policy is usually not the result of a single improvement or intervention (6,7,2). Three factors support greater use of evidence to inform health policy:

1. **Structures**: institutions and institutional mechanisms
2. **Capacities**: institutional and individual skills and competencies
3. **Links**: to overcome researcher-policymaker divides (8,9,14).

Figure 1 outlines a framework for supporting evidence-informed health policy.

**Figure 1: Framework Supporting Evidence-Informed Health Policy**

For these functions to exist, institutions, individuals, and the environment need to be developed (1,23). Institutions include research institutions, government institutions and the media, and rely on leadership and resources. Individuals include researchers and policy makers. Researchers require technical competencies, but also skills in communicating to policy makers. Policymakers need political and policy-making skills and also need to be able to understand research. For individuals and institutions to use evidence in health policy, they must have networks and communication mechanisms and skills. Networks and communication facilitate linkages both between researchers and policy makers and within these groups to support the use of evidence in health policy. This is also connected to an environment that facilitates the use of evidence in health policy generation. Based on the literature, it is the environment, and how transparent the policy making process is that impacts the extent to which evidence is used (1).
IV. Role of Researcher-policymaker, Leadership and Research Grant for Evidence-informed Health Policy

4.1. Links to overcome researcher-policymaker divides

Structures and capacities alone are not sufficient to facilitate evidence use. Links between structures, in the form of networks and exchange between institutions and individuals, are a fundamental feature of successful evidence use in health policy (4,9,11,12). Particularly important among these are links between the key groups involved in evidence-informed health policy: researchers and policymakers (4,9,10). Each of these groups has different goals, training, motivation, values, interests, and organizational structures. If differences are not overcome, it can be difficult for evidence to significantly influence health policy. Strong links between the two groups are defined by formal and informal connections, trust, bridging language gaps, creating timeframes that work for both researchers and policymakers, and research that asks policy-relevant questions (9,11).

Figure 2: A baby visiting a health facility for well-child care

Improving links between policymakers and researchers aims to facilitate increasing the supply of policy-relevant research and the demand for this research from policymakers (13,14). While links and proximity between policymakers and researchers are important, it is also important that researchers, and policy analysts, have autonomy from policy makers so that political interests do not dominate technical work or processes (9,15,16). Supply, demand, proximity, and autonomy are key concepts in developing the use of evidence in health policy.

Interviewees in Ethiopia indicated that there is currently distance between policy makers and researchers, and that this results in challenges with evidence use. Ethiopia has numerous existing opportunities to utilize in order to consistently and effectively integrate resources found in universities, professional associations, and other research institutions into existing consultative platforms (Joint Annual Assessments, various technical working groups, The Annual Review Meeting (ARM), and the National Health Research Council (NHRC)).

Increasing both the number of academics working in the FMoH and employment crossovers between academia and the Ministry can enhance collaborations between the two. In Mexico, interviewees cited academics going into MoH positions as one of the key factors in increasing the practice of evidence use within the Ministry. In Ethiopia, several interviewees cited this as a potential opportunity to increase the use of evidence and reduce gaps between the FMoH and researchers. It could also be possible to use graduate public health training programs as an opportunity to increase the link between...
the FMoH and academia. In Rwanda, the Ministry of Health, under the leadership of the Minister, works to ensure all staff members have at least a master’s degree. The School of Public Health at the University of Rwanda, works with the Ministry of Health in designing research and, as part of grants, sets aside a budget for students to use data collected within the Ministry for their student research. In Rwanda, researchers and NGO staff that work in research and evidence generation have direct access to the Minister of Health and other high-level officials. These direct relationships between researchers and policy-makers reduce the barriers between policymakers and researchers and increase the pathways for evidence translation. This also helps to build trust between researchers and policymakers.

4.2. Interests and leadership

At times, political and economic interests can derail evidence use in health policy (17,18). Leadership within government and institutions is critical to prevent these interests from overwhelming evidence use, and to develop the structures, capacities, and policymaker-researcher links that help to create an environment that facilitate evidence-informed health policymaking (1).

Figure 3: Health workers and health facility management discussing on their facility data

Strong leadership from the highest levels is necessary to ensure that the generation of evidence is free from political motivations, and to confirm that structures for unbiased evidence use are in place. The Rwandan case clearly demonstrates this, and high-level leadership was also a critical factor in every other case study. In the Rwandan context, this means that policies and strategies are not accepted if they are not backed up by evidence. In addition, efforts had to be made to build acceptance of evidence that was not in line with original plans or interests. In Kyrgyzstan, leadership was also central to building the Health Policy Analysis Unit (HPAU) and building the practice of using evidence and policy recommendations coming out of the unit.

