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Use of Evidence in Health Policy Making
in the Gaza Strip

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Use of Evidence in Health Policy Making
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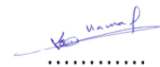Prepared by: Shade Talal El-Haddad

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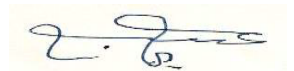The names of signatures of the examining committee members are as follows:

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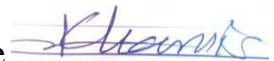
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Dedication

I dedicate this work to the sake of Allah my Creator and my master.

To my parents whose affection, love, encouragement and prays day and night make me able to get such success and honor.

To my dear wife, for her understanding, support and encouragement.

To my children; Aya and Abed Alrahman.

To my brothers, sisters, friends and colleagues.

To everyone who contributed to getting this study a reality, thank you.

Shade Talal El-Haddad

Declaration

I certify that this thesis submitted for the master's degree is the result of my own research, except where otherwise acknowledged, and that this thesis or any of its parts has not been submitted for a higher degree to any other university or institution.

Signed:

Shade Talal El-Haddad

Date: 16/6/2020

Acknowledgment

Abstract

The use of evidence in health policymaking is a global challenge to healthcare systems, Palestine is not an exception. In the Gaza Strip, there is limited research on the use of evidence in the policy-making process. This study explored the perceptions, practices, and skills of policymakers with regard to the use of evidence in health policy and in decision making in the Ministry of Health in the Gaza Strip, including factors affecting health policymaking, barriers and facilitators for the use of evidence and the presence of effective mechanisms for the dissemination and exchange of knowledge. The study aimed to explore the extent to which evidence is used in health policy-making in the Gaza Strip. The findings and recommendations of this study may improve the use of research evidence in health policymaking in the Gaza Strip, thus, improve the performance of the Healthcare system which ultimately reflected on the overall improvement in the health status of Palestinians.

The design of this study is an analytical, cross-sectional one. The study population included all health policymakers at the Ministry of Health or those involved in policymaking. We utilized a triangulated approach employing both quantitative and qualitative tools. Quantitative data were collected through an interviewed questionnaire , where the study population was 169 policymakers. Qualitative data were collected from 12 Key informants through interviews, including 7 researchers and experts in health policy, and 5 policymakers. The response rate was 85.7%. The reliability of the data collection tool was high (Chronbach's alpha=0.961). Data were entered and analyzed using SPSS, version 23, for the quantitative data. Open thematic techniques were used to analyze qualitative data.

Males accounted for 88.8% of the study participants, as the top management positions are dominated by men. More than half of the participants (56.4%) have postgraduate degrees. The results have shown that more than half of the participants (54.5%) used evidence in their work, and more than half of the participants (56.5%) responded that they received training in health policy decisions. Health policymakers in the Ministry of Health in the Gaza Strip have somewhat positive perceptions about the importance of using evidence in health policymaking with a weighted mean of 77.77%, and it has been observed that there is a lack of ability to acquire, assess, adapt, and apply research evidence with a weighted mean of 68.77%. There is a weakness in mechanisms for transferring and exchanging knowledge with a weighted mean of 58.77%, where the participants emphasized that there is a lack of interaction between policymakers and researchers, the lack of appropriate structures to support the use of evidence, and a limited ability to understand the language of the scientific paper, mainly the statistics. Donor organizations and political parties exert a strong influence on the health policy-making process. Lack of resources and incentives are the most important barriers to the use of evidence in health policy-making. Improve the skills of policymakers on how to use evidence and promoting a research culture will greatly increase the uptake of the use of evidence in policymaking.

There is a need to strengthen the infrastructure for scientific research and to allocate enough resources to it. Additionally, policymakers and researchers need to agree on research priorities. Establishing a unified repository of research, especially local ones, and developing continuing education programs for health policymakers to enhance the skills of using evidence are highly needed.

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List of Abbreviations

ANOVA	One-way Analysis of Variance
EBM	Evidence Based Medicine
EBP	Evidence-Based Policy
EIPM	Evidence-informed policymaking
GDP	Gross Domestic Product
GS	Gaza Strip
HCS	Healthcare System
KII	Key Informant Interviews
Km	Kilometer
KTE	Knowledge Transfer and Exchange
MD	Median
MOH	Ministry of Health
N	Number
NGOs	Non-governmental Organizations
NIS	New Israeli Shekel
OCHA	Office for Coordination of Humanitarian Affairs
PA	Palestinian Authority
PCBS	Palestinian Central Bureau of Statistics
PHC	Primary Health Care
PHIC	Palestinian Health Information Center
PNGO	Palestinian Non-Governmental Organizations Network
Sd	Standard Deviation
SPSS	Statistical Package for Social Sciences
UK	United Kingdom
UN	United Nations
UNDP	United Nations Development Program
UNRWA	United Nations Relief and Works Agency for Palestine Refugees in the Near East
USA	United States of America
USD	United State Dollars
WB	West Bank
WHO	World Health Organization
WM	Weighted Mean

Chapter One

Introduction

1.1   Background

Effective health policy making is usually reported with the best evidence available. Evidence-based policymaking can affect the policy-making process, however, evidence must be systematically validated, critically evaluated and carefully synthesized. (Oxman, Lavis, Lewin, & Fretheim, 2009). Evidence is defined as the *"actual or asserted facts proposed for use in support of a conclusion"* (Oxman et al. 2009, p.3). Evidence-informed policy making, *"an approach that aims to ensure that decision-making is informed by the best available research evidence at the time of the decision"* (Oxman et al. 2009, p.4).

Beijing (2012) Second Global Symposium on Health Systems Research emphasized the importance of to promoting confidence among researchers, practitioners and policy makers and support the translation of knowledge into policies, especially in developing countries. Also Bamako (2008) Call to Action, issued at the Global Ministerial Forum on Research for Health in November 2008, Stress the importance that states need to enhance knowledge translation and exchange through the application of effective and safe interventions, evidence-informed policies, policy informed research, and effective dissemination of research outputs taking into account multilingualism and development in information technology.

The use of health evidence in policy making is a problem for both developed and developing countries (El Jardali, Lavis, Ataya, & Jamal, 2012), check all the references Palestine is not an exception. Generally, low and middle income countries have less resources to find solutions to their health system problems compared to developed countries, and in order to optimize the use of their limited resources, they are in a more urgent need to reducing the gap between policy making and evidence (Oxman et al., 2009).

1.2   Research problem

Policy making process need to be based on evidence, otherwise there will be negative impacts both on the effectiveness and efficiency of services provided. In fact, Health

policy making processes are often not well-informed by evidence, particularly in developing countries (Oxman, Lavis, & Fretheim, 2007; Lavis, Ross, & Hurley, 2002).

The application of Health Systems and Policy Research (HSPR) guides is of particular concern in countries where health systems are in a state of rapid transition such as in several Middle Eastern countries. In these countries, there are greater political concerns about health system performance, a wider range of pressing health systems challenges, increased demand for transparent policy makers, and a new role for non-governmental actors (El-Jardali et al., 2010).

The strategic agenda for World Health Organization (WHO, 2017) cooperation in Palestine since 2017–2020 called for the strengthening the national civil registration and vital statistics system to improve coverage, quality and utilization as part of broader efforts to enhance the national health information system, to support the development of evidence-based policies and strategies, and to strengthen hospital information systems. In a qualitative study in Palestine, all experts and policy makers recognized the need for evidence to support decision-making, participants acknowledged that the use of evidence in health decision-making was unsatisfactory and weak and needed a serious corrective strategy (Aljeesh & AL-Khaldi, 2014).

In the Gaza Strip, limited research exists on the use of evidence and contributing factors in the policymaking process (Aljeesh & AL-Khaldi, 2014; El Jardali, Lavis, Ataya, Jamal, et al., 2012; Nassar, 2011; Zeedia, 2018). This study will attempt to assess the extent to which evidence is used in the health policies and will examine the contexts surrounding both the use of evidence and health policy making processes. It will also determine what may hinder or facilitate the use of evidence. This study will also determine the gap between researchers and health policymakers and the root causes of this gap if it is proven.

With the researcher best knowledge, this study will be among the first in the GS to explore the issue of utilizing evidence in policy making, it will be also among studies to explore the perspectives of researchers and health policy makers within the context of the GS.

1.3 Justification of the study

Research is an important process for finding knowledge, but if this knowledge is not used as policies and practices, the process is ineffective (Parkhurst, Ettelt, & Peters, 2018). It is widely agreed, including global health organizations, that evidence is necessary to inform

policy formulation and implementation (Parkhurst et al., 2018).

Using evidence in health policy making is a global challenge to health systems, including Palestine. The results of a study of Eastern Mediterranean countries, including Palestine, indicated that the limited value of research hindered the development of evidence-based policies (El Jardali, Lavis, Ataya, & Jamal, 2012).

Results of the study will be critical in the light of the country cooperation strategy of the WHO and the Occupied Palestinian Territory 2017-2020 which emphasized the importance of promoting evidence-based decision-making (WHO, 2017).

If this study achieves its objectives, this may help decision makers to pinpoint the real causes of the gap between the production of evidence and its use in policy making taking into account the surrounding contexts, which may improve the performance of the health system in the GS and reduce the waste of already limited resources. The study will help researchers identify the real obstacles that prevent their research from being used and will also help researchers identify the best mechanisms for transfer their knowledge to policy makers and stakeholders.

1.4   Study objectives

1.4.1   Overall aim

The overall aim of the study is to explore the extent to which evidence is used in health policy-making in the MoH in the GS. The findings and recommendation of this study may improve the use of research evidence in health policymaking in the GS, thus, improve the performance of the Healthcare system (HCS) which ultimately reflected on the health status of the population.

1.4.2   Study objectives

1. To explore perceptions about the use of evidence in policy making process
2. To determine the ability to assess, acquire, adapt and apply research evidence
3. To explore the current knowledge transfer mechanisms, exist in the GS, if any
4. To identify promoting and inhibiting factors that influence the use of evidence by health policy makers
5. To identify the factors that influence the health policy-making process
6. To suggest possible recommendations that might improve the use of research evidence in health policymaking in the GS.

1.5   Context of the study

1.5.1   Gaza Governorate demographic characteristics:

The total area of Palestine is about 27000 square kilometers, GS and West Bank (WB) represent 22% of Occupied Palestine, with a total population 4,781,2484, million are in the state of Palestine Palestinian Central Bureau of Statistics (PCBS, 2018). Annex (1)

About 60.3% of the population reside in WB, while 39.7% reside in GS (PCBS, 2018). The GS is a small piece of land on the eastern coast of the Mediterranean Sea with total area of 365 square kilometers and a total population around 1,899,291 million (PCBS, 2018). Annex (2) It is divided into five governorates: North Gaza, Gaza City, Mid Zone, Khan Younis and Rafah. According (PCBS, 2018), GS considers as one of the most dense areas over the world that reach to 5,204people by Km^2, the vast majority of GS population 66.7% of refugees. Children under 15 years represents 41.7% of population, and elderly population who are more than 60 years represent 3.8% from total population (PCBS, 2018).

Changes in the size of the population in the GS affect the necessary health care resources, care systems provided, and even the conditions associated with each population group. The Palestinian health care system will have to adapt quickly to meet the changing needs of their patients - all while addressing health-reform requirements. The use of evidence alone in policy-making cannot improve the performance of health systems. Demographic characteristics should be taken into account as these characteristics may lead to healthier health policies.

1.5.2   Health care system:

A defining feature of the health system in Palestine is its fragmentation. At the historical, geographic, institutional and organizational levels (WHO, 2017). This fragmentation is difficult to examine adequately both as a structural and functional level, and poses enormous challenges to the MoH in formulating robust strategies and coordinating stakeholders (Giacaman et al., 2009).

There are four main providers of health care services in the WB and the GS: MoH, UNRWA, NGOs and the Palestinian Military Medical Services, each with its own respective network of primary health care centers and hospitals. For example, UNWRA operates an extended network of clinics providing free services to registered refugees and the nongovernmental organizations is a mixture of traditional charities, Islamic charitable

committees, Christian charities and non-profit organizations, often supported by the Palestinian diaspora and mainly offering primary care, maternal health care, rehabilitation and specialized care in referral hospitals, complementing the public sector services. The stratification of the health sector creates some redundancy among service providers and contributes to overall inefficiency, although arguably it offers choice and access to users and enhances system resilience to shocks (WHO, 2017).

In 2014, human resources for health remained at the same gross levels as they were in 2010, with about 14 000 employees for Palestine. However, this overall figure obscures the fact that human resources for health increased in WB and decreased in GS, in the wake of the political divide between Fatah and Hamas (WHO, 2017). Low remuneration and delays in salary payment have resulted in low morale and large-scale strikes, with implications for service delivery. Yet, according to the World Bank, public spending on health is close to 5% of GDP, exceeding the regional average of 2.6% and the low- and middle-income country average of 1.7% of GDP, and fuelled by relatively high spending on salaries, medical referrals for tertiary care46 and pharmaceuticals. Public and private spending for health more than tripled from 2000 to 2012, to US$ 1.3 billion, more than 12% of GDP. Per capita total health expenditure more than doubled between 2000 and 2012, from US$ 126 to US$ 294,47 reflecting high out-of-pocket spending, especially for pharmaceuticals (World Bank, 2016).

Generally, the Palestinian health system suffers from severe fragmentation and weak coordination among different health care providers. MOH is the main provider faced significant challenges resulting from the impact of the Israeli Occupation, it also suffers from political and financial crises due to the Palestinian split, the matter that reflected in the functionality of the system.

The use of evidence in health policy-making can have a significant impact on the performance of the health system in spite of all the obstacles we have mentioned.

1.5.3 Health management culture:

Decision making

Decision making in the Palestinian health care system is highly influenced by cultural related factors. Appointments, promotion or rewarding are to a great extent subject to connection, political affiliation or personal favors (Hamad, 2009; Yaghi, 2009). Career development is unrelated to the individual's performance; therefore, performance-based

competition is completely non-existent (Hamad, 2009). Healthcare organizations are generally managed in a traditional fashion. Decision-making is judgmental rather than information based (Hamad, 2009). System, management structure and decision-making criteria can significantly vary from one place to another, even within MoH itself (Abed, 2007; Hamad, 2009). Most organizations within the health system lack clearly defined organizational structures, which regulate the relationship and information flow among people and departments (PNGO, 2009). Instead, most organizations follow strongly centralized command and control systems, resulting in a predominant club culture with little worker involvement in the decision-making process (Hamad, 2009). These practices precisely foster the development of the inconsistency of evidence-based culture. Feeling of lack of ownership, loss of motivation, lack of teamwork, loss of valuing professionalism and increased communication gaps between top management and the field could be the logical consequences.

1.5.4 Health information system

Different bodies are involved in generating of health statistics and other health related information on a national basis. Since its establishment the Palestinian Health Information center (PHIC) has collected health related data that include vital statistics and clinic- based data and publishes an annual report "Health Status in Palestine". PCBS collects and compiles demographic data and conducts health surveys. Other UN agencies such as WHO or the UN office for coordination of Humanitarian Affairs (OCHA) provide important web-based information like digital maps or the 3Ws mapping system of health and other organizations.

Despite all the efforts made by different stakeholders, there is still a great need to improve the current health information system, especially in terms of inclusiveness and integration of all players. Many service providers, NGOs and international agencies collect and analyze data for the purpose of monitoring their own programs and activities, which leads to a flow of scattered, conflicting and sometimes contradictory information. For instance, differences in the denominator definitions between MoH and UNRWA results in significant variation in the estimates of major health status indicators such as infant mortality. Data collection, analysis and reporting capacities at central and district level remain insufficient (Mataria et al., 2009). The data scarcely support national planning efforts, policy development, research and evaluation. Obvious weaknesses are seen in the areas of surveillance of non-communicable diseases, human resources data, nutritional

status, national health accounts, and prevalence of risk behaviors (Abed, 2007; Mataria et al., 2009). The existing HIS is not capable to produce reliable periodic reports routinely and timely.

1.6   Operational definition

Evidence-informed health policymaking

Is to make health policies informed by the best evidence, taking into account all contexts surrounding policy-making.

Evidence-based Practice

The integration of the current best evidence (from research) with our clinical expertise and patient's values (Sackett et al. 1996).

Health policy

Refers to the decisions, plans, and actions taken to achieve the specific healthcare goals within the community (WHO, 2020).

Chapter Two

Conceptual Frame Work & Literature Review

2.1 Conceptual framework

The conceptual framework is a structure that the researcher expects can better explain the natural progression of the phenomenon to be studied (Camp, 2001). The conceptual framework provides an integrated way to look at a problem under study (Liehr & Smith, 1999).

According to previous studies, health policy preparation should have the best evidence available. The researcher has developed a conceptual framework for the study, which includes three axes, the first axis are named for the inputs and includes the demographic characteristics of the participants and their perceptions about the use of evidence, while the second axis names for input factors and includes the ability of policymakers to acquire, assess, adapt and apply evidence and also includes current knowledge transfer mechanisms, while the third axis is named Outputs, including groups and factors that influence health policy making, barriers and facilitators to the use of evidence, this study includes researchers and health policy makers in the Gaza Strip. As shown in Figure (2.1)

2.1.1 Inputs factors

2.1.1.1 Characteristics of the participants

Several previous studies have shown that the characteristics of the participants may influence the use of these evidence in policy making (Ellen, Lavis, & Shemer, 2016; El-Jardali, Lavis, Ataya, & Jamal, 2012). In this study, the researcher will research the relationship of these characteristics using research evidence such as age, gender, education, years of experience, governorate, professional background, current work, years of experience, and Managerial Position. As shown in Figure (2.1)

2.1.1.2 perceptions about the use of evidence

Many studies have shown that perceptions which have an impact on the use of evidence in health policy making (Scholar & Treadway, 2015; I. Young et al., 2014). This scope will include an assessment of the knowledge and attitudes of policy makers / decision makers on the use of evidence in health policy making. As shown in Figure (2.1)

2.1.2 Process factors

2.1.2.1 Assess, Acquire, Adapt and Apply scientific evidence

In most developing countries, including Palestine, one of the most difficult issues related to linking evidence to policy is the constraints of policymakers' ability to assess, acquire, adapt and apply available research evidence. As this scope will discuss in detail, the ability and skills of policymakers on how to use the evidence, it will also include knowledge of the availability of research and whether this research is available in a timely, relevant, credible and quality manner and whether decision makers can apply this evidence and whether they have access to and understanding of the research. As shown in Figure (2.1)

2.1.2.2 Current knowledge transfer mechanisms

Many studies have pointed the importance of bridging the gap between knowledge production and knowledge use and has identified many activities that facilitate or hinder the transfer of knowledge into policies (Lavis et al., 2010).. This study investigates the factors that influence the translation of research evidence into policy, such as funding for production and transfer and exchange of evidence, incentives for Knowledge transfer and exchange (KTE), mutual trust between researchers and policy makers, coordination between researchers and policy makers, technical experience of access HSPR research, structure and processes help communicate, role of media. As shown in Figure (2.1)

2.1.3 Outcome factors

2.1.3.1 Groups or factors that Influence Health Policymaking

The policy-making process must be informed and not based on evidence because other factors can influence policy making (Gauthier, 2016). Several studies have identified several factors (Ellen, Lavis, Horowitz, & Berglas, 2018), governmental/ministerial relation, government/ health provider relations, political influences of governing parties, role of donor organizations, groups that powerful influence on the health policy-making process example physician , nursing , media , governing parties ,et al. As shown in Figure (2.1).

2.1.3.2 Barriers and facilitators use of evidence in policy making

This area includes a number of barriers and facilitators that can influence the use of evidence in health policy-making, such as policy relevant research, time, the unacceptable environment for evidence-making in policy-making, insufficient skills, environment for evidence, incentive, Resources, interest, laws as shown in Figure (2.1).

Inputs factors	Process	Outcome
Characteristics of participants (Gender - Age - Education-Governorate) **Work-related variables** (Professional background -Current Workplace - Years of Experience - Managerial Position) **Training and resources** (Received training - Available resources) **Perceptions about evidence** (Knowledge - Attitudes)	**Assess, Acquire, Adapt and Apply scientific evidence** Timely availability of research Relevant research. ١ Validity of research finding. ٢ Quality research. ٣ Applicable research. ٤ Availability research. ٥ Ability to understand research. ٦ Accessibility of research. ٧ **knowledge transfer mechanisms** Funding for transfer and exchange Incentives for KTE Mutual trust between researchers and policy makers Coordination between researchers and policy makers Technical experience for access research Structure and processes Role of media Availability of formal intermediary	**Groups or factors that Influence Health Policymaking** Governmental/ministerial relations 1.Government/ health provider relations 2.Political influences 3.Role of donor organizations 4.Groups that powerful influence on the health policy **Barriers and facilitators use of evidence in policy making** (Policy relevant research- Time - Policy environment (non-receptive or receptive)- Insufficient skills - Environment for evidence - Incentive- Resources - Interest - Laws)

Use of Evidence in Health Policy Making

Figure (2.1): Conceptual Framework-self development

2.2 Literature review

2.2.1 Development of the concept of evidence

In recent decades, efforts to promote population health and reduce health disparities within countries and the world between countries have been linked, with what is called Evidence-Based Policy (EBP). Drawing on the idea of Evidence Based Medicine (EBM), health policy professionals see dealing with policy-relevant evidence to identify the most effective, and therefore cost-effective, interventions as a way to achieve their overall policy goals. Evidence-based medicine as a concept is based on the idea that medicine should be practiced through "*conscious, clear and wise use of current best evidence in decision-making about caring for individual patients*" (Sackett et al. 1996). Since the concept of evidence-based medicine has emerged, there was recognition that it is not necessarily appropriate to rely solely on research evidence when making decisions on diagnoses and medical treatment. Professional experience and judgment on the part of medical practitioners, in light of the evidence base and relevant inferences from this, remain important (Sackett et al. 1996).

The EBM movement has, overall, *was heralded* as a triumph and is credited with ensuring that medical treatments produce beneficial results, particularly compared to the past, when many interventions were promoted just on the basis of hypotheses of potential cause and effect that may, in fact, have been incorrect (Howick, Kennedy, & Mebius, 2011). For example, the Royal Medical College Academy considered EBM "the key to the success of modern health care" (Sense About Science & Academy of Medical Royal Colleges, 2013). The success of EBM has been seen by many authors as the inspiration for calls to expand the concept to other forms of decision making including 'evidence based policymaking' in health and other social policy areas (Parkhurst, 2016; Wright, Parry, & Mathers, 2007). This is despite recognition of the challenges in appropriating ideas from clinical practice and applying them to shape policymaking processes. For example, Black (2001) urged the medical community to "move ahead with care" of the idea of evidence-based policy because of the qualitatively different nature of policymaking compared to medicine (Black, 2001).

A number of other authors likewise have argued that the political realities of policy decisions mean that politics cannot simply be "based" on evidence in the same way that clinical decisions are made and that the idea of a linear relationship between evidence and politics is a fallacy (Lewis, 2003; Greenhalgh & Russell, 2009).

There is thus a need to examine the complex interrelationship of evidence use and politics to form a more nuanced conception of the health policy process. This starts from an explicit recognition of the fundamentally political nature of the policy process that recognizes that, while evidence can and should be an important factor informing policy debates, it cannot provide the sole basis for policy decisions or is usually insufficiently suited to resolve policy conflicts (El Jardali, Lavis, Ataya, Jamal, et al., 2012; Parkhurst et al., 2018).

2.2.2 Definition of evidence

Evidence is defined as the actual or confirmed facts proposed for use in support of the conclusion (Oxman et al., 2009). Evidence informed policymaking (EIPM), an approach that aims to ensure that decision-making is informed from the best research evidence available at the time of decision making (Oxman et al., 2009).

2.2.3 What is evidence informed policy (EBP)?

We say that EBP is one that examines a wide range of research evidence; evidence from citizens and other stakeholders; evidence from practice and policy implementation as part of a process that takes into account other factors such as political facts and current public debates. We do not consider it a policy that is exclusively based on research or based on one set of results. We accept that in some cases, research evidence can be considered and rejected; if the refusal is based on an understanding of the insights presented by the research, we will still consider any EBP resulting. EBP does not necessarily imply a linear transition of search results to policy decisions. Research can inform political discourse in multiple and sometimes accurate ways. This can range from influencing the language used to discuss a specific issue to changing the behavior of key political actors (Weyrauch & Langou, 2011).

2.2.4 Why use research evidence?

We write publicly from the perspective that the use of research in policy formulation, in general, is a "good thing" that can contribute to positive policy outcomes. In doing so, we

share the assumptions that led to the infusion of large amounts of development assistance in financing research as a strategy towards achieving development results.

However, we do not see the relationship between research and policy as linear or non-problematic. We are positioning ourselves close to what has been described as a "pluralism and opportunism model" (Jones, 2009) who sees policy processes as chaotic and opportunistic but maintains assumptions about the possibility of research to contribute to better policy formulation.

We acknowledge that there are some who question the value of the research, especially its claims of objectivity and impartiality. They may argue that knowledge and power cannot be separated, that this occurs in the manner in which research is conducted, how research agendas are established, and who is included and excluded from the processes of assuming neutral knowledge. This may be particularly important in development contexts, as research processes may reflect Western norms and traditions and marginalize intellectual agendas and other knowledge methods (Alatas, 2000). We agree that the way research agendas and research is carried out is affected by values and culture, but we discuss that research evidence can provide objective (and relatively) specific answers to specific questions, and therefore is a valuable source of evidence for policy reporting (Newman, Fisher, & Shaxson, 2012).

