World Health Organization
REGIONAL OFFICE FOR Europe

SITUATION ANALYSIS MANUAL

EVIPNet Europe

country context

health system and policy-making context

health research system

health information system

evidence-informed policy-making processes

The Evidence-informed Policy Network (EVIPNet) Europe

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ACRONYMS AND ABBREVIATIONS

CRVS	civil registration and vital statistics
CSO	civil society organization
DFiD	Department for International Development (United Kingdom Government department)
EIP	evidence-informed policy-making
EVIPNet	Evidence-informed Policy Network
GDP	gross domestic product
HIS	(national) health information system
ICD-10	International Statistical Classification of Diseases and Related Health Problems, 10th Revision
ICT	information and communication technology
KB	knowledge brokering
KT	knowledge translation
KTP	knowledge translation platform
M&E	monitoring and evaluation
MoH	Ministry of Health
NGO	nongovernmental organization
NHRS	National Health Research System
OECD	Organisation for Economic Co-operation and Development
SA	situation analysis
SWOT	strength, weakness, opportunities, threats. The acronym stands for a type of analysis that takes into account these elements.
USAID	United States Agency for International Development (United States Government agency)
WHO	World Health Organization

SLOVENIA'S EXPERIENCE OF USING THE SITUATION ANALYSIS MANUAL

A workshop held in Ljubljana on 18 March 2014 marked the launch of the Evidence-informed Policy Network (EVIPNet) in Slovenia. Tanja Kuchenmüller and Janine Bröder from the WHO Regional Office for Europe came to Ljubljana for the workshop and explained to us, the future EVIPNet country team, what would be the next steps for Slovenia. I must admit that despite my involvement in the organization of the workshop, as a newcomer to EVIPNet, it was only at the launch that I understood well the whole concept of EVIPNet and the activities expected of network members.

As many readers of this Manual would know, the first big task that an EVIPNet Member country undertakes is a situation analysis. So after the launch, as a member of the team tasked with the preparation of that analysis, I found myself in front of a blank Word document, wondering: "Now, what?"

Well … not really. The blank Word document is meant in a figurative sense. Our country team started its work by reading through the Situation Analysis Manual; and that did the trick. The Manual guided us through every step of the way and we never felt that we did not know what needed to be done next.

Was it easy? No. The situation analysis required time. Besides, the area of evidence-informed policy-making was new to us, so we were often unsure of whether we were on the right track. Furthermore, the analysis involves a lot of interpretation, which made many of us feel somewhat uncomfortable at the lack of empirically verifiable objectivity at times. But such challenges cannot be resolved by a manual. In our case, help came from the WHO Secretariat of EVIPNet Europe and from several stakeholders in the country, who were consulted throughout the preparation of the analysis.

The Situation Analysis Manual is not the answer to the questions of life, the universe and everything else, but it is the answer to the question: "How do I do a situation analysis in my country?" I firmly believe that it is a powerful tool for you, the reader, whether you are involved in EVIPNet or interested in strengthening evidence-informed policy-making in other contexts. As a user of the tool, I am very grateful to the WHO Secretariat of EVIPNet Europe for having developed it.

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1 GENERAL OUTLINE OF THE EVIPNET EUROPE SITUATION ANALYSIS MANUAL

Purpose

The World Health Organization (WHO)'s Evidence-informed Policy Network (EVIPNet) has supported Member States in designing, implementing and institutionalizing efforts to support evidence-informed policy-making (EIP). This experience has shown the importance of systematically and comprehensively identifying important contextual factors that can either support or hinder countries in identifying the organizational and operational niche of the future EVIPNet knowledge translation platform (KTP) at the country level. The Situation Analysis Manual guides the analysis of such contextual factors.

The purpose of this Manual is twofold:

1. to assist WHO Member States in planning and conducting a situation analysis (SA) to understand the local context with regard to EIP/KTP. An SA aims to gather background information that supports a systematic and comprehensive reflection on the most important local factors that will either support or act as barriers to the establishment and operationalization of future KTPs. KTPs are the fundamental units of EVIPNet at the country level (*see* Textbox 1 on page 4 for details);

2. to provide general principles, approaches and tools that can be applied to conduct and present the findings from an SA. While several tools and approaches are meant to assist users in tackling the SA, the Manual is not a rigid protocol. The data collection methods should be, as required, adapted to the local context. For instance, questions can be amended to ensure that these are culturally and/or politically sensitive.

Target audience

The primary audience for this Manual are SA teams responsible for planning and supporting the establishment of KTPs. An SA team should consist of the following individuals/groups:

- representatives of the WHO Country Office;
- implementation team (including EVIPNet Europe national champion(s) in evidence-informed policy-making[1] and national consultant(s), who may be hired to conduct parts of the SA); and
- oversight group (including key stakeholders, e.g. from the policy and research communities as well as civil society).

The WHO Secretariat of EVIPNet Europe can guide the team in implementing the SA.

1 Each member of EVIPNet Europe has selected one or two national champions as national focal points with whom the Network collaborates and who advance the EIP agenda of their country as long as the KTP has not yet been established. In many cases, the national champions also serve on or remain affiliated to the future KTP.

Contents

The Manual has five chapters. The chapters should be read in sequence, as each chapter builds on the concepts and content presented in the preceding one. The intention in presenting the chapters in this way is to provide an easy-to-follow guide for SA teams: from the initial planning for an SA to the presentation of findings in a report.

Chapter 1 (this chapter) provides an introduction to the Manual, a short background on EVIPNet Europe, the key objectives of the Manual, an overview of the methods used to conduct an SA, and the ways in which the findings may be used.

Chapter 2 – "**How to prepare and plan for the situation analysis**" – outlines the main steps in conducting the assessment. The steps include preparation and planning; collecting information; analysis and reporting; dissemination and use.

Chapter 3 – "**Collecting the information and completing a descriptive analysis**" – serves as the "core" of the Manual, and provides the SA framework, suggested tools and processes to undertake the analysis and collect the necessary data.

Chapter 4 – "**Summarizing the findings in an overall SWOT analysis and focusing on major EIP issues**" – offers guidance on synthesizing the material gathered into a general SWOT analysis of the countries' situation with regard to EIP.

Chapter 5 – "**Writing the situation analysis report**" – offers guidance on how to present the findings as a written report for discussion in a stakeholder consultation.

The Manual is followed by annexes to support users who are tasked with conducting the SA using the concepts presented in the Manual (Annexes 1 and 2), to support evaluation (Annex 3) and to provide clarification about the meaning of some of the key terms used throughout the Manual (Annex 4). In particular, the following can be found in the annexes:

- **Annex 1** provides an expanded version of the tables to be filled in as the user progresses throughout the document (these correspond to Tables 3a, 5a, 8a, 11a, 13a, 14a and 16a in the text);
- **Annex 2** provides tables (intended for use as supportive tools) to assist users in identifying key stakeholders and their major characteristics in relation to supporting EIP;
- **Annex 3** contains an evaluation table of the tools used throughout the document; and
- **Annex 4** contains the EVIPNet Europe KTP Starter Kit glossary with key terms and phrases that are referred to throughout the document.

Complementary documents

For users of the Manual interested in gaining a deeper understanding of EIP, the types of efforts that can be pursued to support EIP at the country level, guidance on how to establish a KTP, as well as lessons learned from others who have established a KTP, some additional documents should be reviewed. In particular, the following complementary documents provide a more in-depth context to and background on EVIPNet Europe:

- *Introduction to EVIPNet Europe: conceptual background and case studies (1)*; and
- *EVIPNet Europe: developing viable scenarios for knowledge translation platforms (2)*.

Deliverables

The final output that is expected of users conducting an SA based on this Manual is a preliminary report to be presented and discussed during a local stakeholder consultation. This consultation will ensure that the recommendations of stakeholders are incorporated into a final report. In addition, members of the implementation team are expected to provide the tables of findings with complete lists of references and a repository of data sources used.

Next steps

The findings of the SA will inform a scenario development exercise on the potential organizational form and tasks to be performed by the KTP in the country. This follow-up step of the SA is not described in this Manual. (For further information on the subject, *see* the document *EVIPNet Europe: developing viable scenarios for knowledge translation platforms (2)*.

BACKGROUND: INTRODUCTION TO EVIPNET EUROPE AND ITS SITUATION ANALYSIS

EVIPNet Europe

WHO launched the EVIPNet in 2005. The goal of EVIPNet is to improve public health outcomes by promoting the systematic and transparent use of the best available research evidence for the development of health systems policy. EVIPNet aims to establish KTPs as a support infrastructure to improve the uptake of evidence in policy processes. Towards this goal, EVIPNet functions as a network consisting of individuals and organizations from around the world, operating on three distinct, yet closely interconnected, levels: country, regional and global.

Since its launch, EVIPNet has established regional networks in sub-Saharan Africa, the Americas, Asia and the Eastern Mediterranean Region. In October 2012, EVIPNet launched its European network: EVIPNet Europe. More detailed information on the global EVIPNet and its work can be found in its 2012–15 Strategic Plan *(3)* and on its online portal (www.evipnet.org). Information on EVIPNet Europe and its work is available in its Strategic Plan 2013–17 *(4)* and on its website (www.euro.who.int/en/evipnet).

At the country level, a KTP brings together key national actors, including policy-makers, researchers and civil society representatives to plan and implement knowledge translation (KT) and knowledge brokering (KB) activities (*see* Textboxes 2 and 3) adapted to the local context. A summary of the key characteristic of a KTP – also called the country team or national advisory body – can be found in Textbox 1 and in the “Introduction to EVIPNet Europe: conceptual background and case studies” *(1)*.

TEXTBOX 1.
EVIPNET EUROPE KNOWLEDGE TRANSLATION PLATFORMS

- A KTP is an organization or network that brings together the worlds of research and policy. A KTP designs, leads and/or delegates strategies to understand the prevailing situation on a particular issue; to harvest the local evidence and experience base, and synthesize it with global evidence and experience to provide guidance in policy development and implementation; to broker among stakeholders on key issues; to package syntheses and other communications for specific audiences; and to strengthen the capacities of researchers, policy-makers and other stakeholders in accessing research evidence, in performing synthesis work, and in KT more generally *(5)*.
- A KTP supports and enhances evidence-informed policy; it neither makes policy nor is it a pure research actor.
- KTPs are typically multidisciplinary, and have developed credible and legitimate positions in the policy-making process.
- A KTP has competencies in problem-scoping, evidence-gathering, critical appraisal, contextualization skills, and in active and passive KT.
- There is no one structure or organizational form that characterizes a successful KTP; however, its essential characteristics include ensuring methodological soundness, transparency, and independence from individual stakeholders in the policy-making process.

TEXTBOX 2.
KEY ACTIVITIES OF KNOWLEDGE BROKERS

A KB is an individual or an institution that performs the following set of activities:

- providing scientific (interdisciplinary) evidence related to public health/health systems/health services research;
- synthesizing existing knowledge and evidence in health systems according to the international evidence appraisal standards;
- presenting the evidence in an understandable and accessible way to enhance the use of evidence in health system decisions;
- supporting identification and coordinating decision-makers' needs with the timely and adequate generation and synthesis of health systems evidence;
- understanding and providing relevant knowledge about the specificities of the local context to support the implementation of adapted heath system decisions;
- mobilizing a critical mass of competent people from different disciplines to engage in developing, synthesizing and critically appraising evidence and adequate use of KT mechanisms to ensure sustainability;
- engaging in the development and use of proven KT or KB mechanisms;
- knowing and understanding the stakeholder communities at local and national levels, and having easy access to them to enhance collaboration;
- monitoring and evaluating the KTP's activities, including impact on health systems.

TEXTBOX 3.
KEY ACTIVITIES OF KNOWLEDGE TRANSLATION

KT approaches are generally differentiated into three different models: the push, pull and exchange efforts. KT activities include the following:

- packaging and disseminating research evidence outside the scholarly community (i.e. going beyond research reports, newsletters, annual reports, articles), e.g. through the preparation of evidence briefs for policy, study summaries, systematic review summaries, compendium of summaries or policy dialogue reports (push efforts);
- focusing on the efforts by health system managers and policy-makers to access and use research evidence, e.g. ensuring the availability and promoting access to an online repository to retrieve relevant research evidence in a timely manner and in a format that is useful (pull efforts);
- establishing and supporting exchange efforts either of a short-term nature (such as mutually beneficial partnerships at any point in the research or policy process), or bringing researchers, policy-makers and stakeholders together in a more sustainable, institutionalized manner (leading to the establishment of KTPs, as is the case for EVIPNet). Promising mechanisms include: convening deliberative dialogues, online discussion forums, online briefing or webinars, training workshops and personalized briefings.

EVIPNet Europe situation analysis

An EVIPNet Europe country SA is a systematically and transparently conducted approach to developing a deeper understanding of the major factors that may facilitate or hinder the successful establishment of a KTP in a particular country setting. The specific objectives of these analyses are as follows:

1. to describe and understand the local context (structures, processes and conditions) that would potentially enable or inhibit KT and EIP;
2. to deliver background information to guide deliberations on the organizational form, location, strategic direction, staffing, etc. for a suitable and sustainable KTP; and
3. to strengthen collaboration with international partners to support the future work of the KTP.

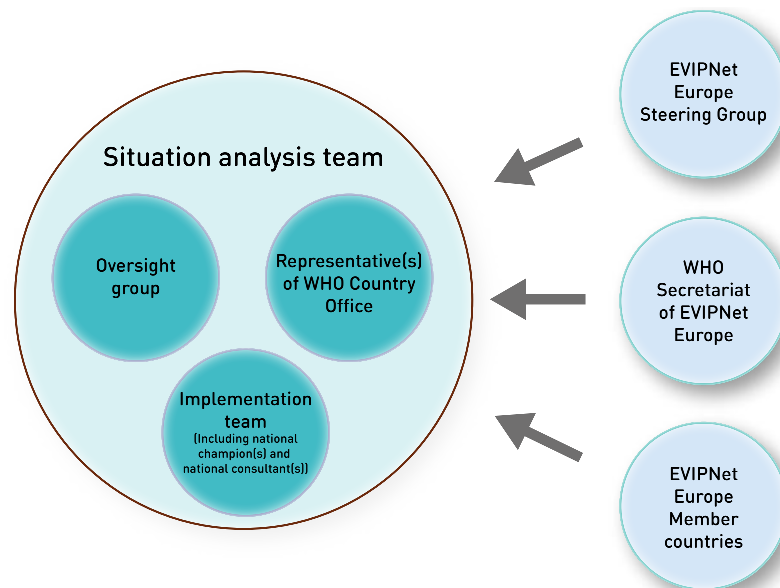
Roles and responsibilities

The SA will be conducted by a local implementation team[2], which should be formally appointed by the Ministry of Health (MoH), the WHO Country Office or other competent authority. Its members will include representatives from the local WHO Country Office, an implementation team (including national EVIPNet Europe champion(s) and national consultant(s)), and an oversight group (including key stakeholders, e.g. from the policy and research communities as well as civil society). The implementation team may subcontract tasks for the SA to a local consultant(s) but should always

2 The terms of reference of the implementation team can be provided by the WHO Secretariat of EVIPNet Europe upon request.

assume an oversight role in order to optimize the quality of the analysis. The implementation team has the final responsibility for the successful completion of the SA and the final report based on this analysis (Fig. 1).

