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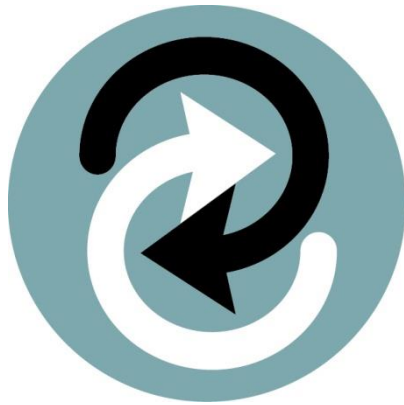
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EAS Briefing Note 4

## **Evidence Advisory System Briefing Notes: Ethiopia**

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GETTING RESEARCH INTO HEALTH POLICY AND PRACTICE

**GRIPHEALTH**

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## 1 Introduction

There has been a growing global concern for improving the use of evidence to inform health policy in recent years. Increasingly there is recognition that individual projects or programmes building evidence synthesis skills, may be limited in their effect without a broader consideration of the systems in place which ‘embed’ or ‘institutionalise’ evidence informed policy making practices (Alliance for Health Policy and Systems Research and WHO 2007).

The GRIP-Health programme is a five year project supported by the European Research Council which studies the political nature of health policy to understand how to best improve the use of evidence. This explicitly political lens enables us to focus on the contested nature of health issues as well as the institutions that shape the use of evidence in health policy making. We understand institutions as including both formal structures and rules, as well as informal norms and practices (Lowndes and Roberts 2013). The GRIP-Health programme follows the World Health Organization’s view that Ministries of Health remain the ultimate stewards of a nation’s health, and further play a key role in providing information to guide health decisions (World Health Organization 2000, Alvarez-Rosette, Hawkins, and Parkhurst 2013). As such, GRIP-Health is particularly concerned with the structures and rules created by government to gather, synthesise, or otherwise provide evidence to inform policy making.

This working paper is one of a series of six briefs covering a set of countries in which the GRIP-Health programme is undertaking research. This brief presents an overview of what is termed the ‘Evidence Advisory System’ (EAS) for health policy making within the country of interest, which is taken to encompass the key entry points through which research evidence can make its way into relevant health policy decisions. This can include both formal (government mandated) and informal structures, rules, and norms in place.

Individual reports in this series can be useful for those considering how to improve evidence use in specific country settings, while taken together the reports identify the differences that can be seen across contexts, permitting reflection or comparison across countries about how evidence advisory systems are structured – including which responsibilities are given to different types of bodies, and how well evidence advice aligns with decision making authority structures.

This paper describes the Evidence Advisory System (EAS) in Ethiopia, a lower income country situated in the Horn of Africa, at the crossroads between the Middle East and Africa.

Since 1991, Ethiopia has made improvements to health care delivery and set the basic foundations of a health system, improvements which are recognized as a success story of health system reform (Downie 2016). In this process, the role of health research has emerged as critical; consequently, Ethiopia has made explicit commitments to evidence-informed policy in health (Ethiopian Academy of Science 2013). Ongoing challenges in terms of the low research technical and human capacity, and the absence of strong research priority-setting mechanisms

seem not to have undermined the capacity of the Federal Ministry of Health (FMOH) to make decisions in health and enforce commitments with development partners (Downie 2016). Ethiopia has undertaken a major process of restructuring the public service, known as Business Reengineering Program (BPR). This process is driven by the principle of evidence-informed policy and its purpose is to foster good governance by improving the transmission of information between different decision-making bodies at the national level (Debela 2009).

The centralized health information system supports a centralized decision-making structure. Data gathering and analysis is concentrated in two main national agencies, the Central Statistical Agency and the recently reorganised Ethiopian Public Health Institute. Data on health facilities are collected at the community level, then reported to the district (*woreda*), regional and national levels; the FMOH uses them to produce indicators which are national, thus down streaming them to the regional and *woreda* level; the *woreda* administration finally utilises such indicators to elaborate a local health plan, which is ultimately sent to the FMOH for consolidation (Federal Ministry of Health Ethiopia 2014).