Having said that, we also realize that research evidence can be distorted or used to support retrogressive policies. Consequently, we do not believe that (alleged) policy informed by research evidence is necessarily better, but we believe that, when there is a will to develop policies that benefit society, better policies can be achieved when research is systematically considered as one factor in decision-making (Newman et al., 2012).

2.2.5 What is demand for research evidence?

Recent years have seen an increased focus on research and research communication from international development organizations (Conway & Waage, 2010; J. Young & Mendizabal, 2009). We believe that increased availability, accessibility, relevance, and effective communication are all important factors if the policy is to be informed of evidence. However, these aspects relate to the provision of research and are insufficient without a corresponding demand for it from decision-makers. For us, the demand for research evidence includes two factors: the ability to access, evaluate, and use research and the motivation to do so. The other factor is the positive attitude toward research which is part of the organization's ability (Newman et al., 2012).

An increasing number of papers focus on the motivations that drive policymakers in developing countries to use research evidence (Datta, Jones, Febriany, & Harris, 2011; Porter, 2010). Nevertheless, we feel that there was a lack of discussion of capacity issues.

One of the reasons for this is the failure of international development organizations to recognize the lack of capacity within partner organizations. Thus, just as DFID (2011) argued that we assume a "diplomatic assumption" that policymakers are a prior development, we tend to assume that policymakers are aware of evidence and that if evidence is not used, it must be because of a conscious decision they reject. Unfortunately, this is not often the case; we have seen many instances where decision makers do not use the research evidence just because they do not know how to find and evaluate it or because there is no regulatory system to integrate the search (Newman et al., 2012).

Another reason that capacity is not mentioned is that there is a perception that focusing on the ability of policy makers [presumably] that the use of knowledge in government is a technical problem that can be solved through technical "reforms" and improved knowledge management (Stone, 2002). We will distance ourselves from this assumption. For one reason, we take a broader view of the capacity than "technical reforms". Additionally, we do not believe that improving capabilities is the only key to better driving the use of research evidence; however, we believe it is a necessary basis. Therefore, while we recognize the importance of a wide range of factors in influencing policymakers 'decisions, we focus here on the issue of policymakers' ability to consider research evidence (Newman et al., 2012).

2.2.6 What are the capabilities required to increase the demand for research evidence?

We have considered the ability (to seek research evidence) on three levels - individuals, organizations, and the environment. However, we also relied on the "knowledge incentive structures" model presented by Jones and Colleagues (2012) which highlights the area of organizational processes that are often overlooked as an important area of capacity (Jones, Jones, Shaxson, & Walker, 2012).

Individual ability is generally defined as a mixture of knowledge, skills, and attitudes that together influence behavior. In order to find, assess, and use research evidence, individuals need to have a wide range of capabilities including: knowledge of what research is and how it can be used; skills of searching and evaluating research information; critical

thinking skills to absorb information, criticism, and inclusion; and a positive attitude toward research evidence. The importance of situations means that individual capabilities, especially senior decision makers, can have a major impact on organizational capabilities (Newman et al., 2012).

It is also important to think about individuals who need the ability to seek research evidence. When people think about policymakers, they usually think of ministers and / or members of parliament. However, in reality there are many other important actors, particularly employees within both the legislative and executive branches of government. Given the important role these officials can play in policy-making, and their tendency to stay in their roles longer than those in elected / appointed positions, their support for capacity building can lead to important results long-term results.

Organizational capabilities are an integral part of the processes that the organization operates through. Some of the processes that clearly encourage the use of evidence include, for example, evidence-based peer reviews of internal policy briefings and committee inquiries that require regulators to collect evidence to audit a specific policy (Newman et al., 2012). These operations include strategy, planning, policy evaluation and most importantly budgeting. The research and statistics sections are often seen as "weak relationships" in the policymaking process, but if they participate in planning processes, they can make real contributions to evidence-based policymaking (Newman et al., 2012).

Wider environmental capacity, which influences the demand for evidence, consists of factors in both formal and informal institutions within a country or region (Broadbent, 2012). This may include whether there is a culture of enquiry and how it is developed through institutions such as higher education; what influences broader societal values and beliefs in the use of evidence; and the extent to which it is socially acceptable to challenge power structures. Attitudes toward the policy-making institution itself, what it should lead and who will lead it will be a research role in these processes. Related to this are ideas about accountability: the extent to which policymakers are held accountable for the "quality" of their decisions and examined by state or other civil society organizations including the popular media (Newman et al., 2012).

2.2.7 Perceptions about the use of evidence

In a study done in West Virginia in the United States of America that included 100 policy makers in the education sector where the study showed many important results, where

most of the participants agreed that high-quality research results can be a huge asset for policymakers, because it enables policymakers from making informed decisions. Those researchers who want the fruits of their work to make a difference in policy making should learn to adopt strategies to facilitate the transfer of research evidence to policy makers while working to avoid potential barriers to such transfer. More than anything else, policymakers want accurate, timely, easy-to-understand, concise and bias-free information (Scholar & Treadway, 2015).

In a study in Nigeria where the role of evidence was compared between three case studies representing different health policies, where most respondents considered the evidence realistic and concrete to support the decision. Evidence is more used if it is viewed as context specific, accessible and timely. In general, respondents reported that official evidence, such as survey reports and research publications, was very helpful at the stage of setting the agenda to determine the need for policy and thus initiate the policy development process (Onwujekwe et al., 2015). International and domestic evidence has been used to demonstrate the need for policy and policy development, and even less to develop policy implementation options (Onwujekwe et al., 2015).

In a study that occurred in Australia that included both policy makers and researchers where policymakers reported that they rarely use research to inform policy agendas or to assess policy impact, research is more commonly used to inform policy content (Campbell et al., 2009). Most researchers reported that their research informed local politics, mainly by raising awareness of an issue. Policymakers report harder access to useful research groups, and only a third of researcher's report was developed targeted strategies to inform policymakers of their findings. Both policymakers and researchers wanted more exchange and considered it important to increase the use of research evidence in policy; however, both groups reported a high level of participation by policy makers in the research (Campbell et al., 2009).

2.2.8 Ability to the assess, acquire, adapt and apply research evidence

In most developing countries, including Palestine, one of the most difficult issues related to linking evidence to policy is the constraints of policymakers' ability to access, synthesize, adapt and use available research evidence (El Jardali, Lavis, Ataya, & Jamal, 2012; El Jardali, Lavis, Ataya, Jamal, et al., 2012). In a study to assess the various efforts and initiatives taken to involve policymakers and other stakeholders in the health sector in

Nigeria, all studies indicated positive outcomes and impacts regarding quantitative improvement in policymakers' knowledge and competence in evidence of the policy process. She also noted that a participatory mechanism is needed to strengthen the capacity of both researchers to generate better evidence and for policymakers and healthcare professionals to better use the available evidence (Uneke, Sombie, Keita, Lokossou, Johnson, & Ongolo-Zogo, 2017).

Another study in Nigeria also showed low averages for policymakers with regard to conducting research, the ability to assess evidence, validity, reliability, reliability, relevance, applicability, and organizational capacity to enhance research and its use in policy making. The study also recommended developing programs to develop the capacity of policymakers to improve evidence-based policymaking (Uneke, Sombie, Keita, Lokossou, Johnson, Ongolo-zogo, et al., 2017).

In a study based on the responses of managers in 25 HIV / AIDS community-based organizations in Ontario, Canada, the study found that organizational capacity to acquire, evaluate, adapt, adapt, and apply research evidence is low. The managers also indicated that they lack the skills, time, resources, incentives, and connections with experts to obtain research, assess its quality, reliability, and summarize it in an easy-to-use manner (Wilson, Rourke, Lavis, Bacon, & Travers, 2011).

2.2.9 The importance of using evidence in policy making

Evidence is an important tool for better understanding how to prioritize and allocate limited resources to meet the needs of the population. Evidence generated can have a powerful influence on policy when used to develop and implement cost-effective solutions, track progress, analysis of what works, and make changes in policy, and an understanding of the impact interventions has (Taddese & Anderson, 2017). The role of research evidence in improving health systems and delivering health services has become increasingly recognized by policymakers and researchers in most countries of the world. The *Beijing Statement called* for the Second Global Symposium on Health Systems Research, held in November 2012 to promote confidence among researchers, practitioners and policy makers and support the translation of knowledge into policies, especially in developing countries (Beijing, 2012).

Also the Bamako Call for Action, it called on state governments of countries to promote knowledge translation and exchange of knowledge through the application of effective and

safe interventions, policy informed research, evidence-informed policies, and effective dissemination of research findings, including the public, taking into account multilingualism and development in information technology (Bamako, 2008).

2.2.10 Consequences of not using evidence in policy making

Over the recent years we have observed an explosion in both the availability and accessibility of information. Thus, we have witnessed greater recognition and interest in the traditional economic dilemma of scarcity of resources and our unlimited needs, making it more difficult to allocate resources and set priorities. A burden has been placed on policymakers at all levels and areas to justify their decisions in response to this dilemma. Decisions have become more transparent, and have shifted from implicit to clear decision-making (Coast, Donovan, & Frankel, 1996). Evidence-based decisions have been developed as a way to meet this growing demand for clearly justified decisions (Dobrow, Goel, & Upshur, 2004).

2.2.11 Barriers of using evidence

Previous studies have identified the expected reasons for not using evidence to inform policy (Ellen, Lavis, et al., 2016; Oliver, Innvaer, Lorenc, Woodman, & Thomas, 2014). Some of these findings point to political and economic hurdles for which health system researchers and policymakers have little impact. However, there are areas identified as contributing to reducing the gap between policy guides through which researchers and policy makers can make a difference. Despite the efforts made by researchers, policymakers have not seen research as relevant and applicable to policy formulation, and that research is not easily accessible when policymakers need it, but these studies have also indicated that potential policymakers use research evidence Low (Grimshaw, Eccles, Lavis, Hill, & Squires, 2012; Oliver et al., 2014; Orton, Lloyd, Taylor, Flaherty, & Capewell, 2011). The policy is not likely to draw on the best available evidence if the infrastructure for research findings is not effectively used in a timely manner (Orton et al., 2011).

Despite the documented importance of research evidence in developing health policies that can promote health, researchers have documented the poor or inadequate use of research evidence pointing too many barriers, including: decision makers' perceptions of research evidence; the gap between researchers and decision makers; culture Decision-making; competing influences on decision-making; and practical limitations (Orton et al., 2011).

On the other hand, researchers noted some internal barriers to using research evidence and emphasized that without adequate capacity to translate knowledge and health policy research, policymakers will not have the ability to access and synthesize sound information on decision-making (Dawad & Veenstra, 2007). Results of other research have shown practical limitations such as inconsistent research and policy-making timeframes (Bickford & Kothari, 2008; Lavis et al., 2005), and problems in disseminating and accessing research evidence (Lavis et al., 2005), the most important of which is the exclusion of policy makers who are supposed to be consumers of the evidence. As a way to overcome the barrier of policy makers 'assimilation of research evidence, some strategies have been proposed, including promoting effective interaction between researchers and policy makers (Innvær, Vist, Trommald, & Oxman, 2002), and conducting research that targets decision-makers' needs, in addition, the way research evidence is presented is important because policymakers prefer access to Contain information in summary form so they can quickly review it and if appropriate, they are considering more information (Bickford & Kothari, 2008).

A study in South Africa indicated that policymakers generally realize that they must make the best use of available evidence, but have highlighted systemic barriers that go beyond the influence of individual managers to solve. The study indicates that improved use of evidence throughout the policy cycle, especially in analyzing problems and needs, is a condition for learning through evidence-based policy development. It suggests that the political and administrative leadership will need to agree on standards and methods of dealing with barriers to effective use of evidence and on the role of each of them during the policy cycle in ensuring the availability and use of appropriate evidence (Cronin et al., 2015).

Policy makers, a role they play in the use of research where research evidence may be one of only a few factors in the decision-making process and policy, there is an increasing awareness of its value (Campbell et al., 2009). One of the tasks of health policy makers is to make important and costly health decisions about governance, financial arrangements, and implementation that determine whether the right programs, services, and medicines reach those who need them (Lavis, Posada, Haines, & Osei, 2004). Policymakers should be open and receptive to evidence-based work and be an integral part of creating an encouraging environment for research. Moreover, if users of knowledge do not know how to acquire, evaluate or apply research evidence, and if they do not implement the

infrastructure that supports the use of evidence, the likelihood of using research evidence to enrich the policy industry will be weak (Ellen, Lavis, Ouimet, Grimshaw, & Bédard, 2011; WHO, 2012).

Understanding the local context and the views of key players in the process can help identify the barriers and facilitators to use evidence in health policy-making.

2.2.12 Transfer and exchange of knowledge

Globally, countries spend billions of dollars annually in both the public and private sectors on biomedical, clinical and health research, continuous professional development, quality improvement, patient safety and risk management. However, health care systems fail to ensure that such research is used for health policy-making processes (Grimshaw et al., 2012). Bridging the gap between producing knowledge and using knowledge is a global challenge (Ellen et al., 2011; Hoffman, Lavis, & Bennett, 2009; WHO, 2012). Several KTE frameworks and approaches have been proposed; however, there is no comprehensive framework yet to help better understand impacts on decision-making and evidence-based policy-making (World Heatlh Organization, 2012; World Health Organization, 2005).

It is clear from the frameworks and research that local climate and context, weak relationships between producers and users of knowledge, and perceptions of knowledge producers with regard to the roles they need to play in order to transfer knowledge can serve as barriers to the KTE process (Grimshaw et al., 2012; Lavis et al., 2005). Knowledge Transfer and Exchange (KTE) is one of the tools used to bridge the 'know-do' gap' (WHO, 2005). KTE is defined as *"a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to improve the health of [citizens], provide more effective health services and products and strengthen the health care system"* (Boyko, Lavis, Abelson, Dobbins, & Carter, 2012). Simply providing evidence through publications or meetings is an insufficient means to get research evidence into policy decisions (Straus, Tetroe, & Graham, 2011).

KTE is vital because knowledge can be scattered, the spread of research is enormous, and the cost of making bad decisions or slow implementation of knowledge in health care can have serious consequences. The success of any KTE strategy depends on adapting the approaches and initiatives implemented in the local context, barriers and facilitators working in these contexts (Ellen et al. 2011).

In a qualitative study in Ethiopia, the participants suggested a number of different ways in which the Federal Ministry of Health can build capacity for policy analysis and use of evidence in health policy development where career knowledge management development will facilitate the use of existing evidence, and help in understanding the current scope and status of research. This is necessary, but it will not facilitate the use of evidence alone. Creating a health policy analysis unit is key. The institutional arrangements for the PMU are a critical factor in ensuring that a unit is able to generate evidence and proactively review health policies and policies.

The unit should be formed based on a comprehensive long-term strategic plan that includes sustainable financing mechanisms. There are advantages to creating this unit as an independent institute, but this can also be created within the Minister's Office of the Ministry of Health, under the direct supervision of the Minister, with a long-term strategic goal of becoming an independent institution. Coordination of comprehensive research and priority-setting mechanisms will help meet the research needs of the Ministry of Health, reduce duplication in research, and improve resource use (Tilahun, Flannery, & Berman, 2016).

2.2.13 Links between researchers and policy makers

Structures and capabilities alone are not sufficient to facilitate the use of evidence. Links between structures, in the form of networks and exchanges between institutions and individuals, are an essential feature of the use of successful evidence in health policy (Alliance HPSR, 2007; Campbell et al., 2009; Koon, Rao, Tran, & Ghaffar, 2013).

It is especially important that these links are among the major groups involved in evidence-based health policy: researchers and policy makers (Buse, Mays, & Walt, 2012; Koon et al., 2013). Each of these categories has different goals, motivation, training, interests, values, and organizational structures. If the differences are not overcome, it may be difficult for evidence to significantly influence health policy. Strong ties between the two groups are identified by formal and informal ties, trust, bridging language gaps, and creating time frames that work for both researchers and policy makers (Alliance HPSR, 2007; Koon et al., 2013).

Improving linkages between policy makers and researchers aims to facilitate an increase in the supply of policy research and the demand for this research from policy makers (Adam,

Moat, Ghaffar, & Lavis, 2014). While the links and closeness between policy makers and researchers are important, it is also important for researchers and policy analysts be independent of policy makers so that political interests do not dominate artwork or operations (Alliance HPSR, 2007; Bennett et al., 2012; Doherty et al., 2010). Supply, demand, proximity and independence are key concepts in developing the use of evidence in health policy.

2.2.14 The use of evidence

International organizations and Governments provide recommendations and implement policies that they claim are based on the best evidence available at the time. Nevertheless, the results of some studies have shown that most of the time, these recommendations are not based on the best available evidence, and there are gaps between the available evidence at the time of taking the recommendation and the recommended actions (Hoffman et al., 2009; Lavis et al., 2002).

There have been many qualitative studies comparing the perceptions of researchers and policy makers, exploring their areas of agreement and differences. It is necessary to get examples from other health systems because the solutions are dynamic. Some factors may be applicable across contexts, while others may be local only (Campbell et al., 2009). Among the few studies examining KTE's activities and the views of researchers, researchers from 10 low- and middle-income countries were questioned and found that less than 50% of them participated in the activities of KTE (Lavis et al., 2010).

Interviews researchers separately from policy makers and perceptions from each group regarding the transformation of research into policy. Participants reported their perceptions of research used in policy-making, if policymakers found that access to research was useful, communication and exchanges between researchers and policy makers, and their suggestions on how to increase the use of research in policy. Each category noted that although the research evidence is used in policy planning, more can be done to increase its use in policy (Petticrew, Whitehead, Macintyre, Graham, & Egan, 2004; Whitehead et al., 2004).

Conducted two studies examining the evidence base of policies to reduce health inequalities and examined the views of researchers and policy makers on the use of evidence in policy-making, they reported a significant match between researchers and policy makers, suggesting that there may be a common understanding between them and

that both groups recognized the need to promote an evaluation culture, including training of researchers beyond the description of the research towards assessing the results of interventions (Choi et al., 2005; Shroff et al., 2015; Uzochukwu et al., 2016). Studies have confirmed the benefits of working together, as shown in other studies (Choi et al., 2005; Shroff et al., 2015; Uzochukwu et al., 2016).

Researchers in Argentina had similar feelings about the lack of support and incentives, but they also felt the growing mistrust of policymakers, and even of other researchers, because of their social and political history (Corluka, Hyder, Winch, & Segura, 2014).

Recently, the focus has been largely on policymakers, whether in understanding their perceptions or in providing potential interventions (Dobbins, Ciliska, Cockerill, Barnsley, & Dicenso, 2002; Graham et al., 2006; Kitson, Harvey, & McCormack, 1998). While research has been conducted in the field of KTE and understanding the views of key actors in the process and the actual use of research in policy development in Canada, some Arab countries, and elsewhere (Campbell et al., 2009; El Jardali, Lavis, Ataya, Jamal, et al., 2012; Lavis et al., 2010).

In one study conducted in South Africa on the use of evidence in policy making, the study provided a descriptive snapshot of attitudes toward the use of evidence in policy making. All 54 senior government officials interviewed felt that the use of evidence was very limited to ensure effective and relevant policy responses.

This includes policies that underlie complex outcomes and those that have long-term and highly resource implications. Although all respondents considered EBPM intuitively desirable, there were different views on practical application. The examples provided indicate that, if evidence was used, it was often associated with a borrowed international policy without analysis based on prior evidence of successes and failures or their relevance and relevance in terms of issues and local context (Cronin et al., 2015).

In a study targeting health policy makers in Zambia that indicated that participants did not understand the concept of informed health policy for evidence so well that less than half of the respondents reported that they specifically heard about the informed health policy of evidence at the same time about two thirds reported that they used research evidence in decision-making And formulate policies. A similar contradiction was expressed in the understanding and use of rapid response mechanisms such that although half of the

respondents reported that they had heard about it. Regarding information sources, about half of the respondents reported scientific articles as the main source of evidence (Katowa-mukwato, Mwape, & Siwale, 2018).

2.2.15 The use of evidence at the level of the Eastern Mediterranean region

There is a lack of health systems research and systematic reviews from the countries of the EMR (El-Jardali et al., 2010; Law, Lavis, Hamandi, Cheung, & El-Jardali, 2012). The EMR has the lowest (after Africa) share of scientific publications dealing with health topics in the world (0.8% among all WHO regions) (WHO, 2004).

A study of 12 countries of the Eastern Mediterranean region was conducted. The majority (76%) indicated that policy formulation was based on elements other than evidence-based processes such as donor preferences and internal MOH discussions. A similar majority felt that there was insufficient evidence of how health policies were produced, and that there was a lack of coordination among stakeholders in policy making, perhaps because of their derision towards the value of evidence. Again, less than half of the researchers were involved in knowledge transfer activities (El Jardali, Lavis, Ataya, & Jamal, 2012).

The administrative structures of several countries in the region are disrupted by poorly arranged health care systems, which affect health care financing and delivery. This has resulted in a lack of coordination as many countries face challenges related to poor resource allocation, weak public-private partnerships, and lack of fiscal sustainability policies, reflected in poor quality and inefficiency (Schieber G, Maeda A, 1998).

In a previous priority-setting study with policy makers and researchers from the region, participants called for further exploration of health systems research in policy, involving policy makers in health systems research, and conducting surveys to understand the context of policy-making and the design of effective KT strategies in the region (El-Jardali et al., 2010).

A previous analysis of print media in 44 low- and middle-income countries (LMICs) in several countries of the Eastern Mediterranean Region showed that the region is among the lowest in terms of articles describing or using health systems research (Cheung et al., 2011).

2.2.16 The use of evidence at the level of Palestine

In a recent qualitative study of 104 experts in Palestine, the results revealed, firstly, that the HRS system in Palestine was performing remarkably poorly, and most experts were dissatisfied. Participants view the system as ineffective, poorly managed and lacking systematic evaluation. Second, the factors behind the system's poor functioning were (1) an unregulated system, a lack of research culture, and a governing body or policies; (2) health research was seen as individual, unpaid and unutilized in policy decisions; (3) Minor coordination and core resources. The third result showed insufficient support and political participation (Alkhaldi et al., 2018).

In a qualitative study published in 2014, the study noted that there are many obstacles to the conversion of evidence into policies: lack of incentives and capacity building programs, weak information infrastructure, and logistical and technological capabilities also lack the "transfer" of knowledge. In addition, communication, networking and coordination between institutions, researchers and policy makers was fragile. Also, the majority stated that evidence-based practice is not properly used and most of them are personally driven and non-institutionalized in fact, as well as inter-institutional relations are not good (Aljeesh & AL-Khaldi, 2014) . A quantitative and qualitative study in the Gaza Strip indicated high levels of knowledge, attitudes and practice of physiotherapists regarding their views on evidence-based practice, and a low level of efforts by providers of physiotherapy services to provide a supportive environment for evidence-based practice (Zeedia, 2018).

In a cross-sectional study using a web-based questionnaire to assess awareness, attitudes and knowledge about evidence-based medicine where the study included Palestinian doctors working in health centers of the MoH, UNRWA, academics, and the private sector, most respondents welcomed the concept of EBM , And they agreed that EBM is beneficial in their daily practice and can improve patient care, claiming that more than half of their daily clinical practice is evidence-based. However, two-thirds of respondents believed that evidence-based medicine practice would impose requirements on physicians who are already suffering from an overload. About a third of respondents said they received formal training in evidence-based medicine. The main perceived barriers to practicing evidence-based medicine were insufficient knowledge and skills, lack of administrative and institutional support, limited resources and free access to databases or libraries, excessive

work, and a negative attitude towards evidence-based medicine among some colleagues, especially the most senior (Albarqouni & Elessi, 2017).

The first EBM conference was organized in Palestine, and perhaps one of the first in many Arab countries. It was entitled EBM as part of Medical Education and Clinical Practice. Held at the Islamic University, Gaza on 25-26 October 2013, the conference covered 15 different local medical practices in hospitals in the GS. The aim of the conference was to promote the dissemination of the principles of EBM in Palestine to a wider audience of health professionals and raise awareness of the need to conduct a practice evaluation and the need to review our clinical practices regularly and also to make a number of recommendations on how to improve current local practice (Elessi, 2016).

The first EBM initiative was created in the GS by the Faculty of Medicine at the Islamic University and Dr. Khamis Elessi is the owner of this initiative and this initiative works with governmental and NGOs, locally and internationally, to impose its role in clinical practice gradually, and this initiative has accomplished a lot of training For doctors about the concept and practice of EPM (Islamic University - Gaza, 2020).

Chapter Three

Methodology

3.1   Introduction

This chapter provides a detailed description of the study methodology. It begins by explaining the design of the study, the method of data collection and analysis, sampling technique, study population, and study settings. Then, it describes the validity and reliability of the study instruments, ethical considerations, and finally the study main limitations.

3.2   Study Design

In order to assess the use of evidence in health policy making, the researcher chose a triangulated, descriptive-analytical, cross-sectional design. The descriptive research method is the main research approach that examines the situation, as it occurs in its current state (Williams, 2007). Analytic research recognizes relationships between variables and creates new knowledge about concepts (Burns, Grove, & Stuppy, 1997). The cross-sectional design reveals the present facts at the same point in time of data collection, it is less expensive and it consumes less time than other longitudinal studies (Fathalla, 2004).

In this study, methodological triangulation would present an integration of quantitative (structured interview questionnaire) and qualitative paradigms key informant interviews (KII) to confirm outcomes from one model with another, and to maximize the strengths of the quantitative and qualitative. Also, to add new facts having an important relation to the study, and ultimately to provide better understanding of the research problem or issue than understanding research approach alone (Bulsara, 2015).