FIG. 1. ROLES AND RESPONSIBILITIES WHEN CONDUCTING A SITUATION ANALYSIS



A typical SA team has the following three components (*see* Fig. 1):

1. an operational implementation team consisting of two to five persons who prepare and conduct the study, regularly report on progress to the oversight group, WHO Country Office and WHO Secretariat of EVIPNet Europe. The national champion(s) should play a leading role in the conduct of the SA. The implementation team can also include national consultant(s) who may be hired to conduct parts of the SA;
2. an oversight group consisting of representatives from key stakeholder organizations, who support the implementation team by validating or peer-reviewing their work;
3. representatives from the WHO Country Office, who may be consulted to provide technical advice as well as logistic and administrative support for execution of the SA.

At the regional level, additional roles and responsibilities fall upon the following three groups:

1. the WHO Secretariat of EVIPNet Europe, which will provide further technical advice and support throughout the conduct of the study;
2. the EVIPNet Europe Steering Group, which can provide additional technical support to local teams, and facilitate transnational sharing of expertise; and
3. EVIPNet Europe Member countries that have gained experience in conducting their own SA, and can offer peer support by serving as a contact point and resource for those who wish to learn from their experiences.

Five core content areas of focus in the situation analysis

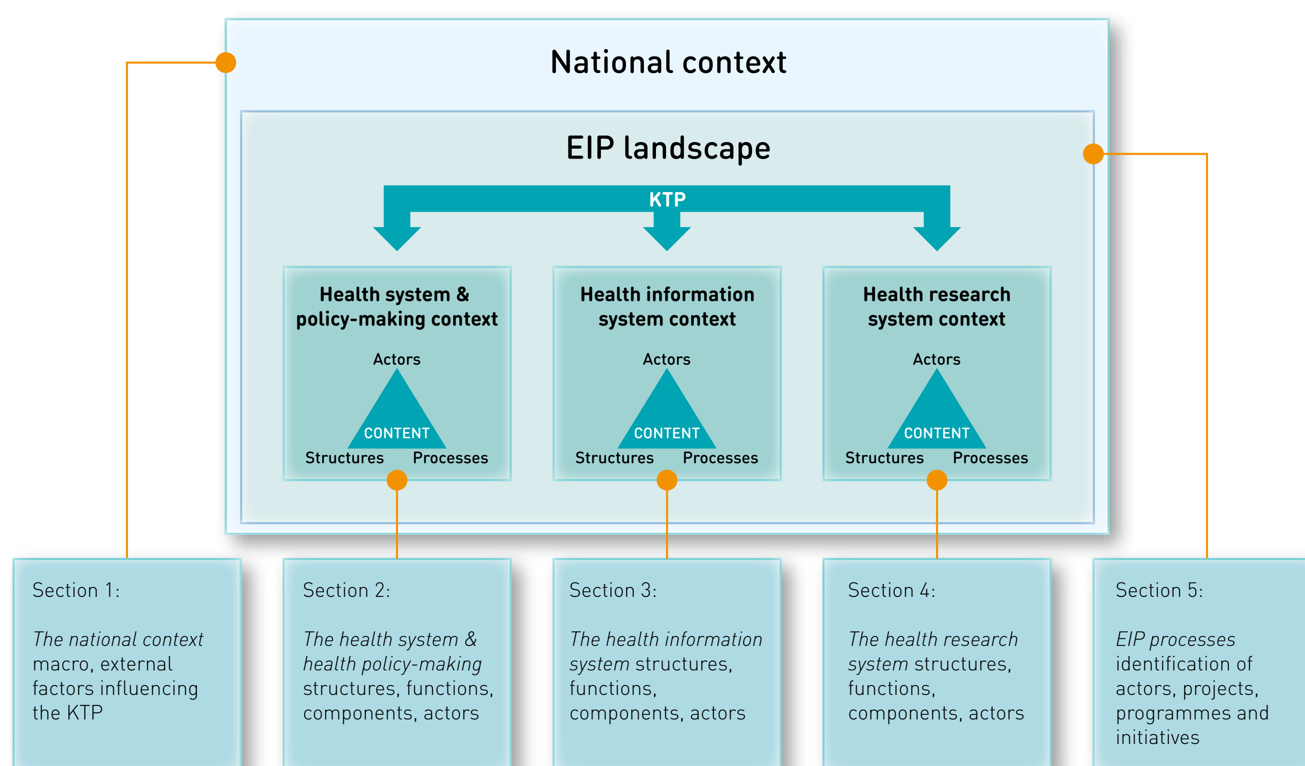
Following this chapter (which provides an introduction and background) and Chapter 2 (which covers key considerations needed when planning to conduct the SA), Chapter 3, "Collecting the information and completing a descriptive analysis" serves as the core of the Manual, as it enables users to begin the work of collecting data and undertaking their analysis. As shown in Fig. 2, an SA is structured around five major focus areas, which are covered in Chapter 3.

1. Focus on the **national context** helps users to develop a general understanding of the country's major political, social, public health, socioeconomic and cultural characteristics.
2. Focus on the **health system and health policy-making context** describes in detail the characteristics of its stakeholders, structures, decision-making processes, and key issues in public health and the health system. Both in the sections on the national context and health system and health policy-making context it is important to focus on those elements that can either facilitate or hinder the use of evidence in policy-making.
3. **Focus on the health information system** (HIS) describes key aspects of how information on health is gathered, assessed, used and disseminated, and on how the system is governed.
4. Focus on the **context of the national health research system** describes in detail key research stakeholders, available structures, overall processes and funding mechanisms, as well as key research areas on health in the country.
5. Focus on the existing landscape for **EIP** provides an overview of current EIP efforts and how they affect the establishment of a new KTP. This last section offers the possibility for the implementation team to not only describe but also explain how the possible bottlenecks and strengths in the national context, health system and health policy-making processes, as well as the research system influence the demand for evidence and the processes/structures that are used to translate evidence into policy-making.

An analysis within these five content sections will enable users to comprehensively assess the most important contextual factors that could either positively or negatively affect the establishment of a KTP.

Chapter 4 supports users with an approach to synthesizing the insights gained across all five content sections.

FIG. 2. THE CORE CONTENT AREAS OF FOCUS IN A SITUATION ANALYSIS



EIP: evidence-informed policy-making; KTP: knowledge translation platform; SA: situation analysis

Methods: data collection, data sources and quality of data

The following key sources will be used to collect data for the SA:

1. **a literature review** to capture both the literature published in scientific journals and the grey literature;
2. **key informant interviews** either by phone or through face-to-face meetings; and
3. **focus group discussions** (e.g. physical meetings to be organized at a venue accessible to all invited participants).

Should information be missing when consulting these resources, a "reasoned opinion" or tacit knowledge derived from the observations and experiences of the SA team can be an acceptable data source as long as the grounds for the arguments are adequately documented. A specific set of instructions related to the methods that can be used to collect data for each content area of focus is provided in Chapter 3.
All of the different data sources used need to be compared, validated and discussed (data and methodological triangulation). Data sources therefore need to be consistently documented and stored in an electronic repository (e.g. Dropbox), permanently accessible to the implementation team and the WHO Secretariat of EVIPNet Europe.

The findings and the draft report of the SA are expected to be reviewed, critically appraised, validated and consolidated at a local stakeholder consultation. Recommendations of stakeholders are to be incorporated into the final SA report.

2 HOW TO PREPARE AND PLAN FOR THE SITUATION ANALYSIS

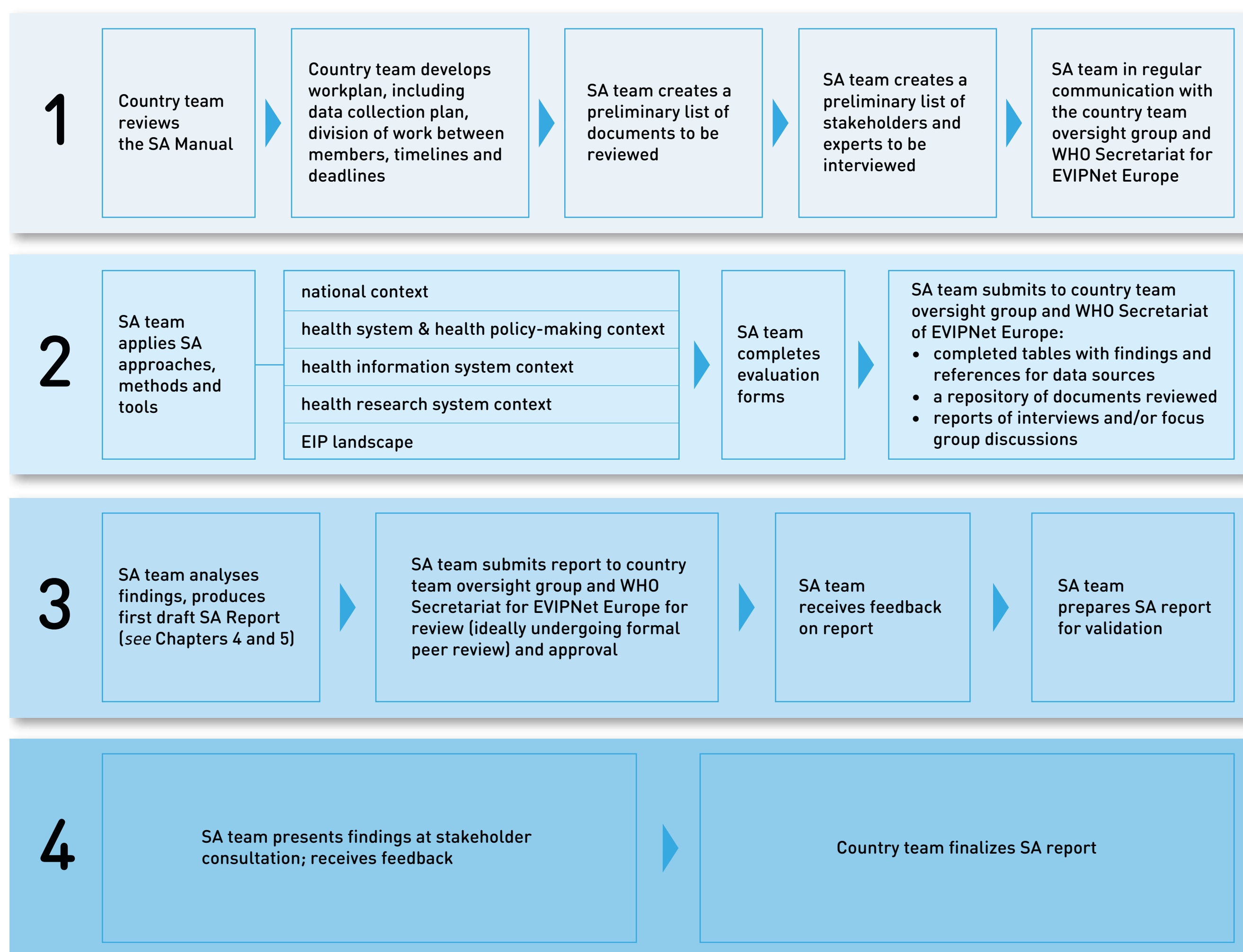
Implementation of the SA has four distinct phases, each of which involves a number of key activities: (i) planning; (ii) data collection and descriptive analysis; (iii) interpretive analysis and synthesis of key findings into a draft report; and (iv) validation and finalizing the report (*see* Fig. 3).

In the **first phase**, i.e. the planning stage, five activities will be pursued in accordance with the roles and responsibilities outlined in Fig. 1. First, the SA team will review the SA Manual to ensure that the work to be undertaken and expectations are clear to each member of the team. Second, the SA team will develop a workplan using Table 1 as a guide. This activity will map out the division of work among the members of the implementation team and the support required from the oversight group, establish an approach for data collection and management (e.g. whether interviews will be conducted over the phone or face-to-face, who will be responsible for collecting and organizing all data sources in a shared-access electronic repository), devise a timeline and establish deadlines for key deliverables. Third, members of the implementation team will create a preliminary list of documentary sources and documents to be reviewed for each core content area (national context, health system, health research system, health information system, EIP processes). Fourth, members of the implementation team will create a preliminary list of key informants to be contacted for an interview. As an overarching fifth activity, all of these activities will include regular communication with and review by the oversight group and WHO Secretariat of EVIPNet Europe.

In the **second phase**, the implementation team will apply the approaches outlined in this Manual to undertake the descriptive component of the SA, related to the five key content areas that are focused on in Chapter 3. This entails using the methods described and the tools provided in the Manual to develop detailed descriptions of the national context, the health system, the HIS, the health research system and EIP processes, and to complete and submit the full range of tables that summarize the descriptive analysis (complete with references and information about the data sources used). The implementation team will also be expected to complete the evaluation forms to provide feedback on the methods, tools and approaches presented in the Manual.

The **third phase** involves the interpretive analysis and synthesis of major findings from each component of the analysis conducted in the previous phase into a draft report, the submission of this report to the oversight group for review (and potential peer review), and revisions. This is followed by the **fourth** and **final phase** – validation and finalizing the report – in which stakeholders are convened to discuss the findings, and additional changes are made if needed to finalize the report.

FIG. 3. THE FOUR PHASES OF IMPLEMENTATION OF THE SITUATION ANALYSIS



Time frame and resources

The estimated time to collect and analyse data, and to write the draft and final report varies between 26 and 47 working days. These two scenarios have been used in Table 1 to provide an illustrative example of a project timeline that can be used to plan your own approach (considering that your planning may fall anywhere in between the 26- and 47-day planning cycle).

It is estimated that conducting a "quick" SA is possible in 26 days if the implementation team considers a few recommendations (related to focusing and condensing activities). Easy access to information and documents, and being acquainted with the country context are necessary to speed up the process of analysis. The implementation team should be aware that the "quick" SA has the inherent risks of missing important information and/or neglecting the involvement of key stakeholders.

Good planning before commencing the SA and time management (including a clear understanding of the essential aspects of the SA) are important to adhere to the timelines related to both the "quick" and the "thorough" SA approach. Note that these estimates do not take into account the phases of preparation or the potential travelling time to conduct interviews, focus group discussions or discussions with stakeholder groups.

