The Eastern Africa Health Policy and Research Organization (EA-HPRO) In the IMCHA Program

Presents

The Ethiopia Maternal, Newborn and Child Health Policy Context Mapping Report

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Contents

1. Executive Summary

The MNCH context mapping exercise conducted in 2016 provided a better understanding of the policymaking process in Ethiopia, existing policies on Maternal Newborn and Child Health (MNCH) as well as opportunities available for the Implementing Research Teams (IRTs) and the Eastern Africa - Health Policy and Research organization (EA-HPRO) in creating awareness on IMCHA research as well as informing policy action.

Below are key messages identified from the report:

1. The current initiatives being implemented in the health sector have contributed to the reduction of the maternal mortality ratio to an annual average of 4.9%. However, more interventions need to be done to increase the ratio of newborns survival.

2. The health system is decentralized to cater for maternal health care and access to referral facilities for high-risk pregnancies. However, there is no linkage to gender issues which influence decision making in MNCH regionally and locally.

3. There are several policies and strategies touching on MNCH issues in place. Most policy documents are developed through a consultative processes involving various stakeholders within technical working groups established at various levels.

4. There are several types of platforms supporting knowledge transfer and exchange activities across the country. They include national councils for science and technology, EVIPNet nodes, divisions or directorates in charge of research, guidelines development committees, technical working groups, task force committees, and stakeholders' forum, e-learning platform for research skills, online data repositories, research utilization units, and internal archival systems. Some are however not fully operational.

SWOT analysis summary

To summarize the country report, a SWOT analysis structure has been used to highlight the status of MNCH issues in Ethiopia. This analysis tool has also been used to outline areas the HPRO and IRTs can intervene in research, advocacy and policy influence.

I. Strengths

MNCH is one of the six priorities under the National Reproductive Health Strategy. This shows the government's and stakeholders' commitment to addressing issues in this area.

The Ethiopian government is implementing several policies and strategies that provide effective interventions in improving the indicators of reproduction and MNCH in the country. Some of the key policies are; the Women's Policy, the Health Policy, the National Population Policy, the HIV/AIDS Policy, the Health Sector Strategy, the Child Survival Strategy, National Nutrition Strategy, and the Family Planning Guidelines.

Health services have been decentralized to ensure adequate maternal health care and access to referral facilities catering for high-risk pregnancies. In addition, decentralization has

enabled the provision of integrated primary health care services at the community level through finance allocation and the construction on new facilities.

There is a relatively favorable environment for policy influence in MNCH issues as well as use of research data to inform policy development in the health sector.

II. Weaknesses

There are gaps in recording health related data as the Health Management Information System (HMIS) is outdated.

Monitoring and evaluation of the MNCH services and workforce is limited because of compensation challenges among other issues.

Most health services are lacking quality assurance mechanisms which is further challenged by poor communication channels and scarce resources.

Formulation of research problems are rarely made based on priority health problems. Most of the research activities within academia do not focus on key issues in the health sector which have policy and strategy relevance but are apparently driven by funding opportunities.

There is poor linkage between research and policy influence. This means in most cases, research information is not accessible to actual implementers.

Most of the institutions involved in health research do not translate their research outputs into action. In the few cases where there is action, there is no mechanism to monitor the implementation of their research recommendations.

Most research results are disseminated through publications in international and local journals that have limited distribution to relevant stakeholders. In addition, health workers who are able to access the publications, find it difficult to understand the technical language.

The role of the media in health research does not seem to be significant. Media involvement is neither systematic nor institutionalized.

The knowledge translation platforms established to foster EIHP and EBHP in Ethiopia, are not fully operational due to challenged leadership and scarce human and financial resources.

While most decision makers in the health sector value the evidence in informing policy, resources allocation for research is limited. In addition, there is no guidance document on how to formulate health policies and MNCH guidelines.

III. Opportunities/Action areas

In this section, I highlight the opportunities available for intervention. They have been linked to some of the five areas of work outlined under the first approach in the revised 2015 EA-HPRO strategy.

1. Evidence synthesis

The IRTs research stands a good chance of providing evidence in areas where there are knowledge gasp on the causes of maternal mortality. The HPRO can work with the IRTs in developing dissemination materials that communicate the research findings/evidence such as video testimonials.

2. Networking and alliance building

Create networks within the forums organized under the Health Sector Development Program (HSDP's). The IRTs need to work closely with national/regional task-forces, technical working groups, advisory committees which are forums where evidence can be disseminated to influence policy action.

Support for national research uptake

The HPRO can advocate on MNCH issues by working with IRT policymakers in national consultations such as professional associations, periodic discussions in annual conferences among other forums.

HPRO can support IRTs in translating research outputs into actions and decisions that are simple and easy to disseminate through various tools such as policy briefs, infographics, blogs, and posters among others. To increase the level of research uptake within stakeholders.

HPRO working with IRTs can facilitate media engagement by providing training for journalists and editors who have a keen interest in reporting health issues. This will increase the journalists understanding on how to report on MNCH issues from a research and policy perspective, thereby acting as advocates for the sector.

B. Ensuring greater impact

The HPRO will work with the IRTs on how to collaborate with existing KT networks to prioritize the MNCH agenda nationally. It seems policies in this area are linked to bigger international initiatives.

IV. Threats

If IRTs lack policy and engagement plans, this will hinder HPRO support as they have a better understand of their national working environment.

Follow-up points

Are you already engaged with the existing technical working groups in the MNCH area?

What is the nature of relationship between your teams and the Ministry of Health?

2. Abstract

Ethiopia has demonstrated a rapidly increasing coverage for multiple interventions across the continuum of MNCH care and is cited amongst the four top performing countries that registered more than 5 percentage points over five years in composite coverage index for the eight interventions along the continuum of care (UNICEF, 2014)[1]. Based on the Sector Wide Approach to Development (SWAP), the country received development assistance for the road, education, and health sectors. Growing road construction and communications expansions have facilitated access to information and health services. Expansion of education in the country has led to increase in girls school enrollment and pursuing education, and improving living conditions-housing, safe water and sanitation have contributed to the gradual betterment of RMNCH status in the country. The SWAP led Health Sector Development Program (HSDP) has led to rapid expansion of health facilities at all levels improving access to a range of services and human resources. The HSDP has been a key component of the Growth and Transformation Plan (GTP) 2011-2015 designed to maintain the rapid and broad-based economic growth enjoyed by Ethiopia in the recent past (MOFED, 2010)[2]. Furthermore, the Health Extension Program through disease prevention and health promotion approach has contributed towards improved health status, and as proxy, productivity of the population. Similarly, the number of health teaching institutions has increased in the last few years (FMOH, 2016)[3].

2. Population in Ethiopia

The Population of Ethiopi**a** is increasing at a fast pace. In 2015, the estimated population was 90,076,012, with nearly 84% living in rural areas. According the 2014 Ethiopian Demographic and Health Survey (EDHS)[4]: the estimated total fertility rate (TFR) is 4.1 children per woman; crude birth rate (CBR) is 28 births per 1,000 population; contraceptive prevalence rate is 29 percent for all women and 42 percent for currently married women; 40% of pregnant women who gave birth in the five years preceding the survey received antenatal care from a skilled provider; 15% of births are delivered at a health facility ; 40% of children under age five are stunted, and 18% of children are severely stunted; 9% of children are wasted, 3% are severely wasted, and 3% of children below age five years are overweight or obese; 25% of children under age five are underweight, and 7% are severely underweight.

In Ethiopia, **maternal mortality ratio** has dropped from 950/100,000 live births in 1990 to 350/100,000 live births in 2010.[5] With an average annual reduction of 4.9%/year, Ethiopia was categorized as a country making progress in MDG5.[6] Under-five mortality and infant

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[1] United Nations Children's Fund (UNICEF). The state of the world's children 2014. New York; UNICEF, 2014

[2] Ministry of Finance and Economic Development (MOFED) [Ethiopia]. *Growth and Transformation Plan, 20110/11-2014/15.* Addis Ababa, Ethiopia: Ministry of Finance and Economic Development. 2010.

[3] Federal Ministry of Health (FMOH). Health and health related indicators for 2007 EC. Addis Ababa; FMOH, 2016

[4] Central Statistical Agency (CSA). Ethiopia mini-demographic and health survey 2014. Addis Ababa; CSA, 2014

[5] Abdella A. Maternal mortality trend in Ethiopia. *Ethiop J Health Dev* 2010;24 (Special Issue 1):115-122.

[6] World Health Organization (WHO) & United Nations Children's Fund (UNICEF). Building a future for women and children: The 2012 report. Countdown to 2015: Maternal, newborn & child survival. Washington DC; WHO/UNICF, 2012

mortality have declined; however, improvement in newborn survival is sluggish.[7] **Acute febrile illnesses** were the first among the top causes of morbidity among adults in the country during 2014/15, while diarrheal diseases were the corresponding causes of morbidly among children under five years.[8] In terms of mortality, pneumonia was the top killing disease both among adults and children under five years. The top diseases/conditions that affect more females than males include: iodine deficiency related goiter, anemia, urinary tract infections, malaria, and HIV/AIDS. On the other hand, trauma, diarrhea, and pneumonia were among the top diseases/conditions that affect more males than females.