3.3   Study Population

It is a census survey, the study group includes all top and middle level managers in the MoH in the GS, and they are 169 participants and 5 key informants (policy makers), the managers of the top and middle levels were defined as those who participate directly in health policy making as well as those who support Such operations. In addition to 7 key informants (researchers and experts) from outside the MoH, who have significant experience in the field of health policy research. The study population was divided into policy makers, researchers, and experts, each respondent were divided into two quantitative and qualitative sections as follows:

3.3.1 Quantitative Part

The quantitative part of the study includes the entire study population (census), who are the top and middle level managers in MoH. Thus, the total study population is 169 managers divided as follows: Head of Department 139, Director of Unit 9, General Director 21. Where the response rate was 85.7% (145\169 participants), while the response rate in another similar study 75.7% (El Jardali, Lavis, Ataya, Jamal, et al., 2012). the researcher has reached this rate of response because of frequent contact with managers to conduct interviews, and the researcher has also reached all the geographical locations where the participants work.

3.3.2 Qualitative part

This part includes in-depth interviews with 12 participants (5 health policy makers, 7 researchers and experts in the field of health policies) were selected by the researcher and the supervisor and then the researcher conducted interviews with them (Annex 3).

3.4 Eligibility criteria

It included the inclusion and exclusion criteria for the study population.

3.4.1 Inclusion criteria: quantitative and qualitative part

- Policymakers: Policy makers: at least two years' experience at the top or middle management level.
- Researchers and experts: They have health policy research and have much experience in health policy and are not required to be employees of MoH.

3.4.2 Exclusion criteria: Quantitative study

- Policymakers working outside the MoH

3.5 Study setting

This study was conducted in the GS, targeting health policymakers working for MoH from the five governorates, along with targeting also researchers and policy experts from academic institutions and other service providers.

3.6 Study period

The study was conducted over 16 months; it has begun in sept 2018 and finished in May 2020.

3.7 Study instruments

This study utilized various instruments for quantitative and qualitative parts:

3.7.1 Quantitative part

The first tool was a structured interviewed questionnaire, the survey was adapted and customized from several similar tools developed by other researchers. (Canadian Foundation for Healthcare Improvement, 2014; El Jardali, Lavis, Ataya, Jamal, et al., 2012; Kothari et al., 2009) some elements were reformulated, edited, or removed to suit the context of health policy-making in the GS. (Annex 4) . The questionnaire composed of two parts: The first part covers the socio-demographic data of the participants, the educational qualification of the participants and their Managerial position and other questions. It includes 23 questions. The second part explore the extent to which evidence is used in health policy-making using Likert's model scale with five options (Strongly Disagree (1), Disagree (2), neutral (3), Agree (4), Strongly Agree (5). Total questions of the questionnaire were (99) questions divided into five domains like the following:

1. Perceptions Policymaker about the use of evidence in policy making process (17 questions).
2. Determine the ability to assess, acquire, adapt and apply scientific evidence (50 questions).
3. Current knowledge transfer mechanisms (12 questions).
4. Groups or factors that Influence Health Policymaking (10 questions).
5. Inhibiting factors, the use of evidence by health policy makers (10 questions).

3.7.2 Qualitative part

The second tool used in the data collection was guiding questions for the in-depth interviews for 12 key informants, the policymakers, and health policy experts. The guiding questions were developed after the analysis of the quantitative part (Annex 5).

3.8 Ethical and administrative considerations

In order to start this study, the proposal was accepted by Al Quds University-School of the public health research committee for discussion and academic approval. Additionally, the revised International Code of Ethics Standards (1975), known as the Declaration of Helsinki, which is approved by the World Medical Assembly were followed and an official letter of approval to conduct the research was achieved from the Helsinki Committee (Annex 6). According to the Principles of the Helsinki Ethical Declaration, every study participant was given a clear and complete explanation of the research purposes, and confidentiality (Annex 4). Every participant in the study had the opportunity to accept or decline to participate in the study. Additionally, the participants who entered the study received verbal consent. Official permission was received for taking notes and recording the Interviews with the key informants. To strengthen the integrity of the report, by protecting privacy and confidentiality, the researcher-maintained adherence to the Ethical Code Principles. The researcher expected additional ethical rights to be protected.

Official letters were sent from Al Quds University-School of public health of the Palestinian Ministry of Health for administrative approval, (Annex 7) then it was obtained for the data collection process (Annex 8).

3.9 Pilot study

The study was divided into two parts, quantitative and qualitative parts as follows

3.10 Quantitative Part

For the quantitative part; a pilot study was done to assess the reliability of the questionnaire and to investigate the suitability of the study tools, the transparency of meaning and scales or rating. In addition, the pilot study design helps to assist many aims of the study.

It was performed to expect response rate, time spent to fill in the questionnaire by the respondent, validity, and appropriateness of the questionnaire. Furthermore, this design highlights the points that need some modifications. 20 participants were included in the pilot study. According to the results of the pilot study, one question was removed and some were changed or some details were added to the other questions.

3.10.1 Qualitative Part

This part included two key informants from participants in qualitative part, which allow for additional enhancement of the study regarding validity and reliability. At this stage; the questions were organized and developed to be more focused.

3.11 Data collection

3.11.1 Quantitative data

The researcher used a structured interview questionnaire as a formal instrument for data collection. The formal instrument was used for validity and reliability testing to ensure scientifically sound findings. The researcher asked and explained the nature of all questions for the participants.

In addition, the attached consent form was placed in front of each questionnaire and the participants were asked to voluntarily participate in the study. The researcher explained to each participant the importance, the aim and purpose of the study, and then ticked all questions that were answered by the participants. Time allocated for each questionnaire was 20–25 minutes (Annex 4).

3.11.2 Qualitative data

In in-depth interviews with five key informant (KII) from policymakers in MoH and seven researchers and experts in health policy. The researcher gave a brief introduction to the aim of the study, prolonged engagement and probing techniques were used to make sure that ideas are reasonably reflected. In addition, short notes were taken and recorded through the interviews to allow further capturing of information, each interview lasted from 50 to 60 minutes. Interviews were conducted after the quantitative data collection was completed. Annex 1 and 5 shows the questions discussed and the KII who participated in the study.

3.12 Scientific rigor

3.12.1 Quantitative part (questionnaire)

Face and content validity

The validity of a study tool means that the level to which a tool measures what it is assumed to be measured. The face validity means whether the tool looks as though it is measuring the suitable form (Polit & Beck, 2009). The face validity assisted the

researchers to reach the complement of readability and clarity of the tool, while the content validity concerns the degree to which a tool has a suitable sample of items for the structure being measured. An instrument content validity is essentially based on judgment (Polit & Beck, 2009).

The questionnaire was presented to an expert panel with experience and knowledge in this field who give ideas and opinions about the suitability of the questionnaire (Annex 9).

The experts expressed their ideas and advice about the transparency, simplicity, completeness of domains and statements on the questionnaire, therefore the researcher did some changes according to the experts' suggestions. The questionnaire was formulated in order to ensure face validity, including attractive layout and rational sequences of questions and clarity of instructions.

In addition, a pilot study was done before the actual data collection to assess the participant's replies to the questionnaire and how they understand it. This assured and improved the validity of the questionnaire, especially after changing it to be clearer and more understandable (Annex 9).

Internal Consistency:

To test internal validity, the researcher evaluated the correlation between each item and the corresponding field. Tables (3.1) existent the correlation coefficient for each domain and the total of the corresponding field. The p-values (Sig.) are less than 0.05, thus the correlation coefficients of all domains are significant at $\alpha = 0.05$, therefore it can be said that all items of each field are consistent and valid to measure what it was set.

Reliability of the instruments

The reliability of an instrument is the degree of uniformity with which it measures the characteristic it's supposed to measure (Heale & Twycross, 2015). The reliability test was performed for the structured interview questionnaire after the pilot stage and also after the data were completely collected and entered.

The researcher used the Crombach alpha coefficient to discover the reliability for each domain and the total reliability of the scale was (0.961), table 3.2 below presents the reliability test result for all domains.

Table (3.1) Reliability domains of the structured interview questionnaire

Domains	Cronbach's Alpha	Split-Half Coefficient
Perceptions of policymaker about the use of evidence in policy making process	0.838	0.735
The ability to assess, acquire, adapt and apply research evidence	0.843	0.801
Current knowledge transfer mechanisms	0.869	0.749
Groups or factors that influence health policymaking	0.835	0.797
Inhibiting factors, the use of evidence by health policy makers	0.927	0.861
Overall	0.961	0.867

3.13 Data entry and analysis

3.13.1 Quantitative part

Data entry model has been designed and questionnaires and variables were coded and entered, then data cleaned by using the SPSS program. Later the analysis process was done by using the different tests of the SPSS, central tendency measures were performed, including descriptive frequencies, mean, median, mode, standard deviation (SD) and frequency tables for the quantitative variables and the percentages were found out for the qualitative variables.

The researcher used inferential analysis to test the statistical significance of differences; an independent t-test was used to mean scores of the independent variable with two categories such as gender. One-way Analysis of Variance (ANOVA) test was used to compare the mean scores of the independent variable with more than two options such as governorates.

The P-value equal to or less than 0.05 was considered statistically significant, with a confidence interval of 95%.

The Statistical Package for Social Sciences version (SPSS) program, version 23 was used for data entry and analysis.

3.13.2 Qualitative part

Debriefing reports for each interview were made immediately after the end of each one. Related qualitative data and reflections on initial results were obtained Transcription was done to every interview, and then an open coding thematic analysis technique was used to examine the records of the in-depth interviews. The researcher, achieved the main results from the records of the interviews. Then, the classification of related ideas and comparison and a combination between the quantitative and the qualitative results were done to generate rich items for discussion.

3.14 Limitations of the study

1. The study in the quantitative part included policy makers in the MoH and did not include policy makers in other health sectors, such as the private sector, UNRWA and NGOs.
2. The study was limited to the GS and did not include the WB.
3. The study includes researchers in health policies as a qualitative part that is not covered by the quantitative part.
4. The study did not include stakeholders and actors outside the MoH, such as the Legislative Council, donor institutions, and others that could also influence health policy adoption.
5. The study includes evidence-based health policies and does not include evidence-based practices and EBM.

Chapter Four

Results and Discussion

4.1 Introduction

This Chapter illustrates the results of statistical analysis of the data, including descriptive analysis that presents the demographic characteristics of the study sample and the answers to the questions of the study.

The researchers used statistical tests, including frequencies, bivariate, and multivariate analysis to analyze the connotative data. The Chapter also summarizes the main findings of the qualitative data. Also, the Researcher discusses the results of the study in the light of similar studies, both local and international and determine the extent of compatibility or difference with this study findings.

4.2 Descriptive statistics

4.2.1 Distribution of the study participants according to selected demographic data

In this domain, the researcher will discuss the main finding of the demographic characteristics of the respondents which include but not limited to age, gender, residency, professional background, level of education).
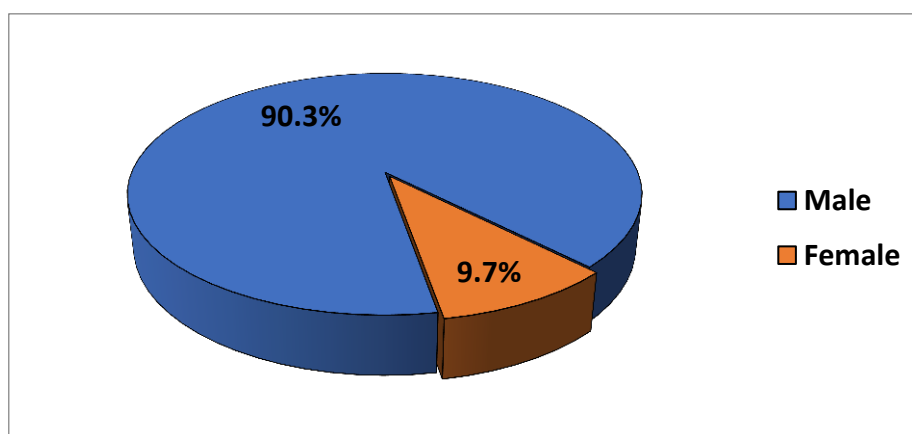
Figure (4.1): Distribution of the study participants according to gender

Regarding the distribution of participants by gender, the results showed that most of the study participants were male (90.3%) while 9.7% of them were female Figure (4.1). These results were somewhat consistent with a study that included 245 managers at the MoH in the GS, (86.1%) of males compared to 13.9% of females (Balawi, 2013). The results of this

study also differed with a study that included managers in 42 NGOs in the GS, where the percentage of male managers was (67.7%) and females 32.3% (Abu Aisha, 2014). It also differed with a study in Canada targeting policymakers in the field of agricultural, food and public health, where the results showed that 72.7% of the participants were women (I. Young et al., 2014). A study conducted on the policy makers in Nigeria showed an increase in the percentage of females 34.6% compared to our study (Uneke et al., 2011). Another study in the Israeli occupation state showed a difference with this study, where the results showed that 71.8% of policymakers are men and 29.2% are women (Ellen, Horowitz, Vaknin, & Lavis, 2016). According to many local and international studies, the researcher believes that the representation of women in administrative positions in the MoH in the GS is low and the researcher believes that the culture of Palestinian society, especially the GS, is a culture that tends to males and reduces the ability of women to bear burdens. The researcher recommends an in-depth study to determine the true causes of the underrepresentation of women in managerial positions.

Table (4.1) Distribution of the study participants according to their demographic characteristics

Items	Number	%
Age		
Less than 45 years	38	26.2
From 45 to 50 years	47	32.4
From 51 to 55 years	24	16.6
More than 55 years	36	24.8
Total	**145**	**100.0**
Mean= 49.26, MD = 49.00, Std= 6.40		
Level of education		
Bachelor	63	43.4
Master	54	37.2
PHD	10	6.8
Board	18	12.4
Total	**145**	**100.0**
Professional background		
Medicine	31	21.4
Pharmacy	17	11.7
Nurse	25	17.2
LAP Technician	17	11.7
Management	34	23.4
Other	21	14.5
Total	**145**	**100.0**

Table 4.1 with regard to the age groups of the study participants, the results showed that the highest percentage of age groups among the study population were from 45 to 50 years (32.4%) followed with less than 45 years (26.2%), more than 55 years (24.8%) and lowest groups were from 51 to 55 years (16.6%).

In brief, the average mean age of participants was 49.26 years. The results of this study age group differed with the results of another study conducted in the Gaza Strip, where the study included the administrative level in the MoH and the results showed in the age group more than 50 years (18%) while the result was in this study of the same category (41.4%) (Balawi, 2013).

The results of this study also differed with a study that included managers in 42 Non-Governmental organizations (NGOs) in the GS, where the mean age of managers was 40.9 while our study was the mean age of 49.26 (Abu Aisha, 2014). Also in another study conducted in Israel, it included the same group that was included in our study, and the average age of the participants was 54.7% (Ellen, Horowitz, et al., 2016).

The researcher explains this difference is that our study included the top and middle management levels It did not include the first management level.

Regarding the distribution of participants by place of residency; Figure (4.2) the results showed that the highest percentage of participants (51%) was from the Gaza governorate, while the North Governorate were ranked second with 15.9% of the total, and these results are consistent with Balawi (2013) findings.
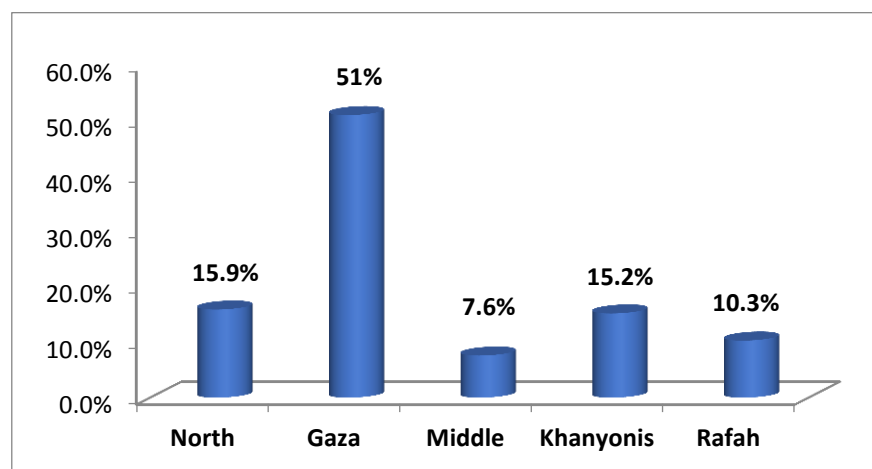
Figure (4.2): Distribution of the study participants according to their place of residency

With regard to the level of education, the study results showed that (56.2%) hold post-graduation degree distributed as follows: 37.2% Master, 6.8% Ph.D, 12.4% Board, and the remaining numbers of managers hold a Bachelor's degree with a percentage of 43.4%. Our study agreed to a study that included managers in the MoH (Balawi, 2013). It was also consistent with a study conducted with NGOs directors (Al-Khaldi, 2012), a clear difference was observed in the post-graduation between managers in the MoH and their peers in NGOs (Abu Aisha, 2014; Nassar, 2011), where the results showed a decrease in the number of managers holding higher post-graduation in NGOs (31.3%) compared Managers in the Ministry of Health (56.2%). The study also differed with a study conducted on policymakers in Nigeria, where it showed a decrease in the educational level of the postgraduate level (31.8%) compared to the results of our study (56.20%) (Uneke et al., 2011).

Regarding the distribution of participants according to the professional background, the medical profession ranked first, with a 21.4%, followed by the management profession, with a 23.4% at the second level and then the nursing profession third with a 17.2%. These results were somewhat in agreement with other studies (Balawi, 2013).

4.2.2 Distribution of the study participants according to work related variables

This domain will discuss work-related variables of study participants such as place of work, current managerial position, years of experience at current position, years of experience at the MoH, employees are you currently managing, the number of articles read per month, and the number of times evidence is used per month.

Table (4.2) Distribution of the study participants according to work-related variables

Items	Number	%
Place of work		
PHC	27	18.6
Hospital	52	35.9
Supportive technical administrations	66	45.5
Total	**145**	**100.0**
Current managerial position		
Head of Department (Middle level manager)	**125**	**86.2**
Male	111	88.8
Female	14	11.2
Total	125	100.0

Gender of top-level manager: Unit manager	**13**	**9.0**
Male	13	100.0
Female	0	0
Total	13	100.0
Gender of top-level manager: General Director	**7**	**4.8**
Male	7	100.0
Female	0	0
Total	7	100.0
Total	**145**	**100.0**
Years of experience at the current position		
5 years and less	42	29.0
From 6 to 10 years	63	43.4
More than 10 years	40	27.6
Total	**145**	**100.0**
Mean = 8.43, MD = 9.00, Std = 4.09		
Years of experience at MoH		
14 years and less	21	14.5
From 15 to 20 years	49	33.8
More than 20 years	75	51.7
Total	**145**	**100.0**
Mean = 21.77, MD = 21.00, Std = 6.71		
Number of employees currently Managing		
10 and less	40	27.6
From 11 to 20	21	14.5
From 21 to 50	43	29.7
More than 50	41	28.3
Total	**145**	**100.0**
Mean = 61.55, MD = 25.00, Std = 105.10		
Number of articles you read per month		
Zero	27	18.6
From 1 to 2	33	22.9
From 3 to 5	40	27.8
More than 5	44	30.6
Total	**145**	**100.0**
Mean = 6.72, MD = 3.00, Std = 12.85		
How often do you use results of scientific research and literature in the decision / policy making		
Never	32	22.1
once per month	47	32.4
2-5 times per month	44	30.3
6-10 times per month	12	8.3
More than 10 times a month	10	6.9
Total	**145**	**100.0**

Table 4.2 regarding the workplace variable, the study results showed that supportive technical administrations at the first level (45.5%) and hospitals at the second level (35.9%), followed by primary health care (18.6%). The MoH in the GS consists of several general administration such as the general administration of hospitals and the general administration of primary care and both of them considered the largest administrations in the MoH. The researcher divided the general administration into three sections: the general administration of hospitals and the general administration of primary care and the third section included the rest of the administrations in MoH and named supportive technical administrations, including but not limited to general administration for pharmacy, general administration for financial and administrative affairs, general administration for supportive medical units, general administration for legal affairs, general administration for mental health, general administration for international cooperation, general administration of nursing, ambulance and emergency unit and other departments.

Regarding the current managerial position, the study showed that 86.2% of the study participants are head of the department (111 males, 14 females), 9.0% and unit managers (13 males, zero females) and 4.8% general manager (7 males, zero females).

Our results showed the lack of representation of women in top management positions (unit managers and general managers). According to the Palestinian Central Bureau of Statistics (PCBS), women working in the government sector in Palestine constitute 11.6% of general managers, compared to 88.4% for men in the same class, and this does not correspond to the results of our study (PCBS, 2018), as the results showed that there were no women among the respondents to study in the position of general manager at MoH in the Gaza Strip, the results of a study that included manager in NGOs was better than the MoH, where the results showed 20.6% of general managers are female (Abu Aisha, 2014).

When the participants were asked about years of experience in the current position, 29% answered that they have 5 years of experience and less, and 43.4% said that they have experience from 6 to 10 years, and the remaining respondents, 27.6% answered that they have experience in the current position more than 10 years. Also, our results did not agree with a study conducted on policy makers in Canada, where the category of experience less than 5 years constituted 48.5% of the participants, while our study for the same category made up 29% of the participants. (I. Young et al., 2014).

As for the years of experience in MoH, 14.5% of the respondents answered that they have 14 years and less of experience, 33.8% answered that they have experience from 15 years to 20 and the rest (51.7%) answered that they have more than 20 years' experience in MoH. The mean for years of experience in MoH was 21.77, this result is inconsistent with the Al-Balawi (2013) study that included decision makers in MoH where the mean was 13.2 years.

When the participants were asked about the number of employees who currently manage them, the weighted mean the mean among study participants was 61.55, came first to 29.7% of respondents answered that they manage from 21 to 50 employees, followed by 28.3% who answered that they manage more than 50 employees, and 27.6% answered of respondents said that they manage 10 employees and less, and finally answer 14.5% that they manage 11 to 20 employees.

When asked of respondents about the number of articles he reads monthly, 18.6% said that they do not read any articles, and 22.9% answered that they read from 1 to 2 articles per month, followed by 27.8% who answered that they read 3 to 5 articles per month, and 30.6% answered that they read more than 5 articles per month, where the average number of articles was 6.72 articles per month. When asked the study participants about the number of times they use scientific evidence and literature in policy / decision making, 22.1% said they do not use any evidence in policy / decision making, while 32.4% of the respondents answered that they use evidence once a month, and 30.3% of respondents answered that they use evidence 2 to 5 times a month, and 8.3% said they use evidence 6 to 10 times a month, and 6.9% of respondents said they use evidence more than 10 times a month.

4.2.3 The distribution of the study participants according to available resources and training

This scope will discuss variables related to availability of resources and training, such as (resources and training, received training in health policy, access to search engines, access to electronic libraries, access to a computer, access through your smart phone, access to databases, access to publications).

Table (4.3) Distribution of the study participants according to available resources and training

Items	Number	%
Received training in health policy		
Yes	82	56.5
No	63	43.5
Total	**145**	**100.0**
Have access to search engines to access health policy research free of charge at workplace?		
Yes	139	**95.9**
No	6	4.1
Total	**145**	**100.0**
Search engines accessed often		
Google	130	90.3
Yahoo	13	9.0
PubMed	12	8.2
UpToDate	7	4.8
Other	21	14.4
Have access to electronic libraries		
Yes	46	31.7
No	99	**68.3**
Total	**145**	**100.0**
Have access to computer at work		
Yes	145	100.0
No	0	0.0
Total	**145**	**100.0**
Have access to search engines through smart phone at work		
Yes	130	89.7
No	15	10.3
Total	**145**	**100.0**
Have access to MoH database at work		
Yes	133	91.7
No	12	8.3
Total	**145**	**100.0**
Have access to MoH publications including annual reports		
Yes	141	97.2
No	4	2.8
Total	**145**	**100.0**

Table 4.3 Regarding health policy training answered 56.5% of the respondents indicated that they received training in health policy While 43.5% answered that they did not receive any training on health policy. This result is somewhat close to a study conducted on health policy makers in the Middle East and included Palestine (El Jardali, Lavis, Ataya, Jamal, et al., 2012). The researcher believes that this percentage is relatively low, as failure to

develop and train policymakers in making health policies will lead to wasting the already limited resources, and this will ultimately be reflected in people's health.

Regarding the availability of resources, 95.9% of study participants indicated that they can access health policy research from their workplace. The majority of respondents (90.3%) said that Google is the engine they use most often for evidence, and 9% of respondents said they use the Yahoo engine often to search for evidence, and 8.2% said they use PubMed and 4.8% of respondents reported that they use Up-To-Date.

As for the participants when asked about the availability of a computer in the workplace, 100% of the respondents answered yes, and in a question about access to electronic libraries such as Henri from the workplace 68.3% answered that this is not possible while 31.7% answered that they can access e-libraries from a place the work, and when the participants are asked About the possibility of access to search engines through a smartphone 89.7% answered yes, 91.7% of the respondents replied that they had access to the MoH database related to their work and 8.3% answered no, and 97.2% of the respondents indicated that the reports and publications of the MoH, including annual reports, reached them. The researcher believes that the infrastructure for using evidence is fairly good and needs some minor improvements. Based on the results of this scope, the researcher believes that we need to develop other aspects such as developing skills and providing incentives for policymakers / decision makers to increase reliance on evidence.

4.2.4 Distribution of the study participants according to Perceptions of Policymaker about the use of evidence in policy making process

This domain will discuss participants' perceptions, knowledge, and attitudes about the use of evidence in health policy making.