TABLE 1. TWO TIMELINES FOR CONDUCTING THE SITUATION ANALYSIS

Conducting the situation analysis	Quick situation analysis 26 working days (wd)	Thorough situation analysis 47 working days (wd)	Recommendations for quick situation analysis	Disadvantages of the quick approach
Assessing the national context (Chapter 3.1)	1–3 wd		Focus only on the questions that your team identifies as potentially having an impact on EIP/KTP.	Some important national context issues might be missed.
Assessing the health system and health policy-making context (Chapter 3.2)	4–14 wd		Ask stakeholders to fill in the tables on key players and organizational characteristics, to be assessed by the implementation team.	Not all key stakeholders may provide feedback.
Assessing the health information system context (Chapter 3.3)	4 wd			
Assessing the health research system context (Chapter 3.4)	4 wd			
Assessing the evidence-informed policy-making landscape (Chapter 3.5)	4–10 wd		Reduce the number of interviews.	Some important information may be lost (which potentially can be compensated for at the stakeholder consultation).
Conducting a SWOT analysis and writing the draft report (Chapter 4)	4–6 wd		Plan on performing all activities from Chapter 4 in one SA team meeting.	Some relevant issues might be overlooked (which potentially can be compensated for at the stakeholder consultation).
Conducting a stakeholder consultation	4–5 wd		Provide a succinct report of the stakeholder consultation. Focus on changes to the SA report.	Some information on what was discussed at the consultation, which could be useful for future reference, might be lost.
Finishing the report	1 wd			

Note: The SA is a balancing exercise between collecting necessary and useful information and getting lost in details. Answering the questions always requires taking into consideration the core objective of the exercise (developing insight into the country's challenges and opportunities to establish a KTP and enhance EIP). This aim should be balanced with the efforts to collect data within the time frame and human resources available. The core aim is to focus on understanding the evidence-informed policy processes, and identifying the strengths and challenges within the country under study. In order to do so, descriptive background information has to be collected, but the purpose of the exercise should not be forgotten. One needs to assess how to optimally use time and resources and avoid getting lost in excessive detail.

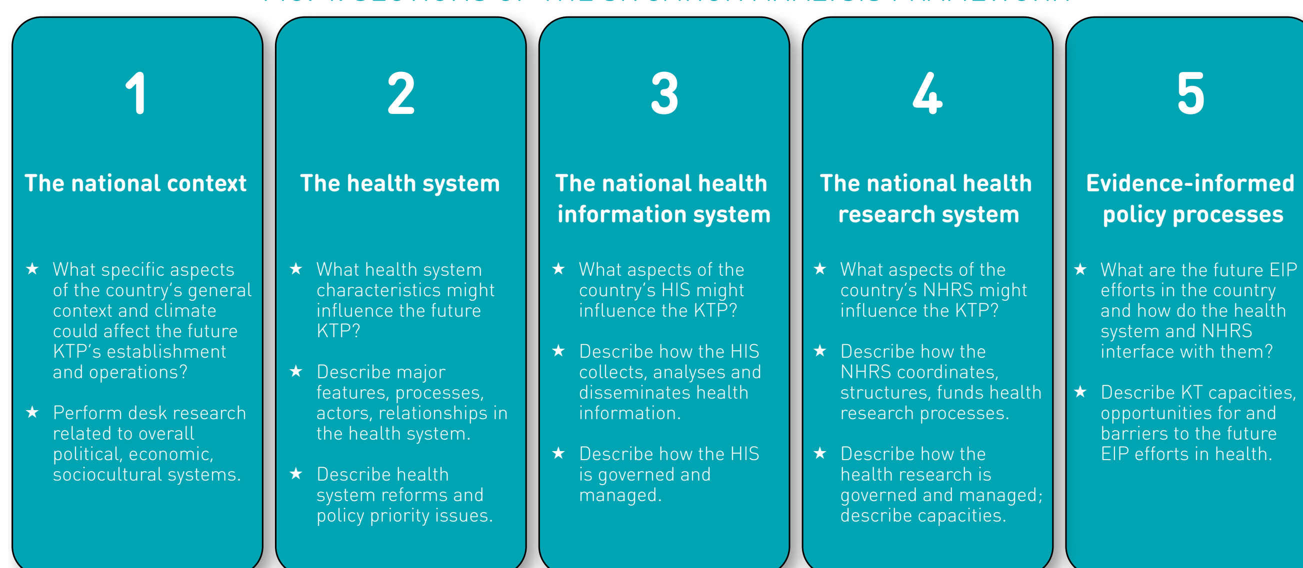
3 COLLECTING THE INFORMATION AND COMPLETING A DESCRIPTIVE ANALYSIS

Objectives of the chapter

This chapter provides the guidance and tools required to collect information and complete the descriptive analysis on the five content sections of the SA framework: (i) the national context; (ii) the health systems and health policy-making context; (iii) the HIS context; (iv) the health research system context; (v) and the EIP landscape (*see* Fig. 4). Each section begins with an overarching question that can help orient users as to how the information collected in this chapter contributes to the "big picture". Specifically, by completing the work outlined in this chapter, users will be able to answer the following questions:

1. What specific aspects of my/our country's general context could affect the future establishment and operations of a KTP?
2. What health system characteristics, or characteristics of the health policy-making context in my/our country may influence the future establishment and operations of a KTP?
3. What aspects of my/our country's HIS could influence the future KTP?
4. What aspects of my/our country's health research system could affect the future establishment and operations of a KTP?
5. What are the current EIP efforts in my/our country?

FIG. 4. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK



Each section contains the following three resources to facilitate this work:

1. suggested data sources;
2. tools and a description of methods that can be adapted to suit local requirements; and
3. tables to summarize the findings.

3.1 THE NATIONAL CONTEXT

By completing the work outlined in this section, users of this Manual will be able to answer the following overarching question related to the core content focus area of the national context:

What specific aspects of my/our country's general context could affect the future establishment and operations of a KTP?

Objective

The main objective of conducting this section of the SA with a focus on the national context is to describe the general conditions that may either promote or hinder EIP.

The aim is:

- to develop a general understanding of the patterns of political structures and decision-making;
- to develop a general description of key social, public health, socioeconomic and cultural characteristics of the country and its national policy-making processes, its institutions and organizations, the relations between policy domains, political relations between provinces/states, relations between State and non-State entities, etc.

FIG. 5. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK: THE NATIONAL CONTEXT

Background

This section aims at understanding the political system as a set of institutions and agencies that formulate and implement the collective requirements of a society.

To map the national context, the types of information sought will be driven by components of the "3-i's" framework, which draws on a number of established theoretical concepts in the field of political science, and consists of *institutions, interests, ideas* and *external events (6).*

Institutions include government structures (e.g. whether policy is made in a unitary or a federal state) and the legacies of past policies that may shape the policy process at different levels. Institutional factors (e.g. existing regulations, established legislative processes or capacity for policy analysis) help to understand the parameters within which policy can be developed as well as who has the authority over and/or access to the policy process in terms of setting the agenda and formulating policy *(7,8)*.

The *interests* category captures the characteristics of political actors (e.g. traits of interest groups, civil society and legislators), the extent to which they have the power to influence the policy process as well as whether they will mobilize in support of or against a particular policy (based on whether they win or lose as a result of a given policy, and by how much) *(9,10)*.

Ideas include what is known (from research or practical experience) as well as the societal values that characterize the policy arena, and actors in that arena *(11)*.

Finally, **external events** include factors outside of this political context that can influence the policy-making process (e.g. economic or political crises, the outbreak of a disease epidemic/pandemic or the inequitable distribution of disease burden, environmental disasters, as well as longer-term processes such as European Union integration or new economic or trade agreements).

Method

Completing the tables in this section should be done primarily through desk research. Desk research generally consists of a review of the published literature (i.e. journal articles) and the grey literature (i.e. government policy documents and reports) using available documents and Internet sources to collect the relevant data. Though not a requirement, key informant interviews can be conducted to complement the findings and for triangulation.

Data sources

Various international and regional sources may be consulted to find relevant documents for completing this section. Table 2 offers a few suggestions that can be used as a starting point; these can be complemented with local resources.

TABLE 2. INTERNATIONAL AND REGIONAL RESOURCES

Source	Link
WHO's Health Systems in Transition (HiT) series	http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits
The Economist Intelligence Unit	http://www.eiu.com/home.aspx
Country analysis – United Nations	https://data.un.org/
European Neighbourhood Policy Country Report	http://eeas.europa.eu/enp/index_en.htm
UN Public Administration Country Profile	http://www.unpan.org/country_profiles

Freedom House	http://www.freedomhouse.org
Countries and their cultures	http://www.everyculture.com
OECD – health policies and data	http://www.oecd.org/els/health-systems
World Bank – health	http://www.worldbank.org/en/topic/health
Commonwealth Fund	http://www.commonwealthfund.org/

OECD: Organisation for Economic Co-operation and Development

Key informants might be contacted and interviews or focus group discussions performed, in case data cannot be found through desk research, or if it is clear that a key informant may be able to suggest/provide additional documents. We recommend that these external interviews/focus groups be performed **after** all questions from Chapter 3 have been addressed through the desk research.

Tools and process

Members of the implementation team should start by reading through the prompting questions included in Table 3a, which will help to clarify the kinds of information that should be sought from the data. The aim of this section is to collect information and develop answers for all (or the majority) of the questions/prompts provided, in order to develop an insight and understanding of the general political and country context in which the establishment of a KTP is being considered. Note that the process of data collection and descriptive analysis (i.e. providing answers to the questions posed) will be iterative in nature, requiring interwoven steps of reading collected documents, identifying gaps in understanding the available documents, and searching for new documents and data to fill the identified knowledge gaps. Additional information that is important but that does not directly address any of these questions may also be included.

The implementation team should first collect data that answer the prompts/questions in Table 3a, and then complete the **summary table** (Table 4), keeping the guiding question of this section in mind: what specific aspects of the country's general context could affect the future KTP's establishment and operations? For example, it could be that within the "Institutions" section, you have determined that your country is a federal state, with policy-making authority related to public services (including health) delegated to provincial governments. You may identify this as a key factor in shaping where and how to establish a new KTP in your country (e.g. you might determine that you should establish a KTP with strong policy networks in a specific province, rather than nationally, given that this is where most social policies are developed).

Deliverables

- Table 3a, which consists of the findings and complete lists of references
- Table 4, which includes a succinct summary of the main findings, i.e. a repository of data sources used.

The questions in Table 3a guide a descriptive analysis of the general country context. Please refer to the "tools and process" part of this section for guidance on how to use the table. Implementation teams should respond to the questions in bullet form and provide the specific source (e.g. document,

interview, opinion) used to frame the answer. Document your answers electronically in the blank version of Table 3a provided in Annex 1. Textbox 4 provides an example of two answers to the question marked in red in Table 3a.

TABLE 3A. QUESTIONS ON THE POLITICAL STRUCTURE OF THE COUNTRY

Questions
Institutions: formal and informal rules, norms, precedents and organizational factors that structure political behaviour
1. What are the characteristics of current government structures? 1a. Is it a unitary (one legislature within which policy development takes place to govern the entire country) or (con)federal state (with a number of provincial/regional/state legislatures) or a combination of both? 1b. What is the frequency of turnover of government(s) and what are the reasons (voluntary or involuntary)? 1c. What type of political structure prevails in the country (single party/coalition political parties; minority/majority)? 1d. To what extent is decision-making authority concentrated or supported by advisory boards and adjacent organizations (e.g. involvement of parliamentary task forces, external agencies, civil society or expert advisory groups)? 1e. What examples of obligations or incentives are there in decision-making bodies to prompt the use of research evidence (e.g. requests for systematic analyses of problems and grounding of recommendations in research and evidence)? 1f. What is the proportion of the national budget spent on generating research evidence across all sectors? 1g. Are government staff members (administrative or technical staff) in general academically trained? If not, what is their typical training background? 1h. Is there any capacity for policy analysis (understanding the determinants of policy processes, and competencies to design, implement and evaluate policy interventions)?
2. What are the characteristics of the civil service? 2a. Is the civil service an important employer in the country? In absolute and relative terms? Are there high or low rates of turnover and internal role transitions of the civil service (i.e. civil servants do not stay in their positions for long periods of time)? 2b. What is the level of (academic) skills and professional backgrounds of civil service staff members? 2c. Is the State's role complemented by private organizations (for profit or non-profit) for delivering public services?

3. What are the characteristics of the policy-making stakeholders (i.e. professional associations, civil society organizations, nongovernmental organizations (NGOs) and the public)? 3a. How are stakeholders involved and supported in order to contribute to the policy-making process? What type of stakeholder is better involved and organized compared to others? 3b. What is the influence of third-party payers (e.g. insurers, public and/or private) in the policy-making process? 3c. Are structures in place to coordinate stakeholders' activities (e.g. coalitions, networks)? 3d. Do stakeholders engage in and what is their capacity for policy analysis (understanding the determinants of policy processes, and competencies to design, implement and evaluate policy interventions)?
Interests: interests of stakeholders that could influence the policy process and the power relationships between stakeholders
4. What types of influence do key stakeholders have over policy-making? Please provide specific examples. 4a. What is the extent to which civil freedoms exist? How can important and interested stakeholders (e.g. professional associations, civil society organizations, NGOs, the public, donors/international organizations/supranational structure) engage in the policy process? Are there formal and significant roles for interested stakeholders outside of government?
Ideas: societal values that characterize the policy arena and actors
5. What are the general prevailing values with regard to the use of research evidence? 5a. Does the public value the role of research evidence as an input to policy-making (e.g. does the public demand that decisions be made based on the best available research evidence)? 5b. Do ministries or governments directly support the generation and/or synthesis of research evidence as part of the overall governance culture? If yes, in what way (e.g. direct commissioning of research for the sake of policy-making, general research promotion to support specific research branches, promotion of young researchers' research capacity)? 5c. Is civil society participation valued within the country?
External factors: country-specific factors affecting policy-making
6. How do external factors (e.g. social, economic, military, media characteristics) influence policy-making in the country? 6a. Is there an impact of linguistic and cultural groups in the country on policy-making? 6b. How important is the role of the media and what freedom does the media have to report on political processes? Has the role of the media recently changed? 6c. How is the socioeconomic condition of the country (e.g. gross domestic product [GDP] growth rate per capita, employment rate, poverty rate, public debt, health spending and its distribution (public/private), and how does it affect policy-making processes? 6d. Has the country been subject to economic/political/military crisis or changes that have an impact on political developments and policy-making processes in the country?

After completing Table 3a, reread your "raw" data, then complete Table 4 below and summarize the key findings that you consider relevant to EIP/KTP. Briefly explain how each finding potentially relates to EIP/KTP establishment. These summary tables will be presented in the core of the (draft and final) report (Chapter 5). You may need to consult with members of the WHO Secretariat of EVIPNet Europe, or with individuals from other SA teams who have already conducted an SA to better understand how these factors may (or may not) influence the establishment of a KTP.