4.3. A grant-making body to increase the research supply

In Thailand, the establishment of the Health Systems Research Institute (HSRI), a grant-making organization established with Rockefeller Foundation’s funding, helped spur research supply, which was key to building the environment for evidence use. A key feature of this institution is that it allowed local decision-making about who would get grants, based on national research priorities. Ethiopia could consider seeking funding for a similar domestic grant-making body, which would promote both greater funding of research and increased domestic voice in which research is funded.
V. Case Studies of Experiences in Evidence-Informed Health Policy

This section summarizes experience from Thailand, Ghana, Mexico, Kyrgyzstan, Rwanda and Ethiopia’s Agricultural Transformation Agency (ATA). Summary descriptions of lessons from these countries is found in the Annex (Table 1).

**Thailand**

Thailand has multiple institutions working on evidence generation, policy, and advocacy for health. The country also has a universal health plan, known as the “30 baht scheme”, that fills the gaps between numerous social and collective insurance schemes to provide universal healthcare (49). The scheme was developed by technical experts, and promoted by a political party that used it as part of their platform to win election (49,50).

Thailand has many institutions involved in evidence use for health policy. This includes professional associations, civil society, and NGOs. Organizations have functions in funding, research coordination, evidence generation, and advocacy (1). The development of each of these key functions is an important component of institutional development in Thailand. Many of these organizations spun off from the Health Systems Research Institute as gaps related to the use of evidence in health policy became clear. The Health Systems Research Institute began as an institute conducting and coordinating Health Systems Research and has gone through several iterations. It now functions primarily as an agenda setting, research coordination, partner development, and a funding agency (1,52).

The International Health Policy Program (IHPP), established under the Health Systems Research Institute and the Ministry of Health (MoH), is promoting policy-relevant health systems research and has built capacity to do policy-relevant health systems research (1,53). The Thai Health Promotion Foundation (ThaiHealth), funded by Thailand’s alcohol and tobacco excise taxes, conducts evidence generation, policy advocacy, and awareness creating activities. ThaiHealth is governed by a board chaired by the Prime Minister and co-chaired by the Minister of Public Health and an independent expert (1,54).

**Ghana**

Ghana’s experience is an example of the political nature of health policy-making. The Ghanaian government had a mandate to ensure implementation of social health insurance. A technical panel was formed to put together a plan on how to implement the social health insurance scheme (55). The technical panel developed a technical document that did not meet the parameters set by the government, which the panel felt were not technically sound (56). Decision makers were unhappy with the panel’s work and removed the head of the panel (a technical expert), later replaced with a political appointee. Gradually, technical experts on the panel left or were removed and replaced by political appointees (55,56). The resulting panel produced an insurance scheme that was accepted by decision makers and was enacted. The implemented package has challenges, particularly with regard to financial sustainability (56).

**Mexico**

Mexico has made several achievements in evidence-informed health policy. The implementation of the social insurance scheme - Seguro Popular - is the most well-known of these (57). Beginning in the 1980s, Mexican academics began working in high-level positions within the Ministry of Health. After working in the Ministry of Health, they returned back to academia. This built the capacity of the Ministry of Health for using evidence and the built the capacity of academia in presenting research findings in a policy-acceptable manner and translating research finding into policy actionable terms.

In addition, in the mid-1980s, Mexican Health Foundation (Funsalud) was established. This is a private institution with the broad vision of contributing to health improvements in Mexico by identifying problems, conducting research, and designing solutions (58). Around the same time, Mexico’s National Institute of Public Health (INSP) was established under the Ministry of Health. INSP is a research and training institution with a specific interest in translation of evidence into practice. The institute covers multiple research disciplines across medical, public health, social sciences, and basic sciences (60). The presence of institutions that help in generating evidence, commitment of technically capable individuals, and procedures that support evidence use facilitated evidence-informed policymaking in Mexico.
Kyrgyzstan

Kyrgyzstan's Health Policy Analysis Center (HPAC) was developed amidst the implementation of broad health sector reform and a sector-wide approach (SWAP). The Minister of health at the time wanted evidence on the effectiveness of reforms being implemented (37).

To facilitate this, the HPAU was formed under the World Health Organization with funding from DFID. There was flexibility in the funding, which allowed the unit to respond to emerging issues (19). The unit was staffed with masters-level researchers with backgrounds in public health, health financing, and health systems. A technical expert from the WHO helped with technical capacity building on a day-to-day basis and with structuring overall training for staff.