Table (4.4) Distribution of the study participants according to perceptions of policymaker about the use of evidence in policy making process

N	Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		WM
		N	%	N	%	N	%	N	%	N	%	
1.	Evidence-informed policymaking EIPM is necessary to improve the performance of the health care system	2	1.4	0	0.0	11	7.6	39	26.9	73	64.1	90.40
2.	I am interested in improving the skills needed to integrate EIPM in my organization/ department	0	0.0	0	0.0	6	4.1	52	35.9	87	60.0	91.20
3.	EIPM improves the quality of services provided by my organization/department	0	0.0	0	0.0	3	2.1	46	31.7	96	66.2	92.80
4.	EIPM takes into account the surrounding contexts in policy making / health decisions	0	0.0	1	0.7	26	17.9	63	43.4	55	37.9	83.80
5.	Research evidence should always be used to develop health plans	0	0.0	1	0.7	16	11.0	70	48.3	58	40.0	85.60
6.	Research evidence should always be used in health decision-making	0	0.0	4	2.8	18	12.4	65	44.8	58	40.0	84.40
7.	Research evidence should always be used in health service provision and practices	0	0.0	0	0.0	17	11.7	71	49.0	57	39.3	85.60
8.	Health policy literature (such as magazines and textbooks) and research findings are useful in my daily work	0	0.0	6	4.1	49	33.8	60	41.4	30	20.7	75.80
9.	There is a lack of necessary evidence in my work that I can use as a health policy/ decision maker	6	4.1	39	26.9	48	33.1	45	31.0	7	4.8	61.20
10.	I need to develop the skills needed to improve the process of using evidence in policy / decision making.	1	0.7	17	11.7	37	25.5	61	42.1	29	20.0	73.80
11.	EIPM is a waste of time and adds a burden on me	84	57.9	51	35.2	6	4.1	4	2.8	0	0.0	89.60 *
12.	I have an interest in attending workshops related to the use of evidence in health policymaking	0	0.0	2	1.4	19	13.1	63	43.4	61	42.1	85.20
13.	Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society	2	1.4	2	1.4	6	4.1	77	53.1	58	40.0	85.80
14.	Most of the time, relevant research is not available	11	7.6	38	26.2	57	39.3	32	22.1	7	4.8	58.00
15.	Decision making is mostly judgmental in my department	15	10.3	42	29.0	40	27.6	42	29.0	6	4.1	62.40 *
16.	Decision-making is influenced by political views	9	6.2	9	6.2	43	29.7	54	37.2	30	20.7	48.00 *
17.	Decision making is mostly based on personal preference and interest	19	13.1	53	36.6	50	34.5	17	11.7	6	4.1	68.60 *
	Mean = 77.7, MD =77.65, Std= 7.17											

* Negative question

Table 4.4 shows that the total mean score for the domain perceptions of policymaker about the use of evidence in policy making process was 77.77%. The highest results that managers agreed upon was that "*EIPM improves the quality of services provided by my organization / department*" with a weighted mean of 92.80%, followed by the phrase "*I am interested in improving the skills necessary to integrate EIPM into my organization/ department*" with a weighted mean 91.20%.

Participants answered the phrase "*Evidence-informed policymaking EIPM is necessary to improve the performance of the health care system*" with a high approval rating of 90.40%, and respondents also answered the phrase "*EIPM is a waste of time and adds a burden on me*" with a high disapproval rate of 89.60%, this reflects a positive attitude of the participants on the importance of using evidence in policy / decision making.

The results of the qualitative part of the interview of the main informants in this study showed that there is awareness for both researchers and policymakers about the importance of using evidence as one KII 58years said, "We can only advance and develop when we make the research a daily culture" (KII, researcher). Another KII 55years added that "*In the health system administration, it is not possible to think of setting any policy without conducting an assessment of the aspect in which we want to develop a policy and this evaluation should be based on accurate and accurate information and evidence confirming the validity of this information in order for us to develop a correct policy*" (KII, policymaker). Another KII 53years added that "*Relying on any false and unedited evidence will definitely lead you to make an incorrect policy and will have to review it again*" (KII, policymaker).

The researcher added the WHO definition of health policy to know the extent to which the participants understood the concept of health policy, where the respondents answered with a score of 85.80% agreeing the phrase "*health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society*". Participants also answered the following two statements with the same approval score of 85.60% "*Research evidence should always be used to develop health plans*" and "*Research evidence should always be used in health service provision and practices*".

When respondents were asked in the phrase "*I have an interest in attending workshops related to the use of evidence in health policymaking*", the respondents answered with an approval score of 85.20%. In another phrase, "*Research evidence should always be used in*

health decision-making" with an approval score of 84.40%. The phrase "*EIPM takes into account the surrounding contexts in policy making / health decisions*" received an approval score of 83.80%.

The phrase "*Health policy literature (such as magazines and textbooks) and research findings are useful in my daily work*" got a score of 75.80%, while the phrase "*I need to develop the skills needed to improve the process of using evidence in policy / decision making*" approval score of 73.80% where the result of this phrase shows that the participants have a lack of skills in using evidence, and this can be linked to a previous question about the participants receiving training in health policy, where the proportion of those who received training was 56.5% which is a low percentage.

The phrase "*Decision making is mostly based on personal preference and interest*" obtained a rejection rate of 68.60%, meaning that the approval of the statement is 32.4%. The phrase "*Decision making is mostly judgmental in my department*" got a rejection rate of 62.40%. The phrase "*There is a lack of necessary evidence in my work that I can use as a health policy / decision maker*" obtained a score of 61.20%, meaning that 39.8% suffer from a lack of evidence necessary in their work. As this study agreed to some extent with the El Jardali (2012) study, which included several countries in the Middle East, where 36.8% of the respondents reported the lack of sufficient evidence related to preparing health policies.

Almost half of respondents (48.00%) indicated when asked "*Decision-making is influenced by political views*". More than half of respondents (58.00%) answered the question "*Most of the time, relevant research is not available*".

Quantitative results did not agree with the qualitative results in this study regarding the availability of evidence and its relevance to the work of policymakers where most of the KII participants indicated that the evidence is available, sufficient and relevant, as One of KII said that (48years), "*The evidence is available and available, but some decision makers consider it a kind of intellectual luxury*" (KII, researcher).

Another KII added that (50 years), "*There is evidence that is relevant and available at the right time but decision makers do not have access to it because they have not learned it*" (KII, researcher). Another KII added that (52 years), "*Global research is available, but*

there is a lack of local evidence and a lot of local evidence available there is a problem with its quality" (KII, policymaker).

In the results of one of the studies that included health policy makers in many countries in the Middle East region, including the State of Palestine, where the study included 237 policy makers, the results were better than the results of this study regarding the perceptions and opinions of participants about the use of evidence in health policy making Where respondents (88.5%) answered that they are interested in searching for scientific evidence to support the formulation of health policies, while the results of our studies in this domain weighted Mean 77.7 (MD = 77.65) (El Jardali, Lavis, Ataya, Jamal, et al., 2012).

The results of a study conducted in the Israeli occupation state on the views of policymakers on the role of health policy research in making health policies. The study included 37 policy makers, where about half of the respondents indicated that political influences hindered the use of health policy research, while two thirds of the participants felt that health policy research It helped to identify or select policy alternatives, and nearly half of the respondents indicated that health policy research helped raise awareness about public policy issues (Ellen, Horowitz, et al., 2016).

In general, the quantitative part was consistent with the qualitative part of the study regarding perceptions health policy makers' about the use of evidence since the majority of KII participants confirmed that the knowledge and attitudes of decision makers are somewhat positive, as One of KII said that (48years), "*The Ministry of Health in Gaza The age group that governs the ministry is a young class, most of whom have higher degrees that support the idea of being a healthy decision-maker, because we are talking about a qualified class*" (KII, policymaker).

Another KII added that (40 years), "*Knowledge and attitudes are generally positive, but add to them personality, which is a key factor in the sense that the decision maker may have knowledge, trends and good practices, but he does not have the personal ability to impose change*" (KII, researcher).

Another KII added that (58 years), "*Policymakers' perceptions of scientific evidence are good in theory but on the ground, we do not find this, and we rely on our plans for what we desire, not for evidence*" (KII, researcher). Also, two of KII the participants considered that

they did not agree with the opinions of the other 10 participants. One of KII added that (70 years), "*The attitudes are positive for everyone, as everyone says we want something based on science, but knowledge is little*" (KII, researcher).

Finally, results appear in this domain that weighted Mean 77.7%, which means that 23.3% of policy makers in MoH in the GS have negative perceptions about the use of evidence in health policy making as the qualitative results have shown somewhat consistent with qualitative results. The researcher believes that the result is somewhat acceptable, but it is assumed that policymakers have a higher degree of awareness of the importance of using evidence in health policy making, especially with the Palestinian health system suffering from a scarcity of resources and thus making the policy based on opinion without being informing by scientific evidence will lead to more waste for resources. The researcher recommends the concerned authorities to raise more awareness about the importance of evidence and how it can be used in making health policies.

4.3 Distribution of the study participants according to Determine the ability to assess, acquire, adapt and apply research evidence

This section will discuss the results of the second domain with regard to the ability to assess, acquire, adapt and apply research evidence. The primary strength of this domain is that it provides a fundamental assessment of the ability of policy / decision makers to assess, acquire, adapt and apply research, which can be used to identify areas of future capacity building strategies. In addition, the data for this study can be used in future evaluations of organizational capacity after implementing capacity building initiatives. However, the results should be interpreted with caution given that the survey included policy / decision makers in the MoH in the GS only. Adding to that the survey did not include NGOs.

Table (4.5) Distribution of the study participants according to Ability to the ability to assess, acquire, adapt and apply research evidence

N	Items	Mean	MD	Std
1.	Ability to acquire research evidence	69.51	68.89	9.45
2.	Ability to assess research evidence	73.33	76.67	12.03
3.	Ability to adapt research evidence	74.90	75.56	10.42
4.	Ability to apply research evidence	63.12	63.53	12.84
5.	The ability to assess, acquire, adapt and apply research evidence	68.77	68.80	8.63

Table (4.5) shows that the weighted mean of the total sub-domains of the second domain in the study was 68.77%. According to the results of the first (highest) sub-domain (3) "Ability to adapt research evidence" with a weighted mean of 74.90%, the second is a sub-domain (2) "Ability to adapt to research evidence" with a weighted mean of 73.33%, followed by sub-domain (1) " Ability to acquire research evidence "with a weighted mean of 69.51%, Finally, (lowest) sub-domain are (4)" Ability to apply of research evidence "with a weighted mean of 63.12%.

Regarding the skills of health policy makers in how to use evidence, there was an incompatibility between researchers and health policy makers participating in in-depth interviews where most researchers indicated that health makers in MoH do not have sufficient skills to use evidence and they need more training on this, One of KII said that (55 years) "*I think there is a weakness in that, and if there was no weakness, our health status would be better than that and I think this is the main problem in not using the evidence*" (KII, researcher). And another KII (40 years) explained that, "*The main problem is not having the skills to use the evidence, and the reason for this is that the choice of decision makers is not based on competence, and also the lack of institutional interest in developing skills and neglecting decision makers to develop themselves*" (KII, researcher). On the other side, the participants in the in-depth interviews of policymakers indicated that a large number of decision makers in the Ministry of Health have the skills to use evidence in health policy making.

One of KII said that (55 years) "*the largest group to know them have a lot of skills, but the ministry is required to weigh these skills As the skills do not stop at a certain limit, but there is a disparity between decision makers, so they are at a very high level and some of*

them are at a low level and therefore we need to reduce this disparity and make everyone a good level of skill" (KII, policymaker).

4.3.1 Distribution of the study participants according to ability to acquire research evidence

This domain answers the extent to which participants are able to acquire the research evidence and whether the participants were searching for the research evidence in the right places.

Table (4.6) shows that the average overall score on the ability of policy/decision makers to acquire research evidence is 69.51%. According to the results, the highest results that were agreed by the participants were that "*My workplace is equipped with computers connected to the Internet*" with a weighted mean of 89.00% followed by a statement explaining that "*Computers are available to all policy /decision makers in your organization*" with a weighted mean of 86.40 %.

Looking at the results previously mentioned in the same study, when the participants were asked about the availability of resources such as computers and the Internet, the respondents answered with a high approval rate, and this corresponds to what came in this range.

Participants also answered the phrase "*I learn from peers through informal and formal networks to exchange ideas, experiences, and best practices*" with weighted mean of 80.40%, and respondents also answered the phrase "*I look for information on different web sites*", with a weighted mean of 76.40% .This was followed by the phrase "*I look for evidence in different databases*" with a weighted mean of 73.60%.Then came the phrase "*I have good experience in conducting research studies*" with a weighted mean of 72.40%, while the respondents answered the phrase "*I regularly follow internationally published reports such as WHO and WB reports*" with a weighted mean of 71.80%, and the degree of approval of the participants came to the phrase "*I have the motivation to conduct research*" is lower than the previous phrases, reaching a weighted mean of 71.60%.

Table (4.6) Distribution of the study participants according to ability to acquire research evidence

N	Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
		N	%	N	%	N	%	N	%	N	%	
1.	I have good experience in conducting research studies	0	0.0	13	9.0	43	29.7	75	51.7	14	9.7	72.40
2.	Computers are available to all policy / decision makers in your organization	0	0.0	1	0.7	19	13.1	57	39.3	68	46.9	86.40
3.	My workplace is equipped with computers connected to the Internet	0	0.0	1	0.7	11	7.6	55	37.9	78	53.8	89.00
4.	I have enough time to search health policy evidence	5	3.4	21	14.5	44	30.3	58	40.0	17	11.7	68.40
5.	I have the motivation to conduct research	2	1.4	14	9.7	45	31.0	66	45.5	18	12.4	71.60
6.	I have the resources to do research related to my work	11	7.6	41	28.3	41	28.3	43	29.7	9	6.2	59.80
7.	I always look for evidence in peer-reviewed journals	4	2.8	25	17.2	54	37.2	51	35.2	11	7.6	65.60
8.	I look for evidence in locally published reports	1	0.7	23	15.9	34	23.4	73	50.3	14	9.7	70.40
9.	I regularly follow internationally published reports such as WHO and WB reports	2	1.4	23	15.9	29	20.0	70	48.3	21	14.5	71.80
10.	I look for evidence in different databases	2	1.4	11	7.6	34	23.4	82	56.6	16	11.0	73.60
11.	I look for information on different web sites	4	2.8	8	5.5	20	13.8	91	62.8	22	15.2	76.40
12.	I work with researchers through formal networking meetings with our staff	5	3.4	30	20.7	45	31.0	53	36.6	12	8.3	65.20
13.	I work with researchers through informal networking meetings with our staff	2	1.4	42	29.0	49	33.8	46	31.7	6	4.1	61.60
14.	I get involved with researchers as a researcher	12	8.3	55	37.9	43	29.7	26	17.9	9	6.2	55.20
15.	I get involved with researchers as a decision-maker	6	4.1	22	15.2	33	22.8	69	47.6	15	10.3	69.00
16.	I get involved with researchers as a sponsor	29	20.0	53	36.6	36	24.8	18	12.4	9	6.2	49.60
17.	I learn from peers through informal and formal networks to exchange ideas, experiences, and best practices	0	0.0	3	2.1	25	17.2	83	57.2	34	23.4	80.40
18.	I can use statistics (technical language) efficiently	6	4.1	27	18.6	49	33.8	52	35.9	11	7.6	64.80
Mean = 69.51, MD =68.89, Std= 9.45												

With regard to monitoring and informing health policy makers about international and domestic publications, these questions got a weighted average of 70% to 76%, and these results did not consistent what the researchers said during in-depth interviews. One of KII (55-year) said that, "*I expect that the percentage of managers who do not follow local and international publications is more than that, and the participant says" We just finish a study and we feel we know everything "and that is why I think part of the study respondents have answered that they are shy about the researcher*" (KII, researcher). Another KII (58-year) Added that, "*My perception is that the percentage of those who do not follow local and international publications is more than that because those who do not have a motivation to read will not read where the concerns of people are very great and the concerns of society are great and I think that the answers of some were ashamed of the researcher and the result is less than that, except for those who are policymakers and academics at the same time, they are forced to read*" (KII, researcher).

The participants agreed on the phrase "*I look for evidence in locally published reports*" with a weighted mean of 70.40%, and the respondents answered the phrase "*I get involved with researchers as a decision-maker*" with a weighted mean of 69.00%, while the respondents answered with a low degree of approval reaching a weighted mean of 68.40% on the phrase "*I have enough time to search health policy evidence*".

The phrase "*I always look for evidence in peer-reviewed journals*" got a weighted mean of 65.60%, while phrase "I work with researchers through formal networking meetings with our staff" got a weighted mean of 65.20%, and Participants responded to the phrase "*I can use statistics (technical language) efficiently*" with a weighted mean of 64.80%, and the phrase "*I work with researchers through informal networking meetings with our staff*" got a low approval score of a weighted mean of 61.60%.

While the lowest score statement stating that "*I get involved with researchers as a sponsor*" with a weighted mean of 49.60%, followed by a statement stating that "*I get involved with researchers as a researcher*" with a weighted mean of 55.20%, followed by the phrase "*I have the resources to do research related to my work*" where I got a weighted average of 59.80%.

In a study conducted in Nigeria targeting health policy makers in the filed of maternal and child health, the results of this study were consistent with the results of this study, where

total the weighted mean was 65.32%, while the total weighted mean in our study for the same sub-domain was 69.51% (Uneke, Sombie, Keita, Lokossou, Johnson, Ongolo-zogo, et al., 2017).

Regarding the availability of resources and incentives to acquire scientific evidence as well as the skills of policymakers to access evidence, the results of this study were slightly better than another study that took place in Canada and included the executives of the community organizations concerned with HIV / AIDS, where the executives reported that there is a lack of skills, time, resources and incentives to acquire scientific evidence (Wilson et al., 2011).

In a study that included 107 policy makers or those involved in making health policy decisions in the health sector in Nigeria, where the study included both the governmental and non-governmental sectors; the results appeared in the sub-domain of acquiring scientific evidence somewhat inconsistent with the results of this study where total the weighted mean was 60.60 % (Uneke et al., 2011).

The researcher believes that the result is somewhat acceptable, but it needs to be improvements through encouraging continuous meetings between researchers and policy makers, as well as providing incentives and resources to encourage health policy makers to see and follow up on the latest produced evidence and finally it is necessary to facilitate methods of accessing evidence of all kinds.

4.3.2 Distribution of the study participants according to Ability to Assess of Research Evidence

This domain answers the ability of policy/decision makers to know if the research evidence is reliable and of high quality and also their ability to determine whether the research evidence is relevant and applicable.

Table (4.7) Distribution of the study participants according to ability to assess of research evidence

N	Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
		N	%	N	%	N	%	N	%	N	%	
1.	You have critical appraisal skills for evaluating the quality of methodology used in research	4	2.8	15	10.3	33	22.8	84	57.9	9	6.2	70.80
2.	You have critical appraisal skills to evaluate the reliability of specific research	4	2.8	21	14.5	38	26.2	75	51.7	7	4.8	68.20
3.	Are you in contact with experts who could help you in critically assess the reliability of specific research (either internal or external)	2	1.5	12	8.3	26	17.9	90	62.1	15	10.3	74.40
4.	You can relate research to your organization and point out similarities and differences	0	0.0	5	2.4	29	20.0	91	62.8	20	13.8	77.40
5.	You can identify the relevant similarities and differences between what we do and what the research says	0	0.0	10	6.9	32	22.1	87	60.0	16	11.0	75.00
6.	Are you in contact with experts who could help you to identify the relevant similarities and differences between what we do and what the research says (either internal or external)	2	1.4	9	6.2	33	22.8	87	60.0	14	9.7	74.00
Mean = 73.33, MD =76.77, Std= 12.03												

Table (4.6) shows that the weighted mean of participants' ability to evaluate research evidence was 73.33%. The highest results that participants agreed upon was that "*You can relate research to your organization and point out similarities and differences*" with a weighted mean of 77.40% followed by a statement explaining that "*You can identify the relevant similarities and differences between what we do and what the research says*" weighted mean 75.00%.

When the respondents answered the phrase "*Are you in contact with experts who could help you in critically assess the reliability of specific research (either internal or external)*" their approval with a weighted mean was 74.40%, and the following statement got "*Are you in contact with experts who could help you to identify the relevant similarities and differences between what we do and what the research says (either internal or external)*"on a score of approval lower than the previous phrases with a weighted mean 74.00%.

While the lowest phrase indicates that "*You have critical appraisal skills to* assess *the reliability of specific research*" at a weighted mean of 68.20%, followed by a statement stating that "*You have critical appraisal skills for evaluating the quality of methodology used in research*" with a weighted mean 70.80%.

Uneke and Colleagues (2017) showed that the ability of policy makers to assess research evidence was relatively low, with total a weighted mean of 63.86%, and the results showed that there was a decrease in the ability of study participants to assess the authenticity, validity, and reliability and assess the quality of evidence and its applicability, Also, the incentives to assess research evidence were very low.

The results of another study also showed a weakness in the ability of respondents to assess the research evidence, and this corresponds to some extent with the results of our study (Wilson et al., 2011)

Uneke and Colleagues (2011) results have shown a significant decrease in the field of assessing the research evidence where total the weighted mean was 62%, and this range includes the ability of decision makers to assess the quality, validity and applicability of research evidence where our study was slightly better in this area where it reached The total weighted mean was 73.33%.

Looking at the qualitative results, where most of the participants confirmed in the in-depth interviews that there is a weakness in the ability of health policy makers to assess the quality and reliability of research evidence and this is somewhat inconsistent with the quantitative results as the researcher believes that the participants in the quantitative part of the study may have overestimated their capabilities evidence assess. The researcher urges the concerned authorities to increase attention to the capabilities of policymakers through training and the weight of skills for evaluating scientific evidence.

4.3.3 Distribution of the study participants according to Ability to adapt research evidence

This domain answered the ability of policy / decision makers to summarize research findings in an easy-to-use manner if time, incentives, and resources are available to them. It also answered policy/ decision makers 'arrangements with external experts to assist it if needed.

Table (4.8) Distribution of the study participants according to ability to adapt research evidence

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
You have the ability to present research results concisely and in an easy language	1	0.7	11	7.6	32	22.1	90	62.1	11	7.6	73.60
Are you in contact with experts who could help you to research results concisely and in accessible language (either internal or external)	3	2.1	8	5.5	33	22.8	92	63.4	9	6.2	73.20
You have the ability to summarize findings of any research/report in one document	1	0.7	8	5.5	37	25.5	84	57.9	15	10.3	74.40
Are you in contact with experts who could help you to synthesize in one document all relevant research (either internal or external)	3	2.1	15	10.3	37	25.5	82	56.6	8	5.5	70.60
You have the ability to link research results to key issues facing policy makers in your organization	0	0.0	3	2.1	26	17.9	103	71.0	13	9.0	77.40
Are you in contact with experts who could help you to link research results to key issues facing policy makers in your organization (either internal or external)	2	1.4	13	9.0	36	24.8	81	55.9	13	9.0	72.40
You have the ability to provide recommended actions to policy makers in your organization	0	0.0	1	0.7	23	15.9	85	58.6	36	24.8	81.60
Are you in contact with experts who could help you to provide recommended actions to decision-makers in your organization (either internal or external)	2	1.4	8	5.5	29	20.0	90	62.1	16	11.0	75.20
You have the ability to push your results and recommendations into the agenda of policy makers.	2	1.4	5	3.4	39	26.9	75	51.7	24	16.6	75.80
Mean = 74.90, MD =75.56, Std= 10.42											

Table (4.8) shows that the weighted mean about the ability of policy / decision makers to adapt research evidence was 74.90%, where the highest statement that participants agreed was that "*You have the ability to provide recommended actions to policy makers in your organization*" at a weighted mean of 81.60%, followed by the statement that "*You have the ability to link research results to key issues facing policy makers in your organization*" with a weighted mean 77.40%.

Participants answered the phrase "You have the ability to push your results and recommendations into the agenda of policy makers" with a weighted mean of 75.80%, and also answered the phrase "Are you in contact with experts who could help you to provide recommended actions to decision- makers in your organization (either internal or external) "with a weighted mean of 75.20%.

In the phrase "*You have the ability to summarize findings of any research / report in one document*", the participants agreed with a weighted mean 74.40%, while the participants agreed to the phrase "*You have the ability to present research concisely and in an easy language*" with a weighted mean 73.60% , and the phrase "*Are you in contact with experts who could help you to research results concisely and in accessible language (either internal or external)*" received a score of approval lower than the previous phrases with a weighted mean of 73.20%.

Whereas the lowest phrase indicates that "*Are you in contact with experts who could help you to synthesize in one document all relevant research (either internal or external)*" at a weighted mean of 70.60%, followed by a phrase stating that "*Are you in contact with experts who could help you to link research results to key issues facing policy makers in your organization (either internal or external)* "with a weighted mean of 72.40%.

The results of one of the studies showed a convergence of results with our study on the ability of policymakers to adapt research evidence and this domain included the ability to summarize the results of research in an easy to use way and the ability to present research results to decision makers in addition to organizational incentives to encourage the provision of research evidence to decision makers (Uneke et al., 2017).

In this scope, the study of Uneke et al., (2011) coincided to some extent with this study, where the total weighted mean was 71.20%, while the total weighted mean in this study was 74.90%, as the study included the ability to summarize research findings, prepare

recommendations, and access to experts in research and policy development. The results of another study in the same domain were very low, as the results of our study were better (Wilson et al., 2011).

With regard to the ability to adapt research evidence, the results were somewhat acceptable, as the researcher believes that these skills need to be improved by improving the ability of decision makers to summarize research results and extract recommendations in addition to finding structures that support the use of evidence as these structures help policymakers from By connecting them with experts in the field of research and providing the necessary consultations.