TEXTBOX 4.
POLITICAL STRUCTURE OF THE COUNTRY – EXCERPT FROM WORKING DOCUMENTS OF THE SA PERFORMED IN SLOVENIA

Is it a unitary (one legislature within which policy development takes place to govern the entire country) or (con)federal state (with a number of provincial/regional/state legislatures)?

Slovenia is a parliamentary democracy, with one national Parliament, representing the legislative branch of government. Self-governance of the municipalities is stated in the Constitution and defined in the Local self-government Act. While a unitary government facilitates the policy-making process, the multitude of municipalities (there are 211 of them) is a barrier to smooth coordination and their effective participation in the policy-making process. However, the authority of municipalities in health care is very limited.

Sources:

Albreht T, Turk E, Toth M, Ceglar J, Marn S, Pribaković Brinovec R, et al. Slovenia: health system review. Health Systems in Transition. 2009;11(3):1–168 (http://www.euro.who.int/en/about-us/partners/observatory/health-systems-in-transition-hit-series/countries-and-subregions/slovenia-hit-2010, accessed 14 August 2016).

Republic of Slovenia: public administration country profile. United Nations, Department of Economic and Social Affairs; 2004 (http://unpan1.un.org/intradoc/groups/public/documents/un/unpan023226.pdf, accessed 14 August 2016).

What is the frequency of turnover of government(s) and what are the reasons (voluntary or involuntary)?

The formation of the Government is based on a coalition of parties. The governments were fairly stable before 2008. Since 2008, a turnover of three governments was followed by early elections. This situation was partly due to economic instability. Changes in government act as a significant barrier to KT, because they support very short-term-oriented policy-making and add instability to long-term goals.

Source:

Zajc D. Razpad vlad in oblikovanje novih koalicij v Sloveniji v obdobju 2008–2013 [Disintegration dissolution of governments and the formation of new coalitions in Slovenia between 2008 and 2013] [Article in Slovenian] Teorija in praska. 2013;50 (5–6):753–69 (http://www.fdv.uni-lj.si/docs/default-source/tip/razpad-vlad-in-oblikovanje-novih-koalicij-v-sloveniji-v-obdobju-2008-2013.pdf?sfvrsn=0)

TABLE 4. SUMMARY TABLE OF FINDINGS ON THE GENERAL COUNTRY CONTEXT

Characteristic	Summary findings	Link to EIP/KTP
Institutions		
Interests		
Ideas		
External factors		

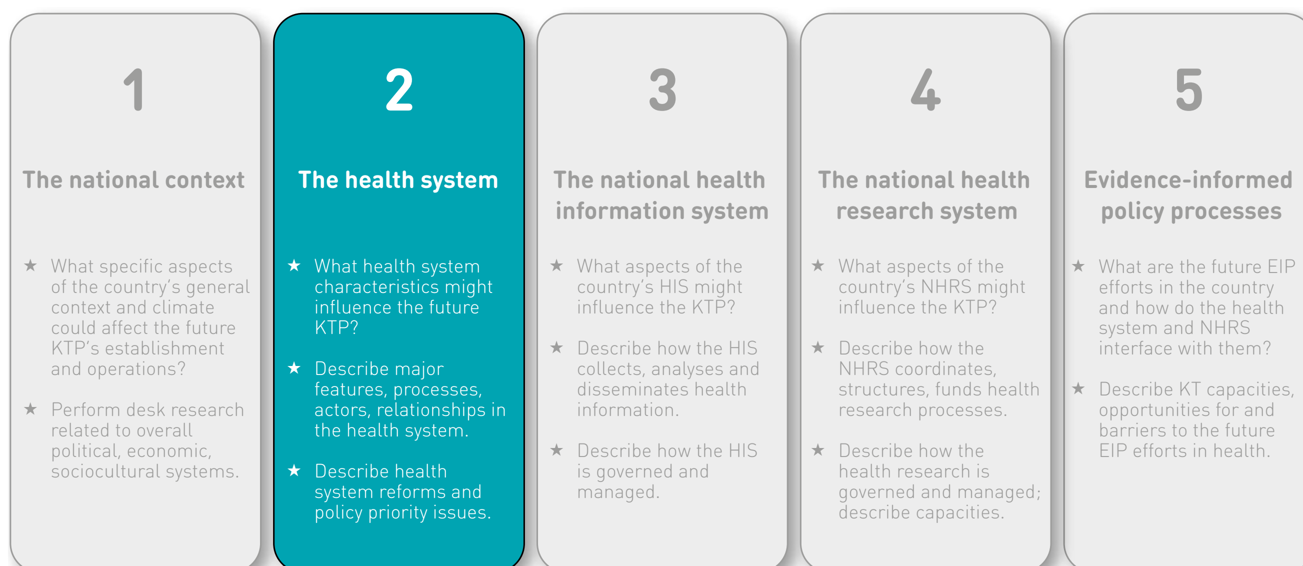
3.2 THE HEALTH SYSTEM

By completing the work in this section, users of the Manual will be able to answer the following question in relation to the content focus area of the health system and health policy-making:

What health system characteristics, or characteristics of the health policy-making context in my/our country influence the future establishment and operations of a KTP?

The following section provides guidance and tools on the health system and health policy-making context, including the major actors in the health system that are involved in shaping the health policy-making process (*see* Fig. 6 below). Many of the concepts covered in the previous section, which focused on the general policy-making context in the country (and specifically the influence of institutions, interests and ideas on policy development), are also relevant to the health policy-making process covered in this section. Note, however, that this section will not repeat this material, as the Manual assumes users are building on concepts already covered to enrich their understanding of the topics in this section. As such, users are encouraged to revisit their completed work from section 3.1 throughout this section so that they generate a comprehensive assessment of the health policy-making dynamics in their setting.

FIG. 6. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK: THE HEALTH SYSTEM



Objective

The objective of this second section of the SA is to assess how the health system, and specific characteristics of the health policy-making context, may affect the future establishment and functioning of the KTP.

The aim is:

- to examine the features of the health system, including health policy-making processes; the general characteristics of service delivery (infrastructure); health workforce; information; medical products, vaccines and technologies; health financing (health and social insurance), health system stewardship (leadership and governance, and regulatory aspects of the health system); information management; and
- to identify health system reforms and priority policy issues, where research is likely to be demanded by the government.

Background

A health system comprises all activities whose primary purpose is to promote, restore and maintain health *(12)*. A health system (or health-care system) is an organization of people, institutions and resources that deliver health services to meet the health needs of target populations *(13)*. A health systems approach helps individuals to understand the provision of health services, not only by a mere description of the different structural components offering provision of health services, and governing and financing them, but also of their relationships/interrelationships with the health needs and characteristics of the populations. A health systems approach also promotes a better understanding of key system functions as a means to achieving final health system goals (such as health, financial protection and responsiveness), as well as intermediate objectives and interim outcomes (such as, for instance, related to access to health services, quality and efficiency).

To describe and analyse health systems, WHO has identified a set of six interconnected key functions, referred to as the building blocks of health systems *(14,15)*. We rely on these blocks in this Manual.

1. Service delivery
2. Health workforce
3. Information
4. Medical products, vaccines and technologies
5. Finance
6. Leadership and governance *(13)*.

As suggested in the EIP literature *(14)*, the SA focuses on three key building blocks of the health system:

- *Service delivery*. The organization of public and private health services is the most visible product of the health-care system and is concerned with the delivery of individual services and population-based interventions.
- *Financial arrangements*. Health system financing includes the health financing subfunctions of collecting revenues (collection of funds), pooling of funds (accumulation of funds in order to share financial risks of ill-health), and allocating funds (allocating funds in exchange for health services, also known as paying for or purchasing health services).
- *Governance arrangements*. Stewardship (leadership and governance) within the health system is usually (but not always) a governmental responsibility and is expected to tackle questions

such as: what are the health priorities at which public resources should be targeted? What is the institutional framework in which the system should function (within the health-care and with other sectors) and how is it regulated? How are decisions about health priorities and resource generation made, with a short-, intermediate- or longer-term perspective in mind? What information is needed and by whom to ensure effective decision-making on health matters, and how are appropriate data (public health, health services, health system performance, health status) managed for policy-making?

The building block "information" will be assessed in the following section on the health information system.

Method

As in the previous section, desk research is conducted, consisting of the published literature (i.e. journal articles) and the grey literature (i.e. government policy documents and reports) using available documents and Internet sources to collect the relevant data. Where necessary, this can be complemented by key informant interviews and or/focus group discussions.

Data sources

Suggestions from the international published literature include the following:

- WHO's Health Systems in Transition series (http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits).
- Health System Performance Assessment (HSPA) publications, if available (https://kce.fgov.be/sites/default/files/page_documents/KCE_259C_performancereport2015.pdf).
- Organisation for Economic Co-operation and Development (OECD) – Health policies and data (http://www.oecd.org/els/health-systems/).
- World Bank – Health (http://www.worldbank.org/en/topic/health).
- Commonwealth Fund (http://www.commonwealthfund.org/).

Suggestions on the grey literature include:

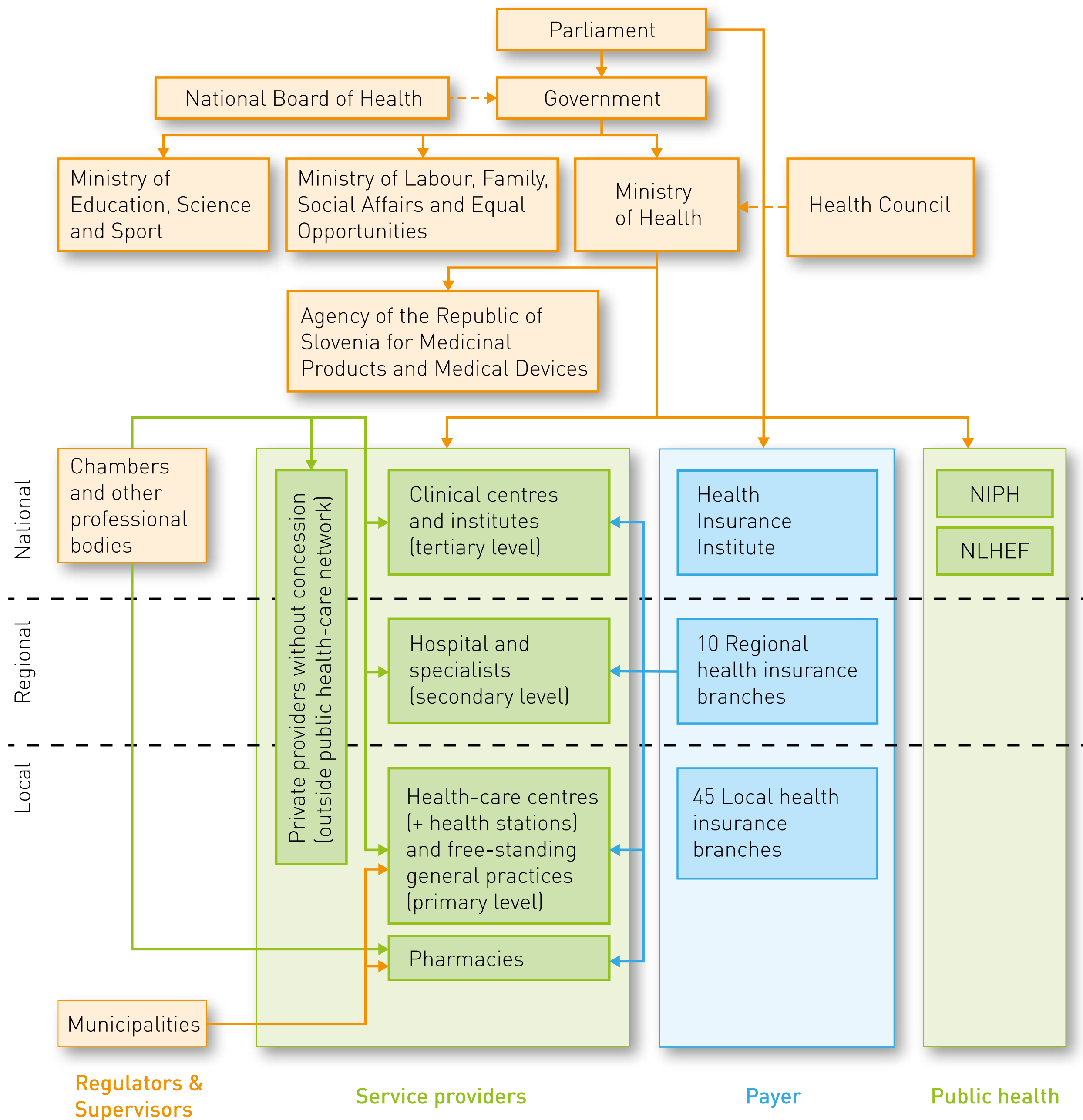
- national health system reports
- the websites of all the major health system actors, including the MoH, health financing agencies, civil society organizations, the private sector, and (other) international actors, including WHO
- if not online, the information may be retrieved via a personal visit or a phone call/email correspondence.

Tools and process

The implementation team should start by filling in Table 5a (health system review) and tables of the organizational characteristics within which key players are located in the system (*see* Annex 1 for blank versions to work with electronically). In addition, it is recommended that the implementation team locates or creates an **organogram** illustrating the country's health system. The example of Slovenia is presented in Fig. 7.

It is not likely that the implementation team will be able to answer all the questions through desk research. As such, key informants may need to be interviewed, or focus group discussions conducted. We recommend performing external interviews after all the questions from Chapter 3 have been reviewed.

FIG. 7. SIMPLIFIED ORGANOGRAM OF THE SLOVENE HEALTH-CARE SYSTEM



Source: adapted from Albreht T, Turk E, Toth M, Ceglar J, Marn S, Pribaković Brinovec R, et al. Slovenia: health system review. Health Systems in Transition. 2009;11(3):1–168.

NIPH: National Institute of Public Health; NLHEF; National Laboratory of Health, Environment and Food

Legend: orange line indicates hierarchical relationship, dotted orange line indicates advisory relationship, blue line indicates contractual relationship, green line indicates professional oversight.

After completing Table 5a, the tables of key players' organizational characteristics (Annex 2) and the organogram, summary Table 6 should be completed, keeping the guiding question in mind: what health system characteristics influence the future establishment and operations of the KTP?

Deliverables

- Table 5a and Table 6, comprising the findings and complete lists of references
- Data from key informant interviews/focus group discussions
- Repository of data sources used
- Tables with organizational characteristics of the key health system and national health system actors (*see* Annex 2)
- Organogram of the key players' organizational characteristics.