Adult prevalence of HIV seems to be decreasing though comparison across time is a challenge because of the different methodologies that were used. The HIV infection incidence rate has decreased from 0.68 to 0.29. On the other hand, the number of facilities that provide HCT, PMTCT and ART services has increased by twofold, threefold and fourfold, respectively**.** ART services for people living with HIV/AIDS (PLWHA) reached 52% of eligible persons in 2009.[9]

The practice of **female genital mutilations** is decreasing slightly while attitude favoring the practice is declining remarkably. Gender-based violence including abduction has decreased country-wide though the harmful practices still exist everywhere including the capital Addis Ababa.[10] There is still gender disparity in the health governance structure. The number of females in high-level decision making is low though there is a slight improvement. Monitoring and evaluation of the RMNCH services and workforce is limited because of the prevailing low rate of per-diem and other competitive priorities.[11]

RMNCH indicators show wide disparity across regions and socio-economic status. CPR in urban and rural residences is 52.5% and 23.4%, respectively; there is an fourfold difference in CPR between the wealthiest and the poorest – 51.8% Vs 13.3%, respectively; threefold difference between the uneducated and those with college level education (22.2% and 67.8%). ANC coverage in urban and rural residences is 76% and 26.4%, respectively; fourfold difference between the wealthiest and the poorest – 74.9% and 16.9%. Institutional delivery rate in urban and rural residences is 49.8% and 4.1%, respectively and 38.5% Vs 2.0%, respectively amongst the wealthiest and the poorest and; 58.2% and 4.4% in those with college level education and the uneducated. Similarly DPT3 coverage in urban and rural areas was 60.5% and 32.5% respectively, while it was 61.5% and 26.0% among the wealthiest and the poorest respectively.[12] In addition, there is huge discrepancy in highly trained health workforce across regions and the coverage in the wealthiest is 61.5% and 26.0% in the poorest.[13]

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[7] Central Statistical Agency (CSA), Ethiopia. *Ethiopia Demographic and Health Survey 2010.* Addis Ababa; CSA, 2011

[8] Federal Ministry of Health (FMOH). Health and health related indicators for 2007 EC. Addis Ababa; FMOH, 2016.

[9] Federal Ministry of Health (FMOH). Health and health related indicators for 2002 EC. Addis Ababa; FMOH, 2010

[10] Central Statistical Agency (CSA), Ethiopia. Ethiopia Demographic and Health Survey 2010. Addis Ababa; CSA, 2011

[11] Dasgupta R, Arora NK, Haile Mariam D, Kumbi S, Chaturvedi S, Patwari A, Ganguly KK. Reproductive health services in Ethiopia. In Anjula Gurtoo and Colin Williams (eds.): *Developing country perspectives on public service delivery*. Springer; 2015. ISBN-13: 978-8132221593; IBN-10: 8132221591.

[12] Central Statistical Agency (CSA), Ethiopia. Ethiopia Demographic and Health Survey 2010. Addis Ababa; CSA, 2011

[13] Federal Ministry of Health (FMOH). Health and health related indicators for 2007 EC. Addis Ababa; FMOH, 2016

3. Policy and Legal Environment for MNCH

The Ethiopian government is implementing several policies and strategies to provide effective interventions and improve RMNCH status in the country. Overall, there are dozens of policies relevant to MNCH. The Constitution of The Federal Democratic Republic of Ethiopia (FDRE) bestows basic human rights to the people that are related and relevant to reproductive, maternal, newborn and child health; and it also safeguards women's health and decision-making through providing equal rights in marriage and its dissolution, economic inheritance, information and means to utilize family planning, child immunization, as well as child education (FDRE Constitution).[14] Furthermore, the Women's Policy, the Health Policy, the National Population Policy, the HIV/AIDS Policy, the RH Strategy, the Child Survival Strategy, National Nutrition Strategy, and the Family Planning Guideline for family planning services are all documents that give emphasis to RMNCH services. Specific policy considerations to improve RMNCH services are also in place.

4. Health Policy

With a main focus of decentralization of services, the **Health Policy**[15] outlines the need to promote family health services through core strategies such as ensuring adequate maternal health care and referral facilities for high-risk pregnancies, intensifying family planning for the optimal health of the mother, child and family, and inculcating principles of appropriate maternal nutrition to guide maternal health initiatives in the country. However, gender issues are not specifically mentioned. The Health Policy aims to improve and ensure access to and equity of service distribution through the emphasis on decentralization and strong community representation at all levels.

The **Health Sector Strategy**[16] focuses on the provision of comprehensive and integrated primary health care services at the community level through the redirecting of finance from tertiary to primary levels of care, and building new institutions in neglected areas to address remarkable health iniquities. For ensuring women's right to have easy access to basic health care facilities, information about traditional and modern family planning methods, a **National Policy on Ethiopian Women**[17] was enacted in 1993. Its goal is to enable women to hold public office and participate in the decision making process at all levels in order to eliminate prejudices as well as customary and other practices reinforcing stereotypes of male supremacy. The policy enables the institution of measures, including legislation to ensure the equal right of women to work in the Civil service in any capacity as well as the right for equal pay for equal work and to perform public functions, including decision-making within their communities and at the national level.

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[14] Federal Democratic Republic of Ethiopia (FDRE). The constitution of the Federal Democratic Republic of Ethiopia. Addis Ababa; FDRE, 1995.

[15] Council of Ministers, Ethiopia. Health policy of the transitional government of Ethiopia. Addis Ababa; Council of Ministers, 1993.

[16] The Transitional Government of Ethiopia. Health sector strategy. Addis Ababa; Council of Ministers, 1995.

[17] The Transitional Government of Ethiopia. National policy on Ethiopian women. Addis Ababa; The Prime Minister's Office (Women's Affairs Sector), 1993.

The **National Population Policy**[18] adopted in 1993 aims at harmonizing the population growth rate, the capacity of the country for the development and rational utilization of natural resources thereby creating conducive conditions to improving the welfare of the population. It also promotes female participation across the educational system, the abandonment of all legal customary practices impeding the full enjoyment of economic and social rights by women including the property rights and access to rewarding employment and, measures to significantly improve the social and economic status of vulnerable groups (women, youth, children, street children and the elderly).

The **National HIV/AIDS Policy**[19] aims to provide an enabling environment to prevent and control of the epidemic. Its preparation adequately accounted for the contribution of gender inequalities in the further spread of the HIV/AIDS problem by establishing mechanisms to ensure universal access to information and services regarding HIV/AIDS and family planning. It also includes strategies for empowering women, youth, and other vulnerable groups to take actions to protect themselves against HIV/AIDS; providing health care to PLWHA on a scheme of payment according to ability with special assistance for those who cannot afford to pay.

The **Health Extension Program**, the county's health sector flagship program, has a maternal and child health package for providing all women of child bearing age and especially the rural women, with the necessary and full information and education about their health without going far away from their homes.[20] The program is tailored to address issues within urban, rural, as well as pastoral areas of the country with the protection of women's reproductive health rights as one of its implementation strategies.

The **National Strategy for Child Survival**[21] aims at reducing the under-five mortality rate with emphasis on multi-sectoral collaboration as well as the development of health extension package tailored to specific needs of population segments as a strategy to address the health care needs of children of pastoralists. There are no specific gender related issues or strategies mentioned in the document.

The **Criminal Code** was revised to permit abortion for an expanded range of indications.[22] The revised code stipulates that the woman's word is all that is needed to justify pregnancy termination in cases of rape and incest; it also notes that poverty and other social factors (such as underage) may be grounds for reducing the criminal penalty for abortion. According to the 2006 organizational structure of the Ethiopian Ministry of Health,[23] the Maternal, Child Health, and Nutrition Department, there is a gender office that is responsible for gender

[18] The Transitional Government of Ethiopia. National population policy of Ethiopia. Addis Ababa; National Population Office (Office of the Prime Minister), 1993.

[19] Federal Democratic Republic of Ethiopia. Policy on HIV/AIDS of the Federal Democratic Republic of Ethiopia. Addis Ababa; Federal HIV/AIDS Prevention & Control Office, 1998

[20] Federal Ministry of Health, Ethiopia. Health extension program. Addis Ababa; FMOH, 2003

[21] Federal Ministry of Health (FMOH), Ethiopia. National strategy for child survival in Ethiopia. Addis Ababa; FMOH, 2005

[22] Council of People's Representatives, Ethiopia. Revised abortion law. Addis Ababa; Council of Ministers, 2005

[23] Federal Ministry of Health, Ethiopia. Maternal, Child Health, and Nutrition Department Organogram. Addis Ababa; FMOH, 2006

mainstreaming within the sector's activities. There are also units that focus on MNCH care needs of the poor, the vulnerable, those in rural as well as pastoral areas of the country.

The 2006-2015 **National Reproductive Health Strategy**[24] identifies six priority areas for intervention namely the social and cultural determinants of women's reproductive health, fertility and family planning, maternal and newborn health, HIV/AIDS, reproductive health of young people, and reproductive organ cancers. At the core of the strategy are improving maternal health, promoting gender equality, and combating HIV/AIDS, as these provide entry points to address indicators such as fertility and gender. The strategy equally addresses gender and equity issues by confronting the demographic, cultural, geographic diversity of Ethiopia while ensuring educational and economic opportunities for all, family and community, and seeking to deliver health services to where they are needed most. Improving the health status of the Ethiopian people through provision of adequate and optimum quality of promotive, preventive, curative and rehabilitative health services to all segments of the population is the specified focus of the health component[25] of the **National Growth and Transformation Plan (GTP) II**. Ensuring women's participation, engagement and involvement in the health system; and strengthening and scale up of the health extension program are mentioned as strategies for addressing issues of gender and equity respectively in that plan component.

The Policy guidelines for family planning services[26] were issued to guide family planning programmers and implementers as well as for serving as a guide to the providers of family planning services. By fostering male involvement, the guidelines propose to address the following gender issues: the patriarchal family system wherein males are bread winners in most families and decision makers at all levels; polygamous relationships nurtured by the longer fertility lifespan; the male mobility and risk-taking behavior; their privileged access to information and familiarity with family planning methods; the burden of FP usually falling on females. The guidelines also provide targeted strategies addressing the needs of specified groups such as adolescents and youth, PLWHA, survivors of sexual violence and, the people with mental disability. The **roadmap for accelerating the nationwide efforts in the reduction of maternal and newborn morbidity and mortality**[27] clearly articulates the linkages between poverty and low status of women, as well as early marriage and childbearing and the high maternal mortality; it also highlights the need for technical support to boost multi-sectoral committees in order to address the regional disparities in technical capacity particularly in the regions which have women's reproductive health on their agenda.