## 2 Background to Ethiopia

Ethiopia is one of the few African countries to have maintained independence during the colonial era, primarily under the leadership of Haile Selassie (Wubneh and Abate 1988). However, the country has also gone through a troubled history of conflicts. After a period of military rule (1974-1991) under the regime of Mengistu Haile Mariam, the Ethiopian People's Revolutionary Democratic Front (EPDRF), the current ruling coalition, established a federal system of government in recognition to the cultural and ethnic diversity of the country (Zimmermann-Steinhart and Bekele 2012, Habtu 2003, Adimassu 2015, Zemedagegnehu 2014). Today, Ethiopia is structured into nine regional states and two city administrations, Addis Ababa and Dire Dawa Administration Councils. It is further subdivided into 550 *woredas* (districts) and several special *woredas*. Each of the nine Regions has its own Parliament and is governed by members or affiliates of the EPDRF. Despite its federal system of governance and the extent of power devolution to Regional administrations, there have been concerns raised over central control in policy-making and limited civil society participation in Ethiopia.

Since 1991, Ethiopia has experienced improvements in many sectors of its economy, including infrastructure, education and health. Downie (2016) has argued that the government of the EPDRF has played an active role in these improvements. He explains that foreign aid to Ethiopia has been channelled through a clear vision and leadership from the government, as well as a national policy strategy focused on achieving results (although he does mention some uncertainty about the data). Ethiopia is currently the second largest recipient of foreign aid in Africa according to the OECD official statistics on ODA. This seems to confirm a longstanding relationship between the government and development partners (DPs).

Despite praises for its rate of development, Ethiopia remains among the ten poorest countries in the world in terms of GDP per-capita. Despite its recent economic performance, which led to its per-capita GDP doubling between 2007 and 2014, Ethiopia's GDP is still significantly inferior to the average of Sub-Saharan states (\$1,638) (World Bank, 2015). Ethiopia has a population of 96.96 million (World Bank, 2014) making it the second most populated country of Sub-Saharan Africa.

Health outcomes have improved across a number of indicators. Thus, life expectancy at birth has increased over the last 25 years (from 45 in 1990 to 65 years of age in 2015). The under-5 mortality rate and maternal mortality rate have also experienced significant reductions; however, the maternal mortality rate is likely to fall short of reaching the 5<sup>th</sup> Millennium Development Goal of 267 deaths per 100,000 live births. Further, whilst still heavily burdened by infectious diseases, rates of malaria, tuberculosis, and HIV/AIDS have experienced reductions as well (National Planning Commission and United Nations 2015).

One specific challenge to health system development is access in rural areas, given that 80 of the Ethiopian population lives in such areas. Based on this, the overall development effort has included improvement of infrastructure, including road networks, access to clean water and sanitation, and particularly construction of new health centres and hospitals. These improvements were linked with the implementation of the health extension program (HEP), introduced nationally to ensure access to primary health care services. However, the extent to which the quality of health service provision has also improved remains unclear. The government has recently committed to ensuring equity and quality in health care provision across the country (The Federal Democratic Republic of Ethiopia Ministry of Health 2015).

### 3 Primary decision making points for health

While there is a general use of terminology such as 'Evidence Based Policy' or 'Evidence Informed Policy' in the health sector, what 'policy' is, is all but unambiguous. 'Policy' can refer to a range of concepts from projects and programmes, to sector-specific plans, to broad statements of intent (Hogwood and Gunn 1984). Policy is also not the responsibility of a single body; rather, policy decisions affecting health take place across a range of governmental levels and authorities.

This lack of a universal object of study complicates health policy research. However, there are some types of decisions common to many countries' health sectors for which research evidence is often held as critical. This allows a basic classification of decision types to provide at least a starting point for comparisons/analyses of country evidence advisory systems, as follows:

- Public Health and Health Promotion: Usually high level decisions affecting large segments of the population. Can involve agencies outside the health service and broader sectoral interests. Often the responsibility of national legislatures, ministries of health, or devolved authorities. Common examples include: tobacco control, occupational health, healthy eating, sanitation, etc. A broad range of evidence will be relevant to such decisions, including epidemiological, economic, social attitude, and others which speak to relevant decision criteria.
  - Health Service Priority Setting and Management: Decisions concerned with the allocation of resources across the health system or the structure of service provision and funding, including priorities within the system. Often the responsibility of Ministries of Health or national health services. Common examples: Health system priorities, health worker responsibilities, resource generation or allocation decisions, etc. Relevant evidence forms include health technology appraisals/assessments (HTA), epidemiological and clinical studies, health services research, etc.
  - Programme Planning: Decisions within the remit of specialised agencies, such as programmes dedicated to individual conditions (malaria, HIV, cancer, etc.). Decisions within these bodies often require evidence both about efficacy or cost effectiveness of different prevention and treatment options, but equally often are informed by locally generated data (e.g. routine data from surveillance or facility information).
- Service Provider Decision Making is the most specific and tailored to individual cases. It can be health centre or hospital policies, or individual clinician decisions about patient care. Relevant evidence may include specific case details or specific realities of the context as well as more top-down use of guidelines.