The prompt questions in Table 5a below guide an analysis of the national health system. Please refer to the "Tools and process" part of this chapter for guidance on how to use the table. Implementation teams should respond to the questions in bullet form and provide the specific source (e.g. document, interview, opinion) used to determine the answer. A ready-to-use form with the questions below is provided in Annex 1.

TABLE 5A. HEALTH SYSTEM REVIEW

Questions
1. Health system – general
1a. *Health system governance*. What are the major governance and organizational structures of the health system? Specify especially the characteristics and extent of centralization and decentralization of the health system and its governance.
1b. *Health system stakeholders*. Who are the major stakeholders involved in the development of the health system and how do they engage in (or resist) the uptake of research evidence in health system policy-making?
1c. *Non-State actor involvement*. What is the role of the State compared to the role of non-State actors in delivering health services? Does this role differentiation affect the use of research evidence in policy-making or implementation processes?
1d. *Major health system challenges in delivery of health services*. What are the major issues currently faced in adequate provision of health services for the population?
1e. *Demography*. Are there any demographic factors that are particularly important to consider?
1f. Which types of diseases (acute vs chronic) are most prevalent in the country and how are they distributed among particular populations?
1g. Are there any minority groups for which health is a particular challenge?
2. Health system reforms
2a. What past or ongoing health system reforms mark the organization of the health system? How was research evidence used in these reforms?
2b. Who are the major actors leading the implementation of the reforms and what is their attitude towards the use of research evidence?

2c. Does the health system promote innovation, change and reforms that make the system adapt to changing needs? If so, who are the key actors promoting or hampering this process? Is there a strategy that enhances the use of research evidence?
2d. How transparent are these reform processes and objectives? What accountability mechanisms are in place to monitor the reforms (e.g. monitoring and evaluation [M&E], public reporting, accountability agreements)?
3. Service delivery
3a. *Comprehensiveness*. Does the health system cover the whole range of population health needs from health promotion, health protection, disease prevention, treatment and rehabilitation? What is the quality of the provided services (e.g. are practices evidence-based? Are best practices being used? Is a quality and safety monitoring system in place? To what extent are national/international (clinical) guidelines being implemented to improve the quality of health services? What are the major quality challenges that have to be tackled?
3b. *Accessibility* (entry points). In general, does the population have adequate access to medically necessary services (e.g. primary, secondary and tertiary care)? Are there adequate formal processes that regulate the distribution of facilities and equipment with which to deliver health services in the country, and are these accessible to all?
3c. *Accessibility barriers*. What are the known barriers that affect access to health services? Are these barriers specific for particular groups?
3d. *Human resources.* Is there a national workforce planning process? Do you consider the supply and distribution of health-care professionals in the country sufficient to meet the needs of the population? What are the key challenges with regard to qualifications and competencies of the health workforce?
4. Health financing
4a. *Revenue collection (financing mechanisms).* What are the sources of funding (e.g. employees, employers, firms, individuals, households, foreign governments or NGOs)? What are the mechanisms that generate national health-care revenues and in what approximate shares (e.g. indirect and direct taxes, compulsory insurance contributions, voluntary insurance premiums, out-of-pocket payments)? What agents are responsible for collecting the revenues (e.g. central/regional governments, independent body or social security agency, private insurance funds, providers)?
4b. *Revenue collection (health insurance)*. What is the prominent health insurance scheme? Is there a mandatory pre-payment scheme? Are there gaps in the coverage of people or services?
4c. *Setting health services prices.* Who is responsible for setting health-care prices and packages (services and medicines)?
4d. *Health expenditure*. What is the current health expenditure as a share of the GDP? How is health expenditure funded (e.g. what is the share of household out-of-pocket financing in health)? What is the structure of health-care spending by provider (e.g. hospital, primary care, long-term care)?
4e. *Purchasing and paying for health services.* What are the prominent payment methods for the individual health professionals and organizations who provide care? Are there any financial incentives to promote the use of evidence in health services delivery?

5. Governance and leadership
5a. *Legislative framework(s).* What are the major legislative arrangements that govern how individuals and organizations function within the health system?
5b. *Strategic policy direction (strategic framework).* Does a recent strategic national vision (e.g. a national health strategy) to achieve better health system outcomes exist? What are its main directions? Is there a role specified for health research and/or EIP processes?
5c. *Accountability and oversight: policy authority.* Is the decision-making authority for the health system mainly centralized or decentralized? How does this centralization or decentralization affect (a) coordination and communication, and (b) the uptake of research evidence in health system decision-making? Are there means of holding all health system actors (public and private, providers, payers, producers of other resources, stewards) accountable for their actions? What corruption protection mechanisms are in place for the health system?
5d. *Accountability and oversight: professional authority.* Is there legislation and/or are there specific regulations in place to regulate health-care professionals' entry into the system? What educational or training requirements are in place for each of the health professions? Who is responsible for the oversight of each of the health professions?
5e. *Accountability and oversight: monitoring and evaluation.* To what extent are research-based evaluations of health system components being done, by whom, and are they influencing policy or practice? Are there mechanisms in place to prompt periodic transparent reviews of the health system and the range of governance, financial and service delivery arrangements to ensure that they are aligned with strategic health sector goals?
5f. *Coalition-building and participation (whole-of-society approach).* Is health considered a cross-sectoral topic? Do any line ministries have a direct role or influence in health policy-making processes? If so, does this affect the uptake of evidence? What is the involvement/participation of patients and the general public in the decision-making process? Does this affect the use of research evidence in policy-making?

Once you have completed Table 5a, reread your "raw" data on the features of the health system, as well as any work you have done to fill out key players' organizational characteristics (Annex 2). Complete Table 6 and summarize the key findings that you consider relevant for EIP/KTP. Briefly explain how each finding potentially relates to EIP/KTP. These summary tables will be presented in the core of the (draft and final) report (Chapter 5). As with the previous section, in order to develop insights about how the factors you have identified and described may influence the establishment of a KTP in your country, you may need to consult with experienced members of the WHO Secretariat of EVIPNet Europe, or with members of other SA teams who have completed their own SA.

TABLE 6. SUMMARY TABLE OF HEALTH SYSTEM FINDINGS

Characteristic	Summary findings	Link to EIP/KTP
General features of the health system, including policy-making processes		
Health system reforms		
Service delivery issues, including health workforce		
Health financing (and health insurance)		
Issues that the future KTP might choose to address and support with the provision of evidence		
Health system reform		
Service delivery		
Health financing		
Related to stewardship (governance and leadership)		
Stakeholder characteristics, their relationships and dynamics		

3.3 THE HEALTH INFORMATION SYSTEM

By completing the work in this section, users of the Manual will be able to answer the following question in relation to the content focus area of health information (*see* glossary for a definition) and health policy-making:

What health information system characteristics in my/our country influence a future KTP's establishment and operations?

FIG. 8. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK: THE NATIONAL HEALTH INFORMATION SYSTEM

Objective

The main objective of this section of the SA is to assess the national health information system (HIS).

The aim is to develop a better understanding of the following components:

- available HIS governance and resources, indicators, data sources, data management and data quality;
- dissemination and use of health information.

Background

WHO Member States in 2007 acknowledged that "sound information is critical in framing evidence-based health policy and making decisions" *(16)*. It is therefore important to assess the HIS, as this will likely have an impact on the functioning of the KTP. Furthermore, the availability of reliable and accessible information at national and subnational levels may considerably influence the work done by

the KTP. The assessment will help to understand how information is generated, accessed and used for policy-making at the country level, and identify good practices for the future KTP to take advantage of.

The objective of this section is to provide a short overview of what information resources are available, how reliable and accessible they are, and how they have contributed to decision-making in the past.

The overview follows the structure recommended by the *Support tool to assess health information systems and develop and strengthen health information strategies (17)* (the Support tool), developed at the WHO Regional Office for Europe. As the assessment in the Support tool, Table 8 is also structured considering six components of the HIS:

1. Resources
2. Indicators
3. Data sources
4. Data management
5. National HIS data quality/information products
6. Dissemination and use.

The approach used in this Manual, however, differs from the one recommended by the Support tool, in that it does not aim at scoring the performance of countries on a number of answers, but rather provides an overview of the system with a series of open-ended questions.

The Support tool builds on the approaches of the former WHO Health Metrics Network *(18)*, and outlines the process of designing and implementing a strengthened HIS, thereby strengthening evidence-informed policy-making. The HIS assessment is part of the first phase in this process, where a coordination mechanism is established in the form of a national working group to guide and carry out this assessment. The assessment is then used in the second phase, where the results of the assessment are used to focus the discussion on performance gaps, set priorities for action and do strategic planning on how to implement them. The plan is then implemented in the third phase, along with monitoring and replanning at regular intervals.

The scope, transparency and access of health information is also greatly influenced by e-health. E-health "involves a broad group of activities that use electronic means to deliver health-related information, resources and services: it is the use of information and communication technologies for health" *(19)*. It has been recognized to play a "unique and pivotal role in achieving universal health coverage" *(19)*. It is therefore important to also consider e-health aspects in the context of the HIS. This has also been confirmed through the current experience in using the Support tool in countries, suggesting improvements to the Support tool by incorporating recent developments in the domain of e-health in the forthcoming revision of the tool *(20)*.

Method

As in the previous section, desk research is performed, consisting of the published and grey literature (comprising documents such as the WHO country profile, highlights on health and well-being, core health indicators, etc., *see* Table 2) and Internet research to collect the relevant data. Where necessary, this should be complemented by key informant interviews and/or focus group discussions.

Data sources

TABLE 7. INTERNATIONAL AND REGIONAL RESOURCES

Source	Link
WHO European Health for All family of databases	http://gateway.euro.who.int/hfa-explorer
WHO European Health Information Gateway	http://gateway.euro.who.int
WHO European Data and Evidence website	http://www.euro.who.int/en/data-and-evidence
Health Systems in Transition (HiT) series	http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits
HIS assessment reports	To enquire with the WHO Country Office whether such assessment reports are available
WHO Country profile	http://www.who.int/countries/
WHO Highlights on health and well-being	*See* individual WHO country websites at http://www.euro.who.int/en/countries
Core Health Indicators in the WHO European Region	http://www.euro.who.int/en/data-and-evidence/core-health-indicators-in-the-who-european-region
WHO Core Health Indicators	http://www.who.int/healthinfo/indicators/en/
Health data and statistics	http://www.who.int/healthinfo/statistics/en/
Eurostat	http://ec.europa.eu/eurostat
OECD Health Statistics 2016	http://www.oecd.org/els/health-systems/health-data.htm

Suggestions for the published literature include:

- the Support tool to assess HIS and develop and strengthen health information strategies *(17)*
- *Public Health Panorama (20)*.

Suggestions for the grey literature include documents from:

- Government health agencies and public health institutes
- Universities
- Research centres and research projects
- Conference proceedings
- WHO collaborating centres in the area of health information, health information systems and e-health
- Professional organizations in the area of public health, health information management and health information systems management.

Tools and process

The implementation team should start by filling in Table 8a on the HIS characteristics. It is not likely that the implementation team will be able to answer all questions through desk research. As such, key informants may need to be interviewed, or focus group discussions conducted. We recommend that external interviews be performed after all questions from Chapter 3 have been reviewed.

If an exhaustive review of the HIS has already been performed recently in line with the Support tool, the implementation team may use the corresponding report as a substitute for Table 8.

After completing Table 8a, Table 9 should be completed, keeping the guiding question in mind: what health information system characteristics may significantly influence the future KTP's establishment and operations?

Deliverables

- Table 8a, comprising the findings and complete lists of references
- Table 9, which includes a succinct summary of the main findings.

The questions in Table 8a below guide a profiling of the HIS. Please refer to the "Tools and process" part of this chapter for guidance on how to use the table. Implementation teams should respond to the questions in bullet form and provide the specific source (e.g. document, interview, opinion) used to determine the answer. A ready-to-use form with the questions below is provided in Annex 1.

TABLE 8A. HEALTH INFORMATION SYSTEM REVIEW

Questions
1. Resources (policy and planning; HIS institutions, human resources and financing; HIS infrastructure)
1a. Is there an up-to-date legislation providing the legal framework for all relevant components of the national HIS, such as vital registration, notifiable diseases and private sector data, including social insurance, confidentiality and fundamental principles of official statistics? Ideally, this legal framework also covers an evidence-informed policy cycle.
1b. Is there a comprehensive, written HIS and/or e-health strategic plan in active use and is it implemented at the national level? What are its key components? Does it include intersectoral approaches such as, among others, ministries of health, information and technology?
1c. Has the MoH established a multisectoral HIS coordination mechanism with other main HIS stakeholders in the country (e.g. a task force on health statistics)? Does this coordination mechanism have a clear role and mandate?
1d. Is there a routine system in place for monitoring the performance of the HIS, its various subsystems and e-health?
1e. Do the institutions with official roles in the HIS (e.g. the MoH, national statistical office, national public health institute, subnational health authorities) have adequate and sustainable capacity in core health information sciences (epidemiology, demography, statistics, information and communication technology [ICT], knowledge integration [including forecasting], health reporting and KT)?

1f. Do the institutions with official roles in the HIS (e.g. the MoH, national statistical office, national public health institute, subnational health authorities) have adequate and sustainable resources for their health information activities?
1g. Is adequate ICT infrastructure (e.g. computers, data management software, Internet access) and adequate ICT support in place at the national level, at relevant subnational levels and at hospital/provider level?
2. Indicators
2a. Have national minimum core indicators been identified for the national and subnational levels covering all categories of health indicators (e.g. determinants of health, health system inputs, outputs and outcomes [health systems performance assessment], health status, health inequalities)?
2b. Is there regular reporting on the set(s) of core indicators and are they regularly evaluated for usefulness and completeness, together with policy-makers and other end-users?
2c. Is there adequate alignment between the core indicators used at the national and subnational levels, and between the core indicators used by the different subnational health authorities?
3. Data sources
3a. What are the main data sources in your country, including the census, civil registration and vital statistics (CRVS), population-based surveys, health and disease records, health service records, resource records?
3b. For each of these data sources, does the country have adequate capacity: (i) to implement data collection; (ii) to process the data; (iii) to analyse the data; and (iv) to disseminate the results of analyses and (micro)data?
3b.i. In addition, related to CRVS, is there (i) high coverage of deaths registered through CRVS, (ii) high coverage and quality of cause-of-death information recorded on the death registration form?
3b.ii. In addition, related to population-based surveys, do the health and statistical constituencies in the country work together closely on survey design, implementation, and data analysis and use?
3b.iii. In addition, related to health and disease records (including disease surveillance systems), is there adequate capacity: (i) to diagnose and record cases of notifiable infectious diseases; (ii) to report and transmit timely and complete data on these diseases; and (iii) to analyse and act upon the data for outbreak response and planning of public health interventions?
3b.iv. In addition, related to health and disease records (including disease surveillance systems), is/are there (i) a high level of implementation of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for reporting hospital discharge diagnoses; and (ii) adequate and sustainable resources available for operating the national cancer registry and other registries according to international standards?