4.3.4 Distribution of the study participants according to ability to apply of research evidence

This field discusses the ability to apply research evidence by knowing the value of research among policy / decision makers and also whether research has a place in policy / decision-making processes

Table (4.9) Distribution of the study participants according to ability to apply of research evidence

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
Using research findings is a priority in your organization	9	6.2	26	17.9	47	32.4	61	42.1	2	1.4	62.80
Your organization has committed resources to ensure research is accessed in making policy	11	7.6	38	26.2	48	33.1	46	31.7	2	1.4	58.60
Your organization has committed resources to ensure research is adapted in making policy	9	6.2	43	29.7	47	32.4	44	30.3	2	1.4	58.20
Your organization has committed resources to ensure research is applied in making policy	10	6.9	49	33.8	43	29.7	40	27.6	3	2.1	56.80
Your organization ensures staff is involved in discussions on how research evidence relates to organization main goals	2	1.4	27	18.6	54	37.2	60	41.4	2	1.4	64.60
The management of your organization has clearly communicated its priorities so that those conducting or monitoring research know what is needed in support of organization goals	6	4.1	21	14.5	44	30.3	69	47.6	5	3.4	66.40
Your organization communicate internally in a way that ensures there is information exchanged across the entire organization	2	1.4	16	11.0	44	30.3	64	44.1	19	13.1	71.40

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
Your organization has a culture that accepts change and provides resources for it	5	3.4	25	17.2	51	35.2	52	35.9	12	8.3	65.60
Your organization seeks to improve continuous quality and provides resources for it	2	1.4	11	7.6	34	23.4	84	57.9	14	9.7	73.40
Your organization has the flexibility to accept new evidence	2	1.4	19	13.1	48	33.1	66	45.5	10	6.9	68.60
When your organization make major decisions, your organization usually allow enough time to identify researchable questions and create/obtain, analyses, and consider research results and other evidence	8	5.5	31	21.4	49	33.8	55	37.9	2	1.4	61.60
Your management team evaluates the feasibility of each option, including potential impact across the organization as well as on clients, partners, and other stakeholders	5	3.4	23	15.9	71	49.0	40	27.6	6	4.1	62.60
Decision makers in your organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research	12	8.3	24	16.6	59	40.7	44	30.3	6	4.1	61.20
Staff and stakeholders know when and how major decisions will be made	5	3.4	47	32.4	54	37.2	38	26.2	1	0.7	57.60
Staff and stakeholders contribute to building evidence	3	2.1	26	17.9	57	39.3	57	39.3	2	1.4	64.00
Staff who provides evidence and analysis usually participate in policy-making discussions.	5	3.4	39	26.9	46	31.7	53	36.6	2	1.4	61.20
Staff and stakeholders are informed of how available evidence influenced the choices made in your organization	4	2.8	41	28.3	62	42.8	38	26.2	0	0.0	58.40
Mean = 63.12, MD =63.53, Std= 12.84											

Table (4.9) shows that the total mean score for the range of ability to apply research evidence was 63.12%. According to the results, the highest results approved by the participants are the phrase "*Your organization seeks to improve continuous quality and provides resources for it*" with a weighted mean of 73.40%, followed by a phrase stating that "*Your organization communicates internally in a way that ensures there is information exchanged across the entire organization* "with a weighted mean of 71.40%, followed by the phrase" *Your organization has the flexibility to accept new evidence*" with weighted mean 68.60%.

Participants answered the phrase "*The management of your organization has clearly communicated its identities so that those conducting or monitoring research know what is needed in support of organization goals*" with a weighted mean of 66.40%, followed by the phrase "*Your organization has a culture that accepts change and provides resources for it*" where participants answered them with a weighted mean of 65.60%, followed by the phrase "*Your organization ensures staff is involved in discussions on how research evidence relates to organization main goals* "with a weighted mean of 64.60%.

Participants responded to the phrase "*Staff and contribute to building evidence*" with a weighted mean of 64.00%, while they answered with a lower degree of approval on the phrase "*Using research results is a priority in your organization*" with a weighted mean of 62.80%, followed by the phrase "Your management team evaluates the feasibility of each option, including potential impact across the organization as well as on clients, partners, and other banks "with a weighted mean of 62.60%.

When respondents were asked in the phrase "*When your organization make major decisions, your organization usually allow enough time to identify researchable questions and create / obtain, analyzes, and consider research results and other evidence*", respondents answered with a weighted mean of 61.60%, while the phrases "*Decision" makers in your organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research*" and "*staff who provides evidence and analysis usually participate in policy-making discussions* "less consistent than previous phrases as the weighted mean of both 61.20%, while the phrase "*Your organization has committed resources to ensure research is accessed in making policy*" got a weighted mean of 58.60%, followed by the phrase "*Staff and citizens are informed of how available evidence influenced the choices*" made in your organization "with a weighted mean of 58.40%.

whereas the lowest phrase approved by the participants that "*Your organization has committed resources to ensure research is applied in making policy*" with a weighted mean of 56.80%, followed by a phrase stating that "*Staff and informed know when and how major decisions will be made*" with a weighted mean of 57.60%, followed by the phrase "*Your organization has committed resources to ensure research is adapted in making policy*" with a weighted mean of 58.20%.

With regard to the ability of policy makers to apply research evidence, the results of this sub-domain were low and this result was the lowest of between the other sub-domains in the second domain, and in view of another study conducted in Nigeria this result was somewhat close to our study where the total weighted mean was 59.81%, the total weighted mean in our study was 63.12% (Uneke, Sombie, Keita, Lokossou, Johnson, Ongolo-zogo, et al., 2017).

In the study of Uneke and Colleagues., (2011), where the result was somewhat close to the results of our study as it showed a decrease (weighted average total of 56.24%) in the ability of health policy makers to apply research evidence and also agreed with our study that this sub-domain received the lowest weighted mean among other subdomains. Our study also coincided with another study in Canada (Wilson et al., 2011).

Regarding the use of evidence in health policy making, participants differed in in-depth interviews, where most researchers indicated that the use of evidence is limited. One of KII (58-year) said that, "*Health policy makers do not use evidence and if they use it, they are used randomly because most of their time is occupied with problem solving, crisis management, and extinguishing fires*" (KII, researcher). Another KII (52-year) Added that, "*The decision maker who has the skill and the knowledge uses the evidence, and the one who does not have the skill and the knowledge does not use*" (KII, researcher).

Participants in the in-depth interviews of policymakers were more positive than the researchers, as they indicated that evidence is an essential thing in all decisions and policy that take place. One of KII (55-year) said that, "*The important factor in the ministry is that it is not possible to make a health policy without evidence and if the policy is not based on evidence you will find from within the ministry itself From the top category who prevents that*" (KII, policymaker). Another KII (48-year) Added that, "*When adopting any policy or protocols, specialized technical committees are formed to review everything that is updated to reach the best and security of protocols based on the best evidence*" (KII, policymaker).

The researcher believes, through quantitative and qualitative results, that the application of scientific evidence is limited, yet there are distinct individual efforts that try to make their policies informed by evidence.

The researcher also believes that policymaking informed by evidence should be directed to the ministry and not limited to individuals and provide the necessary resources for the application of evidence and that the use of evidence is linked to the strategic plans of the ministry and that the culture of research within the ministry is encouraged and perhaps the most important factor is the weight of the skills of policymakers and who help them on how to understand and reach research evidence.

4.4 Distribution of the study participants according to current knowledge transfer mechanisms

Table (4.10) shows that the overall weighted mean for the scope of knowledge transfer and exchange mechanisms was 57.25%. The highest results that were agreed upon by the participants were that "*Language is an issue for policy makers as most publications are in English*" with a weighted mean of 63.20%, followed by the phrase "*There is an administrative structure suitable to support the use of evidence-informed health policymaking process (for example; a policy analysis department or a decision support unit)*" where I got a weighted mean of 62.40%, followed by the phrase "*There is a lack of ability for health policymakers to understand the numbers and statistics in research papers*" got a weighted mean of 62.00 %.

Regarding the existence of an administrative structure suitable to support the health policy-making process, 28% of policymakers participating in one of the studies indicated that they agree and strongly agree and this result was somewhat close to our study, where the percentage of agree and strongly agree was strongly 39.3% and this is very low, and in another study in Israel, Occupied Palestine, , the results were inconsistent with our study, as the percentage of agree and strongly agree with reached 68% (El Jardali, Lavis, Ataya, Jamal, et al., 2012; Ellen, Horowitz, et al., 2016).

Table (4.10) Distribution of the study participants according to current knowledge transfer mechanisms

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
There is a lack of interactions between researchers and policymakers within your organization	2	1.4	32	22.1	35	24.1	60	41.4	16	11.0	52.20 *
Dissemination of research findings is done only through academic papers and journals (inappropriate channels as policy-makers might not read)	5	3.4	26	17.9	34	23.4	61	42.1	19	13.1	51.40 *
There is a lack of ability for health policymakers to understand the numbers and statistics in research papers	8	5.5	49	33.8	44	30.4	37	25.5	7	4.8	62.00 *
Language is an issue for policy makers as most publications are in English	11	7.6	58	40.0	28	19.3	39	26.9	9	6.2	63.20 *
I participate in meetings with researchers to identify high-priority policy issues for which research is needed to inform how to address these issues	5	3.4	46	31.7	40	27.6	45	31.0	9	6.2	61.00
There is an administrative structure suitable to support the use of evidence-informed health policymaking process (for example; a policy analysis department or a decision support unit)	7	4.8	39	26.9	42	29.0	44	30.3	13	9.0	62.40
There is limited coordination among policy and research institutions and researchers	8	5.5	46	31.7	26	17.9	59	40.7	6	4.1	58.80 *
Researchers are generally unaware of the necessity of knowledge transfer	12	8.3	43	29.7	35	24.1	47	32.4	8	5.5	60.60 *
Policy makers lack searching skills to access research results	18	12.4	42	29.0	26	17.9	51	35.2	8	5.5	61.60 *
Media plays a key role in disseminating knowledge within our context	4	2.8	17	11.7	32	22.1	71	49.0	21	14.5	47.80 *
Methods used in knowledge dissemination are not effective	3	2.1	33	22.8	39	26.9	55	37.9	15	10.3	53.60 *
Strategy for research uptake is mostly not there	5	4.1	34	23.4	25	17.2	61	42.1	19	13.1	52.60 *
Mean = 57.25, MD =56.67, Std= 10.32											

* Negative question

In the phrase "*Policy makers lack searching skills to access research results*" got a weighted mean of 61.60%, while another phrase "*I participate in meetings with researchers to identify high-priority policy issues for which research is needed to inform how to address These issues*" got a weighted mean of 61.00%, followed by the phrase

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"*Researchers are generally unaware of the necessity of knowledge transfer*" where you get a weighted mean of 60.60%.

The results indicated that 74.2% of the participants in study El Jardali, Lavis, Ataya, Jamal, et al., (2012) agreed that they participate with researchers identifying high-priority policy issues, while the results of our study showed that 61% of the participants agreed that they participate in meetings with researchers.

Study respondents responded to the phrase "*There is limited coordination among policy and research institutions and researchers*" with a weighted mean of 58.80%, while respondents responded to the phrase "*Methods used in knowledge dissemination are not effective*" with a weighted mean of 53.60%, and the consensus of the participants was low in the phrase "*Strategy for research uptake is mostly not there*" as it got a weighted mean of 52.60%.

While the phrase "*Media plays a key role in disseminating knowledge within our context*" was the least agreed upon among the participants as it obtained a weighted mean of 47.80%, followed by the phrase "*Dissemination of research findings is done only through academic papers and journals inappropriate channels as policy-makers might not read*", with a weighted mean of 51.40%, followed by the phrase "*There is a lack of interactions between researchers and policymakers within your organization*" with a weighted mean of 52.20%.

Regarding to the interaction between researchers and health policy makers, one of the studies that conducted in the Middle East region, including Palestine, found that 63% of the total participants from Middle Eastern countries and 63.4% of participants from Palestine answered that there is interaction and cooperation between researchers and policy makers, and Yemen ranked the lowest in the study with a 52.6% and Lebanon came first a 69%, and this study did not agree with the results of our study as 48.8% of the participants agreed that there is cooperation between researchers and policy makers, which is a very low percentage (El Jardali, Lavis, Ataya, Jamal, et al., 2012). The results of a study in Israel were better than the results of our study, where 32% of the participants who were strongly agree and agree indicated that there is a lack of interaction between researchers and policy makers (Ellen, Horowitz, et al., 2016). In another study, 133 researchers from 12 Eastern Mediterranean countries responded, a total of 65% of the respondents indicated

that there is a lack of interaction between researchers and health policy makers in their countries (El Jardali, Lavis, Ataya, & Jamal, 2012).

The qualitative results showed consistency with the quantitative results as most of the participants in the in-depth interviews confirmed that the mechanisms for transferring and exchanging knowledge are ineffective and need a lot of efforts and capabilities. One of KII (48-year) said that, "*This distance between research and decision-making is a distance that needs a lot of development as many of the results of scientific studies which has taken place within the MoH so far has not been clearly utilized within the Ministry*" (KII, policymaker). Another KII (52-year) Added that, "*Producers of evidence and information work toward and decision-makers work in another direction, Sometimes the decision-maker gets the information, but in an unorganized or systematic way because there are no structures that support it, as there is no body in the organizational structure, anybody whose function is to transfer or exchange knowledge*" (KII, researcher). And another KII (55 years) explained that, "*There is a gap between decision makers and researchers, as we find that the research department in the Ministry of Health has only one employee and it is considered the authority responsible for determining the ministry's need for research and reducing the gap between decision makers and researchers*" (KII, researcher).

Another KII (52-year) Added that, "*If an article needs $ 20 to $ 30, do you think that the decision-maker has this amount to buy in light of the current salary crisis?*" (KII, researcher). Another KII (54-year) Added that, *there is also indifference by decision makers to the results of research, perhaps due to the weak links between researchers and decision makers, and some decision makers consider that researchers give unrealistic recommendations and cannot be implemented*" (KII, researcher). Another KII (55-year) Added that, "*The link between research and decision makers has a problem, so if we can fix it, it will be better*" (KII, researcher).

Another KII (40-year) added that, "*In a big gap between researchers and decision makers, this gap has many reasons, among which there is no scholarship abroad to gain skills and see other people's experiences. Also, there is no continuous education for workers where the employee after graduation several years ago becomes the science that he studied is old and does not work update it through continuing education programs*" (KII, policymaker).

In the end, and looking at the results, the researcher believes that the relevant authorities should put effective plans and strategies to accommodate scientific evidence in health

policy making, where the results show a significant weakness in the mechanisms of transfer and exchange of knowledge, and also the researcher sees the need to strengthen the relationship between researchers and policy makers and find a strong administrative structure within The Ministry of Health supports the development of evidence-based policies.

4.5 Distribution of the study participants according to Groups or factors that Influence Health Policymaking

Table (4.11) the results showed that the phrase "*Donor organizations exert a strong influence on the health policymaking process*" ranked first in the factors that affect health policy making process with a weighted mean of 76.2%.

In view of previous studies, the results of our study were consistent with other studies, where Palestine ranked first in 10 countries of the Eastern Mediterranean in terms of strong influence of donors on health policy-making processes. In the same study, Yemen ranked second after Palestine, and Algeria came least affected by donor organizations (El Jardali, Lavis, Ataya, Jamal, et al., 2012). The results of our study also differed with the results of another study in the Israeli occupation state, where 3% of the respondents answered (strongly agree and agree) that there is an impact for donor organizations (Ellen, Horowitz, et al., 2016). The researcher believes that donor organizations cannot build an effective health system because these organizations strive to achieve their goals and objectives. In addition, the Palestinian health system has not clearly defined its strategic needs to compel donor organizations to support the real needs.

While the second phrase is *"Values of governing parties exert a strong influence on the health policymaking process"* with a weighted mean of 72.6%.

Table (4.11) Distribution of the study participants according to groups or factors that influence health policymaking

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
From your perspective, there is a lack of coordination among ministries (such as the MoH, Ministry of Finance, etc.) hindered the health policymaking process	9	6.2	23	15.9	41	28.3	55	37.9	17	11.7	66.6
Lack of coordination between government and health service providers hindered the health policymaking process	7	4.8	26	17.9	41	28.3	54	37.2	17	11.7	66.6
Do you think physicians exert a strong influence on the health policymaking process?	5	3.4	20	13.8	33	22.8	62	42.8	25	17.2	71.4
Do you think nursing exert a strong influence on the health policymaking process?	5	3.4	59	40.7	26	17.9	51	35.2	4	2.8	58.6
Private health providers exert a strong influence on the health policymaking process	12	8.3	45	31.0	48	33.1	39	26.9	1	0.7	56.2
Private insurers exerted a strong influence on the health policymaking process	35	24.1	71	49.0	32	22.1	9	4.1	1	0.7	41.6
Values of governing parties exert a strong influence on the health policymaking process	5	3.4	17	11.7	32	22.1	63	43.4	28	19.3	72.6
Public opinion exerts a strong influence on the health policymaking process	6	4.1	18	12.4	33	22.8	72	49.7	16	11.0	70.2
Media exerts a strong influence on the health policymaking process	5	3.4	19	13.1	39	26.9	65	44.8	17	11.7	69.6
Donor organizations exert a strong influence on the health policymaking process	2	1.4	19	13.1	23	15.9	61	42.1	40	27.6	76.2
Mean = 65.00, MD =64.00, Std= 9.85											

The results of our study regarding the effect of values of governing parties on health policy making process were consistent with the study of El Jardali, Lavis, Ataya, Jamal, et al., (2012), while it differed with the results of the study of Ellen et al., (2016).

The researcher believes that this result in the Palestinian case had a negative impact on the health policy-making process as the health sector entered within the framework of divisions between political parties (Fatah and Hamas) and these divisions led to the existence of two ministries in the West Bank and Gaza and also led to the absence of the role of the Legislative Council related to laws related to health and weakness Control.

Thirdly came the phrase "*Do you think physicians exert a strong influence on the health policymaking process*" where it got a weighted mean of 71.4%.

The results of our study regarding the effect of doctors on the health policy-making process were incompatible with another study where the percentage of agreed and strongly agreed with was 25.4%, while the result of our study was compatible with a study in the Israeli occupation state where the percentage of participants who were agreed and strongly agreed was 59%. The percentage of those who agreed and strongly agreed with our study was 60% of the total participants (El Jardali, Lavis, Ataya, Jamal, et al., 2012; Ellen, Horowitz, et al., 2016).

When asked the participants "*Public opinion exerts a strong influence on the health policymaking process*", the respondents answered with a weighted mean of 70.2%, and the participants had agreed on the phrase "*Media exerts a strong influence on the health policymaking process*" with a weighted mean of 69.6%, while it was participants' answers to the following phrases "*among ministries (such as the MoH, Ministry of Finance, etc.) From your perspective, there is a lack of coordination hindered the health policymaking process*" and "*Lack of coordination between government and health service providers hindered the health policymaking process*" with a weighted mean of 66.6%.

While the respondents answered the phrase "*Private insurers exerted a strong influence on the health policymaking process*" where the phrase was the least agreed among the participants and received a weighted mean of 41.6%, followed by the phrase "*Private health providers exert a strong influence on the health policymaking process*" where it got a weighted mean of 56.2%, followed by the phrase "*Do you think nursing exert a strong influence on the health policymaking process*" with a weighted mean of 58.6%.

4.6 Distribution of the study participants according to inhibiting factors the use of evidence by health policy makers

Table (4.12) Distribution of the study participants according inhibiting factors the use of evidence by health policy makers

Items	Strongly disagreed		Disagree		Neutral		Agree		Strongly agree		Weighted Mean
	N	%	N	%	N	%	N	%	N	%	
Lack of policy relevant research	8	5.5	25	17.2	32	22.1	60	41.4	20	13.8	68.20
Lack of time	7	4.8	37	25.5	25	17.2	58	40.0	18	12.4	66.00
Insufficient skills to critically appraise / evaluate the literature	3	2.1	24	16.6	38	26.2	63	43.4	17	11.7	69.20
Insufficient skills for interpreting research	3	2.1	29	20.0	35	24.1	57	39.3	21	14.5	68.80
An unacceptable environment for evidence-making in policy-making	5	3.4	29	20.0	58	40.0	38	26.2	15	10.3	64.00
Lack of incentive to participate in Evidence-informed policymaking	4	2.8	16	11.0	36	24.8	69	47.6	20	13.8	71.80
Insufficient skills to apply research findings to health policy	3	2.1	36	24.8	28	19.3	69	47.6	9	6.2	66.20
Lack of resources (i.e. access to a computer, the internet or online databases)	28	19.3	49	33.8	20	13.8	35	24.1	13	9.0	54.00
Lack of interest in Evidence-informed policymaking	15	10.3	32	22.1	47	32.4	35	24.1	16	11.0	60.60
Compliance with existing policies or laws, which limits improvements	4	2.8	27	18.6	38	26.2	57	39.3	19	13.1	68.20
Mean = 66.00, MD =65.00, Std= 13.64											

Table (4.12) shows that most of the barriers that prevent the use of evidence in health policy-making according to participants' perspectives are "Lack of incentive to participate in Evidence-informed policymaking" with a weighted mean of 71.80%, followed by the phrase "Insufficient skills to critically appraise / evaluate the literature" With a weighted mean of 69.20%, followed by the phrase "Insufficient skills for interpreting research" with a weighted mean of 68.80%.

Regarding the barriers to using evidence in the health policy-making process, the incentives were the biggest obstacle according to the results of our study, as these results did not coincide with the results of the Ellen et al., (2016) study, which the percentage of

agreed and strongly agreed with was 15% of the total participants, while the percentage of agreed and strongly agreed with in our study reached 61.4%.

Participants answered the following phrases "*Lack of policy relevant research*" and "*Compliance with existing policies or laws, which limits improvements*" with a weighted mean of 68.20%, while answered on the phrase "*Insufficient skills to apply research findings to health policy*" with a weighted mean of 66.20%, followed by the phrase "*Lack of time*" where the respondents answered with a weighted mean of 66.00%.

The study participants indicated that there is a lack of research studies related to health policies and this result did not coincide with another study, as the study showed that 14% of the participants confirmed that there is a lack of relevant research, while the proportion of those who agreed and strongly agreed with our study was 55.2% of the total participants (El Jardali, Lavis, Ataya, Jamal, et al., 2012).

Whereas, the phrase "*Lack of resources (such as access to a computer, the internet or online databases)*" came the least agreed among the participants, where the weighted mean was 54.00%, followed by the phrase "*Lack of interest in Evidence-informed policymaking*" with a weighted mean of 60.60%. This was followed by the phrase "*An unacceptable environment for evidence-making in policy-making*", which got a weighted mean of 64.00%.

The results showed the quantitative results consistent with the opinions of researchers in the in-depth interviews. The results concluded that the environment of the Ministry of Health is not encouraging to use evidence, One of KII (58-year) said that, "*The environment is not encouraging, as there is no culture that supports the use of evidence, and also the capabilities and resources are not available*" (KII, researcher).

Another KII (52-year) Added that, "*I think that the environment is weak and does not have the capabilities, but even what is available does not use it. For example, the ministry provides almost free access to some electronic libraries, but unfortunately a few use that*"(KII, researcher).

While the quantitative results did not coincide with the opinions of policy makers in the in-depth interviews, where decision makers emphasized that the environment is encouraging and supports the use of evidence. One of KII (48-year) said that, "*Certainly the environment is encouraging and we are one of the ministries that encourages this, but we*

need more efforts in addition to the necessity of activating the role of the research department in the Ministry"(KII, policymaker).

Another KII (54 years) explained that, "*Of course the environment is encouraging, and what prevents this, but the Ministry is required to weigh these skills*" (KII, policymaker).

In fact, the participants disagreed about the environment for using evidence in the Ministry of Health, but they agreed that the use of evidence in the Ministry needs to exert more efforts and provide human and logistical resources to improve the environment for using evidence, in addition to enhancing the research culture of employees.

A total of 65% of the researchers participating in a study the eastern Mediterranean region (EMR) indicated that what hinders the use of evidence in the health policy making process is that the policy environment does not accept the use of evidence in health policy making, this study did not match the results of our study where the proportion of those who agreed and strongly agreed with was 36.5% (El Jardali, Lavis, Ataya, & Jamal, 2012).

During the discussion of factors facilitating the use of evidence in health policy making with researchers and policy makers in in-depth interviews, opinions varied. One of KII (58-year) said that, "*Existence of strategies and promotion of a culture of research and the existence of an infrastructure for evidence and research and the provision of resources, and finally that the use of evidence be part of a plan*" (KII, researcher). Another KII (70-year) Added that, "*Creating an appropriate environment for scientific discussion and meetings, for exchanging information and building a strong relationship between universities and research centers on the one hand and the various ministries on the other hand, and these relationships, whenever they are strengthened, will create a good atmosphere for using evidence*" (KII, researcher).

Another KII (55 years) explained that, "*To have an easily accessible information center and also to develop the skills of decision makers and to develop advisers for health policy makers who have experience in the field of research*" (KII, researcher). Another KII (40 years) explained that, "*I think nothing prevents the use of evidence*" (KII, researcher).

Another KII (48 years) explained that, "*There should be confidence in the results of the research produced and also confidence in those in charge of research and also confidence that these topics meet the needs of decision makers, and greater efforts must be made to*

convince decision makers that this research can offer many things to them. It is also good to start research that adopts priorities and challenges of MoH" (KII, policymaker).