Rwanda

Rwanda has had a number of successes with the use of evidence for health policy. Two particularly relevant examples are in developing its community health insurance scheme premium mechanism, which the government adjusted based on evidence, and performance-based financing, in which compensation is based on data collected through the Health Management Information System (HMIS). Rwanda uses routine data, the Demographic and Health Survey (DHS), international evidence, and locally collected data, in the development of policies and strategies. Leadership from higher government bodies, including the Minister of the Ministry of Health, promote evidence-informed policymaking in the country.

Ethiopia's Agricultural Transformation Agency (ATA)

The Agricultural Transformation Agency in Ethiopia was an initiative of the late Prime Minister Meles Zenawi, with funding from the Bill & Melinda Gates Foundation. The agency intends to accelerate agricultural development in Ethiopia through identifying systemic bottlenecks by conducting research and rigorous analysis of evidence, provide implementation support for the agriculture sector, and coordinate stakeholders.

The ATA's functions include analyzing policies, providing information in policy-relevant terms and language, and conducting research. The ATA is a government-affiliated organization and has a direct accountability relationship with the Ministry of Agriculture. The agency takes a management consulting problem-solving approach; much of the staff come from management consulting backgrounds. Many of ATA's functions look similar to the functions the FMoH aims to create.
VI. Ethiopia’s Context in Evidence-Informed Health Policy

Based on key informant interviews in Ethiopia, problems associated with evidence use and policy analysis, and the root causes of the identified problems were analyzed from the recurring themes in the interviews. The identified problems were then broken down into sub-components by continually asking, “why is this happening?” until the problem was as close to its root cause as possible. These were also organized into recurring themes, as reflected in the analysis. The problems and root cause analysis were organized through fishbone diagrams (see Figure 6) to understand the relationships between the problems and their root causes.

Four main problems and six underlying root causes were identified and summarized as follows with quotes from interviewees.

Problem 1. Difficulty in accessing existing evidence

_We use some evidence, but we use them if we have them on our table._ FMoH 5 (an informant from FMoH, coded as No: 5)

According to information obtained from key informants, evidence is not consistently and easily accessible. The above quote epitomizes the problem this presents to those who need to use evidence. The difficulty in accessing evidence and data were in part attributed to the multiple sources of evidence, a large volume of student research, as well as the lack of an accessible platform to store evidence and associated data sets.

![Figure 4: A health information technician organizing data at health facility](image)

Problem 2. Needed evidence doesn’t always existent

_The amount of research itself is small. It is not enough. The focus is limited. In that context it is difficult to tell if it is policy-relevant._ FMoH 3

_There is little health systems research. There is some, but it is not strong._ University Professor

The above quotes indicate the two main evidence gaps described by many interviewees: a small body of research and gaps within specific research disciplines. While interviewees described a lot of current research, they also described specific thematic areas where there is not adequate evidence, for example those related to health systems, including health economics.
Problem 3. Available evidence is not always used

There is lots of research that is not being used. UN Organization Representative 1

Aspects of the problem of evidence use are tied to other problems, like challenges in accessing data, lack of analysis capacity, and concerns about data representativeness, along with other data quality challenges. However, these are not the only challenges around evidence use. A variety of other issues lead to incomplete data use. Two primary issues that lead to incomplete data use are the limited use of small-scale studies, and heavy reliance on certain sources, at the exclusion of other information sources. First, interviewees described limited use of small studies that are considered non-representative. This was tied to gaps in analytic capacity, which could help determine appropriate uses for non-representative studies. Second, several interviewees noted that only specific sources of data are used, for example the Demographic and Health Survey (DHS).

Figure 5: A health extension worker managing her data using family a folder organized by tickler filing system

Problem 4. Existing evidence is not consistently and properly analyzed or synthesized for policy purposes

Policy analysis capacity does not exist. It is not strong. FMoH 2

Limited policy analysis capacity was a major theme in interviews. Upon exploration, when interviewees described limited policy analysis capacity, it was related to; synthesis and analysis of evidence, formulating policy recommendations in a clear and comprehensible manner, and review or analysis of existing policies.
Ethiopia’s Context in Evidence-Informed Health Policy

Figure 6: Problem and Root Cause Analysis

1.) Existing evidence is not available / accessed
- A lot of the available evidence is from a large number of students
- Inconsistent engagement and coordination of all partners
- This means both domestic and external?
  - Large number of diverse partners
- Gaps between the research community and policy makers / program implementers