3b.v. In addition, related to health service records, is there (i) a comprehensive electronic health service-based information system that brings together data on discharge diagnoses, procedures, and other treatments and services provided and their costs from all public and private facilities? (ii) Is support provided to the electronic health service-based information system by a cadre of trained health information staff, both at the central level and at the level of facilities, and regular training to keep the staff's knowledge up to date and to guarantee that a sufficiently large pool of trained staff is provided? (iii) Is there a mechanism in place for verifying the completeness and consistency of data from facilities and for feeding this information back to the facilities?
3b.vi. In addition, related to resource records, is there (i) a national database of public- and private-sector health facilities with complete coverage; (ii) a national human resources database that tracks the number of health professionals by major professional category working in either the public or the private sector with complete coverage? (iii) Is there a national database that tracks the annual numbers graduating from all health training institutions with complete coverage; (iv) availability of financial records on general government expenditure on health and its components (e.g. by the MoH, other ministries, social security, regional and local governments, and extrabudgetary entities), and on private expenditure on health and its components (e.g. household out-of-pocket expenditure, private health insurance, NGOs, firms and corporations)?
3c. Are there adequate human resources and equipment for maintaining and updating the various resource databases, and for producing and disseminating outputs based on these databases?
3d. Are the routine data collections adequate in their periodicity and timeliness, and do they meet the demands of the end-users (e.g. health facility managers, health insurance companies)? Are the data collections regularly assessed for completeness and quality?
3e. Are data from the e-health service-based information system readily available for public health monitoring (that is, policy support) and research purposes, and are they actually being used for such secondary purposes?
4. Data management
4a. Is there a written set of procedures that are implemented throughout the country for data management, including data collection, storage, cleaning, quality control, metadata requirements, analysis and presentation for target audiences? Briefly describe.
4b. Is the HIS unit at the national level running an integrated "data warehouse", containing data from all data sources (at national and subnational levels), and/or are there linkages between relevant health-related databases (both population-based and facility-based sources, including all key health programmes)? Does it have a user-friendly reporting utility accessible to various user audiences? Is an integrated data analysis being performed? Briefly describe.
5. National HIS data quality/information products
5a. Do policy-makers at the national as well as at the relevant subnational levels have access to all the information they need to support their policy decisions, i.e. there are no major information gaps? In particular, are all data and information necessary for monitoring the targets of the national health strategy available?

5b. Is the data collection method for core indicators in line with national and international standards and recommendations? Can the country meet all data delivery requirements from the international organizations of which it is a member and with which it is collaborating? Are there recent publications that tackle the question of data quality in health?
5c. Are the timeliness and periodicity with which the data for official indicators are collected, computed and reported adequate, and do they meet the needs of policy-makers?
5d. Is there high consistency over time of datasets from major data sources used for computing official indicators? Is the coverage of these data sources high?
5e. Can official indicators be disaggregated by demographic characteristics (e.g. sex, age), socioeconomic status (such as income, occupation, education) and locality (e.g. urban/rural, major geographical or administrative region), and do in-country adjustments use transparent, well-established methods?
6. Dissemination and use
6a. Do senior managers and policy-makers demand complete, timely, accurate, relevant and validated HIS information, and know how to interpret and use it?
6b. Are the integrated health reports, including information on the core indicators and their disaggregation, publicly distributed regularly to all relevant parties?
6c. Are integrated health information reports on the core indicators and their disaggregation demonstrably used in national and subnational policy-making processes, such as ▪ in the planning, agenda-setting or problem definition processes, e.g. for annual integrated development plans, medium-term expenditure frameworks, long-term strategic plans and annual health sector reviews? ▪ to set resource allocation in the annual budget for health at national or subnational level? ▪ to advocate equity and allocation of increased resources to disadvantaged groups and communities (e.g. by documenting their disease burden and poor access to services)? ▪ by care providers at any level (national, regional/provincial, district, hospital and health centre) for health service delivery management, continuous monitoring and periodic evaluation?
6d. Are there adequate mechanisms for KT (e.g. resources, tools, networks and platforms to structurally support the uptake of health information in evidence-informed policy-making) in place and functioning well?
6e. Is information on health risk factors systematically used to advocate adoption of lower-risk behaviours by the general public or targeted vulnerable groups?

Once you have completed Table 8a, reread your "raw" data on the features of the HIS, then complete Table 9 and summarize the key findings that you consider relevant for EIP/KTP. Briefly explain how each finding potentially relates to EIP/KTP. These summary tables will be presented in the core of the (draft and final) report (Chapter 5). As with the previous section, in order to develop insights about how the factors you have identified and described may influence the establishment of a KTP in your country, you may need to consult with experienced members of the WHO Secretariat of EVIPNet Europe, or with members of other SA teams who have completed their own SA.

TABLE 9. SUMMARY TABLE OF HEALTH INFORMATION SYSTEM FINDINGS

Characteristic	Summary findings	Link to EIP/KTP
Resources		
Indicators		
Data sources		
Data management		
National HIS data quality/ information products		
Dissemination and use		

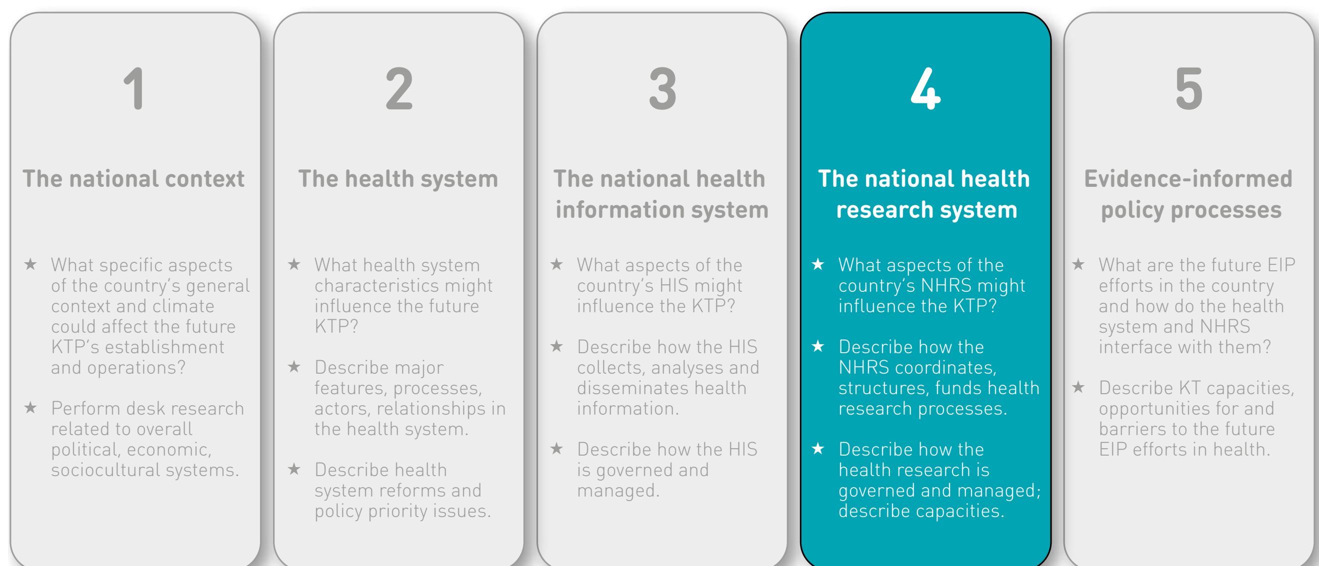
3.4 THE NATIONAL HEALTH RESEARCH SYSTEM

By completing the work outlined in this section, users of this Manual will be able to answer the following overarching question related to the core content focus area of the national health research system (NHRS):

What aspects of my/our country's health research system could affect the future establishment and operations of a KTP?

The following section provides guidance and tools on the NHRS, including the decision-making processes (*see* Fig. 9). For a detailed assessment of key stakeholders, please *see* Annex 2.

FIG. 9. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK: THE NATIONAL HEALTH RESEARCH SYSTEM



Objective

The objective of this section of the SA is to assess the NHRS.

The aim is to develop a better understanding of the following components:

- how the NHRS governs and structures health research processes;
- the capacity of health research actors to conduct high-quality and health systems-relevant research, and of health research funding agencies to signal the importance of this research through robust funding mechanisms;
- the health research culture (e.g. whether researchers are valued in society); and
- the dominant health research practices (e.g. whether researchers address a range of health systems issues or focus narrowly on basic and biomedical sciences).

Background

Health research is multidimensional and covers many types of research, including biomedical, clinical, public health, basic, applied, researcher driven, health systems driven, quantitative, qualitative, and so on. From a public health and health policy perspective, health research should aim to contribute by guiding the health system in the design and implementation of health policies. For the purpose of this exercise, we mainly focus on health systems and services research, but other types are not neglected. A systems approach aims to integrate the objectives, structures, stakeholders, processes, cultures and outcomes of health research. This section of the NHRS describes all the actors and relationships that define a country's ability to produce, synthesize, disseminate and utilize health research adapted to the priorities of the health system, including setting the agenda and building health research capacity. The findings of this section should also describe how research as a whole benefits decision-makers, practitioners in health and related fields, and society at large. Knowledge of the NHRS is crucial to better understand where to possibly locate the KTP, the issues that the KTP might focus on, and the stakeholder dynamics within the research system that might influence its EIP approaches. For example, certain research organizations or funding agencies may have a particularly strong influence on the types of research conducted in the country, or may already be consulted routinely by policy-makers and stakeholders to inform health policy development. This dynamic would be important to acknowledge in determining who is best positioned to house a unit with the intention of supporting the use of research evidence in the health policy-making process.

Method

Desk research that includes a review of the published and grey literature and Internet research should be performed to collect the relevant data. Where necessary, this review should be complemented by key informant interviews and/or focus group discussions for data triangulation, or when gaps in understanding are identified that cannot be understood with existing documents, and when a key informant may provide insights into additional resources that should be consulted to fill gaps in understanding. We recommend performing these external consultations after all questions from Chapter 3 have been reviewed.

Data sources

As the concept of an NHRS is relatively new, there may be little documented information available in the country focused on this. This would require a wider use of key informant interviews. Moreover, it may prove challenging to document and assess an actor's relationship to health research through desk research alone. Some actors (e.g. a funder of health research; a health research institute) will have a very clear, explicit relationship to health research and the NHRS, while others (e.g. the MoH) will have a more complex or varied relationship to health research, which may be more difficult to describe and/or assess. Table 10 below displays different resources relating to the NHRS.

TABLE 10. LOCAL AND REGIONAL RESOURCES RELATING TO THE NHRS

Source	Link
WHO's Health in Transition series	http://www.euro.who.int/en/about-us/partners/observatory/publications/health-system-reviews-hits
Ministry of Health website (especially its research department); research university websites; health financing agency website; civil society organization websites, etc.	Specific to country
Evaluations, white papers, programmes of the major actors in the health system. If not online, these may be retrieved via a personal visit or a phone call/email correspondence	Specific to country
Council on Health Research for Development (COHRED) NHRS assessments	http://www.cohred.org/central_asia
Strengthening Public Health Research in Europe (SPHERE)	http://www.ucl.ac.uk/public-health/sphere http://www.ucl.ac.uk/public-health/sphere/sphereprofiles

Tools and process

The implementation team should start by filling in Table 11a on Dimensions of the NHRS. Like the other sections in this chapter, a number of prompt questions are provided to help the user probe the governance and leadership of the NHRS in their country, the ways in which the NHRS in their country absorbs and distributes funding, and how it produces, synthesizes and utilizes research**.** Table 5a and the **tables of key health research system players**, completed in the previous section and available in Annex 1, may also be important to revisit in this section.

After completing Table 11a, the **summary table** (Table 12) should be completed, keeping the guiding question in mind: what aspects of the NHRS could affect the future establishment and operations of a KTP? As with the previous two sections, in order to develop insights about how the factors you have identified and described may influence the establishment of a KTP in your country, you may need to consult with experienced members of the WHO Secretariat of EVIPNet Europe, or with members of other SA teams who have completed their own SA.

Deliverables

- Tables 11a and 12 comprising the findings and complete lists of references
- Data provided by key informants/focus group discussions.

Table 11a poses a series of questions around NHRS stewardship, funding, creating and sustaining resources, and producing and using research. Please refer to the "tools and process" part of this section for guidance on how to use the table. Implementation teams should respond to the questions in bullet form and provide the specific source (e.g. document, interview, opinion) used to determine the answer.

A ready-to-use form with the questions below is provided in Annex 1. Textbox 5 provides an example of two answers to the question marked in red in Table 11a.

TABLE 11A. DIMENSIONS OF THE NATIONAL HEALTH RESEARCH SYSTEM

Questions
1. Stewardship of health research
1a. Strategic policy directions (strategic framework). Is there an explicitly stated vision, mission and set of goals for the NHRS? How and to what extent does health research in the country address issues regarding health system policy needs?
1b. Research priority-setting. Is there a list of explicit national health system research priorities? How are they identified?
1c. Oversight. Does any agency (ministry, institution or organization) manage or govern the NHRS? Are there national laws, regulations, policies or guidelines on ethical conduct of research on human subjects and other related areas in the country? Do they adhere to international guidelines?
1d. Partnerships and coalitions. Are efforts at health research networking and partnerships (nationally and internationally) promoted? What types of health research partnerships or networks exist in the country and internationally? Are there genuine opportunities to present and openly discuss research data with local, national and international communities?
2. Funding sources for health research
2a. Funding sources. Who are the key national funders and funding agencies of health research (public and private)? What are the current levels of health systems research funding versus funding of other health research areas?
3. Organizational infrastructure and characteristics of health research
3a. Organizational structures. What is the total number and health research staffing levels of organizations, departments or research groups actively involved in generating health research evidence? Are they in the public, private or NGO sectors?
3b. Research infrastructure. Do researchers typically have adequate access to information and research evidence through physical and electronic resources? Are there reliable health information systems in the country? What are the reported gaps and problems? What is the availability of and access to information technology for health researchers?
3c. Human resources. What types of training and education programmes relevant for health systems research are currently offered in the country and what are the areas covered? Is there a viable career structure and funding to attract and retain the most talented individuals?
3d. Research competencies. What are the domains of expertise prominently represented in the country (e.g. clinical research, health systems and policy research, health services research)? What research traditions exist in the country (e.g. quantitative research, qualitative research, mixed methods)? Are there any historic factors influencing the type of research competencies in the country? To what extent is research on health system priorities and EIP valued and regarded as important within the research community? Is it acted upon and, if so, how often?