Another KII (55 years) explained that, "*The most important factor that facilitates the use of evidence is that the existing system in the ministry does not accept to adopt a policy that is not based on evidence. Secondly, there is an authorization from the ministry for decision makers, but it is not an absolute mandate in the sense that decision-makers have no absolute freedom to make policies independently of the ministry's policy that ensures that the policy is evidence-based*" (KII, policymaker).

As for the barriers that prevent the use of evidence, participants answered in in-depth interviews, as most of them agreed that scarcity of resources and lack of incentives is a major obstacle in not using the evidence. One of KII (58-year) said that, "*General conditions, lack of resources, scattered priorities and instability. Decision makers focus on the survival strategy, that is, how do we maintain what is there and this is the biggest achievement*" (KII, researcher). Another KII (70-year) added that, "*The obstacle is always in the available resources, and often they know what is right, but this entails obligations that they cannot do*" (KII, researcher). Another KII (50-year) added that, "*What prevents many things, including the number of a warehouse to collect local research, and also there are no things that attract people to research in addition to that experts in the field of research in our reality did not reach the required expertise in filtering and criticizing the research completely and this is because we do not work and therefore we are not learning and are afraid to mistake*" (KII, researcher).

Another KII (48 years) explained that, "*I think a lot of research presents scientific papers, but some of these papers are theoretical or repeated and sometimes need to be checked in order to be convincing and sometimes the research does not take into account the priorities of the ministry*" (KII, policymaker). Another KII (55 years) explained that, "*There is nothing to prevent, but the ministry acknowledges and admits that there is a large amount of research but is not beneficial from it and is looking at how the ministry can solve this problem by administrative solutions by making the dependency of the scientific research department to other departments to increase the effectiveness of the department and I appreciate that researchers are asking about all these productive research Which only took a small part of its results and left the rest*" (KII, policymaker).

In the end, the researcher believes that the qualitative results include adding new barriers and facilitators that the researcher could not include in the quantitative part where the quantitative and qualitative results agreed that the lack of resources, incentives and weak capabilities of knowledge users are the main barriers that prevent the use of evidence while the quantitative and qualitative results were not consistent with the availability of research related to health policy, where the participants indicated in the in-depth interviews that research is sufficiently available in most health fields, and quantitative results showed additional barriers, including the lack of a warehouse to collect evidence, especially local, and the participants also indicated that there is a weakness in the body of scientific research in the MoH, but with regard to facilitators, the participants in the in-depth interviews varied their opinions, but the common denominator between them was that establishing a strong relationship between knowledge producers and health policy makers and the continuous communication between them and unifying research priorities jointly would greatly improve the use of evidence .

4.6.1 Participants' suggestions in-depth interviews to improve the use of evidence in health policy making

When asked in-depth interviews about their proposals to improve the use of evidence in health policy-making, the participants' proposals varied. One of KII (54-year) said that, "*It is to improve the use of evidence, which could be through the establishment of a research repository to collect all evidence, especially local research from them, and also teach users of evidence about how to make a health policy informed by evidence and finally provide research according to priorities and facilitate access to it*" (KII, researcher). Another KII (58-year) Added that, "*We must have a unified strategy to absorb research and also care for the employee because it is the primary component of any improvement process, in addition to providing incentives and budgets related to absorbing research and creating a research body that is strong and energetic*" (KII, researcher). Another KII (70 years) explained that, "*Increasing trust and interdependence between the MoH and research objects in society. Also, health research and health research support should not be without capabilities*"(KII, researcher). Another KII (55-year) Added that, "*Training university graduates in the skills of using evidence before granting them a university degree and providing financial and logistical capabilities, and also it is better to have a repository for local research*" (KII, researcher).

Another KII (52 years) explained that, "*Administrative promotions in MoH should be linked to evidence through assessments of the capabilities of the candidates, and also the creation of a platform in which all information and research will be collected and readily available to all, in addition to the work of programs that improve the culture of research in society*" (KII, policymaker). Another KII (48-year) Added that, "*For the parties concerned with health research to communicate the results of researchers and not remain trapped in the drawers, and that greater effort be made in informing decision makers of these researches, whether through annual workshops or an annual meeting or by circulating through an annual booklet on all the researches discussed within a year*" (KII, policymaker). Another KII (55 years) explained that, "*To have a body in MoH that receives research and to find research results have an important place and to reduce the disparity between decision makers through the weight of the skills of decision-makers who have weak skills and activate participation in external conferences and not to recognize reality and the blockade and to open a gap in this wall is to benefit from the experiences of other countries*" (KII, policymaker).

Finally, in view of the participants 'proposals, the researcher summarizes the most important proposals agreed upon by both policy makers and researchers. Most of the participants agreed on the necessity of establishing a repository of scientific evidence, especially local evidence, and that scientific research capabilities be built through developing the skills of health policy makers on how to use evidence and strengthening the body of scientific research in MoH by providing logistical and human resources for this body and also supporting the culture of scientific research among the policy makers of MoH and providing incentives for them.

4.7   Distribution of the study participants according to the domains

Table (4.13) Distribution of the study participants according to the domains

N	Items	Mean	MD	Std
1.	Perceptions of policymaker about the use of evidence in policy making process	77.77	77.65	7.17
2.	The ability to assess, acquire, adapt and apply research evidence	68.77	68.80	8.63
3.	Current knowledge transfer mechanisms	57.25	56.67	10.32
4.	Groups or factors that influence health policymaking	64.98	64.00	9.85
5.	Inhibiting factors, the use of evidence by health policy makers	65.70	66.00	13.64

Table 4.8, according to the results the first (highest) domain (1) " Perceptions Policymaker about the use of evidence in policy making process" with a weighted mean of 77.77%, the second domain is a domain (2) " The ability to assess, acquire, adapt and apply research evidence" with a weighted mean of 68.77%, followed by domain (5) " Inhibiting factors the use of evidence by health policy makers" with a weighted mean of 65.70% and domain (4) " Groups or factors that Influence Health Policymaking " with a weighted mean of 64.98%. Finally, (lowest) domains are (3) " Current knowledge transfer mechanisms " with a weighted mean of 57.25%.

4.8 Inferential Statistics

This part represents the relationships between study domains and their relation of participant socio-demographic variables regarding governorates, age, gender, level of education, professional background, work related variables, available resources and training.

4.8.1 Difference between study domains and demographic variables.

Differences between Domains and Place of residency

Shows that there are no statistical differences between domains and Place of residency (P-value = 0.691), (P-value = 0.579), (P-value = 0.792), (P-value = 2.081), (P-value = 0.257) respectively and sig. ≥ 0.05. Annex (11)

Differences between Domains and Gender

Shows that there are no statistical differences between domains and gender (T = 0.803), (T = 0.700), (T = 0.313), (T = 0.733), (T = 0.622) respectively and sig. ≥ 0.05. which mean that the male and female had the almost had the same opinion about the domains Annex (12).

Differences between Domains and age

Shows that there are no statistical differences between domains and age (P-value = 0.464), (P-value = 1.232), (P-value = 0.382), (P-value = 1.474), (P-value = 0.306) respectively and sig. ≥ 0.05. Annex (13).

Differences between Domains and level of education

Table (4.16) shows that there are no statistical differences between domains and level of education (P-value = 1.322) (P-value = 0.185) (P-value = 0.122) (P-value = 0.215) (P-value = 0.463) respectively and sig. ≥0.05. Annex (14)

Differences between Domains and Professional background

Table (4.14) shows that there are no statistical differences between domains (Perceptions Policymaker about the use of evidence in policy making process, current knowledge transfer mechanisms, groups or factors that Influence health policymaking and inhibiting factors, the use of evidence by health policy makers and professional background (P-value = 1.267), (P-value = 0.631), (P-value = 0.561), (P-value = 0.330) respectively and sig. ≥0.05.

While there is statistical difference between the ability to assess, acquire, adapt and apply research evidence and professional background (F = 4.300, P-value =0.001).

While there is statistically significant differences between the ability to assess, acquire, adapt and apply research evidence and the professional background. Participants from the management profession (F= 4.300, P-value= 0.001), with a higher mean score (72.27) followed by participants from the other profession with a mean score (71.94). The participants from lab technician profession a mean score of (70.19), followed by participants from nurse profession with a mean score (66.83), followed by participants from physician profession with a mean score (66.65), followed by participants from pharmacist profession with a mean score (63.13) came last, by using scheffe in Annex (15).

Table (4.14) Differences between Domains and Professional Background

Domain	Profession	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Physician	31	75.41	7.57	1.267	0.282
	Pharmacist	17	78.75	8.26		
	Nurse	25	78.21	6.53		
	Technician	17	78.06	5.06		
	Management	34	79.55	6.45		
	Other	21	76.81	8.58		
	Total	145	77.77	7.17		
The ability to assess, acquire, adapt and apply research evidence	Physician	31	66.65	6.87	4.300	0.001
	Pharmacist	17	63.13	9.01		
	Nurse	25	66.83	8.56		
	Lab Technician	17	70.19	8.93		
	Management	34	72.27	7.99		
	Other	21	71.94	8.47		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	Physician	31	55.43	10.78	0.631	0.677
	Pharmacist	17	56.37	10.24		
	Nurse	25	57.53	9.23		
	Technician	17	59.22	11.49		
	Management	34	56.57	10.59		
	Other	21	59.84	9.94		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	Physician	31	63.29	6.23	0.561	0.730
	Pharmacist	17	64.71	8.97		
	Nurse	25	64.40	9.57		
	Technician	17	64.47	13.74		
	Management	34	67.24	8.61		
	Other	21	65.14	13.35		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	Physician	31	66.26	12.34	0.330	0.894
	Pharmacist	17	66.71	14.05		
	Nurse	25	63.68	13.05		
	Technician	17	63.06	15.69		
	Management	34	66.88	13.45		
	Other	21	66.67	15.44		
	Total	145	65.70	13.64		

4.8.2   Difference between study domains and work-related variables.

Differences between Domains and workplace

Table (4.15) shows that there are no statistical differences between domains (the ability to assess, acquire, adapt and apply research evidence, current knowledge transfer mechanisms, groups or factors that influence health policymaking and inhibiting factors, the use of evidence by health policy makers and workplace (P-value = 0.636), (P-value = 0.295), (P-value = 0.039), (P-value = 0.103) respectively and sig. ≥0.05. While there is statistical difference between Perceptions Policymaker about the use of evidence in policy making process and workplace.The participants from Hospital (F = 4.526, P-value = 0.012), with a higher mean score (78.96) followed by participants from Other administrative units with a mean score (78.31). The participants from PHC got a mean score of (74.16) came last, by using scheffe in Annex (16) the differences was for management profession with mean 72.27%.

Table (4.15) Differences between Domains and Workplace

Domain	workplace	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	PHC	27	74.16	7.36	4.526	0.012
	Hospital	52	78.96	6.42		
	Admin. Units	66	78.31	7.30		
	Total	145	77.77	7.17		
The ability to assess, acquire, adapt and apply research evidence	PHC	27	68.59	8.13	0.636	0.531
	Hospital	52	67.80	9.03		
	Admin. Units	66	69.60	8.56		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	PHC	27	56.98	11.22	0.295	0.745
	Hospital	52	56.51	10.56		
	Admin. Units	66	57.95	9.86		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	PHC	27	64.52	7.47	0.039	0.962
	Hospital	52	65.00	10.54		
	Admin. Units	66	65.15	10.25		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	PHC	27	65.41	12.13	0.103	0.902
	Hospital	52	66.38	15.39		
	Admin. Units	66	65.27	12.93		
	Total	145	65.70	13.64		

Differences between Domains and Managerial Position

Table (4.18) shows that there are no statistical differences between domains and managerial Position (P-value = 0.875), (P-value = 0.564), (P-value = 1.001), (P-value = 4.588), (P-value = 1.239) respectively and sig. ≥0.05, Annex (17).

Differences between Domains and experience in current position

Table (4.19) shows that there are no statistical differences between domains (Perceptions Policymaker about the use of evidence in policy making process, the ability to assess, acquire, adapt and apply research evidence, current knowledge transfer mechanisms, and groups or factors that influence health policymaking) and experience in current position (P-value = 0.272), (P-value = 0.057), (P-value = 0.870), (P-value = 1.568) respectively and P-value ≥0.05, While there is statistical difference between inhibiting factors, the use of evidence by health policy makers and experience in current position (F = 3.434, P-value = 0.035). Participants whose ages are from 5 years and less with a higher mean score (69.33) followed by Participants whose ages are More than 10 years with a mean score (66.85). The Participants whose ages are from 6 to 10 years a mean score of (62.54) came last, by using scheffe in Annex (18).

Table (4.16) Differences between Domains and experience in current position

Domain	experience in current position	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	5 years and less	42	77.73	6.40	0.272	0.762
	From 6 to 10 years	63	77.37	7.76		
	More than 10 years	40	78.44	7.10		
	Total	145	77.77	7.17		
The ability to assess, acquire, adapt and apply research evidence	5 years and less	42	68.53	7.84	0.057	0.944
	From 6 to 10 years	63	68.68	9.13		
	More than 10 years	40	69.15	8.81		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	5 years and less	42	56.83	10.65	0.870	0.421
	From 6 to 10 years	63	58.47	10.30		
	More than 10 years	40	55.79	10.04		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	5 years and less	42	65.86	8.00	1.568	0.212
	From 6 to 10 years	63	63.37	11.07		
	More than 10 years	40	66.60	9.38		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	5 years and less	42	69.33	14.34	3.434	0.035
	From 6 to 10 years	63	62.54	12.57		
	More than 10 years	40	66.85	13.72		
	Total	145	65.70	13.64		

Differences between Domains and experience in MoH

Shows that there are no statistical differences between domains and experience in MOH (P-value = 2.442), (P-value = 0.602), (P-value = 1.503), (P-value = 2.212), (P-value = 0.074) respectively and sig. ≥0.05**,** Annex (19).

Differences between Domains and number of employees currently managing

Shows that there are no statistical differences between domains and number of employees currently managing (P-value = 0.835), (P-value = 0.809), (P-value = 2.394), (P-value = 0.349), (P-value = 0.167) respectively and sig. ≥0.05, Annex (20).

Differences between Domains and Number of articles, related to your area of work, do you read per month

Shows that there are no statistical differences between domains and Number of articles, related to your area of work, do you read per month (P-value = 0.851), (P-value = 1.014), (P-value = 0.951), (P-value = 0.914), (P-value = 0.853) respectively and sig. ≥0.05, Annex (21).

Differences between Domains and How often do you use results of scientific research and literature in the decision / policy making

Table (4.17) shows that there are no statistical differences between domains (perceptions policymaker about the use of evidence in policy making process, current knowledge transfer mechanisms, groups or factors that influence health policymaking, and inhibiting factors, the use of evidence by health policy makers) and how often do you use results of scientific research and literature in the decision / policy making (P-value = 1.195), (P-value = 1.729), (P-value = 0.936), (P-value = 0.716) respectively and sig. ≥0.05, while there is statistical difference between the ability to assess, acquire, adapt and apply research evidence and How often do you use results of scientific research and literature in the decision / policy making (F = 2.722, P-value = 0.032), Participants who use the results of scientific research and literature more than 10 times a month , with a higher mean score (74.88), followed by participants who use the results of scientific research and literature from 6-10 times per month with a mean score (71.77), followed by participants who use the results of scientific research and literature from 2-5 times per month with a mean score (69.70) followed by participants who use the results of scientific research and literature

once per month with a mean score (67.34)The Participants who do not use the results of scientific research and literature got a mean score of (66.54) came last, by using sceffee in Annex (22).

Table (4.17) Differences between domains and how often do you use results of scientific research and literature in the decision / policy making

Domain	How often do you use results of scientific research and literature in the decision / policy making	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Never	32	77.32	8.27	1.195	0.316
	once per month	47	77.45	7.42		
	2-5 times per month	44	77.49	5.57		
	6-10 times per month	12	82.06	7.25		
	More than 10 times a month	10	76.82	8.17		
	Total	145	77.77	7.17		
The ability to assess, acquire, adapt and apply research evidence	Never	32	66.54	8.88	2.722	0.032
	once per month	47	67.34	7.29		
	2-5 times per month	44	69.70	8.20		
	6-10 times per month	12	71.77	11.58		
	More than 10 times a month	10	74.88	8.84		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	Never	32	54.22	9.26	1.729	0.147
	once per month	47	56.38	9.81		
	2-5 times per month	44	58.64	11.68		
	6-10 times per month	12	61.94	9.40		
	More than 10 times a month	10	59.33	8.79		
	Total	145	57.25	10.32		
Groups or factors that influence health policymaking	Never	32	67.94	10.15	0.936	0.445
	once per month	47	63.96	7.94		
	2-5 times per month	44	64.18	9.47		
	6-10 times per month	12	64.33	15.18		
	More than 10 times a month	10	64.60	11.12		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	Never	32	67.44	13.09	0.716	0.583
	once per month	47	64.72	11.90		
	2-5 times per month	44	67.27	14.77		
	6-10 times per month	12	62.00	18.55		
	More than 10 times a month	10	62.20	11.87		
	Total	145	65.70	13.64		

Differences between Domains and have access to search engines to access health policy research free of charge from your workplace

Table (4.18) shows that there are no statistical differences between domains (Perceptions of Policymaker about the use of evidence in policy making process, Current knowledge transfer mechanisms, and Inhibiting factors, the use of evidence by health policy makers) and have access to search engines to access health policy research free of charge from your workplace (T = -0.656), (T = 1.895), (T = -1.107) respectively and sig. ≥0.05, while there are statistical differences between the ability to assess, acquire, adapt and apply research evidence and Groups or factors that Influence Health Policymaking with having access to search engines to access health policy research free of charge from your workplace (T = -2.325), (T =-2.316), respectively and Sig. ≤0.05 the differences were for who have access to search engines to access health policy research free of charge from your workplace with mean 69.11% and 65.37% respectively.

Table (4.18) Differences between domains and have access to search engines to access health policy research free of charge from your workplace

Domain	Yes/ No	N	Mean	Std	T	Sig.
Perceptions Policymaker about the use of evidence in policy making process	No	6	75.88	9.17	-0.656	0.513
	Yes	139	77.85	7.11		
the ability to assess, acquire, adapt and apply research evidence	No	6	60.87	13.18	-2.325	0.021
	Yes	139	69.11	8.28		
Current knowledge transfer mechanisms	No	6	65.00	7.15	1.895	0.060
	Yes	139	56.92	10.32		
Groups or factors that Influence Health Policymaking	No	6	56.00	5.22	-2.316	0.022
	Yes	139	65.37	9.82		
Inhibiting factors, the use of evidence by health policy makers	No	6	59.67	14.22	-1.107	0.270
	Yes	139	65.96	13.61		

Differences between Domains and have access to electronic libraries

Shows that there are no statistical differences between domains and have access to electronic libraries (T = 0.431), (T = -0.502), (T = 0.379), (T = 0.632), (T = -0.130) respectively and sig. ≥ 0.05, **Annex** (23).

Differences between Domains and have access to search engines through your smart phone at work

Shows that there are no statistical differences between domains and have access to search engines through your smart phone at work (T = -0.203), (T = -1.819), (T = 0.295), (T = -0.350), (T = 0.529) respectively and sig. ≥ 0.05, **Annex** (24).

Differences between Domains and have access to the Ministry of Health (MoH) database at work

Shows that there are no statistical differences between domains and have access to the Ministry of Health (MoH) database at work (T = -0.505), (T = -1.501), (T = -1.033), (T = -0.053), (T = 0.609) respectively and sig. ≥ 0.05, **Annex** (25).

Chapter Five

Conclusion and Recommendation

5.1 Conclusion

This study was conducted to find out the extent of using evidence in health policy making among health policy makers in the MoH in the GS. This was done by using a set of quantitative and qualitative tools to evaluate perceptions about the use of evidence in the policy making process, determine the ability to assess, acquire, adapt, and apply research evidence, explore current knowledge transfer mechanisms, identify enhanced and inhibiting factors that affect the use of evidence, and identify the factors that influence policy making Health.

The results showed that the domain of policy makers' perceptions about the use of evidence came first, and secondly, the domain of the ability to assess, acquire, adapt, and adapt research evidence followed by the domain of inhibiting factors the use of evidence in health policy making, then the domain of groups or factors that influence health policy making, and finally , domain of existing knowledge transfer mechanisms.

The participation rate in this study was about 85% of the study population, where the results showed that most of the participants were men, in addition to that the higher administrative positions did not include any of the women, more than half of the participants with post-graduate certificates, and that more than half participants are less than 50 years old, and with regard to the place of residence about half of the participants reside in Gaza City and the rest are distributed over the rest of the governorates, also average years of experience for the participants in MoH were about 21 years.

The results showed that more than half of the participants use the evidence in their work once and less per month, while about half of the respondents answered that they did not receive any training in preparing health policies, the majority of participants indicated that they possess the computer and the internet in their work and also have the ability to access the databases associated with their work, while about two-thirds of the participants indicated that they do not have free access to electronic libraries, Google's browser was the most used by the participants, followed by Yahoo's browser.

The results of this study showed that health policy makers in the MoH of the GS have positive perceptions about the importance of using evidence in health policy making, and the results also showed a general lack of skills of health policy makers with regard to assess, acquire, adapt and apply research evidence, as it was their ability to adapt research evidence has obtained the highest score out of the four sub-domains and their ability to apply research evidence has obtained the lowest results.

The results of this study showed that the current mechanisms for transferring and exchanging knowledge are ineffective and this domain has obtained the least degree among other major domains where the participants emphasized that there is a lack of interaction between researchers and policy makers and the lack of appropriate structures to support evidence-based policy making and also the lack of strategies effective for the use of research evidence, as participants indicated in in-depth interviews that improving mechanisms for the transfer and exchange of knowledge primarily requires resources, incentives and a culture that supports the use of evidence and this is not currently available.

As for the factors that affect health policy making, the results have shown that the biggest impact on health policy making is donor organizations, followed by the values of political parties. On the barriers that prevent the use of evidence, the participants agreed that the lack of resources and the absence of incentives are among the most important barriers that prevent the use of evidence. As for the participants in the qualitative interviews, they indicated that what is preventing is political instability, the Israeli blockade, repeated crises, and also the lack of an environment that encourages the use of evidence. As for what facilitates the use of evidence, the participants unanimously agreed that strengthening the research and evidence infrastructure and improving the capabilities and skills of policymakers on how to use evidence and promoting a culture of evidence use within MoH.

The most important suggestions to improve the use of evidence were that the infrastructure for scientific research be strengthened through an appropriate structure and the provision of human and financial resources for it and the establishment of a research repository to collect local evidence in one place, and research priorities must be agreed between the producers and users of the research, and staff should also be taken care of within the ministry and motivating it to use evidence and train policy / decision makers and those around them on how to access and use scientific evidence.

5.2 Recommendations

Based on the results and conclusion of our study, the following recommendations are proposed:

1. Promoting the culture of using evidence in policymaking within the MoH through supporting researchers, developing guidelines to the use of evidence, and develop mechanisms of knowledge sharing

2. Create a research repository to compile local research and all stakeholders can have free access including health policy makers.

3. The MOH should regularly determine its priorities in an accurate and thoughtful manner, and universities and research institutions are informed accordingly.

4. Researchers and policy experts should be involved in identifying national health priorities conduct a continuous training program to strengthen health policy makers' capacities to access and the use of evidence.

5. Strengthening the relationship and trust between researchers and decision-makers through continuous meetings, workshops, conferences, etc.

6. Promote the production of scientific research within the MoH and not to limit it to external researchers. This could be done by hiring researchers and allocating enough funds to support them.

7. Develop incentives system to policymakers who use evidence in policymaking.

8. The MOH needs to strengthen accountability and temperance in decision making in order to reduce the impact of political affiliations in decision making.

5.3 Recommendation for a new area of research

1. Conduct a study to review the appropriateness of current policies, plans, and procedures to use the best available evidence.

2. Conduct mixed methods studies to examine the use of evidence in clinical settings, such as evidence-based medicine and evidence-based nursing.

3. Study the use of evidence in health policy-making at the national level, covering both the WB and GS and covering main providers.