2.) Needed evidence not always existent
- Research community not being told what research MoH needs
- Research needs have outpaced infrastructure / institutions

Problems with staff retention, leading to capacity challenges

Evidence is not always timely
- Government doesn’t always want findings they don’t agree with published
- Evidence is not always program relevant

Challenges with data quality and Integration of linked data sources

3.) Available evidence not always used
- Limitations in presentation of evidence in 1.) policy relevant terms 2.) policy-maker palatable language

Practice of critical analysis not well developed
- Policy needs are faster than timeframe for thorough analysis

Historical / current MoH orientation towards pressing programmatic work (not to directing research)

Limited organized, dedicated capacity for analysis
- Existing evidence is not available
- Unit charged with this is not doing it

4.) Existing evidence / policies not consistently analyzed / synthesized

Evidence not consistently used to develop health policy / existing policies not systematically analyzed / updated

EPHI tasked with too many competing priorities to fully support evidence informed health policy

Limited research capacity in specific subjects (ex: NCDs) and research disciplines (ex: health systems)

Policy needs are faster than timeframe for thorough analysis
The underlying root causes of the four identified problems summarized above are presented as follows.

**Root cause 1. Gaps between the research community and policy makers / program implementers**

*Universities are operating in silos….I cannot remember a single time they consulted with the MoH.* FMoH 4

Interviewees consistently described a disconnect between researchers (in universities and research institutes, including Ethiopian Public Health Institute (EPHI)), and the FMoH. This disconnect was attributed to different styles of communication, varying orientations and priorities, and a lack of focus on translation of evidence to practice.

**Figure 7: Health worker organizing information after giving care for a client**

**Root cause 2. Inconsistent engagement and coordination of stakeholders (both domestic and external)**

*All stakeholders should be engaged at all levels. It’s an issue.* UN Organization 1

Interviewees described inconsistent engagement of the diverse stakeholders producing evidence and less than optimal utilization of mechanisms designed to facilitate inclusive review and utilization of evidence. This includes lack of a research priority-setting mechanism, lack of participation of professional associations and the private sector, and the lack of engagement of other relevant stakeholders throughout the policy-development process.

**Root cause 3. Historical and current FMoH focus towards pressing, programmatic work**

*Now we try to retroactively look for information. We need to plan and be proactive so we have plenty of information.* FMoH 3

Interviewees described a culture of practice and urgent day-to-day work within the FMoH and less of a well-developed practice of advanced analysis and evidence review. Interviewees described this as limiting the use of evidence, and resulting in the commissioning of evidence when it is needed, instead of identifying needs and challenges based on evidence that comes to the Ministry routinely through an established system.

**Root cause 4. Problems with staff retention, leading to capacity challenges**

*There are only a few people who have stayed long. When issues are raised we get some memories. Things are raised again and treated as a new issue.* FMoH 5

Interviewees described staff retention as a serious problem, impacting the availability of historical knowledge and retention of capable staff that can lead policy development and review processes.
Root cause 5. EPHI, one of the key agencies providing evidence, tasked with too many competing priorities to fully support evidence-informed health policy

*As a research institute it [EPHI] is supposed to do critical analysis, set the research agendas, and harmonize with international and national institutes. That is not happening.* FMoH 4

The Ethiopian Public Health Institute holds many key functions necessary for the use of evidence in health policy and policy analysis, including research, stakeholder coordination, and setting the research agenda. Because EPHI has many key functions that have relevance to evidence-informed health policy, gaps in EPHI lead to gaps in the FMoH’s ability to use evidence in health policy.

Root cause 6. Challenges with data quality and integration of linked data sources

*There are a number of data-sources. Policy-makers and strategists need integrated data-systems. There is a need for a well-integrated system where the policy makers can see everything: meaningful and comprehensive information.* FMoH 4

Interviewees described their concern about the quality of routine HMIS data, which leads to using data from other sources. They also described concerns with a lack of integration of data sources, particularly HMIS with human resource and logistics data.
VII. Recommendations to Strengthen Evidence-Informed Health Policy in Ethiopia

Based on the problem and root cause analysis, and using the case studies along with findings from review of literature, this section outlines key recommendations to be considered in the Ethiopian context to build functional evidence-informed health policymaking processes and practices.