[24] Federal Ministry of Health (FMOH), Ethiopia. National Reproductive Health Strategy, 2006-2015. Addis Ababa; FMOH, 2006

[25] Federal Ministry of Health, Ethiopia. Health chapter of the National Growth and Transformation Plan (GTP). Addis Ababa; FMOH, 2010

[26] Federal Ministry of Health (FMOH), Ethiopia. Policy guidelines for family planning services in Ethiopia. Addis Ababa; FMOH, 2010

[27] Federal Ministry of Health, Ethiopia. Roadmap for accelerating the reduction of maternal and newborn morbidity and mortality in Ethiopia. Addis Ababa; FMOH, 2012

The **MDG Acceleration Compact**[28] aimed at providing a holistic planning framework for identifying bottlenecks and multi-faceted solutions and interventions to speed up country progress toward meeting MDGs that have shown slow progress. With gender mainstreaming into all development programs and projects, gender focal persons are established in all regional bureaus of the government. Inequitable distribution of health services is currently addressed through the health services expansion and strengthening of infrastructure. The **National Nutrition Program**[29] adopted in 2013 strives towards equitable and sustainable multi-sectoral actions towards the realization of optimal nutritional status for all Ethiopian citizens. It proposes to affirm the reciprocal relationship between gender and nutrition through gender mainstreaming into its various components and strengthening of social protection services for improved nutrition. It targets the nutritional problems of children, mothers, the poor, and other vulnerable groups. Reproductive, maternal, newborn, child, adolescent health and nutrition are among the top priority within the Health sector transformation plan (HSTP)[30] of the FMOH. Gender mainstreaming in sector and development programs as well as advocacy and capacity building initiatives are the main strategies for empowering women through creating equal opportunities and affirmative action for women to participate in economic development. Among the strategies outlined in the HSTP for addressing equity issues are coverage with high impact interventions that address the most important causes of disease and mortality; providing quality of health services through the health extension program and through the scale up of effective interventions.

5. Policies and legislations

In summary, most policies and legislations related to MNCH in the country are based on the Health Policy of the Transitional Government of Ethiopia (1993)[31], and the implementation framework is the Health Sector Development Program (HSDP) – 1998-2007[32]. At national level, the HSDP is the health sector component of the larger national frameworks of either the poverty reduction program within the Plan for Accelerated and Sustained Development to End Poverty (PASDEP) or that of the recently adopted Growth and Transformation Plan (GTP)[33]. At global level, most of the policies are reflections of the major global initiatives that include: the Primary Health Care (PHC) and the Health for all by the year 2000[34] movement;

[28] Federal Ministry of Health, Ethiopia. MDG acceleration compact: Accelerated action plan for reducing maternal mortality. Addis Ababa; FMOH, 2014

[29] Federal Democratic Republic of Ethiopia. National Nutrition Program, 2008-2015. Addis Ababa; FMOH, 2013

[30] Federal Ministry of Health (FMOH). Health sector transformation plan (2015/16-2019/20). Addis Ababa; FMOH, 2015

[31] Council of Ministers, Ethiopia. Health policy of the transitional government of Ethiopia. Addis Ababa; Council of Ministers, 1993

[32] Federal Ministry of Health (FMOH), Ethiopia. Health sector development program (HSDP) – 1998-2007. Addis Ababa; FMOH, 1998

[33] Ministry of Finance and Economic Development (MOFED), *Growth and Transformation Plan, 20110/11-2014/15.* Addis Ababa, Ethiopia: Ministry of Finance and Economic Development. 2010.

[34] World Health Organization (WHO). Declaration of Alma-Ata adopted at the international conference on primary health care. Alma-Ata; USSR, 1978

the International Conference on Population and Development (ICPD)[35]; the Millennium Development Goals (MDGs)[36] as well as the Sustainable Development Goals (SDGs).[37]

5.1. Policy formulation

In terms of **policy formulation**, the reviewed documents indicate that they are based on situation analysis of the health sector through highlights of the sector's policies, strategies, and programs; as well as through the review of experiences from other countries. **Consultations** are also made by the Federal Ministry of Health with regional health bureaus, development partners, health professional associations, the academia and other stakeholders. These consultation processes are usually led by the government through the health sector or a delegated entity. **Technical working groups** for different issues are also selected by the health sector from various stakeholders including multi- and bi-lateral partners. There is usually fair representation of professional associations and the academia within these technical working groups. Technical working groups are mostly free to look for evidence and for validating report, but there are instances when a need to "tune" conclusions and recommendations arise. It is not unusual to observe multi- and bi-lateral institutions driving the agenda for some deliberations and what goes into technical reports especially related to MNCH. More importantly, it is common for these partners to commission studies and evaluations by think-tanks and public sector contractors for furthering their own priorities on some specific issues.

5.2. Implementation modality

The implementation modality for the policies and strategies outlined above along with costs of RMNCH activities[38] are embodied in the HSDP that equally serves as strong multi-partner framework including leadership, monitoring and evaluation. Under the leadership of the sector, there are national task-forces, technical working groups, advisory committees composed of representatives from stakeholders. National consultations on different common and relevant topics have been going on for a long time though at irregular intervals. Management protocols and national guidelines related to various RMNCH were developed to improve quality of care and standardize services. Professional associations contribute towards better RMNCH services through periodic discussions in annual conferences, continuing education, participating in the HSDP's annual review meeting, organizing and conducting events related to RMNCH (meetings, rallies, walks), participating in country-wide task forces, technical working groups, TWGs, and committees at FMOH level, fund-raising and implementing projects that promote RMNCH, building evidences through research and conducting evidence-based advocacy, organizing policy dialogue and taking part in international activities. Similarly, multi-lateral, bilateral and other non-government organizations partner with the government in resource mobilization, implementation of projects, policy dialogue, advocacy and other development activities.

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35 United Nations Fund for Population Activities (UNFPA), Report of the International Conference on Population and Development (ICPD). New York; UNFPA, 1995

36 United Nations (UN). United Nations Millennium Development Goals. New York; UN, 2008

37 United Nations (UN). Transforming our world: the 2030 Agenda for Sustainable Development. New York; UN, 2015

38 Federal Ministry of Health (FMOH), Ethiopia. Health sector development program (HSDP-IV) 2010/11 – 2014/15. Addis Ababa; FMOH, 2010.

6. Health System Issues Related to RMNCH

The Ethiopian health service is organized into a three tier system; primary, secondary and tertiary level of care.[39] The primary level of care includes primary hospital and the primary health care unit. The primary health care unit, which is composed of a health center (HC) and five satellite health posts, provides services to approximately 25,000 people. The secondary level is composed of general hospitals that each provide inpatient and ambulatory services to an average of 1,000,000 people; while at the tertiary level; a specialized hospital is intended to serve an average of five million people, in addition to serving as a referral level for the general hospitals. As of 2007 EC (2014/15 GC) there were 234 hospitals, 3,586 health centers, and 16,447 health posts in the country.[40] There has been significant increase in the number of health facilities of all types during the last couple of decades, adding to service delivery points all over the country, and the outpatient attendance per capita has reached to 0.48. The number of health facilities in the country that were providing RMNCH services was: 1,724 for BEmONC services; 696 for CBmONC services; 2,567 for PMTCT; and 1,367 for safe abortion services. In addition, 3,033 health centers were providing IMNCI, and 6,761 health posts were providing ICCM services. The deliberations on health system factors pointed out HMIS gaps/reporting system, the HMIS is outdated with some indicators lacking. The revision of the current HMIS was considered as urgent. The aspiration of high performance is overlooking the reality on the ground namely scarcities pertaining to human resources capacity and commitment as well as high turn-over. Most health services are lacking quality assurance mechanisms and are challenged by poor communication, scarce supplies and commodities and harmful cultural practices. The review mechanisms were deemed well planned but lack of follow up after supervision impedes the performance of MNCH programs thus emphasizing the need to reinforce follow up actions.

7. Research to Policy Efforts related to MNCH

Even though there are documentations with regards to Ethiopian traditional medicine starting from the sixteenth century,[41] the government officially established a research institution only in the 1950s. Currently, there are a number of institutions involved in health research within universities, professional associations, bilateral and multi-lateral organizations, as well as within private firms and non-government organizations. The research undertakings in these institutions used to be conducted on an ad-hoc basis without clearly established policies and strategies. Available records indicate that the total research output in Ethiopia (1990-2009) is about 2% as compared to 37% in South Africa and 27% in Egypt. The number of researchers per million of population (in 2007) was also 21 in Ethiopia compared to 393 and 617 in South Africa and Egypt respectively[42]. The **National Science and Technology Policy** document serves as a spring-board to initiate the formulation of detailed policies & prioritized action programs for the different economic and service sectors. It is aimed at providing the basic framework to initiate, guide, coordinate and support the efforts of the country to acquire, use and master technologies. The policy helps

[39] Federal Ministry of Health (FMOH). Health sector transformation plan (2015/16-2019/20). Addis Ababa; FMOH, 2015.

[40] Federal Ministry of Health (FMOH). Health and health related indicators for 2007 EC. Addis Ababa; FMOH, 2016.

[41] Pankhurst R. An historical examination of traditional Ethiopian medicine and surgery. *Ethiop Med J* 1965; 3: 157 - 168.