In addition to these types of health decisions, this working paper also recognises that decision making for health can take place at different levels within government hierarchies, with authority for decisions, and entry points for evidence resting in: national level bodies, sub-national (regional) level bodies, and local level bodies at times. In different country settings the various decision types listed above might be addressed at any of these three levels or may cut across more than one level. For instance, at the national/federal level, the MoH usually functions as a decision point for certain types of decisions, but movements towards de-centralisation might lead to the shifting of decision-making from national levels to sub-national or local levels (England is a case study of that). This permits consideration of whether systems of evidentiary advice are well aligned with the decision authority structures in a setting. There can also be important considerations on the ways that national evidence systems link to influential non-state decision makers (e.g. development partners in low and middle income settings, or corporate bodies

### 3.1 Federal level decisions

#### 3.1.1 Federal legislature

Ethiopia is a federal parliamentary republic whose structure relies on the division between the Federal Government and the Federal States (regions). Because of such duality, legislative and executive powers coexist at each level of government (Zimmermann-Steinhart and Bekele 2012). The Ethiopian Parliament is bicameral, consisting of the House of Peoples' Representatives and the House of Federation. The House of Peoples' Representatives represents the highest authority of the Federal Government; its members are directly elected, as is the President of Ethiopia. The House of Federation represents all regions and is the highest organ of State authority; its members are chosen by state assemblies or councils. Both Houses have a five-year term mandate (Government of Ethiopia 2016).

The most important function of the House of Peoples' Representatives is to enact laws on matters assigned to federal jurisdiction and ratify national policy standards (Alemu Aneme 2010), including “national standards and basic policy criteria for public health” (Article 51(3) of the 1995 Constitution of the Federal Democratic republic of Ethiopia). These national policies are forwarded to Parliament by the Prime Minister Office, as per the proposals of the FMOH. The House of Peoples' Representatives has authority over the approval of budget estimated and expenditure, including donor's funding. The House of the Federation is not vested with a general legislative power. However, it can initiate civil laws which are then adopted by the House of Peoples' Representatives.

#### 3.1.2 Federal Ministry of Health

The Federal Ministry of Health (FMOH) is a Cabinet ministry, therefore the Health Minister is appointed by the Prime Minister. The Prime Minister is selected by the party in power after the legislative elections. The Council of ministers includes the Prime Minister, the Deputy Prime Minister, ministers for various departments and members chosen by the House of People's Representatives. The Prime Minister and Council of Ministers remain accountable to the House of People's Representatives (Alemu Aneme 2010).

The Ethiopian constitution establishes dual jurisdiction over public health between the Federal and the Regional governments. In line with the principle of “one plan, one report, one budget policy” (Waddington, Alebachew, and Chabot 2012), the FMOH has full control over the national health policy. It does so through a series of fora and specific committees, such as the Regional Health Bureaus (also known as Policy Committees), attended by Development Partners. Policy proposals often stem from these committee meetings, chaired by the Health Minister. The proposals are often forwarded to the relevant body/department in the FMOH to articulate the issue and develop a working paper. The body/department then either uses an existing committee or establishes an ad hoc body to look in depth into the issue, including on any evidence base. Existing committees can be the Annual Review Meeting or the Joint Review Meeting, both with strong participation of donors (Yayehyirad et al. 2012).

The Federal Government formulates and implements national policies, strategies and plans for all economic, social and development matters. The FMOH at the Policy and Planning Directorate

formulates its national strategic plan, i.e. the Health Sector Development Plan - now Health Sector Transformation Plan (HSTP)-, in line with the Growth and Transformation Plan of the country. The HSTP decides on the national health sector priorities and must be approved by the Council of ministers and the House of Representatives. Among other priorities, for instance the establishment of the 'Health Development Army' (HAD – a network of women working to promote healthy behaviours in their communities) (Ramundo 2012) followed the commitment to extension of health services across the country. The HSDP needs approval from the Council of ministers and the House of Representatives. The implementation of health policy goals, in turn, depends on each Regional State, which has control over budget allocation and have some discretion on the formula for implementing national goals (Admasu 2013). Therefore, priority-setting (including programmatic interventions) happen at national level, with implementation (including budget allocation) being carried out at regional (state) level.