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Annexes

Annex (1): Palestine Map
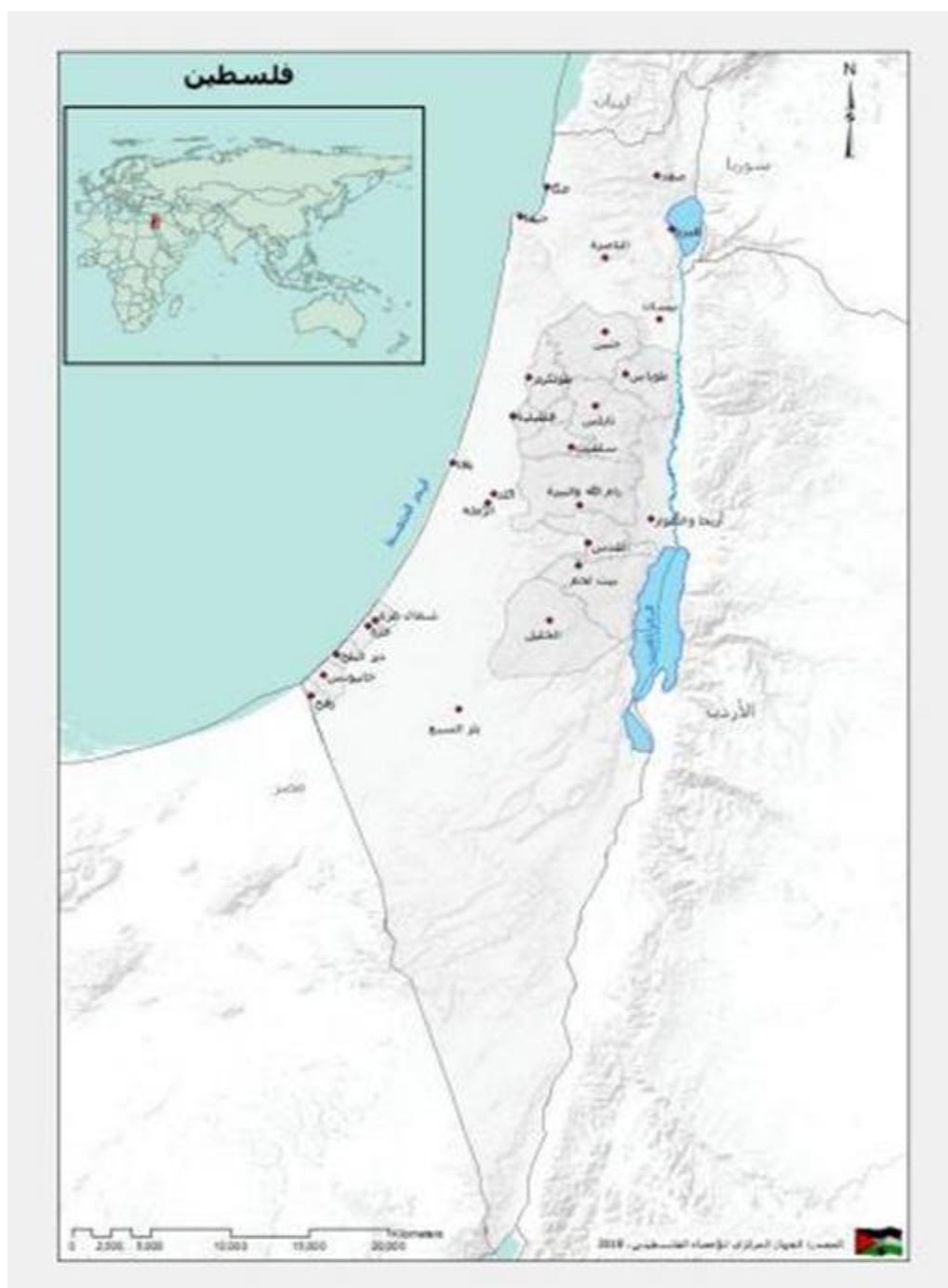
Source: (PCBS, 2017)

Annex (2): Distribution of Gaza Strip Governorates

Source: (PCBS, 2010)

Annex (3) KII participants

Organization	No. of key informant involvement	position
MoH (Policy maker)	**5**	General directorate in MoH
Palestinian universities (Quds University, Islamic University, Al Azhar university) (Researchers)	**5**	Researchers in the field of evidence and health policy
MoH (Researchers)	**2**	Scientific Research Committee in the General Department for Human Resource Development

Annex (4) The study instrument

نموذج موافقة

عزيزي المشارك \عزيزتي المشاركة

أنا الباحث شادي طلال الحداد ملتحق ببرنامج الصحة العامة _مسار إدارة صحية بجامعة القدس أبوديس.

لقد تم اختيارك للمشاركة في هذه الدراسة التي تهدف لدراسة استخدام الأدلة في صنع السياسات الصحية في قطاع غزة.

ستجرى هذه الدراسة كجزء من متطلبات برنامج الماجستير – كلية الصحة العامة.

إذا ابديت الموافقة على المشاركة في هذه الدراسة، عليك الإجابة على أسئلة الاستبانة مع العلم بما يلي:

- مشاركتك في هذه الدراسة طوعية يحق لك القبول أو الرفض او حتى الانسحاب في أي وقت.
- سيحتاج هذا الاستبيان لتعبئته من 20-25   دقيقة على الأقل.
- لا يوجد إجابات صحيحة وأخرى خاطئة، عبر\اي عن وجهة نظرك وقناعتك.
- السرية مكفولة ولن نسألك عن اسمك.

شكرا لتعاونك

مع فائق الاحترام والتقدير

الباحث

شادي الحداد

Serial Number: …………… .		
Part 1: Demographic Data		
1.	Gender	☐ Male ☐ Female
2.	Age: …………… years	
3.	Professional background	☐ Physician ☐ Pharmacist ☐ Nurse ☐ Technician ☐ Management ☐ Other:………….
4.	What is your current workplace in MoH?	☐ PHC ☐ Hospital ☐ Other: …………………
5.	Years of schooling: …………… .	
6.	Level of education	☐ Board ☐ Master ☐ Diploma or less ☐ PhD ☐ Bachelor
7.	Place of residency	☐ Gaza North ☐ Gaza ☐ Middle ☐ Khan yonis ☐ Rafah
8.	Managerial position	☐ Head of Department ☐ Unit Manager ☐ General Director ☐ Other, please specify: ………………
9.	How many years have been serving in this position: ………………	
10.	Does your work entail decision making?	☐ Yes ☐ No
11.	How many years of experience do you have as a decision/ policy maker: ……………………… years	
12.	How many years of experience do you have working for MOH: ……………………… years	
13.	What is the number of employees currently managing? …………………	
14.	Do you have access to search engines to access health policy research free of charge from your workplace?	☐ Yes ☐ No
15.	Which search engines do you access often? (more than one answer) 1. ………………… 2. ……………………. 3. ……………………	
16.	Do you have access to electronic libraries?	☐ Yes ☐ No
17.	How many articles, related to your area of work, do you read per month? …………………article	
18.	How often do you use results of scientific research and literature in the decision / policy making?	☐ Never ☐ once per month ☐ 2-5 times per month ☐ 6-10 times per month ☐ More than 10 times a month
19.	Do you have access to computer at work?	☐ Yes ☐ No
20.	Do you have constant internet access at work?	☐ Yes ☐ No
21.	Do you have access to search engines through your smart phone at work?	☐ Yes ☐ No
22.	Do you have access to the Ministry of Health (MoH) database at work?	☐ Yes ☐ No
23.	Do you have access to MoH publications including annual reports?	☐ Yes ☐ No

Part 2: Perceptions Policymaker about the use of evidence in policy making process

(Perceptions of health policymakers According to many studies it can have an impact on the use of evidence in health policy-making)

Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5

No.	Question	1	2	3	4	5
1.	Evidence-informed policymaking EIPM is necessary to improve the performance of the health care system					
2.	I am interested in improving the skills needed to integrate EIPM in my organization/ department					
3.	EIPM improves the quality of services provided by my organization/department					
4.	EIPM takes into account the surrounding contexts in policy making / health decisions					
5.	Research evidence should always be used to develop health plans					
6.	Research evidence should always be used in health decision-making					
7.	Research evidence should always be used in health service provision and practices					
8.	Health policy literature (such as magazines and textbooks) and research findings are useful in my daily work					
9.	There is a lack of necessary evidence in my work that I can use as a health policy/ decision maker					
10.	I need to develop the skills needed to improve the process of using evidence in policy / decision making.					
11.	EIPM is a waste of time and adds a burden on me					
12.	I have an interest in attending workshops related to the use of evidence in health policymaking					
13.	Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society					
14.	Most of the time, relevant research is not available					
15.	Decision making is mostly judgmental in my department					
16.	Decision-making is influenced by political views					
17.	Decision making is mostly based on personal preference and interest					

Part 3: Determine the ability to assess, acquire, adapt and apply research evidence

(Among the major challenges associated with the lack of uptake of research evidence into policy and practice is the capacity constraints of policymakers to use research evidence in policy making)

1. Acquire Research Evidence

Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5

A. Ability to Acquire Research Evidence

N	Question	1	2	3	4	5
1.	I have good **experience in conducting research** studies					
2.	**Computers** are available to all policy / decision makers in your organization					
3.	My workplace is equipped with **computers connected to the Internet**					
4.	I have **enough time** to search health policy evidence					
5.	I have the **motivation to conduct research**					
6.	I have the **resources to do research** related to my work					
7.	I always look for evidence in **peer-reviewed journals**					
8.	I look for evidence in locally published **reports**					

#						
9.	I regularly follow internationally published reports such as WHO and WB reports					
10.	I look for evidence in different **databases**					
11.	I look for information on **different web sites**					
12.	I work with researchers through **formal networking meetings** with our staff					
13.	I work with researchers through **informal networking meetings** with our staff					
14.	I get involved with researchers as a researcher					
15.	I get involved with researchers as **a decision-maker**					
16.	I get involved with researchers as **a sponsor**					
17.	I learn from **peers** through informal and formal networks to **exchange ideas, experiences, and best practices**					
18.	I can use **statistics** (technical language) efficiently					
2.	**Assess of Research Evidence**					
19.	You have critical appraisal **skills** for **evaluating the quality of methodology** used in research					
20.	You have critical appraisal **skills** to **evaluate the reliability** of specific research					
21.	Are you in contact with **experts** who could help you in **critically assess the reliability** of specific research (either internal or external)					
22.	You can **relate research to your organization** and point out similarities and differences					
23.	**You** can identify the **relevant** similarities and differences between what we do and what the research says					
24.	Are you in contact with experts who could help you to identify the relevant similarities and differences between what we do and what the research says (either internal or external)					
3. Adapt Research Evidence						
25.	You have the **ability to present research results concisely** and in **an easy language**					
26.	Are you in contact with **experts** who could help you **to research results concisely** and in accessible language (either internal or external)					
27.	You have the **ability to summarize findings of any research/report in one document**					
28.	Are you in contact with **experts** who could help you **to synthesize in one document** all relevant research (either internal or external)					
29.	You have the **ability to link research results to key issues facing policy makers** in your organization					
30.	Are you in contact with **experts** who could help you **to link research results** to key issues facing policy makers in your organization (either internal or external)					
31.	You have the **ability to provide recommended actions to policy makers** in your organization					
32.	Are you in contact with **experts** who could help you to **provide recommended actions** to decision-makers in your organization (either internal or external)					
33.	You have the ability to **push your results** and recommendations into the **agenda of policy makers.**					
4. Apply of Research Evidence						
34.	Using **research** findings is a **priority** in your organization					

35.	Your organization has **committed resources** to ensure research is **accessed** in making policy					
36.	Your organization has **committed resources** to ensure research is **adapted** in making policy					
37.	Your organization has **committed resources** to ensure research is **applied** in making policy					
38.	Your organization ensures **staff is involved in discussions** on how research evidence relates to organization main goals					
39.	The management of your organization has **clearly communicated its priorities** so that **those conducting or monitoring** research know what is needed in support of organization goals					
40.	Your organization **communicate internally** in a way that ensures there is **information exchanged** across the entire organization					
41.	Your organization has a **culture that accepts change** and provides resources for it					
42.	Your organization **seeks to improve continuous quality** and provides resources for it					
43.	Your organization has the **flexibility to accept new** evidence					
44.	When your organization make **major decisions**, your organization usually **allow enough time to identify researchable questions** and create/obtain, analyses, and consider research results and other evidence					
45.	Your management team **evaluates the feasibility of each option**, including potential impact across the organization as well as on clients, partners, and other stakeholders					
46.	Decision makers in your organization give **formal consideration** to **any recommendations from staff** who have developed or identified high-quality and relevant research					
47.	Staff and stakeholders **know when** and **how major decisions will be made**					
48.	**Staff** and stakeholders **contribute to building evidence**					
49.	**Staff** who **provides evidence** and analysis usually **participate in policy-making discussions**.					
50.	Staff and stakeholders are **informed** of **how available evidence influenced the choices** made in your organization					

Part 4: Current knowledge transfer mechanisms								
(Knowledge Transfer and Exchange (KTE) is one of the tools used to bridge the 'know-do' gap')								
Strongly Disagree 1		Disagree 2	Neutral 3		Agree 4	Strongly Agree 5		
N		Question				1	2	3	4	5
1.	There is a lack of interactions between researchers and policymakers within your organization									
2.	Dissemination of research findings is done only through academic papers and journals (inappropriate channels as policy-makers might not read)									
3.	There is a lack of ability for health policymakers to understand the numbers and statistics in research papers									
4.	Language is an issue for policy makers as most publications are in English									
5.	I participate in meetings with researchers to identify high-priority policy issues for which research is needed to inform how to address these issues									

		1	2	3	4	5
6.	There is an administrative structure suitable to support the use of evidence- informed health policymaking process (for example; a policy analysis department or a decision support unit)					
7.	There is limited coordination among policy and research institutions and researchers					
8.	Researchers are generally unaware of the necessity of knowledge transfer					
9.	Policy makers lack searching skills to access research results					
10.	Media plays a key role in disseminating knowledge within our context					
11.	Methods used in knowledge dissemination are not effective					
12.	Strategy for research uptake is mostly not there					

Part 5: Groups or factors that Influence Health Policymaking

(Policy-making process must be informed and not based on evidence because other factors can influence policy making).
This goal will show us what these factors are

Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5		

N	Question	1	2	3	4	5
1.	From your perspective, there is a lack of coordination among ministries (such as the MoH, Ministry of Finance, etc.) hindered the health policymaking process.					
2.	Lack of coordination between government and health service providers hindered the health policymaking process.					
3.	Do you think physician exert a strong influence on the health policymaking process?					
4.	Do you think nursing exert a strong influence on the health policymaking process?					
5.	Private health providers exert a strong influence on the health policymaking process.					
6.	Private insurers exerted a strong influence on the health policymaking process.					
7.	Values of governing parties exert a strong influence on the health policymaking process.					
8.	Public opinion exerts a strong influence on the health policymaking process.					
9.	Media exerts a strong influence on the health policymaking process.					
10.	Donor organizations exert a strong influence on the health policymaking process.					

Part 6: Inhibiting factors the use of evidence by health policy makers

(Although the role of researchers and policymakers is important in the use of evidence, some studies have indicated political, economic and technical constraints to which researchers and policymakers have little impact)

Strongly Disagree 1	Disagree 2	Neutral 3	Agree 4	Strongly Agree 5		

N	Question	1	2	3	4	5
1.	Lack of policy relevant research					
2.	Lack of time					
3.	Insufficient skills to critically appraise / evaluate the literature					
4.	Insufficient skills for interpreting research					
5.	An unacceptable environment for evidence-making in policy-making					
6.	Lack of incentive to participate in Evidence-informed					

	policymaking					
7.	Insufficient skills to apply research findings to health policy					
8.	Lack of resources (i.e. access to a computer, the internet or online databases)					
9.	Lack of interest in Evidence-informed policymaking					
10.	Compliance with existing policies or laws, which limits improvements					

Annex (5) Quantitative instruments

1. What do you think of the importance of using evidence in making health policies in Palestine? Please explain
   - If the answer is yes: is it sufficient and relevant and is it available in a timely manner?
   - If not, why do you think the evidence is not available?
   - Available scientific evidence can be used? Please explain
2. What do you think of the knowledge, attitudes, and skills of decision makers about the use of evidence in health policy / decision making?
3. What are the attitudes of decision makers on the use of evidence in health policy / decision making?

Positive Please explain

Negative please explain

4. Do health policy / decision makers have sufficient knowledge of how to use evidence in health policy / decision making?
   - If the answer is yes, please explained
   - If they are not, please explained
   - Do decision makers have the skills to gain and evaluate evidence?
5. Do you think we have mechanisms for transferring and exchanging knowledge? (Explain the meaning of mechanisms)
   - If yes, please explain
   - If they are not, please explained
   - Present but not enough
6. Do you think that policy / decision makers use evidence in their work and when they make the decision?
   - If the answer is yes, please explained
   - If they are not, please explained
   - Insufficiently
   - How is the decision-making process?
   - Who influences the decision?

7. In your opinion, what are the factors that encourage policymakers to use the evidence, and what are the factors that prevent them from using it? If any
   - Availability of recent research
8. Do you think the current Ministry of Health environment encourages the use of evidence in health policy / decision making?
   - Are decision makers adequately trained how to use evidence?
   - Do they have the ability to apply that?
   - Is there oversight by the Ministry of Health to see if the decisions are based on evidence?
9. In your view, how can the use of health evidence in health policy / decision making in the Gaza Strip be improved?
   10. Is there anything else you want to offer?

Annex (6) An official letter of approval from Helsinki Committee in the Gaza Strip

المجلــس الفلسطيـــني للبحـــث الصحـــي
Palestinian Health Research Council

تعزيز النظام الصحي الفلسطيني من خلال مأسسة استخدام المعلومات البحثية في صنع القرار

Developing the Palestinian health system through institutionalizing the use of information in decision making

Helsinki Committee
For Ethical Approval

Date: 2019/04/01　　　　　　　　**Number: PHRC/HC/534/19**

الاسم:

Name: Shade Talal El-haddad

We would like to inform you that the committee had discussed the proposal of your study about:

نفيدكم علماً بأن اللجنة قد ناقشت مقترح دراستكم حول:

Use of Evidence in Health Policy Making in the Gaza Strip

The committee has decided to approve the above mentioned research. Approval number PHRC/HC/534/19 in its meeting on 2019/04/01

و قد قررت الموافقة على البحث المذكور عاليه بالرقم والتاريخ المذكوران عاليه

Signature

Member　　　　　　　　　　　　　　Member

Dr. Yehia Abed

Chairman

Dr. Assed

Nab

Genral Conditions:-
1. Valid for 2 years from the date of approval.
2. It is necessary to notify the committee of any change in the approved study protocol.
3. The committee appreciates receiving a copy of your final research when completed.

Specific Conditions:-

E-Mail:pal.phrc@gmail.com

Gaza - Palestine　　　　　غزة ـ فلسطين
شارع النصر ـ مفترق العيون

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Annex (7) Universities Approval

Al-Quds University

Jerusalem

School of Public Health

جامعة القدس

القدس

كلية الصحة العامة

التاريخ:20/8/2019

حضرة الدكتور/ رامي العبادلة   المحترم

مدير عام تنمية القوى البشرية–وزارة الصحة

تحية طيبة وبعد،،،

الموضوع: مساعدة الطالب شادي الحداد

نشكر لكم دعمكم الدائم لمسيرة العلم والتعليم وخصوصاً دعم كلية الصحة العامة وطلابها، ونود أعلامكم بأن الطالب المذكور أعلاه قوم بعمل بحث كمتطلب للحصول على درجة الماجستير في الصحة العامة–مسار إدارة صحية بعنوان:

"Use of Evidence in Health Policy Making in the Gaza Strip"

وعليه نرجو من سيادتكم التكرم بالموافقة على تسهيل مهمة الطالب في إنجاز هذا البحث حيث أن الفئة المستهدفة جميع صانعي القرارات/السياسات العاملين في وزارة الصحة من مدير دائرة فما فوق حيث سيتم جمع البيانات من خلال استبانة بحثية .

و اقبلوا فائق التحية و الاحترام،،،

د. بسام ابو حمد

منسق عام برامج الصحة العامة

فرع غزة

نسخة:

– للملف

Annex (8) Administrative Approval

التاريخ:07/10/2019
رقم المراسلة 376077

السيد : رامي عيد سليمان العبادله   المحترم

مدير عام بالوزارة /الإدارة العامة لتنمية القوى البشرية ــ /وزارة الصحة

السلام عليكم ،،،

الموضوع/ تسهيل مهمة الباحث// شادي الحداد

التفاصيل //
بخصوص الموضوع أعلاه، يرجى تسهيل مهمة الباحث/ **شادي طلال الحداد**
الملتحق ببرنامج ماجستير الإدارة الصحة العامة ــ مسار الإدارة الصحية ــ جامعة القدس أبوديس في إجراء بحث بعنوان:-
"Use of Evidence in Health Policy Making in the Gaza Strip"
حيث الباحث بحاجة لتعبئة استبانة من عدد من ذوي المسميات الاشرافيه (الفئتين الأولى والعليا) في وزارة الصحة،
وكذلك اجراء مقابلا معمقة مع عدد من أصحاب القرار في القطاع الصحي الفلسطيني (حكومي، أهلي، خاص، خبراء)، بما
لا يتعارض مع مصلحة العمل وضمن أخلاقيات البحث العلمي، ودون تحمل الوزارة أي أعباء أو مسئولية.
وتفضلوا بقبول التحية والتقدير،،،
ملاحظة / تسهيل المهمة الخاص بالدراسة أعلاه صالح لمدة 3 أشهر من تاريخه.

محمد إبراهيم محمد السرساوي
مدير دائرة/الإدارة العامة لتنمية القوى البشرية ــ

Annex (9): List of arbitrators

	Name
1.	Dr. Yehia Abed
2.	Dr. Bassam Abu Hamed
3.	Dr. Khitam Abu Hamed
4.	Dr. Nasser I. Abu El-Noor
5.	Dr. jehad okasha
6.	Dr. Maher Shamia
7.	Dr. Yousef Aljeesh

Annex (10): Validity measures

Validity of participants according to Perceptions of Policymaker about the use of evidence in policy making process

Items	R	Sig.
Evidence-informed policymaking EIPM is necessary to improve the performance of the health care system	0.585	0.000
I am interested in improving the skills needed to integrate EIPM in my organization/ department	0.674	0.000
EIPM improves the quality of services provided by my organization/department	0.574	0.000
EIPM takes into account the surrounding contexts in policy making / health decisions	0.535	0.000
Research evidence should always be used to develop health plans	0.653	0.000
Research evidence should always be used in health decision-making	0.634	0.000
Research evidence should always be used in health service provision and practices	0.542	0.000
Health policy literature (such as magazines and textbooks) and research findings are useful in my daily work	0.401	0.000
There is a lack of necessary evidence in my work that I can use as a health policy/ decision maker	0.270	0.001
I need to develop the skills needed to improve the process of using evidence in policy / decision making.	0.445	0.000
EIPM is a waste of time and adds a burden on me	0.469	0.000
I have an interest in attending workshops related to the use of evidence in health policymaking	0.453	0.000
Health policy refers to decisions, plans, and actions that are undertaken to achieve specific health care goals within a society	0.543	0.000
Most of the time, relevant research is not available	0.233	0.005
Decision making is mostly judgmental in my department	0.334	0.000
Decision-making is influenced by political views	0.256	0.002
Decision making is mostly based on personal preference and interest	0.338	0.000

Validity of the study participants according to Ability to Acquire Research Evidence

Items	R	Sig.
I have good experience in conducting research studies	0.393	0.000
Computers are available to all policy / decision makers in your organization	0.249	0.033
My workplace is equipped with computers connected to the Internet	0.336	0.000
I have enough time to search health policy evidence	0.342	0.000
I have the motivation to conduct research	0.575	0.000
I have the resources to do research related to my work	0.561	0.000
I always look for evidence in peer-reviewed journals	0.534	0.000
I look for evidence in locally published reports	0.646	0.000
I regularly follow internationally published reports such as WHO and WB reports	0.528	0.000
I look for evidence in different databases	0.649	0.000
I look for information on different web sites	0.574	0.000
I work with researchers through formal networking meetings with our staff	0.610	0.000
I work with researchers through informal networking meetings with our staff	0.592	0.000
I get involved with researchers as a researcher	0.546	0.000

	R	Sig.
I get involved with researchers as a decision-maker	0.588	0.000
I get involved with researchers as a sponsor	0.533	0.000
I learn from peers through informal and formal networks to exchange ideas, experiences, and best practices	0.537	0.000
I can use statistics (technical language) efficiently	0.533	0.000

Validity of the study participants according to Ability to Assess of Research Evidence

Items	R	Sig.
You have critical appraisal skills for evaluating the quality of methodology used in research	0.827	0.000
You have critical appraisal skills to evaluate the reliability of specific research	0.818	0.000
Are you in contact with experts who could help you in critically assess the reliability of specific research (either internal or external)	0.778	0.000
You can relate research to your organization and point out similarities and differences	0.651	0.000
You can identify the relevant similarities and differences between what we do and what the research says	0.730	0.000
Are you in contact with experts who could help you to identify the relevant similarities and differences between what we do and what the research says (either internal or external)	0.698	0.000

Validity of the study participants according to Ability to Adapt Research Evidence

Items	R	Sig.
You have the ability to present research results concisely and in an easy language	0.596	0.000
Are you in contact with experts who could help you to research results concisely and in accessible language (either internal or external)	0.763	0.000
You have the ability to summarize findings of any research/report in one document	0.630	0.000
Are you in contact with experts who could help you to synthesize in one document all relevant research (either internal or external)	0.774	0.000
You have the ability to link research results to key issues facing policy makers in your organization	0.728	0.000
Are you in contact with experts who could help you to link research results to key issues facing policy makers in your organization (either internal or external)	0.789	0.000
You have the ability to provide recommended actions to policy makers in your organization	0.609	0.000
Are you in contact with experts who could help you to provide recommended actions to decision-makers in your organization (either internal or external)	0.766	0.000
You have the ability to push your results and recommendations into the agenda of policy makers.	0.578	0.000

Validity of the study participants according to Ability to Apply of Research Evidence

Items	R	Sig.
Using research findings is a priority in your organization	0.569	0.000
Your organization has committed resources to ensure research is accessed in making policy	0.750	0.000
Your organization has committed resources to ensure research is adapted in making policy	0.751	0.000
Your organization has committed resources to ensure research is applied in making policy	0.768	0.000
Your organization ensures staff is involved in discussions on how research evidence relates to organization main goals	0.748	0.000
The management of your organization has clearly communicated its priorities so that those conducting or monitoring research know what is needed in support of organization goals	0.712	0.000
Your organization communicate internally in a way that ensures there is information exchanged across the entire organization	0.717	0.000
Your organization has a culture that accepts change and provides resources for it	0.745	0.000
Your organization seeks to improve continuous quality and provides resources for it	0.659	0.000
Your organization has the flexibility to accept new evidence	0.767	0.000
When your organization make major decisions, your organization usually allow enough time to identify researchable questions and create/obtain, analyses, and consider research results and other evidence	0.745	0.000
Your management team evaluates the feasibility of each option, including potential impact across the organization as well as on clients, partners, and other stakeholders	0.726	0.000
Decision makers in your organization give formal consideration to any recommendations from staff who have developed or identified high-quality and relevant research	0.740	0.000
Staff and stakeholders know when and how major decisions will be made	0.623	0.000
Staff and stakeholders contribute to building evidence	0.693	0.000
Staff who provides evidence and analysis usually participate in policy-making discussions.	0.687	0.000
Staff and stakeholders are informed of how available evidence influenced the choices made in your organization	0.740	0.000