4. Producing and using research
4a. Scientific outputs. Are the country's research findings typically published in peer-reviewed journals? Are these journals well regarded domestically/internationally?
4b. Research utilization. Who are the typical target audiences for research findings and other research outputs? Are there specific activities or mechanisms that translate and communicate research to inform health policy, strategies, practices and public opinion?

TEXTBOX 5.
DIMENSIONS OF THE NHRS – EXCERPT FROM WORKING DOCUMENTS OF THE SITUATION ANALYSIS PERFORMED IN SLOVENIA

3a. Organizational structures. What is the total number and health research staffing levels of organizations, departments or research groups actively involved in generating health research evidence? Are they in the public, private or NGO sectors?

A recently published report concentrated on public health research, seeking research institutions or research groups active in this area. The report states that there is no common definition of public health research and hence it is impossible to define its level of staffing, despite the availability of a national researchers' database. Investigators within the project attempted to recognize all relevant institutions. These institutions were contacted and, in a few cases, provided additional contacts of researchers in public health. The majority of these institutions are publicly funded and part of a university.

Source:
Poldrugovac M, Kraigher A, Albreht T, Zupančič A. PHIRE country report Slovenia. (https://eupha.org/repository/projects/PHIRE_Country_Reports/Slovenia_PHIRE_Country_Report_30nov12.pdf)

3b. Research infrastructure. Do researchers typically have adequate access to information and research evidence through physical and electronic resources? Are there reliable health information systems in the country? What are the reported gaps and problems? What is the availability of and access to information technology for health researchers?

The availability of international databases is the same as in any industrialized country and mainly limited by the costs of subscriptions where these apply. The availability of national databases is diverse, depending on the institution responsible for it and the type of data required. For instance, the Statistical Office has a well-developed information portal, which is openly available. A similar portal is also available for health data collected by the National Institute of Public Health; however, regulation of personal data protection limits open availability to the aggregated data, which reduces its usefulness. According to Slovenian law, researchers can be granted access to individual data for research purposes if a series of specified conditions are met.

Source:
Investigators' own compilation, confirmed by stakeholders, who participated in the SA final consultation.

Once you have completed Table 11, reread your "raw" data on the features of the NHRS. Complete Table 12 and summarize the key findings that you consider relevant for EIP/KTP. Briefly explain how each finding potentially relates to EIP/KTP. These summary tables will be presented in the core of the (draft and final) report (Chapter 5). Again, to make the connection between the factors identified as important, and the influence they may have on establishing a KTP, you may need to consult with members of the WHO Secretariat of EVIPNET Europe, or with team members from other countries who have completed their own SA.

TABLE 12. SUMMARY TABLE OF THE NHRS FINDINGS

Characteristic	Summary findings	Link to EIP/KTP
Stewardship of health research		
Funding sources of health research		
Organizational infrastructure and characteristics of health research		
Scientific output		
Research utilization		
Stakeholder characteristics, their relationships and dynamics		

3.5 EVIDENCE-INFORMED POLICY-MAKING (EIP) LANDSCAPE

By completing the work outlined in this section, users of this Manual will be able to answer the following overarching question related to the core content focus area of the EIP landscape:

What are the current EIP efforts in my/our country and how does it affect the future establishment of a new KTP?

FIG. 10. SECTIONS OF THE SITUATION ANALYSIS FRAMEWORK: EVIDENCE-INFORMED POLICY PROCESSES

Objectives

The objectives of this section are to describe the EIP efforts, barriers and opportunities, issues that could benefit from EIP activities, and the actors, programmes and initiatives that are explicitly involved (*see* Fig. 10).

The aim is:

- to identify the key characteristics, processes and activities of the actors involved in the health system, health information and health research systems with regard to capacity for KT and KB (*see* Textboxes 2 and 3 for details on KT and KB, pages 4 and 5);
- to assess the interface between the research and policy spheres; and
- to bring together the findings from the previous sections, with a particular perspective on how KT and KB are taking shape in the country.

Background

Every country has its own history, its own set of values and its own unique approach to health policy-making processes. Moreover, over time, every country develops its own unique constellation of approaches to, or ground rules for, influencing policy (e.g. through the establishment of different constitutional rules, government structures, and through the ongoing development of legislation).

Insights about the nature of the political context in general (covered in section 3.1), and on the factors influencing the development of health policy, collection and use of health information, and conduct of health research more specifically (covered in sections 3.2, 3.3 and 3.4) are vital for establishing a solid foundation for developing a deeper understanding of:

1. the national context in general;
2. the existing health system;
3. the role of HIS in the policy-making process in the country;
4. the role of research evidence in the policy-making process in the country; and
5. what efforts are currently used (if any) to support EIP.

As this section of the Manual requires users to make linkages between the concepts covered in sections 3.1, 3.2, 3.3 and 3.4 in order to complete the deliverables, revisiting these sections may be necessary before working through this section.

The core of this section focuses on how evidence is used and how it influences national health system-related policy-making processes. There is a wide spectrum of ways in which research evidence tends to influence policy, from ad-hoc methods (e.g. a research project on a high-priority policy issue happens to produce its findings at exactly the right policy moment) to more systematic, embedded approaches (e.g. through the daily actions of a KTP to broker the necessary relationships among research and policy actors). While ad-hoc opportunities for influencing policy will always remain, the challenge lies in developing routine institutional pathways between research and policy processes so that research evidence can regularly influence health decision-making.

In the health systems of most countries, there are some strong examples of how research evidence has both influenced and failed to influence the policy-making process. It is important to highlight success stories so that it is easier to convince those in positions of influence of the value associated with supporting EIP efforts. On the other hand, stories of failure are equally important because they provide important insights as to the major factors that inhibit EIP, and as such indicate the types of obstacles that must be overcome when designing and implementing future EIP activities.

This section provides a particular focus on:

- identifying whether departments of the MoH or other major institutions, institutes or civil society groups have a mandate to support evidence-informed health policy processes for health systems strengthening, and understanding their successes and challenges in doing so;
- identifying whether individuals or institutions work to build relationships among core health system policy-makers, stakeholders and researchers, in an attempt to support the integration of different types of knowledge and evidence in the policy processes; and

- identifying the range of KT programmes or activities that exist in the country to support evidence-informed health policy-making processes, and distilling key lessons learned from the experience gained in the country;
- identifying actors, projects, programmes or initiatives that are explicitly involved in KT and/or KB efforts (*see* Textboxes 2 and 3, pages 4 and 5, for details of KT and KB).

Method

Desk research that includes a review of the published and grey literature and Internet research should be performed to collect the relevant data. If necessary, key informant interviews and or/focus group discussions can be conducted to complement the findings and for triangulation.

Unlike the previous sections, some of the requested information here is analytical in nature and thus depends both on *finding* the information as well as on a *critical analysis* and reasoned opinion. This critical analysis is not an individual exercise but should be grounded in collective reflection (at least within the SA team). A transparent reporting of the "grounds" for this analysis is needed.

Data sources

Some of this section's desired information will be found in the grey literature and in the tables from the previous SA sections, but most of the information will be identified via key informant interviews or through reasoned opinion.

For the data sources in this chapter:

- Table 13a and Table 14a will likely require a combination of desk research, key informant interviews and reasoned opinion. The implementation team should complete Table 14a **for up to five major EIP actors** that support health system development in the country.
- Table 15 requires key informant interviews.
- Table 16a and Table 17 require a review of previous SA work to identify the possible issues for the future KTP to focus on.

In terms of desk research sources, suggestions include:

- websites of relevant EIP projects/initiatives from all sectors, including health;
- previous SA datasets and answers.

Tools and process

The implementation team should start by filling in Table 13a to probe the range of actors involved across sectors in policy analysis, KB and KT efforts. While completing Table 13a, you may find that there are specific actors, projects, programmes or initiatives deserving of further exploration and study. Some of these actors may overlap with the stakeholder assessment exercises conducted in the previous sections.

Following this, it is recommended to contact around five key informants to perform the interviews from Table 15, to explore specific instances where health research has – or has not – influenced the country's policy process. This is also an opportunity to fill in the gaps in the previous tables, in cases where data could not be found through desk research. Besides asking questions that concern concrete examples, a second part of the interview aims to collect more general reflections on the use of evidence and EIP in the country's policy-making process. Therefore, aim to select interviewees with sufficient

knowledge of and experience in health systems and the policy-making process. The anonymity of interviewees should be preserved.

If the SA team feels that a more open discussion could be achieved by other approaches that preserve the anonymity of those involved, such as focus group discussions or small workshops that follow the Chatham House Rule[3] of discussions, then such approaches may be used alternatively to obtain responses to the general questions that constitute part two of Table 15.

After completing Tables 13a, 14a and 15, and while also taking into account all information collected in the previous sections, the summary table (Table 17) should be completed.

Deliverables

- Tables 13a, 14a, 15, 16a and 17 comprising the findings and complete lists of references
- Flagged questions for key informant interviews
- Repository of data sources used
- A table summarizing the key findings.

In Table 13a, questions probe existing efforts that focus on policy analysis, KB and/or KT. The answers will help to identify lessons for the future KTP. The questions also aim to identify existing capacities for performing policy analysis, and KB/KT.

Note: Some of the information may have been collected in previous sections – refer to previous work where appropriate.

Implementation teams should respond to the questions and provide the specific source (e.g. document, interview, opinion) used to determine the answer. A ready-to-use form with the questions below is provided in Annex 1.

While some countries may have little or no experience in EIP, others may have some important examples from which a future KTP can learn. This could include a civil society organization with an explicit KB mandate; a graduate-level university programme focusing on policy analysis; or a ministerial department employing KT activities. Please note that the EIP actors that users are intended to identify are not stakeholders who may have a role to play in the EIP process more generally (many of which will have been identified in previous sections of this Manual), but actors, projects, programmes or initiatives that are explicitly involved in KT and/or KB efforts. Use Textbox 3 as a reference point to determine whether the actor you have identified is actually engaged in one or more EIP efforts.

A blank template of each table that can be used to complete your work in an electronic format is provided in Annex 1.

3 The Chatham House Rule originated at Chatham House with the aim of providing anonymity to speakers and to encourage openness and sharing of information. It is now used throughout the world as an aid to free discussion. (https://www.chathamhouse.org/about/chatham-house-rule#sthash.fE7Gcopt.dpuf).

TABLE 13A. EXISTING EIP EFFORTS

Questions
1. Policy analysis
1a. Are there any: ▪ government agencies, parastatals or ministry departments ▪ NGOs that specialize in policy analysis? What is their mandate/what are their activities?
1b. For the health policy-making process and implementation, are there any incentives or requirements stipulating the use of research evidence and practice?
2. Knowledge brokering and translation
2a. Are there any: ▪ government agencies, parastatals or ministry departments ▪ NGOs that specialize in or perform KB/KT activities for health policy? What is their mandate/what are their activities?
2b. Are there any policies, programmes or projects within the health system that are supported by KB/KT efforts?

TABLE 14A. EIP IN HEALTH: DETAILED DESCRIPTION OF ACTORS AND PROGRAMMES

Questions
1. Mandate
1a. What is the actor's name and mandate?
2. Activities to promote KT
2a. What are the actor's major activities and mechanisms in fostering the use of evidence in policy-making? (*See* Textboxes 2 and 3 for examples.)
3. Knowledge translation capacity
3a. What is the actor's technical capacity in KT/KB? 3b. What is the actor's resource capacity in terms of ▪ financial resources: how is the actor funded? ▪ human resources: how large is the staff and what types of competencies does the staff possess (functions, BA, MSc, PhD, and disciplines, e.g. public health, health economics, social sciences, clinical sciences)?
4. Policy engagement
4a. How is the actor involved in the health policy-making process? 4b. What type of health policy does the actor typically focus on?

5. Interactions/networks/alliances
5a. With whom does the actor mainly work and what is the nature of the actor's relations? E.g. providing information, coordinating different research disciplines and policy-making; connecting with the international (research) community on health systems; co-producing research evidence, etc. 5b. Does the actor have a strong convening power on other health system/policy/research actors?
6. Openness to collaborate with the future KTP
6a. How willing is the actor to further invest and engage in this particular field of bridging the research–policy gap for hosting and/or collaborating with the KTP? 6b. What would be the actor's technical and resource capacity to host and/or collaborate with the KTP?
7. General perception of the actor
7a. Is the actor generally perceived as ▪ being autonomous/neutral/independent; ▪ playing an important role in/supporting policy-making; ▪ a respected, credible actor, trusted by other stakeholders; ▪ benefiting from political support; ▪ a credible communicator?
8. Lessons learned
8a. What major lessons emerge from this actor with direct implications for a future KTP?

The implementation team should have around five completed tables as an output for this section. A blank template that contains each of the questions in Table 15 is provided in Annex 1 to enable users to complete this exercise. The questions may be asked in person or sent via email.

TABLE 15. KEY INFORMANT INTERVIEW: POLICY-MAKING PROCESSES

Questions
1. Example of a health system-related policy process in which evidence was used/not used:
1a. Please identify and describe a recent policy process in the health system in which research evidence was used/not used.
1b. Did you play a (formal or informal) role in the above policy-making process? If yes, what was your role?
1c. How was the problem of the policy scoped? What were the primary influencers or factors on policy-makers in formulating this policy?
1d. What do you think were the driving factors for using/ignoring evidence in this particular policy process?

1e. Who were/are the main actors in (i) drafting or (ii) implementing the policy, and what are their roles and responsibilities? Were stakeholders (e.g. civil society) and researchers consulted?
1f. What precise role did evidence play and in what stages of the policy-making process?
1g. What can you say about the availability and quality of the evidence used, and the processes for obtaining adequate evidence?
1h. Was the research evidence packaged in a particular way for the policy audience?
1i. If evidence was used, do you consider that the use of research evidence facilitated the policy-making process?
1j. What are the key lessons learned? In what ways could the policy process in terms of stakeholder involvement and evidence use be improved? What are the parts of the policy process a KTP should be attentive to?
1k. Anything else related to this policy process that has a high relevance for a future KTP?
2. General reflections of interviewees on EIP
2a. In your opinion, what are the current overall challenges to and facilitating factors for promoting the use of research evidence in health system policy-making?
3. Scoping the problem and setting the agenda: general reflections
3a. In general, is research evidence used to identify problems within the health system? Is it used to highlight the magnitude of an existing problem?
3b. What are the main challenges to and facilitating factors for the use of research evidence and how are these balanced with other processes to "scope" and prioritize a health issue?
Policy formulation: general reflections
3c. When a policy is under formulation, is research evidence typically used to identify different viable policy options? If so, do these options include explicit implementation, financial and governance considerations?
3d. In what ways is research evidence used in determining the *preferred* policy option during the formulation process?
4. Policy implementation: general reflections
4a. Do policies specify the generation of implementation research to monitor, evaluate and improve implementation of the policy? If so, is this research prospective or retrospective? How is the generated knowledge and evidence used in (future) policy processes?
5. Policy evaluation: general reflections
5a. What evaluation procedures are typically in place to determine a policy's effectiveness? Is the evidence for evaluation objective, thorough and/or relevant? Is it synthesized, packaged and communicated back to the policy process and/or to the general public?