Four agencies, which report to both the FMOH and the Ministry of Finance and Economic Development are responsible with the implementation of technical decisions (African Health Observatory 2014b). These include:

1. The Food, Medicine and Health Service Administration and Control Agency of Ethiopia – mandated with the inspection and quality control of drugs, facilities, professional personnel and food products;
2. The Ethiopian Public Health Institute - undertakes research on health priorities as well as having responsibilities on disease surveillance;
3. The Pharmaceuticals Fund and Supply Agency – works to ensure provision and supply of essential drugs, medical supplies and equipment in the public and private sector, as well as the rational use of medicines (Pharmaceutical Fund and Supply Agency 2016). The FMOH has developed a national list for procurement of essential pharmaceuticals in collaboration with regions and development partners (African Health Observatory 2014d);
4. HIV/AIDS Prevention and Control Office - prevention and control of HIV/AIDS, at both federal and regional levels (through regional health bureaus).

## 3.2 Regional/State level decisions

### 3.2.1 State Legislature

Each of the nine State have their own state constitution, with the State Council representing the legislative organ in each of them.

### 3.2.2 State Executive

Regional Governments have the power to formulate and execute their own regional health policies, strategies and plans (Zimmermann-Steinhart and Bekele 2012). They are mandated with the coordination of health coverage extension activities, such as the establishment of health examination centres and of training institutions; the coordination and monitoring of communicable diseases; the purchase and distribution of medical equipment and medicines; the prevention and control of HIV/AIDS (Zimmermann-Steinhart and Bekele 2012).

Regional Health Bureaus (RHBs) are established at each of the nine regional levels and the head of the RHB is confirmed by the State Council. Even if health policy is decided at the federal level, a consultation process is established every two months between the FMOH the RHBs in order to

promote joint supervision of implementation goals. Regional governments have extensive power over health policy following the decentralization process initiated in 1995, with reported cases of “clientelistic” power relationship between federal policymakers and regional/local elites (El-Sahartya et al. 2009). Each RHB has some degree of autonomy and power in decision-making. For instance, partnerships can be established with development partners without notification to the FMOH; also, budget allocation is done at the regional level. However, RHBs remain accountable to the FMOH, as they are expected to submit regular reports to higher levels of governance (Federal Ministry of Health Ethiopia 2014).

### 3.3 Local bodies

Health bureaus are established at the woreda (district) level. Woredas are mandated with primary preventive and curative health care (Zimmermann-Steinhart and Bekele 2012, El-Sahartya et al. 2009) and their offices are mainly responsible for health service delivery and management. Woreda health offices should be also responsible for managing personnel issues, health facility reconstruction, and procurement, as part of efforts for “evidence-based planning” (Federal Ministry of Health Ethiopia 2014). However, central and regional health departments mainly lead such governance efforts (El-Sahartya et al. 2009). Woreda health offices are also tasked with data collection on local facilities through the community health management system. They elaborate their own plans for implementing health targets, which must be consolidated by the Regions and, eventually, by the Federal Ministry of Health.

## 4 Entry points for research evidence

For research evidence to inform policy, it must have a conduit through which it can reach decision makers who might be usefully informed by it. There may be a wide range of structures and norms in place, both formal and informal, which, when taken together, form the evidence advisory system for health decision making. Taking as our starting point the stewardship role of Ministries of Health (and, by extension, national legislatures which govern ministries), we separate between

1. ‘Formal systems’- taken here to represent the officially mandated agencies tasked with evidence synthesis and provision for decision making processes. These can be within national governments (for example, Ministry of Health Research Departments), Semi-autonomous bodies (such as the National Institute of Health and Care Excellence – NICE – in the UK), or independent agencies, so long as they have a formal mandate to provide evidence to inform policy; and
2. ‘Informal systems’ - representing the systems of evidence provision that are not dictated by any formal decree or rule to provide evidence, but which are found to play important roles in evidence provision.

### 4.1 Formal systems

The Federal Ministry of Health carries out or commissions research institutes or consultants (e.g. academic research units) to undertake research on health priorities. These priorities are set by the Federal Ministry of Health, as informed by the official statistics produced by the Central Statistical Agency (Gaym 2008). While challenges remain, there have been consistent efforts to streamline the communication between national government institutions (such as the FMOH and the Central Statistical Agency) and between government institutions and academic

units. The reorganisation and strengthening of the Ethiopian Health and Nutrition Research Institute (EHNRI) was also done in support of enhancing the capacity for evidence-informed policy-making in the country (Federal Ministry of Health Ethiopia 2014). Further, the FMOH established the National Health Research Council within the EPHI, with the aim to oversee, coordinate and strengthen the framework of health research (Ethiopian Public Health Institute 2014).