Validity of the study participants according to Groups or factors that Influence Health Policymaking

Items	R	Sig.
There is a lack of interactions between researchers and policymakers within your organization	0.506	0.000
Dissemination of research findings is done only through academic papers and journals (inappropriate channels as policy-makers might not read)	0.494	0.000
There is a lack of ability for health policymakers to understand the numbers and statistics in research papers	0.441	0.000
Language is an issue for policy makers as most publications are in English	0.389	0.000
I participate in meetings with researchers to identify high-priority policy issues for which research is needed to inform how to address these issues	0.188	0.023
There is an administrative structure suitable to support the use of evidence- informed health policymaking process (for example; a policy analysis department or a decision support unit)	0.305	0.000

Items	R	Sig.
There is limited coordination among policy and research institutions and researchers	0.626	0.000
Researchers are generally unaware of the necessity of knowledge transfer	0.590	0.000
Policy makers lack searching skills to access research results	0.655	0.000
Media plays a key role in disseminating knowledge within our context	0.338	0.000
Methods used in knowledge dissemination are not effective	0.636	0.000
Strategy for research uptake is mostly not there	0.688	0.000

Validity of the study participants according to Groups or factors that Influence Health Policymaking

Items	R	Sig.
From your perspective, there is a lack of coordination among ministries (such as the MoH, Ministry of Finance, etc.) hindered the health policymaking process.	0.446	0.000
Lack of coordination between government and health service providers hindered the health policymaking process.	0.484	0.000
Do you think physician exert a strong influence on the health policymaking process?	0.458	0.000
Do you think nursing exert a strong influence on the health policymaking process?	0.251	0.002
Private health providers exert a strong influence on the health policymaking process.	0.512	0.000
Private insurers exerted a strong influence on the health policymaking process.	0.460	0.000
Values of governing parties exert a strong influence on the health policymaking process.	0.515	0.000
Public opinion exerts a strong influence on the health policymaking process.	0.619	0.000
Media exerts a strong influence on the health policymaking process.	0.689	0.000
Donor organizations exert a strong influence on the health policymaking process.	0.506	0.000

Validity of the study participants according Inhibiting factors the use of evidence by health policy makers

Items	R	Sig.
Lack of policy relevant research	0.645	0.000
Lack of time	0.565	0.000
Insufficient skills to critically appraise / evaluate the literature	0.743	0.000
Insufficient skills for interpreting research	0.748	0.000
An unacceptable environment for evidence-making in policy-making	0.681	0.000
Lack of incentive to participate in Evidence-informed policymaking	0.572	0.000
Insufficient skills to apply research findings to health policy	0.693	0.000
Lack of resources (i.e. access to a computer, the internet or online databases)	0.582	0.000
Lack of interest in Evidence-informed policymaking	0.635	0.000
Compliance with existing policies or laws, which limits improvements	0.594	0.000

Annex (11) Differences between Domains and Place of residency

Domain	Place of residency	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	North	23	78.47	8.95	0.691	0.6
	Gaza	74	78.01	6.77		
	Middle	11	75.19	8.62		
	Khanyounis	22	78.61	6.56		
	Rafah	15	76.16	6.06		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	North	23	69.72	8.05	0.579	0.678
	Gaza	74	68.79	9.06		
	Middle	11	68.40	5.65		
	Khanyounis	22	69.85	9.17		
	Rafah	15	65.87	8.64		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	North	23	54.71	9.74	0.792	0.532
	Gaza	74	57.32	10.42		
	Middle	11	57.73	9.41		
	Khanyounis	22	60.08	11.69		
	Rafah	15	56.33	9.37		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	North	23	69.22	7.83	2.081	0.086
	Gaza	74	65.27	10.25		
	Middle	11	64.18	7.67		
	Khanyounis	22	61.27	10.56		
	Rafah	15	63.07	9.35		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	North	23	65.65	13.21	0.257	0.905
	Gaza	74	66.68	13.69		
	Middle	11	63.09	14.40		
	Khanyounis	22	64.64	17.37		
	Rafah	15	64.40	6.98		
	Total	145	65.70	13.64		

Annex (12) Differences between Domains and Gender

Domain	Gender	Nu	Mean	Std	T	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Male	131	77.93	7.06	0.803	0.423
	Female	14	76.30	8.34		
the ability to assess, acquire, adapt and apply research evidence	Male	131	68.93	8.55	0.700	0.485
	Female	14	67.23	9.57		
Current knowledge transfer mechanisms	Male	131	57.34	10.28	0.313	0.754
	Female	14	56.43	11.03		
Groups or factors that Influence Health Policymaking	Male	131	65.18	9.47	0.733	0.465
	Female	14	63.14	13.19		
Inhibiting factors, the use of evidence by health policy makers	Male	131	65.47	12.96	-0.622	0.535
	Female	14	67.86	19.43		

Annex (13) Differences between Domains and age

Domain	age	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Less than 45	38	78.85	6.66	0.464	0.708
	From 45 to 50	47	77.67	7.54		
	From 51 to 55	24	76.81	8.09		
	More than 55	36	77.39	6.72		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	Less than 45	38	69.71	8.56	1.232	0.301
	From 45 to 50	47	67.82	8.37		
	From 51 to 55	24	71.13	9.64		
	More than 55	36	67.43	8.25		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	Less than 45	38	57.02	10.25	0.382	0.766
	From 45 to 50	47	57.87	10.84		
	From 51 to 55	24	58.47	8.87		
	More than 55	36	55.88	10.83		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	Less than 45	38	66.21	8.12	1.474	0.224
	From 45 to 50	47	62.85	10.70		
	From 51 to 55	24	67.50	8.51		
	More than 55	36	64.78	10.92		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	Less than 45	38	67.42	14.58	0.306	0.821
	From 45 to 50	47	64.60	13.69		
	From 51 to 55	24	65.50	9.94		
	More than 55	36	65.44	15.00		
	Total	145	65.70	13.64		

Annex (14) Differences between Domains and level of education

Domain	level of education	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Bachelor	63	78.69	7.26	1.322	0.270
	Master	54	77.28	6.63		
	PHD	10	79.18	6.88		
	Board	18	75.23	8.32		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	Bachelor	63	69.10	8.90	0.185	0.906
	Master	54	68.54	8.75		
	PHD	10	69.84	10.44		
	Board	18	67.69	6.60		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	Bachelor	63	57.17	10.54	0.122	0.947
	Master	54	57.69	9.72		
	PHD	10	57.67	11.92		
	Board	18	56.02	11.18		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	Bachelor	63	65.21	9.85	0.215	0.886
	Master	54	65.26	11.02		
	PHD	10	65.20	9.44		
	Board	18	63.22	6.18		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	Bachelor	63	66.98	13.61	0.463	0.709
	Master	54	64.67	13.57		
	PHD	10	67.00	14.31		
	Board	18	63.56	14.27		
	Total	145	65.70	13.64		

Annex (15): Differences between the ability to assess, acquire, adapt and apply research evidence and Professional background

						95% Confidence Interval	
Dependent Variable	(I) Q03A: Professional background	(J) Q03A: Professional background	Mean Difference (I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
the ability to assess, acquire, adapt and apply research evidence	Physician	Pharmacist	3.51575	2.46721	.844	-4.8133	11.8448
		Nurse	-.18684	2.19753	1.000	-7.6055	7.2318
		Technician	-3.54307	2.46721	.840	-11.8721	4.7860
		Management	-5.62543	2.03015	.183	-12.4790	1.2281
		Other	-5.29770	2.31048	.390	-13.0976	2.5023
	Pharmacist	Physician	-3.51575	2.46721	.844	-11.8448	4.8133
		Nurse	-3.70259	2.56993	.838	-12.3784	4.9732
		Technician	-7.05882	2.80402	.281	-16.5249	2.4073
		Management	-9.14118*	2.42835	.018	-17.3391	-.9433
		Other	-8.81345	2.66716	.059	-17.8175	.1906
	Nurse	Physician	.18684	2.19753	1.000	-7.2318	7.6055
		Pharmacist	3.70259	2.56993	.838	-4.9732	12.3784
		Technician	-3.35624	2.56993	.887	-12.0321	5.3196
		Management	-5.43859	2.15381	.278	-12.7096	1.8325
		Other	-5.11086	2.41986	.488	-13.2801	3.0583
	Technician	Physician	3.54307	2.46721	.840	-4.7860	11.8721
		Pharmacist	7.05882	2.80402	.281	-2.4073	16.5249
		Nurse	3.35624	2.56993	.887	-5.3196	12.0321
		Management	-2.08235	2.42835	.981	-10.2802	6.1155
		Other	-1.75462	2.66716	.994	-10.7587	7.2494
	Management	Physician	5.62543	2.03015	.183	-1.2281	12.4790
		Pharmacist	9.14118*	2.42835	.018	.9433	17.3391
		Nurse	5.43859	2.15381	.278	-1.8325	12.7096
		Technician	2.08235	2.42835	.981	-6.1155	10.2802
		Other	.32773	2.26894	1.000	-7.3320	7.9874
	Other	Physician	5.29770	2.31048	.390	-2.5023	13.0976
		Pharmacist	8.81345	2.66716	.059	-.1906	17.8175
		Nurse	5.11086	2.41986	.488	-3.0583	13.2801
		Technician	1.75462	2.66716	.994	-7.2494	10.7587
		Management	-.32773	2.26894	1.000	-7.9874	7.3320

*. The mean difference is significant at the 0.05 level.

Annex (16): Statistical difference between Perceptions Policymaker about the use of evidence in policy making process and workplace

Multiple Comparisons							
Scheffe							
Dependent Variable	(I) Q04A: What is your current workplace in MoH?	(J) Q04A: What is your current workplace in MoH?	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Perceptions Policymaker about the use of evidence	PHC	Hospital	-4.79806[*]	1.66168	.017	-8.9087	-.6874
		Other supporting medical units	-4.14538[*]	1.60031	.038	-8.1042	-.1865
	Hospital	PHC	4.79806[*]	1.66168	.017	.6874	8.9087
		Other supporting medical units	.65268	1.29892	.882	-2.5606	3.8660
	Other supporting medical units	PHC	4.14538[*]	1.60031	.038	.1865	8.1042
		Hospital	-.65268	1.29892	.882	-3.8660	2.5606
*. The mean difference is significant at the 0.05 level.							

Annex (17) Differences between Domains and Managerial Position

Domain	Managerial Position	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Head of Department	125	77.46	7.35	0.875	0.419
	Unit Manager	13	80.00	5.06		
	General Director	7	79.16	7.27		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	Head of Department	125	68.48	8.38	0.564	0.570
	Unit Manager	13	71.08	9.52		
	General Director	7	69.60	11.92		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	Head of Department	125	57.01	10.37	1.001	0.370
	Unit Manager	13	56.67	10.65		
	General Director	7	62.62	8.38		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	Head of Department	125	65.31	9.59	4.588	0.012
	Unit Manager	13	67.38	7.46		
	General Director	7	54.57	13.25		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	Head of Department	125	65.95	13.45	1.239	0.293
	Unit Manager	13	67.38	13.10		
	General Director	7	58.00	17.59		
	Total	145	65.70	13.64		

Annex (18) Statistical difference between Inhibiting factors, the use of evidence by health policy makers and experience in current position

Multiple Comparisons							
Scheffe							
Dependent Variable	(I) Years in this position	(J) Years in this position	Mean Difference (I-J)	Std. Error	Sig.	95% Confidence Interval	
						Lower Bound	Upper Bound
Part6.Total	5 years and less	From 6 to 10 years	6.79365*	2.67293	.042	.1814	13.4059
		More than 10 years	2.48333	2.96442	.705	-4.8500	9.8167
	From 6 to 10 years	5 years and less	-6.79365*	2.67293	.042	-13.4059	-.1814
		More than 10 years	-4.31032	2.71273	.286	-11.0211	2.4004
	More than 10 years	5 years and less	-2.48333	2.96442	.705	-9.8167	4.8500
		From 6 to 10 years	4.31032	2.71273	.286	-2.4004	11.0211
*. The mean difference is significant at the 0.05 level.							

Annex (19) Differences between Domains and experience in MOH

Domain	experience in MOH	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	15 years and less	31	79.05	7.31	2.442	0.067
	From 16 to 20 years	39	79.49	5.81		
	From 21 to 25 years	34	75.47	8.73		
	More than 25 years	41	77.07	6.42		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	15 years and less	31	69.82	7.47	0.602	0.615
	From 16 to 20 years	39	69.64	9.27		
	From 21 to 25 years	34	67.44	7.44		
	More than 25 years	41	68.24	9.78		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	15 years and less	31	59.52	9.45	1.503	0.217
	From 16 to 20 years	39	56.92	11.28		
	From 21 to 25 years	34	54.41	8.60		
	More than 25 years	41	58.21	11.08		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	15 years and less	31	63.48	10.65	2.212	0.089
	From 16 to 20 years	39	64.56	9.32		
	From 21 to 25 years	34	68.65	8.69		
	More than 25 years	41	63.46	10.17		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	15 years and less	31	66.00	13.85	0.074	0.974
	From 16 to 20 years	39	65.13	14.55		
	From 21 to 25 years	34	65.24	11.94		
	More than 25 years	41	66.39	14.37		
	Total	145	65.70	13.64		

Annex (20) Differences between Domains and number of employees currently managing

Domain	number of employees currently managing	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	10 years and less	40	79.00	7.30	0.835	0.477
	from 11 to 20 years	21	77.59	6.86		
	from 21 to 50 years	43	76.53	7.51		
	More than 50 years	41	77.96	6.88		
	Total	145	77.77	7.17		
the ability to assess, acquire, adapt and apply research evidence	10 years and less	40	67.81	7.24	0.809	0.491
	from 11 to 20 years	21	70.86	10.28		
	from 21 to 50 years	43	67.93	8.58		
	More than 50 years	41	69.51	9.08		
	Total	145	68.77	8.63		
Current knowledge transfer mechanisms	10 years and less	40	53.63	9.32	2.394	0.071
	from 11 to 20 years	21	59.13	9.68		
	from 21 to 50 years	43	58.18	10.80		
	More than 50 years	41	58.86	10.52		
	Total	145	57.25	10.32		
Groups or factors that Influence Health Policymaking	10 years and less	40	66.25	9.73	0.349	0.790
	from 11 to 20 years	21	63.81	12.46		
	from 21 to 50 years	43	64.79	9.33		
	More than 50 years	41	64.54	9.23		
	Total	145	64.98	9.85		
Inhibiting factors, the use of evidence by health policy makers	10 years and less	40	66.70	12.98	0.167	0.919
	from 11 to 20 years	21	64.76	13.83		
	from 21 to 50 years	43	66.05	14.67		
	More than 50 years	41	64.83	13.48		
	Total	145	65.70	13.64		

Annex (21) Differences between Domains and Number of articles, related to your area of work, do you read per month

Domain	Number of articles, related to your area of work, do you read per month	Nu	Mean	Std	F	Sig.
Perceptions Policymaker about the use of evidence in policy making process	Nothing	27	78.04	8.42	0.751	0.523
	From 1 to 2	33	76.58	7.35		
	From 3 to 5	40	79.03	6.21		
	More than 5	44	77.43	7.16		
	Total	144	77.79	7.19		
the ability to assess, acquire, adapt and apply research evidence	Nothing	27	67.50	9.50	1.014	0.388
	From 1 to 2	33	67.71	6.79		
	From 3 to 5	40	68.71	8.20		
	More than 5	44	70.59	9.62		
	Total	144	68.83	8.63		
Current knowledge transfer mechanisms	Nothing	27	55.62	9.18	0.951	0.418
	From 1 to 2	33	55.45	9.30		
	From 3 to 5	40	57.92	12.19		
	More than 5	44	58.83	9.90		
	Total	144	57.20	10.34		
Groups or factors that Influence Health Policymaking	Nothing	27	67.04	9.96	0.914	0.436
	From 1 to 2	33	65.21	8.37		
	From 3 to 5	40	65.60	8.09		
	More than 5	44	63.23	12.01		
	Total	144	65.06	9.84		
Inhibiting factors, the use of evidence by health policy makers	Nothing	27	65.48	11.46	0.853	0.467
	From 1 to 2	33	68.12	12.43		
	From 3 to 5	40	66.65	15.56		
	More than 5	44	63.32	14.03		
	Total	144	65.75	13.68		

Annex (22) Statistical difference between the ability to assess, acquire, adapt and apply research evidence and How often do you use results of scientific research and literature in the decision / policy making

						95% Confidence Interval	
Multiple Comparisons							
Scheffe							
Dependent Variable	(I) Q18A: How often do you use results of scientific research and literature in the decision / policy making?	(J) Q18A: How often do you use results of scientific research and literature in the decision / policy making?	Mean Difference (I-J)	Std. Error	Sig.	Lower Bound	Upper Bound
Part3.Total	Never	once per month	-.80718	1.93237	.996	-6.8395	5.2252
		2-5 times per month	-3.16250	1.95887	.627	-9.2776	2.9526
		6-10 times per month	-5.22917	2.85405	.502	-14.1388	3.6804
		More than 10 times a month	-8.34250	3.05457	.120	-17.8781	1.1931
	once per month	Never	.80718	1.93237	.996	-5.2252	6.8395
		2-5 times per month	-2.35532	1.76867	.777	-7.8766	3.1660
		6-10 times per month	-4.42199	2.72701	.623	-12.9350	4.0910
		More than 10 times a month	-7.53532	2.93623	.166	-16.7015	1.6308
	2-5 times per month	Never	3.16250	1.95887	.627	-2.9526	9.2776
		once per month	2.35532	1.76867	.777	-3.1660	7.8766
		6-10 times per month	-2.06667	2.74586	.966	-10.6385	6.5052
		More than 10 times a month	-5.18000	2.95374	.547	-14.4008	4.0408
	6-10 times per month	Never	5.22917	2.85405	.502	-3.6804	14.1388
		once per month	4.42199	2.72701	.623	-4.0910	12.9350
		2-5 times per month	2.06667	2.74586	.966	-6.5052	10.6385
		More than 10 times a month	-3.11333	3.61012	.945	-14.3832	8.1565
	More than 10 times a month	Never	8.34250	3.05457	.120	-1.1931	17.8781
		once per month	7.53532	2.93623	.166	-1.6308	16.7015
		2-5 times per month	5.18000	2.95374	.547	-4.0408	14.4008
		6-10 times per month	3.11333	3.61012	.945	-8.1565	14.3832

Annex (23): Differences between Domains and have access to electronic libraries

Domain	have access to electronic libraries	Nu	Mean	Std	T	Sig.
Perceptions Policymaker about the use of evidence in policy making process	No	99	77.94	7.22	0.431	0.667
	Yes	46	77.39	7.13		
the ability to assess, acquire, adapt and apply research evidence	No	99	68.52	8.72	-0.502	0.617
	Yes	46	69.30	8.51		
Current knowledge transfer mechanisms	No	99	57.47	10.22	0.379	0.705
	Yes	46	56.78	10.63		
Groups or factors that Influence Health Policymaking	No	99	64.63	9.80	-0.632	0.528
	Yes	46	65.74	10.02		
Inhibiting factors, the use of evidence by health policy makers	No	99	65.60	12.72	-0.130	0.897
	Yes	46	65.91	15.60		

Annex (24): Differences between Domains and have access to search engines through your smart phone at work

Domain	have access to search engines through your smart phone at work	Nu	Mean	Std	T	Sig.
Perceptions Policymaker about the use of evidence in policy making process	No	15	77.41	6.26	-0.203	0.840
	Yes	130	77.81	7.29		
the ability to assess, acquire, adapt and apply research evidence	No	15	64.96	11.42	-1.819	0.071
	Yes	130	69.21	8.19		
Current knowledge transfer mechanisms	No	15	58.00	12.17	0.295	0.768
	Yes	130	57.17	10.14		
Groups or factors that Influence Health Policymaking	No	15	64.13	11.07	-0.350	0.727
	Yes	130	65.08	9.74		
Inhibiting factors, the use of evidence by health policy makers	No	15	67.47	17.65	0.529	0.597
	Yes	130	65.49	13.17		

Annex (25): Differences between Domains and have access to the Ministry of Health (MoH) database at work

Domain	have access to the Ministry of Health (MoH) database at work	Nu	Mean	Std	T	Sig.
Perceptions Policymaker about the use of evidence in policy making process	No	12	76.76	7.11	-0.505	0.614
	Yes	133	77.86	7.20		
the ability to assess, acquire, adapt and apply research evidence	No	12	65.20	7.59	-1.501	0.135
	Yes	133	69.09	8.67		
Current knowledge transfer mechanisms	No	12	54.31	12.96	-1.033	0.303
	Yes	133	57.52	10.07		
Groups or factors that Influence Health Policymaking	No	12	64.83	9.08	-0.053	0.957
	Yes	133	64.99	9.94		
Inhibiting factors, the use of evidence by health policy makers	No	12	68.00	15.68	0.609	0.543
	Yes	133	65.49	13.49		

العنوان: استخدام الأدلة في صنع السياسات الصحية في قطاع غزة

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الملخص

استخدام الأدلة في صنع السياسات الصحية هو تحد عالمي لنظم الرعاية الصحية ، بما في ذلك دولة فلسطين. في قطاع غزة ، هناك أبحاث محدودة حول استخدام الأدلة في عملية صنع السياسات. استكشفت هذه الدراسة تصورات وممارسات ومهارات صانعي السياسات فيما يتعلق باستخدام الأدلة في السياسة الصحية في وزارة الصحة في قطاع غزة ، بما في ذلك العوامل التي تؤثر على صنع السياسات الصحية والحواجز والمسهلات لاستخدام الأدلة ومدى وجود آليات فعالة لنشر المعرفة وتبادلها. هدفت الدراسة إلى استكشاف مدى استخدام الأدلة في صنع السياسات الصحية في قطاع غزة. قد تؤدي نتائج وتوصيات هذه الدراسة إلى تحسين استخدام الأدلة البحثية في رسم السياسات الصحية في قطاع غزة ، وبالتالي ، تحسين أداء نظام الرعاية الصحية الذي تنعكس في النهاية على التحسن العام في الوضع الصحي للفلسطينيين.

في هذه الدراسة تم استخدام التصميم الوصفي التحليلي المستعرض، شمل مجتمع الدراسة جميع صانعي السياسات الصحية في وزارة الصحة أو من يشارك في صنع السياسات الصحية. استخدمنا نهجًا ثلاثيًا باستخدام الأدوات الكمية والنوعية. تم جمع البيانات الكمية من خلال استبيان مقابلته ، حيث كان مجتمع الدراسة 169 من صانعي السياسات. تم جمع البيانات النوعية من 12 من المخبرين الرئيسيين من خلال المقابلات ، حيث شمل ذلك 7 باحثين وخبراء في السياسة الصحية ، و5 صناع سياسة. كان معدل الاستجابة 85.7٪. كانت موثوقية أداة جمع البيانات عالية (كرونباخ ألفا = 0.961). تم إدخال البيانات وتحليلها باستخدام الإصدار 23 من SPSS للبيانات الكمية. تم استخدام التقنيات المواضيعية المفتوحة لتحليل البيانات النوعية.

مثل الذكور 88.8٪ من المشاركين في الدراسة ، حيث يهيمن الرجال على مناصب الإدارة العليا. أكثر من نصف المشاركين (56.4٪) يملكون درجات علمية عليا (ما بعد البكالوريوس). كما زعم أكثر من نصف المشاركين (54.5٪) أنهم يستخدمون الأدلة في عملهم ، وأكثر من نصف المشاركين (56.5٪) ردوا بأنهم تلقوا تدريباً على قرارات السياسة الصحية. لدى واضعي السياسات الصحية في وزارة الصحة في قطاع غزة تصورات إيجابية حول أهمية استخدام الأدلة في صنع السياسات الصحية بمتوسط مرجح 77.77٪ ، ولوحظ أن هناك نقص في القدرة على اكتساب وتقييم وتكييف وتطبيق أدلة البحث بمتوسط مرجح قدره 68.77٪. هناك ضعف في آليات نقل وتبادل المعرفة بمتوسط مرجح قدره 58.77٪ ، أكد المشاركون على ضعف التفاعل بين صانعي السياسات والباحثين ، ونقص الهياكل المناسبة لدعم استخدام الأدلة ، ومحدودية القدرة على فهم لغة الورقة العلمية وخاصة الإحصائيات. تمارس المنظمات المانحة والأحزاب السياسية تأثيرًا قويًا على عملية صنع السياسة الصحية. نقص الموارد والحوافز هي أهم العوائق التي تحول دون استخدام الأدلة في صنع السياسات الصحية. إن تحسين مهارات واضعي السياسات حول كيفية استخدام الأدلة وتعزيز ثقافة البحث سيزيد بشكل كبير من استيعاب استخدام الأدلة في صنع السياسات.

هناك حاجة لتعزيز البنية التحتية للبحث العلمي وتخصيص موارد كافية لها. بالإضافة إلى ذلك ، يحتاج واضعو السياسات والباحثون إلى الاتفاق على أولويات البحث. هناك حاجة ماسة إلى إنشاء مستودع موحد للبحوث ، وخاصة المحلية منها ، وتطوير برامج التعليم المستمر لواضعي السياسات الصحية لتعزيز مهارات استخدام الأدلة.