[42] African Union–New Partnership for Africa's Development (AU-NEPAD). African innovation outlook 2010, Pretoria; AU-NEPAD, 2010

research institutions in the country in the planning of their respective science and technology activities and serves as a basis for international cooperation on scientific and technological matters.[43] According to the policy, research in Ethiopia should address the major challenges of the country and contribute to the achievement of national development objectives, and within the health sector, health research is also given high priority and its importance for the development of the health sector has been properly documented in all the major health policy documents. **Formulation of research problems** are rarely based on priority health problems. They are rather driven by the agenda of funding sources, especially within the academia because of the poor linkage between researchers, implementers and policy-makers. Most of the institutions involved in health research neither make the effort to translate their research outputs into actions and decisions in the health sector nor have the mechanisms for monitoring the implementation of their research recommendations even in the rare cases where there are operational linkages to the health system. Most research results are disseminated through publications in international and local journals that have limited distribution to relevant circles. Further dissemination efforts usually target the same academic community. In addition, frontline health workers may not have the time or the technical know-how to digest results from publications usually written in technical language.

7.1. Research syntheses

In terms of systematic reviews and evidence briefs for policy are increasingly being done within the universities. However, dissemination of evidence synthesis is not well developed mostly within the academic milieu and there is no systematic support or funding for evidence synthesis activities. Overall, there is poor linkage between conducting research and policy action as research results are not readily accessible to those formulating or implementing the policy. The demand for research findings by policy makers, managers and implementers is also usually low, and research is somewhat considered a luxury by most of the public, and some politicians who represent the public. This is due to lack of awareness about its utility and the low level of scientific culture in the society. Relatively little attention has been given to generating demand for research among policy-makers, health workers, community groups and others. There is poor networking for research at national, regional and global levels. South-to-south collaborations are particularly rare. Weak cross-sectoral links (e.g.; health and education) are a continuing hindrance to effective health research conduct and dissemination. The role of the media in health research does not seem to be significant, and when there are involvements of the media in research-related issues, these are usually done not in a systematic or institutionalized manner. Therefore, most institutions involved in research have not put the necessary effort for translating their research outputs into actions within relevant sectors. They have also not devised mechanisms for monitoring the uptake of their research findings and recommendations, even in the rare cases where there are operational linkages to the relevant sector. In addition, people who are placed in positions of implementation may not have the time or the technical know-how to digest results from publications that are usually written in technical languages. Nevertheless, there are also

[43] Ministry of Science and Technology (MOST), Ethiopia. Science and technology policy of Ethiopia. Addis Ababa; MOST

instances where some outputs from research are being used to inform policies (those closely linked with FMOH and Health Bureaus).

8. Critical issues

8.1. Deliberations during the stakeholders' dialogue

The **critical issues** discussed related to (i) who does what on MNCH in Ethiopia? (ii) the discrepancies in MMR information especially population health indicators, relation to diseases, regional level indicators, and socio-cultural determinants; (iii) the low utilization of MNCH services, including reporting problems of service utilization; (iv) the M&E systems – poor reporting, and policy not matching with reality and the complicated data capture system for MNCH. The identified **underlying factors** included (i) HR skills; (ii) inadequacies in service delivery; (iii) the socio-cultural background; (iv) nutrition; (v) prevailing emergencies such as drought; and (vi) geopolitical factors. The following **actions** were suggested: (i) harmonize research with the agenda of the National Research Council; (ii) revise HRH strategy and programs – incentivize and re-train; (iii) TWG to involving professional expertise to revise MNCH programs; (iv) linking research to policy and practice; (v) conducting operations research; (vi) increasing resources for research; (vii) enhancing inter-sectoral collaboration; (viii) developing better models for information and data capture and for harmonization of data from various levels; (ix) community involvement in decision making through improved communication on programs; and (x) applying an ecological model to improvement. Some innovations were suggested namely revising the DHS protocol so as to capture vaccination data and data from health facilities; piloting use of m-health systems; training on BEmOC, compassionate and respectful MNCH, M&E, and on-site support supervision; and registration of population dynamics.

8.2. Policy process drivers

The **policy process drivers** include experiences from other countries as well as he push from donors and development partners. Typically the Ministry of health takes the lead – others contribute. Most policies are driven by evidence from baseline research and indicators derived from surveys in order to align with the country's international commitments. The policy implementation facilitators include well organized health delivery structure, community support and existing guidelines. The policy implementation barriers are mainly budget constraints; limited capacity of implementers (number, skill, and attitudes) as well as weak dedication of implementers. At the community level, culture and myths impede policy implementation. There are other factors such as poor infrastructure; lack of M&E and feedback system; and lack of implementation plans.

8.3. Equity and gender issues

Most health policy and strategy documents issued before 2005 did not explicitly articulate strategies to address equity and gender issues. Some areas are not covered and/or not well institutionalized and implementation not uniform. On the other hand, recent documents clearly mainstream gender and equity dimensions pertaining to MNCH. While equity is mentioned in most policies, its actual implementation is weak in practice and programs. There are several needs such as technology for accessing mobile communication; the family

decision-making frameworks whereby husbands make decision which affect services utilization; health infrastructure; community support and; existing guidelines.

8.4. Stakeholder analysis

Stakeholder analysis: power and interest matrix with regard to MNCH issues.

		Interest	
		Low	**High**
Power	**Low**	- Military - Husbands	- Communities - NGOs - Faith based organizations - Donors e.g. UNICEF - Professional Associations - Minister of Women & Child Affairs - Mid-wife association - Ethiopian society of Obstetrics & Gynecologists - Ethiopian Public Health Association - Policy maker(s)
	High	- Researchers /academics - Faith Based Organizations - NPC - Prime Minister - Politicians	- First Lady - Federal Ministry of Health (MNCH Directorate) - Local community - Ethiopian Pediatrics Society - World Health Organization - CDC - Save the Children - Health Minister - UNFPA - Bilateral/ Multilateral organizations

9. Key lessons from the surveys

9.1. Survey of MNCH stakeholders

A total of 36 stakeholders (21M/15F) were surveyed with 42% being into office for more than five years and 44% having a direct influence on policy-making in the three countries. In terms of Knowledge & Application of ICTs, 50% of stakeholders ranked their level of familiarity with internet as source of information « adequate » to « very adequate » and while 55% ranked their capacity to identify and obtain relevant research evidence from electronic databases « adequate » to « very adequate ». In terms of individual knowledge of policy-making process, the proportion of stakeholders ranking their familiarity « adequate » to

« very adequate » was 61% for the understanding of the policy-making process, 67% for the understanding of the meaning of priority, 61% for the understanding of the meaning of a policy brief, 47% for the understanding of what a policy dialogue is and 47% for the knowledge on the role of researchers in policy making. In summary, building additional capacities to enhance familiarity and levels of knowledge of research-to-policy tools such as policy briefs and policy dialogues is imperative.

912. **Organizational capacity**. All countries are confronted with polymorphic scarcities and shortages of resources. Fifty-three percent of stakeholders ranked the manpower of their organization « adequate » to « very adequate » while 29.4% and 32.3% ranked respectively logistics and funding « adequate » to « very adequate ». Forty-four percent of stakeholders ranked facilities as « adequate » to « very adequate » while 37.5% ranked external support « adequate » to « very adequate ». The accessibility of the services provided by organization within it geographical area of operation was ranked inadequate to fairly adequate by 58.8% of surveyed stakeholders. An ethics unit was available in 63.6% of stakeholders' organization while documents on health research ethics and benchmarking or best practices were available respectively in 72.7% and 69.7% of organizations. Finally, the degree of adherence to guidelines on ethics, benchmarking and best practices was ranked « adequate » to « very adequate » for 57.1% of stakeholders.

913. **Policy & policymaking process related to MNCH.** The following table indicates the stakeholders' views on the general climate for use of evidence in MNCH policy-making. There exist favorable conditions such as an inclusive policy on research related to MNCH and mechanisms to incorporate stakeholders' perspectives into research priorities and the proof of use of evidence from routine health information systems and surveys during health policy-making.

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Existence of a policy on health research related MNCH in your organization involving all key stakeholders									
Yes	8	66.7	5	71,4	9	69,2	22	68,8	0,976
No	4	33.3	2	28,6	4	30,8	10	31,3	
Are stakeholders' views defined and integrated within a policy on health research related to MNCH in your organization?									
Yes	8	66,7	4	66,7	9	64,3	21	65,6	0,99
No	4	33,3	2	33,3	5	35,7	11	34,4	
Existence of a forum or process to coordinate the setting of health research priorities related to MNCH in your organization									
Yes	10	90,9	5	71,4	10	66,7	25	75,8	0,346
No	1	9,1	2	28,6	5	33,3	8	24,2	
Extent your organization uses the research done by others related to MNCH									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	3,0	0,496
Inadequate	1	8,3	1	14,3	4	28,6	6	18,2	
Fairly adequate	2	16,7	2	28,6	3	21,4	7	21,2	
Adequate	6	50,0	2	28,6	6	42,9	14	42,4	

Very adequate	3	25,0	2	28,6	0	0,0	5	15,2	
Extent of use of research related to MNCH initiated/done by your organization for policymaking									
Grossly inadequate	1	8,3	0	0,0	2	14,3	3	9,4	0,64
Inadequate	1	8,3	1	16,7	5	35,7	7	21,9	
Fairly adequate	4	33,3	1	16,7	3	21,4	8	25,0	
Adequate	4	33,3	2	33,3	3	21,4	9	28,1	
Very adequate	2	16,7	2	33,3	1	7,1	5	15,6	
Extent of use of data collected routinely or by survey related to MNCH by your organization for policymaking									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	3,1	0,661
Inadequate	1	8,3	2	33,3	5	35,7	8	25,0	
Fairly adequate	3	25,0	1	16,7	2	14,3	6	18,8	
Adequate	5	41,7	2	33,3	2	14,3	9	28,1	
Very adequate	3	25,0	1	16,7	4	28,6	8	25,0	
Relevance of evidence related to MNCH used by your organization for policymaking									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	3,1	0,421
Inadequate	0	0,0	0	0,0	1	7,1	1	3,1	
Fairly adequate	1	8,3	1	16,7	3	21,4	5	15,6	
Adequate	9	75,0	2	33,3	4	28,6	15	46,9	
Very adequate	2	16,7	3	50,0	5	35,7	10	31,3	
Number of policy documents related to MNCH made by policymakers from your organization in the last 5 years									
1-3	0	0,0	0	0,0	3	21,4	3	10,0	0,522
4-6	2	20,0	1	16,7	1	7,1	4	13,3	
7-10	1	10,0	0	0,0	2	14,3	3	10,0	
>=11	1	10,0	1	16,7	0	0,0	2	6,7	
Don't know	6	60,0	4	66,7	8	57,1	18	60,0	

914. **Acquisition of research evidence relevant to MNCH.** The table below illustrates the low level of incentives for research use in the organization. On the other hand, individual knowledge to conduct research, to access and use existing evidence and the organizational capacities to initiate and to source evidence needed for MNCH policy-making are ranked from fairly adequate to very adequate by a large majority of stakeholders.