**Recommendation 1. Develop Functional Knowledge Management Systems**

Information access is one of the primary challenges described by interviewees in Ethiopia. Efforts towards evidence synthesis, priority setting, and building research capacity are contingent on accessing the products of research and programs, including datasets, reports, student research, published manuscripts, and presentations of findings.

In developing an entity that effectively serves as a knowledge management unit of FMoH, it is important to give attention to its location, how it will collect information, what type of storage mechanisms need to be in place, and the staffing arrangement.

Interviewees suggested that a knowledge management unit could be created either under EPHI, within the FMoH’s Policy and Planning Directorate (PPD), or within the National Health Research Council (NHRC). The advantage of putting the function under the NHRC is that the council brings stakeholders together, which could help to engage researchers in the process of gathering research and program output documents. On the other hand, EPHI is involved in providing ethical clearance, which may help them to coordinate the collection of research outputs, including data sets, however, this should consider whether the function would be fully operationalized by EPHI inline with their capacity.

In Thailand, the National Health Foundation (an NGO), and the HSRI, an agency independent of the government, are both involved in knowledge management. In Rwanda, the knowledge management entity sits within the Ministry of Health and does some work collecting partner research, but primarily collects internal documents.

The knowledge management unit will require a detailed implementation plan, procedural guidelines, equipment, staffing, budget, and an electronic storage and other systems. Rwanda may provide a useful example for effectively developing a detailed plan. Rwanda has a technical working group in charge of developing a knowledge management platform and coordinating different stakeholders.

Interviewees noted that there is a need for better management of internal FMoH documents as a means to improve institutional memory. This function would logically sit somewhere within the FMoH. In Rwanda, there are several report specialists, who are, in part, responsible for managing internal documentation.

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*Figure 8: Health worker conducting laboratory test at health facility*
In summary, FMoH needs to give more attention to the development of an internal knowledge management unit within the Ministry to make relevant documents easily accessible for use. This is a doable short-term strategy. In the longer-term, by building on the knowledge management strategy of the FMoH, it could create a strong unit either within the FMoH or EPHI that handles knowledge management functions comprehensively as a vital function for the Ministry.

**Recommendation 2. Create a Policy Analysis Unit (PAU)**

Based on review of global practices and lessons, and as suggested by key informants, it is recommended to create a functional Policy Analysis Unit (PAU). This unit would be intended to; synthesize and analyze evidence, write policy briefs, review existing policies, coordinate health systems/implementation research, and serve a rapid response function whenever evidence is needed immediately.

Establishing an effective structural or institutional arrangement, with optimum capacity and adequate resources, is critically important to establishing a well-functioning PAU. These components are briefly discussed below. Detailed information on the proposed structural arrangement, their advantage and disadvantages is found in the Annex (Table 2).

**Structural or institutional arrangement**

Based on review of experiences from other countries and as suggested by key informants, three options are proposed, with each having advantages and disadvantages.

One option is to establish an autonomous independent unit or policy institute outside of FMoH. Some of the advantages of this option are; it facilitates recruitment and retention of competent staff, it facilitates proactivity, policy recommendations are less likely to be overcome by politics, and resource mobilization through grants will be easier. The main disadvantage of this option is difficulty of establishing strong and trusted links with FMoH, and that this may lead to less buy-in from policy designers and implementers. The experience of Kyrgyzstan and Mexico's Funsalud are examples of independent policy analysis units.

Another option is to establish a PAU within FMoH. This could be created as a separate unit within the Minister's office under the direct guidance of the Minister or a delegate. This arrangement would facilitate close working relationships with higher officials of the FMoH and the unit would be well-positioned to respond to the pressing policy needs of the Ministry. It would also be possible to create a unit within PPD, although this is a less preferred option as this arrangement would not give the unit the level of attention to deal with high-level and complex policy matters. The experiences of Rwanda and Ghana have some similarities with what is proposed here.

A third option is to create an independent, semi-autonomous unit within a government institute outside of FMoH, but related to FMoH. Creating the PAU within EPHI could be considered, but it will have its own challenges with regard to hiring and retaining highly competent staff, establishing strong linkages with the FMoH, and understanding and responding to pressing policy needs of the FMoH in a timely fashion. Thailand's International Health Policy Program and the experience of Ethiopia's Agricultural Transformation Agency (ATA) can be considered as examples of this model.