#### 4.1.1 Federal Ministry of Health

In terms of evidence generation, the FMOH identifies research topics to be undertaken by the Ethiopian Public Health Institute and the Central Statistical Agency, as well as conducting its own surveys, either directly or by commissioning (Gaym 2008). Some of the most important surveys include the Malaria Indicator Surveys, Behavioural Surveillance Surveys, the Expanded Programme on Immunization Cluster Surveys, drug use surveys, HIV surveillance surveys at antenatal care clinics, and nutrition surveys) (African Health Observatory 2014d).

The Policy and Planning Directorate within the FMOH hosts the functional central unit of the Health Management Information System (HMIS) which is the key component of a centralized system of decision-making in health based on a decentralized structure of data collection. Through the HMIS, the FMOH receives and gathers administrative data information from regional health bureaus, which in turn collect data from the woreda and facility level. The HMIS is tasked with identifying funding gaps and priorities in order to inform the need for donor assistance (Federal Ministry of Health Ethiopia 2014).

The MOH has several fora in which data are reported and decisions discussed. The Joint Steering Committee is set every two months with Regional Health Bureaux in order to supervise goals implementations. The Central Joint Steering Committee is the highest body of a consultative governance structure put in place with DPs. Its technical arm is the Joint Core Coordinating Committee. Chaired by the Policy and Planning Directorate of the MOH, this technical committee serves sharing and reporting the draft policy planning document to the MOH and DPs (African Health Observatory 2014a).

#### **Central Statistical Agency (CSA)**

The CSA is the statistical arm of the Government of Ethiopia. It is the main body tasked with the collection, processing, analysis and dissemination of population-based data, i.e. socioeconomic and demographic statistical data. Input data are always collected at the local community level, eventually being assembled, aggregated and passed on to successively higher levels until they reach the national level (Central Statistical Agency 2011). While the CSA conducts health and health-related research activities on priority issues identified by the Federal Ministry of Health, but it also has decisional power on research priorities. It produces censuses, ad-hoc surveys, demographic health surveys (DHS), and provides assistance on continuous registration and administrative recording systems to government agencies. The CSA provides critical evidence in support of:

- policy planning (e.g., the Growth and Transformation Plan, GTP);

- policy evaluation and monitoring in health (e.g., the implementation of the Health Sector Development Plan, HSDP) (Central Statistical Agency and ICF International 2012).

This evidence is mainly in the form of indicators for population health (e.g. malaria and HIV/AIDS) and nutrition.

#### 4.1.2 Research institutes

##### **Ethiopian Public Health Institute (EPHI)**

The EPHI is a semi-autonomous institution under the FMOH and is the technical arm of the FMOH. Its main tasks are to undertake research on “priority health and nutrition problems” (TB and HIV; nutrition and food science research; traditional and modern medicine; vaccines and diagnostic production; technology transfer and research translation; health system research; bacteriology, parasitology and zoonosis) and on public health emergencies management. Within these, health systems research is notable, with the EPHI committed to carrying out research on health system performance, including health financing, governance, delivery, health workforce, medicines and technology and health information systems (Ethiopian Public Health Institute 2016a).

The EPHI is autonomous in the choice of its research collaborations, however it must respond to the research needs as indicated by the government (research topics in health are identified by the FMOH and included in the Institute's strategic and annual plans). The EPHI is organized into three ‘wings’, public health emergency management, public health laboratory service quality, research and technology transfer. Across the variety of these areas, the EPHI produces different types of research evidence mainly destined to the FMOH, but not exclusively. For example, the EPHI produces:

- surveys – e.g. the service provision assessment survey – used to support monitoring and evaluation needs of HSDPs, but also research dissemination to and collaboration with other government agencies including the Central Statistical Agency (Federal Ministry of Health 2010);
- policy briefs, which are especially devoted to improve research translation into policy, including so-called ‘policy dialogues’ between the FMOH and other relevant stakeholders (Ethiopian Public Health Institute 2016c) ;
- national plans – e.g. the National Nutrition Plan – which are elaborated to support agenda-setting (Ethiopian Public Health Institute 2016b).