	Malawi		**Tanzania**		**Ethiopia**		**All**		**p**
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
Present knowledge about initiating/conducting research in general and in MNCH specifically									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,777
Inadequate	2	16,7	0	0,0	1	7,1	3	8,8	
Fairly adequate	3	25,0	2	25,0	5	35,7	10	29,4	
Adequate	4	33,3	3	37,5	6	42,9	13	38,2	
Very adequate	3	25,0	3	37,5	2	14,3	8	23,5	
Ability to access and use existing research evidence in general and in MNCH specifically									
Grossly inadequate	1	8,3	0	0,0	0	0,0	1	2,9	0,768

Inadequate	0	0,0	0	0,0	1	7,1	1	2,9	
Fairly adequate	3	25,0	2	25,0	5	35,7	10	29,4	
Adequate	6	50,0	4	50,0	4	28,6	14	41,2	
Very adequate	2	16,7	2	25,0	4	28,6	8	23,5	
Capacity of your organization to initiate research in general and in MNCH specifically									
Grossly inadequate	0	0,0	1	12,5	1	6,7	2	5,7	0,617
Inadequate	0	0,0	1	12,5	2	13,3	3	8,6	
Fairly adequate	6	50,0	1	12,5	6	40,0	13	37,1	
Adequate	4	33,3	2	25,0	3	20,0	9	25,7	
Very adequate	2	16,7	3	37,5	3	20,0	8	22,9	
Capacity of your organization to source for research evidence in general and MNCH specifically									
Grossly inadequate	0	0,0	1	12,5	1	6,7	2	5,7	0,255
Inadequate	1	8,3	0	0,0	2	13,3	3	8,6	
Fairly adequate	2	16,7	1	12,5	6	40,0	9	25,7	
Adequate	7	58,3	2	25,0	4	26,7	13	37,1	
Very adequate	2	16,7	4	50,0	2	13,3	8	22,9	
Level of research incentives available in your organization in general and in MNCH specifically									
Grossly inadequate	1	8,3	0	0,0	2	13,3	3	8,6	0,502
Inadequate	2	16,7	3	37,5	4	26,7	9	25,7	
Fairly adequate	6	50,0	2	25,0	4	26,7	12	34,3	
Adequate	3	25,0	1	12,5	4	26,7	8	22,9	
Very adequate	0	0,0	2	25,0	1	6,7	3	8,6	

915. **Assessing the validity, quality, applicability of research evidence.** The levels of incentives to assess the validity, quality and applicability or to encourage the use of research evidence ranked grossly inadequate/inadequate by 28.6 to 31.4% while the skills to do so ranked inadequate by 8 to 27.3% of stakeholders. These findings point at pressing needs for capacity building amongst policy-makers, managers and implementers in matters related to EIHP and EBHP.

	Malawi		**Tanzania**		**Ethiopia**		**All**		**p**
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
The skill to evaluate & appropriate the quality of research methodology									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,486
Inadequate	4	36,4	1	12,5	4	28,6	9	27,3	
Fairly adequate	1	9,1	2	25,0	5	35,7	8	24,2	
Adequate	4	36,4	4	50,0	5	35,7	13	39,4	
Very adequate	2	18,2	1	12,5	0	0,0	3	9,1	
The skill to evaluate the reliability of specific research evidence and to compare research methods and results									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,659
Inadequate	4	33,3	1	12,5	4	30,8	9	27,3	
Fairly adequate	2	16,7	3	37,5	5	38,5	10	30,3	
Adequate	4	33,3	3	37,5	4	30,8	11	33,3	

Very adequate	2	16,7	1	12,5	0	0,0	3	9,1	
The skill to identify relevant similarities and differences between research evidence									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,597
Inadequate	1	8,3	1	12,5	1	7,1	3	8,8	
Fairly adequate	4	33,3	1	12,5	5	35,7	10	29,4	
Adequate	5	41,7	4	50,0	8	57,1	17	50,0	
Very adequate	2	16,7	2	25,0	0	0,0	4	11,8	
The skill to evaluate the differences in the research evidence in the context of your organization									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,201
Inadequate	3	27,3	1	12,5	0	0,0	4	12,5	
Fairly adequate	2	18,2	1	12,5	4	30,8	7	21,9	
Adequate	4	36,4	4	50,0	9	69,2	17	53,1	
Very adequate	2	18,2	2	25,0	0	0,0	4	12,5	
Incentives for assessment of the validity, quality and applicability of research evidence and in MNCH specifically									
Grossly inadequate	0	0,0	1	12,5	1	6,7	2	5,7	0,530
Inadequate	2	16,7	1	12,5	6	40,0	9	25,7	
Fairly adequate	4	33,3	2	25,0	4	26,7	10	28,6	
Adequate	4	33,3	2	25,0	4	26,7	10	28,6	
Very adequate	2	16,7	2	25,0	0	0,0	4	11,4	
Incentives to encourage the application of research evidence in general and in MNCH specifically									
Grossly inadequate	0	0,0	0	0,0	2	13,3	2	5,7	0,302
Inadequate	2	16,7	2	25,0	4	26,7	8	22,9	
Fairly adequate	3	25,0	3	37,5	7	46,7	13	37,1	
Adequate	5	41,7	1	12,5	1	6,7	7	20,0	
Very adequate	2	16,7	2	25,0	1	6,7	5	14,3	

916. **Adapting the format of research results to provide information useful to decision makers.** The table below indicates discrepancy between the high level of skills and the weak incentives to adapt research evidence to the needs of decision-makers.

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Present research results concisely in audience targeted language									
Grossly inadequate	1	8,3	0	0,0	0	0,0	1	2,9	0,169
Inadequate	2	16,7	0	0,0	3	20,0	5	14,3	
Fairly adequate	1	8,3	3	37,5	6	40,0	10	28,6	
Adequate	7	58,3	2	25,0	5	33,3	14	40,0	
Very adequate	1	8,3	3	37,5	1	6,7	5	14,3	
Synthesize in one document relevant research as well as information and analysis from other sources									
Grossly inadequate	0	0,0	0	0,0	1	6,7	1	2,9	0,694
Inadequate	3	25,0	0	0,0	3	20,0	6	17,6	
Fairly adequate	2	16,7	2	28,6	4	26,7	8	23,5	
Adequate	6	50,0	3	42,9	6	40,0	15	44,1	

Very adequate	1	8,3	2	28,6	1	6,7	4	11,8	
Link the research results to key issues and provide recommendations									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,316
Inadequate	3	25,0	0	0,0	2	14,3	5	14,7	
Fairly adequate	0	0,0	2	25,0	5	35,7	7	20,6	
Adequate	8	66,7	5	62,5	6	42,9	19	55,9	
Very adequate	1	8,3	1	12,5	1	7,1	3	8,8	
Ability to present results of research to decision makers in general and in MNCH specifically									
Grossly inadequate	0	0,0	0	0,0	0	0,0	0	0,0	0,802
Inadequate	2	16,7	0	0,0	1	6,7	3	8,6	
Fairly adequate	4	33,3	3	37,5	7	46,7	14	40,0	
Adequate	5	41,7	3	37,5	5	33,3	13	37,1	
Very adequate	1	8,3	2	25,0	2	13,3	5	14,3	
Incentives to encourage the provision of research evidence to decision									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	2,9	0,755
Inadequate	2	16,7	2	25,0	4	28,6	8	23,5	
Fairly adequate	3	25,0	2	25,0	6	42,9	11	32,4	
Adequate	5	41,7	3	37,5	2	14,3	10	29,4	
Very adequate	2	16,7	1	12,5	1	7,1	4	11,8	

917. **Application of evidence in decision making.** The table below shows the findings on the existence of an enabling environment to foster the application of evidence in decision making. Less than 25% of stakeholders ranked all items as grossly inadequate to inadequate except for "usual participation in the discussion before a decision is made"; "effective communication channels" and; "presentation and discussion on research evidence related to the organization main's goals".