Whether the PAU is within the FMoH or outside of it, the Ministry should consider mechanisms to help ensure proactivity of the unit while maintaining some distance from political influence (20). A board is one mechanism for this. One Ethiopian interviewee mentioned the idea of a national think tank group. This may be similar to a technical advisory board, like that of Funsalud's technical advisory council in Mexico. This could be a great option for neutral technical direction. However, a board goes a step further with input to the administrative mechanisms in order to help maintain autonomy from political dynamics, as illustrated in the Ghana case. Implementing both a board and a technical advisory council can help increase proactivity and prevent politics from overtaking technical work. Both would need to have clear guidelines for engagement, membership would need to be defined, and roles and responsibilities would need to be clear.

The necessity for close links with the FMoH is clear: members of the unit need to be trusted; they need to work closely with policy makers to design, conduct, and disseminate research. Very clear guidelines for engaging the Ministry (as in Kyrgyzstan), and stakeholders (as in Thailand), can help to address this issue of maintaining political and technical engagement.

Interviewees expressed that proactivity is one of the main needs of a policy analysis unit. This means a unit that will anticipate the FMoH's needs and provide synthesized analysis and evidence before it is needed, instead of FMoH...
searching for evidence once it is needed. One reason many countries maintain a unit with some level of independence from government institutions is that these units are able to detach themselves from political realities to foresee needs and provide independent evaluation, direction, and opinion.

Finally the PAU will need to work in cooperation with other units and directorates working in programs, research and policy. Ensuring other directorates and institutes understand the unit’s place and how the unit will work to improve their work is also a lesson of the ATA.

Financing the PAU

The PAU will benefit from having a flexible financial system with limited budgetary restrictions in order to allow access to sufficient quantities of resources as needed, and without extensive administrative hurdles. This will allow for rapid response to needs, which will ease the administrative burden and help with the unit’s ability to respond proactively (8,19). This is also important to retain staff. There are two main mechanisms to help ensure there is adequate funding to retain staff. The first is external development funders. This is a good option for initiating the unit or institution, and was used in both Kyrgyzstan and Thailand, but is not sustainable. Research grants are another funding mechanisms that have been used in Thailand and Kyrgyzstan. Research grants might be more viable once the institution is established and has an established track record. These grants can help the institution function in the long-term, but may also require substantial government support (13,20).

Technical Capacity of the PAU

Based on the case studies and interviews in Ethiopia, four types of key technical skill areas are important for the PAU:

1. Capacity in epidemiology, biostatistics, health economics and other related topics;
2. Analytical skills and ability to draw conclusions and make recommendations (e.g. political analysis of research data and contextual analysis of a body of research);
3. Communications skills (e.g. ability to clearly communicate with policy-makers and researchers); and
4. Political skills (e.g. understanding and ability to navigate a political environment).

All of these skills are very important, particularly analytical and political skills, which may be more difficult to find than technical skills. Uniformly, interviewees in Ethiopia felt that the PAU should include a mix of junior and senior researchers and analysts. Junior researchers will need overall capacity building training and senior researchers may need training in specific competencies, like writing policy briefs. Based on the case studies, three short-term options for training are proposed: hands on training by experts; training abroad with a partner institution; and short, in-country trainings in specific competency areas. Along with short-term trainings, in the long run, doctoral level training for PAU staff can help to build the unit’s capacity and research base. In Thailand, training PhD researchers is a major component of efforts to build capacity in health systems and health policy analysis. Building a similar funding mechanism for health systems research for PhDs is a way to build long-term capacity, but needs to be paired with a mechanism for retaining these staff.

The Thai, Kyrgyzstan, and ATA cases emphasize the need to invest in hiring and retaining highly competent staff. The problem of staff retention and turnover is a major challenge in Ethiopia. While some interviewees mentioned using seconded staff within a government-based unit, others did not agree with this idea. The PAU will need some mechanism and arrangement to ensure staff members are competitively paid.

In summary, along with the institutional arrangements, funding, and capacity, the PAU will need clear protocols for its operation. This is critical not only in determining how the unit will interact with Ministry structures, but also in determining how the PAU will conduct its work. In Rwanda, the government has guidelines for health policy development. While these are not the only form of guidelines this unit should have, the guidelines provide an example of clear procedures for consultation, document review, and approvals. The Rwanda approach could serve as a model for the PAU’s guidelines. Having clear strategy and procedures can help the unit to function well in the long-term and impact policy development process (20).
Figure 9. Registrar organizing patient card at health facility

Recommendation 3. Build a Mechanism to Effectively Coordinate Stakeholders

Coordinating research, development funding partners, government bodies involved in health, UN organizations, and implementing agencies (including NGOs), to ensure strong networks, is an essential function connected with knowledge management, priority setting, and discussing research and policies. Coordination intends to minimize duplication, encourage partnered work, increase use of existing research, and spur research in areas where it is needed. Coordination is woven throughout the solution options, but it is important to consider it as a single function. The FMoH should consider connecting partner coordination to the knowledge management function or the PAU, and consider how all of the different forms of coordination (within the NHRC, Technical Working Groups (TWGs), knowledge management, a university coordination platform and others) might relate to each other.