**Armauer Hansen Research Institute (AHRI)**, is another government research centre (established in 2005), carrying out molecular biology and immunology of infectious diseases research. The institute was funded at the initiatives of the Norwegian and Swedish Save the Children organisations, with collaboration of the FMOH. Given its origins, it has a long history of international research collaborations (e.g., European & Developing Countries Clinical Trials Partnership (EDCTP) programme, University of Bergen Norway) (Gaym 2008).

#### 4.1.3 Academic institutions and university units

**Addis Ababa University** is the primary academic venue for health research, including a large number of departments and units which are fully or partly dedicated to it. It includes the College

of Health Sciences which is organized in Schools, the most relevant being the School of Public Health. Other notable university departments and units include the Institute of Health Sciences research and the College of Public Health and Medical Sciences (Jimma University); College of Medicine and Health Sciences (Gondar University), Hawassa University, Debub University, Defense College of Health, St Paul Medical College (Ethiopian Academy of Science 2013).

According to Gaym (2008), academic institutions in the country have tended to focus on clinical research studies and the publication of these outputs in academic journals. He argues that teaching institutions work is not necessarily aligned to major national public health problems, such as HIV and TB (Gaym 2008). An important exception is their generating surveys for collaborations with the FMOH, as done by the School of Public Health at Addis Ababa University. Furthermore, Jimma university has recently started training in evidence utilisation for health planners and policy makers through a project supported by the UK Department for International Development (DFID) (INASP 2016).

#### 4.1.4 Non-government institutions

**The Ethiopian Academy of Sciences (EAS)** is independent from the Government and is mandated by an act of the Parliament to advise the Government on science-related matters. Its advice is mainly directed to the FMOH, the Federal Ministry of Agriculture, the Federal Ministry of Education and the Federal Ministry of Science and Technology (Ethiopian Academy of Science 2013). It is organized in five working groups: agricultural science, engineering, health science, natural science, and social science and humanities.

The main responsibilities of EAS are to:

- Assess data generated, for example, by the CSA;
- Review and commission research (from and to the EPHI, the AHRI, university institutes and professional associations);
- Disseminate evidence.

As such, it aims to act as an evidence-advisory body to the government. Its main initial activity being to promote platforms of discussion for major stakeholders such FMOH, the Federal Ministry of Science and Technology, universities, research institutions. Its ultimate stated aim is to perform as a catalyst of experience for the benefit of a new culture of science in Ethiopia (Nordling 2010).

**The Pharmaceutical Fund and Supply Agency (PFSA)** is an independent agency accountable to the FMOH and the Federal Ministry of Finance, responsible for the procurement and distribution of pharmaceuticals (Federal Ministry of Health Ethiopia 2014). As such, it is one of the major sources of evidence generation on health services delivery, given its functioning aims to be needs-based. The PFSA developed and periodically updates an Essential Pharmaceuticals list. To support this, it developed an Integrated Pharmaceutical Fund and Supply Management Information System (Federal Ministry of Health 2013).

## 4.2 Non-institutionalized systems

**Professional associations**, including the Ethiopian Public Health Association (EPHA) and the Medical Association, conduct research in collaboration with universities, depending on funding availability from development partners. Their research focuses primarily on HIV/AIDS,

tuberculosis and malaria. Results are disseminated through workshops, seminars, conferences, and sometimes also circulated to policy-makers at the FMOH and Parliament through position papers. However, according to interviews carried out in this project, research results are insufficiently used by policy makers and annual review meetings on the health sector strategic five-year plan are more likely to provide a venue for voicing health issues, rather than disseminate research evidence. Consequently, any influence on the FMOH depends, for example, on the extent to which members of the FMOH share the same professional background as members of the EPHA.

**Development Partners'** funding a great proportion of the research activities of the country (Ethiopian Academy of Science 2013), might give them, according to our interviewees, indirect influence on agenda setting, as well as on evidence production. On the other hand, the Government requests evidence from its agencies that donors supported research projects are in line with national strategic plans (Federal Ministry of Health Ethiopia 2014).

## 5 Discussion

It is generally indicated in the available literature that evidence production and use in Ethiopia are still low, mainly due to insufficient human capacity in generating evidence and in the relatively young establishment of the culture of evidence-informed policy-making (African Health Observatory 2014c). Consolidating and publishing existing evidence for policy-making and decision-making is still weak and unsystematic (Gaym 2008). However, as outlined in this mapping, there are existing pathways of evidence use within the health governance system of Ethiopia. For example, the FMOH uses the principle of evidence-informed policy-making to guide its health policy-making and works to ensure that evidence provided by DPs fits within the needs of the Ethiopian health system.

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