	Malawi		**Tanzania**		**Ethiopia**		**All**		**p**
	n	**%**	**n**	**%**	**n**	**%**	**n**	**%**	
Using research is a priority									
Grossly inadequate	0	0,0	1	14,3	1	7,1	2	6,1	0,424
Inadequate	1	8,3	1	14,3	2	14,3	4	12,1	
Fairly adequate	4	33,3	3	42,9	6	42,9	13	39,4	
Adequate	4	33,3	0	0,0	5	35,7	9	27,3	
Very adequate	3	25,0	2	28,6	0	0,0	5	15,2	
Enough focus on activities which encourage using research									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	2,9	0,278
Inadequate	2	16,7	1	12,5	2	14,3	5	14,7	
Fairly adequate	3	25,0	4	50,0	7	50,0	14	41,2	
Adequate	4	33,3	0	0,0	4	28,6	8	23,5	
Very adequate	3	25,0	3	37,5	0	0,0	6	17,6	
Presentation and discussion on research evidence related to the organization main's goals									
Grossly inadequate	0	0,0	0	0,0	1	7,7	1	3,0	0,618

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Inadequate	3	25,0	4	50,0	2	15,4	9	27,3	
Fairly adequate	2	16,7	1	12,5	4	30,8	7	21,2	
Adequate	4	33,3	2	25,0	5	38,5	11	33,3	
Very adequate	3	25,0	1	12,5	1	7,7	5	15,2	
Management has clearly communicated corporate strategy and priority areas for improvement									
Grossly inadequate	0	0,0	0	0,0	2	14,3	2	6,1	0,172
Inadequate	3	25,0	2	28,6	1	7,1	6	18,2	
Fairly adequate	2	16,7	4	57,1	5	35,7	11	33,3	
Adequate	3	25,0	0	0,0	5	35,7	8	24,2	
Very adequate	4	33,3	1	14,3	1	7,1	6	18,2	
Effective communication channels									
Grossly inadequate	0	0,0	0	0,0	3	20,0	3	8,6	0,4
Inadequate	2	16,7	2	25,0	2	13,3	6	17,1	
Fairly adequate	2	16,7	1	12,5	1	6,7	4	11,4	
Adequate	3	25,0	2	25,0	7	46,7	12	34,3	
Very adequate	5	41,7	3	37,5	2	13,3	10	28,6	
Our corporate culture is to value and reward flexibility									
Grossly inadequate	0	0,0	1	14,3	2	14,3	3	9,1	0,905
Inadequate	1	8,3	1	14,3	3	21,4	5	15,2	
Fairly adequate	3	25,0	2	28,6	3	21,4	8	24,2	
Adequate	5	41,7	2	28,6	4	28,6	11	33,3	
Very adequate	3	25,0	1	14,3	2	14,3	6	18,2	
Allowing enough time to identify researchable questions									
Grossly inadequate	0	0,0	0	0,0	2	14,3	2	6,3	0,356
Inadequate	1	8,3	2	33,3	2	14,3	5	15,6	
Fairly adequate	5	41,7	3	50,0	5	35,7	13	40,6	
Adequate	4	33,3	0	0,0	5	35,7	9	28,1	
Very adequate	2	16,7	1	16,7	0	0,0	3	9,4	
Enough expertise to evaluate to evaluate the feasibility of each options									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	2,9	0,606
Inadequate	1	8,3	2	25,0	2	14,3	5	14,7	
Fairly adequate	3	25,0	1	12,5	2	14,3	6	17,6	
Adequate	5	41,7	5	62,5	8	57,1	18	52,9	
Very adequate	3	25,0	0	0,0	1	7,1	4	11,8	
Decision makers usually give formal consideration to any resulting recommendations									
Grossly inadequate	0	0,0	0	0,0	2	14,3	2	6,1	0,202
Inadequate	1	8,3	0	0,0	2	14,3	3	9,1	
Fairly adequate	4	33,3	6	85,7	3	21,4	13	39,4	
Adequate	5	41,7	1	14,3	5	35,7	11	33,3	
Very adequate	2	16,7	0	0,0	2	14,3	4	12,1	
Knowing when and how major decisions will be made									

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	3,0	0,705
Inadequate	0	0,0	1	14,3	2	14,3	3	9,1	
Fairly adequate	4	33,3	3	42,9	6	42,9	13	39,4	
Adequate	6	50,0	3	42,9	4	28,6	13	39,4	
Very adequate	2	16,7	0	0,0	1	7,1	3	9,1	
Usual participation in the discussion before a decision is made									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	2,9	0,788
Inadequate	2	16,7	2	25,0	5	35,7	9	26,5	
Fairly adequate	3	25,0	2	25,0	2	14,3	7	20,6	
Adequate	5	41,7	4	50,0	4	28,6	13	38,2	
Very adequate	2	16,7	0	0,0	2	14,3	4	11,8	
Rational inclusion for the decision, and review of how the available evidence influenced the choice made									
Grossly inadequate	0	0,0	0	0,0	1	7,1	1	3,0	0,61
Inadequate	1	8,3	1	14,3	4	28,6	6	18,2	
Fairly adequate	4	33,3	4	57,1	3	21,4	11	33,3	
Adequate	5	41,7	2	28,6	5	35,7	12	36,4	
Very adequate	2	16,7	0	0,0	1	7,1	3	9,1	

9.2. Survey of researchers from IRTs

921. A total of 31 researchers (27M/4F) were surveyed with 80% having direct influence in health policy-making. In terms of knowledge & application of ICT, computer literacy was almost 99%. The level of knowledge of electronic databases where health research evidence is available ranked adequate to very adequate by 53.3% of respondents while the capacity to identify and obtain relevant research evidence from electronic databases ranked adequate to very adequate by 56.7% of respondents In terms of individual knowledge of the policy-making process, a minority (22.6%) of researchers were "frequently to very frequently" involved into policy-making within their organization with significant differences across countries while 51.6% ranked their level of knowledge of the meaning of policy adequate to very adequate.

922. **Individual knowledge of policy-making process.** The table below indicates a remarkable level of knowledge of policy-making with disparities across countries.

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Involvement in the policy making process in your organization									
Nil	3	14,3	0	0,0	1	14,3	4	12,9	**0,029***
Less frequently	10	47,6	0	0,0	1	14,3	11	35,5	
Fairly frequently	5	23,8	1	33,3	3	42,9	9	29,0	
Frequently	2	9,5	0	0,0	2	28,6	4	12,9	

Very frequently	1	4,8	2	66,7	0	0,0	3	9,7	
Level of knowledge of the meaning of policy									
Inadequate	1	4,8	0	0,0	1	14,3	2	6,5	0.186
Fairly adequate	12	57,1	1	33,3	0	0,0	13	41,9	
Adequate	6	28,6	2	66,7	4	57,1	12	38,7	
Very adequate	2	9,5	0	0,0	2	28,6	4	12,9	
Understanding of policy context									
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	0.224
Fairly adequate	12	57,1	2	66,7	1	14,3	15	48,4	
Adequate	4	19,0	1	33,3	4	57,1	9	29,0	
Very adequate	2	9,5	0	0,0	2	28,6	4	12,9	
Level of your knowledge about stakeholder's and various actor's involvement in policy making									
Inadequate	2	9,5	0	0,0	0	0,0	2	6,5	0.417
Fairly adequate	11	52,4	1	33,3	1	14,3	13	41,9	
Adequate	6	28,6	2	66,7	5	71,4	13	41,9	
Very adequate	2	9,5	0	0,0	1	14,3	3	9,7	
Level of understanding of policy making process									
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	0.107
Fairly adequate	14	66,7	1	33,3	2	28,6	17	54,8	
Adequate	2	9,5	2	66,7	3	42,9	7	22,6	
Very adequate	2	9,5	0	0,0	2	28,6	4	12,9	
Level of understanding of the meaning of priority setting/policy agenda in policy making									
Inadequate	8	38,1	0	0,0	0	0,0	8	25,8	0.182
Fairly adequate	8	38,1	2	66,7	2	28,6	12	38,7	
Adequate	3	14,3	1	33,3	4	57,1	8	25,8	
Very adequate	2	9,5	0	0,0	1	14,3	3	9,7	
Level of understanding of the meaning of a policy brief									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	**0,016***
Inadequate	5	23,8	1	33,3	0	0,0	6	19,4	
Fairly adequate	13	61,9	1	33,3	1	14,3	15	48,4	
Adequate	1	4,8	1	33,3	6	85,7	8	25,8	
Very adequate	1	4,8	0	0,0	0	0,0	1	3,2	
Level of understanding of what a policy dialogue is									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	0,384
Inadequate	7	33,3	1	33,3	0	0,0	8	25,8	
Fairly adequate	9	42,9	0	0,0	4	57,1	13	41,9	
Adequate	3	14,3	2	66,7	2	28,6	7	22,6	
Very adequate	1	4,8	0	0,0	1	14,3	2	6,5	
Knowledge on the role of researchers in policy making									
Inadequate	1	4,8	0	0,0	0	0,0	1	3,2	0.478
Fairly adequate	8	38,1	1	33,3	0	0,0	9	29,0	
Adequate	9	42,9	1	33,3	4	57,1	14	45,2	
Very adequate	3	14,3	1	33,3	3	42,9	7	22,6	

924. **Individual knowledge for use of evidence.** The table below indicates disparities in individual levels of the types and sources of evidence needed to inform policy-making suggesting there are needs for capacity building among researchers in matters related to EIHP, EBHP and evidence synthesis.

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Level of understanding on what evidence is in policy-making context									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	
Fairly adequate	9	42,9	0	0,0	0	0,0	9	29,0	0,148
Adequate	5	23,8	2	66,7	6	85,7	13	41,9	
Very adequate	3	14,3	1	33,3	1	14,3	5	16,1	
Knowledge on the types of evidence that can be used for policy making									
Grossly inadequate	1	4,8	1	33,3	0	0,0	2	6,5	
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	
Fairly adequate	12	57,1	0	0,0	1	14,3	13	41,9	0,06
Adequate	4	19,0	2	66,7	5	71,4	11	35,5	
Very adequate	1	4,8	0	0,0	1	14,3	2	6,5	
Level of knowledge on the sources of evidence used for policy making									
Grossly inadequate	1	4,8	1	33,3	0	0,0	2	6,5	
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	
Fairly adequate	12	57,1	0	0,0	1	14,3	13	41,9	0,042*
Adequate	4	19,0	2	66,7	4	57,1	10	32,3	
Very adequate	1	4,8	0	0,0	2	28,6	3	9,7	
Capacity to identify/select relevant evidence for policy making									
Grossly inadequate	1	4,8	1	33,3	0	0,0	2	6,5	
Inadequate	5	23,8	0	0,0	0	0,0	5	16,1	
Fairly adequate	11	52,4	0	0,0	3	42,9	14	45,2	0,067
Adequate	3	14,3	2	66,7	2	28,6	7	22,6	
Very adequate	1	4,8	0	0,0	2	28,6	3	9,7	
Ability to adapt evidence used for policy making									
Grossly inadequate	1	4,8	1	33,3	0	0,0	2	6,5	
Inadequate	4	19,0	0	0,0	0	0,0	4	12,9	
Fairly adequate	12	57,1	1	33,3	1	14,3	14	45,2	0,012*
Adequate	2	9,5	1	33,3	6	85,7	9	29,0	
Very adequate	2	9,5	0	0,0	0	0,0	2	6,5	

925. **IRT organizational capacities.** The following table indicates that a majority of researchers are not satisfied with the level of availability of repositories, the level of research production, and the quality of existing peer-reviews mechanisms.