The essential question is how stakeholders can be brought together to ensure that evidence generation and analysis are not duplicative, and work together to share information and ideas. It is recommended that there be one central coordination mechanism. While there may be additional forums for specific purposes (TWGs), the coordinating mechanism should have some engagement with these forums. The ATA, Mexico’s Funsalud, and Thailand’s HSRI are all examples of institutes involved in both policy analysis and stakeholders coordination.
VIII. Summary

In summary, considering the current structure and the felt needs of FMoH, it is advised to create a PAU within the FMoH within the Minister’s office. The unit would ideally be formed with capable fulltime policy analysts and researchers who would work under the guidance of the Minister. Through time, this unit can grow to become an autonomous or semi-autonomous health policy institute. This unit could serve the needed functions detailed above, facilitate communication, and help bring some cohesion to the area of research and evidence generation and use. The challenge would be that it would be a large undertaking to effectively serve all of these functions (knowledge management, policy analysis, coordination). Separating the three functions would mean that the PAU would be a small unit, like Kyrgyzstan’s HPAU. Putting them together would mean developing a large and complex institute, like Thailand’s International Health Policy and Planning Program, this can be considered as a long-term strategy.

The PAU does not need to immediately take on every function it will have in the long term. Its strategic development plan can outline essential initial functions and it can grow over time. All of the units covered in the case study developed gradually over time, but an initial plan for the long-term trajectory can help the unit move towards its goals more effectively.

Knowledge management practices, inclusive research coordination and priority setting mechanisms will help to meet the FMoH’s research needs, limit research duplication, and improve resource use. In addition, using existing mechanisms to more effectively link universities and the FMoH, such as FMoH staff training programs within universities, engaging academics in planning and performance review forums will help to facilitate link between academics and policymakers.
IX. Works Cited


27. HSRI. Thai Health Systems Research Institute [Internet]. 2015. Available from: http://www.hsri.or.th/en

28. IHPP. International Health Policy Program.


33. Funsalud. The Mexican Health Foundation is an autonomous, non-profit, civil association founded in 1985.


## Appendices

### Table 1. Case Study Summaries

<table>
<thead>
<tr>
<th>Case</th>
<th>Key Institutions and Institutional Features</th>
<th>Key Lessons</th>
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| **Thailand: Multiple Institutions for Evidence Informed Health Policy Making** | • Health Systems Research Institute: Research grant-making institution. Involved in agenda setting, research coordination, partner development, and a funding agency  
• International Health Policy Program: Produces policy-relevant health systems policy research (HSPR) and builds capacity for policy-relevant HSPR; has direct connections with MoH, but is semi-autonomous from MoH.  
• Thai Health Promotion Foundation: evidence generation, policy advocacy, and awareness building; governed by a board is chaired by the Prime Minister and co-chaired by the Minister of Public Health and an independent expert; funded by Thailand’s alcohol and tobacco excise tax. | • Supply and Demand: building research supply was the starting place for increasing evidence use  
• Networks: between organizations and individuals facilitated evidence informed policymaking including formal and informal relationships and interaction platforms.  
• Funding mechanisms: helped to build research supply and institutions for EIPM.  
• Country ownership: initially Thailand had some international support in building EIPM institutions. At present, most are internally funded and individual training is supported by internal funds. |
| **Mexico: Academics in the Ministry** | • Funsalud (Mexican Health Foundation): Private institution, conducts research, designs solutions, raises funds, promotes social investment in health. Has board of directors and technical advisory committee.  
• National Institute of Public Health: Placed within MoH, facilitates research and provide training focused on translation of evidence to practice.  
• The MoH developed management procedures and systems for evidence use. | • Institutional crossover from academia into government and vice versa can help to build networks between researchers and policymakers as well as the body of policy relevant research. Management procedures and systems in the MoH helped to develop their capacity to use evidence in health policy. |
| **Ghana: Ghanaian Social Health Insurance** | • Technical panel formed to provide advice on social insurance. Panel had oversight by political appointee who was able to change panel members | • Political dynamics matter.  
• Important to pay attention to timing and use politician-friendly language in communication (proximity is important).  
• If there is no distance between politics and technical processes, politics can overcome technical processes, negatively impacting policy. |
Kyrgyzstan: Health Policy Analysis Unit (HPAU)

- Unit began under WHO with funding from DFID.
- Staffed with masters-level researchers with background in public health, health financing, and health systems.
- Embedded technical expert from WHO helped with technical capacity building.
- Staff trainings held locally as well as for short periods in Europe.
- The unit had direct access to the Minister of Health and it has the trust of the Minister.
- Developed a clear research protocol to ensure cooperation with the MoH at every stage of the process.
- Currently functions as an NGO.
- There was an effort to move it within the MoH, but staff members unwilling to move into MoH because of low salaries and less flexibility.

People are key. When the HPAU left the WHO, it could have moved into the MoH, but it would not have retained its staff.

- Start with the long-term institutional arrangements. The unit’s incubation within WHO caused problems when it was time to relocate.
- Long-term funding mechanisms are a key component of sustainability.
- Locating the Unit within the MoH would have allowed direct access to policymakers. At the same time, independence from the MoH has allowed independence from the political influence of policymaking.

Rwanda: The Academic Ministry

- MoH is primarily in charge of handling policy, planning, and administration matters.
- Rwandan Biomedical Center (RBC) is the MoH’s program arm, under the Ministry.
- Country has a document outlining health policy development process, which is actively used by staff involved in the policy development process.
- There is strong link between MoH staff and the School of Public Health at Rwanda University. The school works to ensure students use the Ministry’s data for research activities.

Leadership from highest levels is key.

- Guidelines and procedures can facilitate EIPM.
- Academic training linked to MoH work for MoH staff helps with evidence use.
- Electronic HMIS makes data access easier, facilitating use in health policy.
### Table 2: Institutional Arrangement Options for a Policy Analysis Unit - Advantages and Disadvantages

<table>
<thead>
<tr>
<th>Institutional Arrangements</th>
<th>Advantages</th>
<th>Disadvantages</th>
<th>Mechanisms for overcoming disadvantages*</th>
<th>Examples</th>
<th>Possible Arrangements in Ethiopia</th>
</tr>
</thead>
</table>
| Units autonomous from the Ministry of Health | • Easier staff recruitment and retention  
• Facilitates proactivity  
• Technically sound solutions less likely to be overcome by politics  
• Possibly easier to get independent (grant) funding | • May have challenges with links and trust with FMoH  
• May not get adequate buy-in from government. | • Guidelines for how the unit interacts with the FMoH.  
• Maintain close day-to-day relationship with FMoH.  
• Be supportive and understand the political context. | • Kyrgyzstan and Mexico’s Funsalud. | • As a non-for-profit NGO (or)  
• As an independent institute in one of the academic institutions (or)  
• Autonomous think-tank. |
| Units under the Ministry of Health | • Clear direct contacts and trust with the FMoH  
• Can be ready to respond to requests from FMoH quickly | • Staff recruitment and retention challenges  
• May be difficult to proactively identify problems within political constraints  
• Technically sound solutions may be overcome by politics  
• Possible challenges with independent (grant) funding | • Design a mechanism to augment staff salaries or come-up with attractive benefit package.  
• Implement boards and technical advisory groups.  
• Develop clear plan for alternative funding mechanism. | • Experience in Ghana and Rwanda. | • As a unit within the Minister’s office of FMoH (or)  
• As a separate unit within or out of PPD. |
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| Semi-autonomous units     | • If appropriate funding and oversight mechanisms are in place, this arrangement may have the same advantages as an autonomous unit.  
  • May be easier to develop robust staff recruitment and retention mechanisms than if directly within the FMoH (as the ATA was able to do).  
  • Facilitates proactivity.  
  • Technically sound solutions.  
  • Possibly easier to get independent (grant) funding.  
  • Facilitates direct trusted relationship with the MoH. | • May have challenges with technically sound solutions being overcome by politics.  
  • May have challenges with links and relationship with MoH, but likely to be less of a problem than a completely independent unit. | • Implement boards and technical advisory groups.  
  • Design system for how the unit interacts with the FMoH and other Ministries. | • Thailand’s International Health Policy Program and Ethiopia’s ATA. | • As a separate unit within EPHI (or)  
• As an independent health policy institute (affiliated with government) outside of FMoH, but work closely with FMoH and other Ministry, such as the Ministry of Finance (MoF). |