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Availability of information repository or data base for members of your team									
Very few	2	10,0	1	33,3	1	14,3	4	13,3	0.904
Few	11	55,0	1	33,3	3	42,9	15	50,0	
Many	6	30,0	1	33,3	3	42,9	10	33,3	
Very many	1	5,0	0	0,0	0	0,0	1	3,3	
Number of health research products published per year by members of your team									
None	1	4,8	0	0,0	0	0,0	1	3,2	0.756
Very few	4	19,0	0	0,0	0	0,0	4	12,9	
Few	11	52,4	3	100,0	6	85,7	20	64,5	
Many	4	19,0	0	0,0	1	14,3	5	16,1	
Very many	1	4,8	0	0,0	0	0,0	1	3,2	
Availability of peer review mechanisms for members of your team									
Not available	1	5,0	0	0,0	1	14,3	2	6,7	0.352
Non functional	3	15,0	0	0,0	0	0,0	3	10,0	
Slightly functional	13	65,0	1	33,3	3	42,9	17	56,7	
Functional	3	15,0	2	66,7	3	42,9	8	26,7	
Quality of peer review mechanisms that members of your team have access to									
									0.888
Non functional	4	21,1	0	0,0	1	14,3	5	17,2	
Slightly functional	7	36,8	1	33,3	3	42,9	11	37,9	
Functional	8	42,1	2	66,7	3	42,9	13	44,8	
Number of research projects initiated/executed in the last 3 years by members of your team									
None	2	10,5	0	0,0	1	14,3	3	10,3	0.904
Very few	4	21,1	0	0,0	1	14,3	5	17,2	
Few	9	47,4	3	100,0	4	57,1	16	55,2	
Many	3	15,8	0	0,0	1	14,3	4	13,8	
Very many	1	5,3	0	0,0	0	0,0	1	3,4	
Number of active MNCH researchers in your team									
None	1	4,8	0	0,0	0	0,0	1	3,2	0.042
Very few	4	19,0	0	0,0	1	14,3	5	16,1	
Few	6	28,6	2	66,7	5	71,4	13	41,9	
Many	10	47,6	0	0,0	1	14,3	11	35,5	
Very many	0	0,0	1	33,3	0	0,0	1	3,2	
How many journals does your team subscribe to?									
None	2	10,0	0	0,0	1	14,3	3	10,0	0,322

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Very few	5	25,0	1	33,3	0	0,0	6	20,0	
Few	8	40,0	2	66,7	6	85,7	16	53,3	
Many	5	25,0	0	0,0	0	0,0	5	16,7	
Number of primary research outputs produced by members of your team in the last 3 years									
None	1	4,8	0	0,0	0	0,0	1	3,3	0,631
Very few	6	28,6	0	0,0	0	0,0	6	20,0	
Few	11	52,4	2	66,7	5	83,3	18	60,0	
Many	3	14,3	1	33,3	1	16,7	5	16,7	
Number of research briefs targeting policy makers produced by your team in the last 3 years									
None	4	19,0	1	33,3	1	14,3	6	19,4	0,521
Very few	6	28,6	1	33,3	4	57,1	11	35,5	
Few	9	42,9	0	0,0	1	14,3	10	32,3	
Many	2	9,5	1	33,3	1	14,3	4	12,9	
Number of systematic reviews produced by members of your team in the last 3 years									
None	9	42,9	1	33,3	0	0,0	10	32,3	0,113
Very few	5	23,8	1	33,3	2	28,6	8	25,8	
Few	5	23,8	0	0,0	5	71,4	10	32,3	
Many	2	9,5	1	33,3	0	0,0	3	9,7	
Dissemination of research products from members of your team on MNCH									
Grossly inadequate	2	9,5	1	33,3	0	0,0	3	9,7	0,335
Inadequate	6	28,6	0	0,0	4	57,1	10	32,3	
Fairly adequate	10	47,6	1	33,3	3	42,9	14	45,2	
Adequate	3	14,3	1	33,3	0	0,0	4	12,9	
Access to a communication specialist by your team on MNCH									
Grossly inadequate	4	20,0	0	0,0	1	14,3	5	16,7	0,976
Inadequate	7	35,0	1	33,3	3	42,9	11	36,7	
Fairly adequate	5	25,0	1	33,3	2	28,6	8	26,7	
Adequate	4	20,0	1	33,3	1	14,3	6	20,0	
Level of priority of research									
Grossly inadequate	2	9,5	0	0,0	0	0,0	2	6,5	0,287
Inadequate	1	4,8	0	0,0	3	42,9	4	12,9	
Fairly adequate	8	38,1	2	66,7	2	28,6	12	38,7	
Adequate	4	19,0	1	33,3	1	14,3	6	19,4	
Very adequate	6	28,6	0	0,0	1	14,3	7	22,6	

926. Policy & policymaking process related to maternal, newborn & child health

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Existence of a policy on health research related MNCH in your organization involving all key stakeholders									
Yes	13	100,0	3	100,0	3	75,0	19	95,0	0,122
No	0	0,0	0	0,0	1	25,0	1	5,0	
Stakeholders' views defined and integrated within a policy on health research related to MNCH									
Yes	14	82,4	3	100,0	2	100,0	19	86,4	0,6
No	3	17,6	0	0,0	0	0,0	3	13,6	
Existence of a forum or process to coordinate the setting of health research priorities related to MNCH									
Yes	12	92,3	3	100,0	5	100,0	20	95,2	0,724
No	1	7,7	0	0,0	0	0,0	1	4,8	
Extent to which your research institution uses the research done by others related to MNCH									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	0,857
Inadequate	2	9,5	1	33,3	2	28,6	5	16,1	
Fairly adequate	9	42,9	1	33,3	4	57,1	14	45,2	
Adequate	8	38,1	1	33,3	1	14,3	10	32,3	
Very adequate	1	4,8	0	0,0	0	0,0	1	3,2	
Extent to which your research related to MNCH was used for policy-making									
Grossly inadequate	2	9,5	0	0,0	2	28,6	4	12,9	0,845
Inadequate	5	23,8	1	33,3	2	28,6	8	25,8	
Fairly adequate	9	42,9	1	33,3	2	28,6	12	38,7	
Adequate	5	23,8	1	33,3	1	14,3	7	22,6	
Extent to which your research institution uses data collected routinely or survey related to MNCH									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	0,776
Inadequate	6	28,6	1	33,3	3	42,9	10	32,3	
Fairly adequate	7	33,3	1	33,3	4	57,1	12	38,7	
Adequate	4	19,0	1	33,3	0	0,0	5	16,1	
Very adequate	3	14,3	0	0,0	0	0,0	3	9,7	
Number of research papers/reports related to MNCH									
None	2	10,5	0	0,0	2	28,6	4	13,8	0,456
1-3	4	21,1	2	66,7	3	42,9	9	31,0	
4-6	3	15,8	1	33,3	0	0,0	4	13,8	
7-10	5	26,3	0	0,0	1	14,3	6	20,7	
>=11	5	26,3	0	0,0	1	14,3	6	20,7	

927. Acquisition of research evidence relevant to MNCH

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Present knowledge about initiating/conducting research in general and in MNCH									
Inadequate	4	19,0	0	0,0	0	0,0	4	12,9	0.825
Fairly adequate	5	23,8	1	33,3	2	28,6	8	25,8	
Adequate	11	52,4	2	66,7	5	71,4	18	58,1	
Very adequate	1	4,8	0	0,0	0	0,0	1	3,2	
Ability to access and use existing research evidence in general and in MNCH									
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	0.815
Fairly adequate	6	28,6	1	33,3	3	42,9	10	32,3	
Adequate	10	47,6	2	66,7	4	57,1	16	51,6	
Very adequate	2	9,5	0	0,0	0	0,0	2	6,5	
Capacity of your organization to initiate research in general and in MNCH									
Inadequate	2	9,5	0	0,0	1	14,3	3	9,7	0.862
Fairly adequate	8	38,1	1	33,3	1	14,3	10	32,3	
Adequate	8	38,1	2	66,7	4	57,1	14	45,2	
Very adequate	3	14,3	0	0,0	1	14,3	4	12,9	
Capacity of your organization to source for research evidence in general and MNCH									
Inadequate	2	9,5	0	0,0	1	14,3	3	9,7	0.32
Fairly adequate	11	52,4	0	0,0	2	28,6	13	41,9	
Adequate	5	23,8	2	66,7	4	57,1	11	35,5	
Very adequate	3	14,3	1	33,3	0	0,0	4	12,9	
Level of research incentives available in your organization in general and in MNCH									
Grossly inadequate	1	4,8	0	0,0	2	28,6	3	9,7	0,147
Inadequate	3	14,3	0	0,0	2	28,6	5	16,1	
Fairly adequate	9	42,9	0	0,0	2	28,6	11	35,5	
Adequate	6	28,6	3	100,0	1	14,3	10	32,3	
Very adequate	2	9,5	0	0,0	0	0,0	2	6,5	

928. **Assessing the validity, quality, applicability of research evidence to MNCH**

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
The skill to evaluate & appropriate the quality of research methodology									
Inadequate	6	28,6	1	33,3	0	0,0	7	22,6	0.365
Fairly adequate	8	38,1	0	0,0	2	28,6	10	32,3	
Adequate	6	28,6	2	66,7	5	71,4	13	41,9	
Very adequate	1	4,8	0	0,0	0	0,0	1	3,2	
The skill to evaluate the reliability of specific research evidence and to compare research methods and results									
Inadequate	5	26,3	1	33,3	0	0,0	6	21,4	0.296
Fairly adequate	9	47,4	0	0,0	2	33,3	11	39,3	
Adequate	4	21,1	2	66,7	4	66,7	10	35,7	
Very adequate	1	5,3	0	0,0	0	0,0	1	3,6	
The skill to identify relevant similarities and differences between research evidence									
Grossly inadequate	1	4,8	0	0,0	0	0,0	1	3,2	0,192
Inadequate	5	23,8	0	0,0	1	14,3	6	19,4	
Fairly adequate	10	47,6	0	0,0	1	14,3	11	35,5	
Adequate	4	19,0	3	100,0	4	57,1	11	35,5	
Very adequate	1	4,8	0	0,0	1	14,3	2	6,5	
The skill to evaluate the differences in the research evidences in the context of your organization									
Grossly inadequate	1	5,0	0	0,0	0	0,0	1	3,6	0,583
Inadequate	3	15,0	1	33,3	1	20,0	5	17,9	
Fairly adequate	10	50,0	0	0,0	1	20,0	11	39,3	
Adequate	6	30,0	2	66,7	3	60,0	11	39,3	
Incentives for assessment of the validity, quality and applicability of research evidence in general and in MNCH									
Grossly inadequate	0	0,0	0	0,0	1	14,3	1	3,3	0,571
Inadequate	6	30,0	1	33,3	1	14,3	8	26,7	
Fairly adequate	9	45,0	1	33,3	4	57,1	14	46,7	
Adequate	2	10,0	1	33,3	1	14,3	4	13,3	
Very adequate	3	15,0	0	0,0	0	0,0	3	10,0	
Incentives to encourage the application of research evidence in general and in MNCH									

Grossly inadequate	1	5,0	0	0,0	1	14,3	2	6,7	0,975
Inadequate	5	25,0	1	33,3	2	28,6	8	26,7	
Fairly adequate	9	45,0	1	33,3	2	28,6	12	40,0	
Adequate	4	20,0	1	33,3	2	28,6	7	23,3	
Very adequate	1	5,0	0	0,0	0	0,0	1	3,3	

929. **Adapting the format of research results to provide information useful to decision makers**

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Present research results concisely in audience targeted language									
Grossly inadequate	0	0,0	0	0,0	1	14,3	1	3,2	**0.017**
Inadequate	4	19,0	0	0,0	0	0,0	4	12,9	
Fairly adequate	11	52,4	1	33,3	2	28,6	14	45,2	
Adequate	6	28,6	0	0,0	1	14,3	7	22,6	
Very adequate	0	0,0	2	66,7	3	42,9	5	16,1	
Synthesize in one document relevant research as well as information and analysis from other sources									
Grossly inadequate	0	0,0	0	0,0	1	14,3	1	3,2	**0.059**
Inadequate	4	19,0	0	0,0	0	0,0	4	12,9	
Fairly adequate	11	52,4	0	0,0	2	28,6	13	41,9	
Adequate	6	28,6	2	66,7	2	28,6	10	32,3	
Very adequate	0	0,0	1	33,3	2	28,6	3	9,7	
Link the research results to key issues and provide recommendations									
Inadequate	4	20,0	0	0,0	1	20,0	5	17,9	0.507
Fairly adequate	8	40,0	0	0,0	1	20,0	9	32,1	
Adequate	7	35,0	2	66,7	2	40,0	11	39,3	
Very adequate	1	5,0	1	33,3	1	20,0	3	10,7	
Ability to present results of research to decision makers in general and in MNCH									
Inadequate	3	14,3	0	0,0	0	0,0	3	9,7	0.708
Fairly adequate	7	33,3	0	0,0	3	42,9	10	32,3	
Adequate	8	38,1	2	66,7	3	42,9	13	41,9	
Very adequate	3	14,3	1	33,3	1	14,3	5	16,1	
Incentives to encourage the provision of research evidence to decision makers in general and in MNCH									
Grossly inadequate	1	5,0	0	0,0	1	16,7	2	6,9	0,239
Inadequate	7	35,0	0	0,0	2	33,3	9	31,0	
Fairly adequate	8	40,0	0	0,0	2	33,3	10	34,5	
Adequate	3	15,0	2	66,7	1	16,7	6	20,7	
Very adequate	1	5,0	1	33,3	0	0,0	2	6,9	

930a. **Application of evidence in decision making**

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Using research is a priority									
Grossly inadequate	1	4.8	0	0.0	1	14.3	2	6.5	0.699
Inadequate	5	23.8	1	33.3	0	0.0	6	19.4	
Fairly adequate	8	38.1	1	33.3	3	42.9	12	38.7	
Adequate	4	19.0	1	33.3	3	42.9	8	25.8	
Very adequate	3	14.3	0	0.0	0	0.0	3	9.7	
Enough focus on activities which encourage using research									
Inadequate	6	28.6	1	33.3	2	28.6	9	29.0	0.8
Fairly adequate	8	38.1	1	33.3	3	42.9	12	38.7	
Adequate	3	14.3	0	0.0	2	28.6	5	16.1	
Very adequate	4	19.0	1	33.3	0	0.0	5	16.1	
Presentation and discussion on research evidence related to the organization main's goals									
Grossly inadequate	1	4.8	0	0.0	0	0.0	1	3.2	0.942
Inadequate	6	28.6	1	33.3	1	14.3	8	25.8	
Fairly adequate	9	42.9	1	33.3	5	71.4	15	48.4	
Adequate	4	19.0	1	33.3	1	14.3	6	19.4	
Very adequate	1	4.8	0	0.0	0	0.0	1	3.2	
Management has clearly communicated corporate strategy and priority areas for improvement									
Grossly inadequate	1	4.8	0	0.0	0	0.0	1	3.2	0,802
Inadequate	9	42.9	1	33.3	1	14.3	11	35.5	
Fairly adequate	4	19.0	1	33.3	3	42.9	8	25.8	
Adequate	7	33.3	1	33.3	3	42.9	11	35.5	
Effective communication channels									
Grossly inadequate	1	5.0	0	0.0	1	14.3	2	6.7	0,82
Inadequate	7	35.0	1	33.3	1	14.3	9	30.0	
Fairly adequate	8	40.0	1	33.3	2	28.6	11	36.7	
Adequate	4	20.0	1	33.3	3	42.9	8	26.7	
Our corporate culture is to value and reward flexibility									
Grossly inadequate	1	5.0	0	0.0	1	14.3	2	6.7	0,88
Inadequate	4	20.0	1	33.3	1	14.3	6	20.0	
Fairly adequate	9	45.0	1	33.3	2	28.6	12	40.0	
Adequate	4	20.0	1	33.3	3	42.9	8	26.7	
Very adequate	2	10.0	0	0.0	0	0.0	2	6.7	
Allowing enough time to identify researchable questions									
Grossly inadequate	1	4.8	0	0.0	0	0.0	1	3.2	0,996
Inadequate	5	23.8	1	33.3	2	28.6	8	25.8	
Fairly adequate	7	33.3	1	33.3	3	42.9	11	35.5	
Adequate	7	33.3	1	33.3	2	28.6	10	32.3	
Very adequate	1	4.8	0	0.0	0	0.0	1	3.2	
Enough expertise to evaluate to evaluate the feasibility of each options									
Grossly inadequate	0	0.0	0	0.0	1	14.3	1	3.2	0,614
Inadequate	7	33.3	1	33.3	1	14.3	9	29.0	
Fairly adequate	8	38.1	1	33.3	2	28.6	11	35.5	
Adequate	4	19.0	0	0.0	2	28.6	6	19.4	
Very adequate	2	9.5	1	33.3	1	14.3	4	12.9	
Decision makers usually give formal consideration to any resulting recommendations									
Grossly inadequate	3	14.3	0	0.0	0	0.0	3	9.7	0,864
Inadequate	5	23.8	1	33.3	3	42.9	9	29.0	
Fairly adequate	8	38.1	1	33.3	3	42.9	12	38.7	
Adequate	5	23.8	1	33.3	1	14.3	7	22.6	
Knowing when and how major decisions will be made									
Grossly inadequate	2	10.0	0	0.0	0	0.0	2	6.7	0,893
Inadequate	7	35.0	1	33.3	1	14.3	9	30.0	
Fairly adequate	6	30.0	1	33.3	3	42.9	10	33.3	
Adequate	4	20.0	1	33.3	3	42.9	8	26.7	
Very adequate	1	5.0	0	0.0	0	0.0	1	3.3	
Usual participation in the discussion before a decision is made									
Grossly inadequate	2	9.5	0	0.0	0	0.0	2	6.9	0,448
Inadequate	8	38.1	1	33.3	1	20.0	10	34.5	
Fairly adequate	4	19.0	1	33.3	4	80.0	9	31.0	

	Malawi		Tanzania		Ethiopia		All		p
	n	%	n	%	n	%	n	%	
Adequate	6	28.6	1	33.3	0	0.0	7	24.1	
Very adequate	1	4.8	0	0.0	0	0.0	1	3.4	
Rational inclusion for the decision and review of how the available evidence influenced the choice made									
Grossly inadequate	2	9.5	0	0.0	0	0.0	2	6.5	0,846
Inadequate	8	38.1	1	33.3	2	28.6	11	35.5	
Fairly adequate	4	19.0	1	33.3	2	28.6	7	22.6	
Adequate	4	19.0	1	33.3	3	42.9	8	25.8	
Very adequate	3	14.3	0	0.0	0	0.0	3	9.7	