Based on the findings from Table 15 and from overall reflections, the implementation team should now complete Table 16a in order to make the link between the information collected in this section and the process of establishing a KTP or supporting EIP more generally in their country.

TABLE 16A. OVERVIEW OF THE LINKS BETWEEN FACTORS IDENTIFIED IN THE SITUATION ANALYSIS AND THE FUTURE FOR EIP

Questions	
Context and climate for EIP (e.g. what types of evidence and resources exist, and what types of efforts are already pursued)	Who produces scientific research evidence on public health, health systems and/or health services topics?
	Is there a database housing local research evidence?
	Is there access to reliable/updated national statistics?
	Who can/will synthesize existing knowledge and evidence?
	Does any group/institution actively synthesize the best available local evidence with the best available global evidence (e.g. systematic reviews)?
	Does any group/institution actively summarize the findings from the best available evidence to make them easier to use by health system policy-makers and stakeholders?
	Does any group/institution convene policy-makers and stakeholders in deliberative processes, so that the evidence can be considered alongside their full range of views, experiences and tacit knowledge?
Actors with influence over EIP (e.g. who are the key champions and can support EIP)	Who are the major decision-makers in the health system to take into account when launching or enhancing KTP and EIP?
	Which are the major civil society organizations in the health system, and should or can they be involved?
	Who has access to and influence over health system stakeholders (researchers, policy-makers, civil society) in order to facilitate collaborations and partnerships?
	Who brokers the needs of decision-makers with the priorities of those generating and synthesizing research evidence?
	What actors or institutions need to be involved in order to mobilize necessary KTP resources (e.g. human, financial)?
	Who can/will communicate and advocate for the KTP?
	Which are the major research institutes focused on disciplines relevant to health systems strengthening that can contribute to the establishment of a KTP and EIP efforts in the country?

Summary of EIP findings

Reread your findings in Tables 13a, 14a, 15 and 16a on the features of the country's EIP efforts. Complete Table 17 and summarize the key findings that you consider have a strong influence on the design, establishment and operations of the future KTP. Briefly explain how each finding potentially relates to KTP establishment. While completing the table, please think of future KT/KB activities that the KTP should address to fill existing gaps and partnership considerations. These summary tables will be presented in the core of the (draft and final) report (Chapter 5).

TABLE 17. SUMMARY TABLE OF EIP PROCESSES

Characteristic	Summary findings	Link to KTP
Most important policy analysis actors and activities		
Most important KB actors and activities		
Most important KT actors and activities		
Examples of research use in policy		
Most important stakeholder relationships and dynamics		
Preliminary concrete activities that a KTP could do	*(Reflecting on all of the above)*	

4 SUMMARIZING THE FINDINGS IN AN OVERALL SWOT AND FOCUSING ON MAJOR EIP ISSUES

This chapter describes the process of using a strengths, opportunities, weaknesses and threats (SWOT) framework. While the sections in Chapter 3 mostly stressed on conducting a descriptive analysis related to each of the five core content focus areas, users will be tasked with using these descriptions to conduct an interpretive analysis to determine the most important factors to consider when establishing a KTP in their country.

Objective

Using the results of the descriptive analyses conducted in the previous chapter as a key input, the SWOT analysis framework aims to provide users with the foundation for making recommendations for different target audiences (e.g. researchers, policy-makers and other key decision-makers). This will be in the form of a final report that outlines specific issues related to establishing a KTP, which require further deliberation or resolution (discussed in Chapter 5).

Background

A SWOT analysis assists in the critical appraisal of all findings by providing a clear and succinct view of the current situation (through the "strengths" and "weaknesses" components), in this case with regard to EIP and a KTP, and supports looking forward (through the "opportunities" and "threats" components). The analysis is organized in a two-by-two matrix designed to analyse the existing resources, opportunities, capacities, etc. in the health system and health research system that might be used to promote EIP generally, and the establishment of a KTP more specifically.

This chapter will provide guidance on how to determine the most salient strengths, weaknesses, opportunities and threats related to establishing a KTP by drawing on the results of the descriptive analyses conducted in the previous chapters. In particular, it will prompt users to undertake an interpretive analysis of their descriptive data in order to determine:

- the features of the country's general political, economic and sociocultural contexts that have a high relevance for the future KTP;
- elements of the country's health system that will likely influence the future KTP, including a consideration of core stakeholders, their dynamics, and their potential influence on the future KTP;
- aspects of the country's HIS and NHRS that will likely influence the future KTP, including an analysis of stakeholders, their relationships, and how they might collectively influence the future KTP; and
- elements of existing EIP efforts or partnerships to which the future KTP could be leveraged and add value.

Method

Data collected through the descriptive analysis stages in the previous chapters need to be compiled, interpreted according to the SWOT matrix, and presented in a visual format.

Tools and process

The implementation team should start by considering the guiding questions in Table 18. Based on the reflections from these questions, the SWOT diagram should be filled out. Considering that this phase is a critical appraisal (and interpretive analysis) of all findings, this activity is best performed as group work, either within the SA team or among a slightly broader group of stakeholders. This should be completed only after all of those engaged have thoroughly familiarized themselves with the results from the descriptive analyses conducted in Chapter 3.

Finally, Table 19 should be used to identify a priority list of policy issues and outline how establishing a KTP could help to improve the prospects for EIP on these issues, thereby adding value. This exercise also offers the best results if the entire SA team or a larger pool of stakeholders is involved.

Data sources

- Summary tables from the five sections in Chapter 3.
- A model organogram of the country's political system (from Chapter 3.2).

Deliverables

- A SWOT table summarizing the current situation, and future barriers and facilitators that will affect the establishment of a KTP in the country.

The implementation team may find it useful to first think through the questions in Table 18 to determine the relevant elements, examples, actors and dynamics to slot into the SWOT.

Note: this is not an exhaustive list, and it is only meant to kick-start reflection.

TABLE 18. GUIDING QUESTIONS FOR THE SWOT ANALYSIS

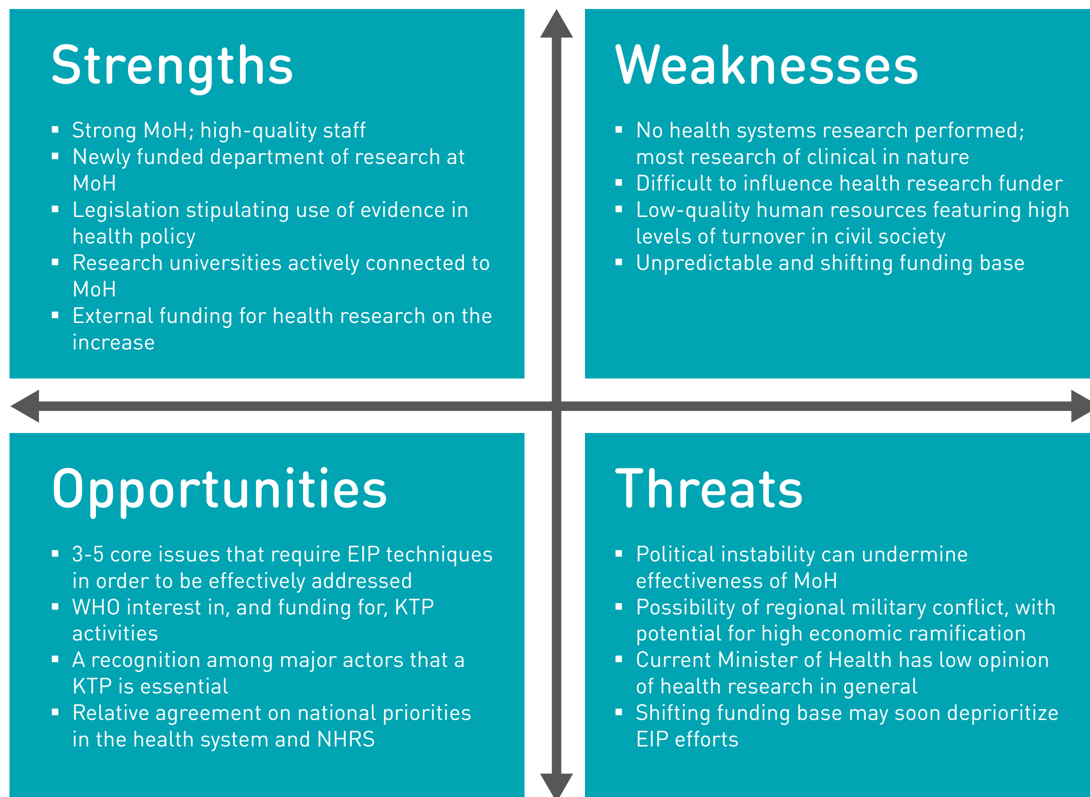
Questions
Related to section 3.1: national context
What are the general contextual factors that might hamper or facilitate EIP processes, with particular consequences for the establishment of a KTP?
Are there any characteristics related to the political system, its structures and processes that facilitate or inhibit research utilization?
How do national stakeholders (professional associations, civil society organizations, NGOs, etc.) and international actors influence policy-making and research utilization? How participatory is the process?
Do the currently prevailing societal values promote EIP?
How do external factors (social, economic, media, military) impact on policy-making and EIP?
Related to sections 3.2, 3.3 and 3.4 on the national health system, the national health information system and the national health research system

How does the governance structure and processes (including accountability and oversight) as well as legislative arrangements of the health system, the HIS and the NHRS influence EIP? Are there opportunities and the interest to increase accountability and transparency, which would strengthen the need for EIP and the KTP?
Do the strategic policy directions of the health system, HIS and NHRS act as barriers or facilitators to EIP and the future KTP?
Which health policies and programmes offer the KTP the greatest opportunity for collaboration in its launch and consolidation stages?
Are there “easy wins” and windows of opportunity for specific health policy topics to be urgently addressed in the country?
How well is the HIS aligned with health system priorities? Is there a need and, if so, are there opportunities for improvement?
How well is the NHRS aligned with health system priorities? Is there a need and, if so, are there opportunities for improvement?
What are the interests, behaviours, intentions and influences of different stakeholders in relation to EIP? How will the establishment and operationalization of the future KTP be perceived by the actors of the health system, HIS and NHRS?
What role do the partnerships and coalitions play within the health system, HIS and NHRS in terms of EIP? For example, what formal and informal mechanisms and relationships exist to connect health system decision-makers and health system researchers and information managers? Are there any barriers to involving the civil society in the KTP and its KB activities in general?
How supportive are funding sources of the NHRS of EIP/a future KTP?
What role does the organizational infrastructure (including human resources) of the HIS play in promoting or hampering EIP/a future KTP?
What role does the organizational NHRS infrastructure (including human resources and dominant fields of health research) play in promoting or hampering EIP/a future KTP?
How does the scientific research output (quality, relevance, etc.) determine EIP and the future operations of the KTP?
Related to section 3.5 on evidence-informed policy-making
What types of EIP activities exist in the country? Have they been successful? What are some of the remaining challenges that need to be addressed by the future KTP to establish a climate that is more conducive to EIP efforts?
What types of policy-influencing skills, capacities, infrastructure and resources exist in the country? Are any missing?
Who are the principal actors in fostering the use of research evidence in health policy-making?
What are the possible strategic entry points at the national/health system/HIS/NHRS level to strengthen EIP efforts?

SWOT figure

Considering your answers in Table 18, complete the SWOT diagram. An example is provided below (*see* Fig. 11).

FIG. 11. ILLUSTRATIVE EXAMPLE OF A SWOT ANALYSIS



4.1 MAJOR EIP ISSUES

This section turns to EIP issues that a future KTP could focus on. Having concrete examples of how the establishment of a KTP could improve the policy-making process by supporting EIP for the actual priority policy issues facing policy-makers in the country now is an essential step towards making the case for establishing a KTP – particularly among those in the country with influence over this process. Reviewing the answers in the previous sections, please provide here examples of 10 priority policy issues or problems for which the existence of a KTP might add immediate value in the country. Provide some information on what type of value a future KTP can add to these issues.

Illustrative examples of issues or topics are listed below.

- Reforms of health service provision for people with chronic care needs, grounded in values of deinstitutionalization, recovery and social participation is supported by adequate evidence and lessons learned on implementation of health systems reforms.
- The country is currently re-examining its tobacco taxation policies. Packaging evidence for the country's multisectoral Tobacco Control Working Group in terms of what works globally and what is working regionally would be extremely valuable and timely.
- Through a large grant from the Gates Foundation, the country is currently evaluating its tuberculosis treatment guidelines and care. The project has no formal linkages with policy-makers, yet its work will likely have little impact without those linkages. The KTP could in this instance help to broker a relationship between the project and the MoH's TB and Policy and Planning departments. Additionally, the KTP could play a role in synthesizing effective/proven TB treatment guidelines from other countries, contextualize them for this country, and help disseminate them to the most affected rural areas.

Implementation team members should complete Table 19 below. The left-hand column should be used to list the specific priority policy issue (e.g. tobacco taxation) and the right-hand column should be used to explain what the future KTP's response could be (e.g. evidence brief and dialogue on completing tobacco taxation schemes and considerations).[4]

4 Please note that the exercise is intended as a broad and quick overview of major EIP issues. A more complex exercise with a similar purpose is expected to be undertaken at a later stage in the planning process of the KTP, in accordance with the guidance document EVIPNet Europe: developing viable scenarios for knowledge translation platforms. Copenhagen: WHO Regional Office for Europe (in press) (*2*).

TABLE 19. MAJOR EIP ISSUES

Issue	Potential KTP response
1.	
2.	
3.	
4.	
5.	
6.	
7.	
8.	
9.	
10.	

5 WRITING THE SITUATION ANALYSIS REPORT

Background

This chapter provides a template for writing the final SA report.

It also explains how a draft version of the report will be discussed in a stakeholder consultation aimed at validating the findings. Additional information provided at the stakeholders' consultation will be used to finalize the report.

The SA report is the written presentation of the key findings of all the exercises conducted by the implementation team in the previous chapters. It also comprises the SWOT figure and a set of recommendations relevant to the establishment and operationalization of future KTPs.

Method

The report is presented as a "case report" of the country, with a specific emphasis on the challenges and opportunities that exist for establishing a KTP. Thereafter, the implementation team will convene a stakeholder consultation to discuss and critique the report. Feedback from the stakeholder consultation will be incorporated into the report, which will precede a last round of editing and dissemination of the final version of the report.

Structure of the report

The SA report should describe and analyse the components that were discussed in this Manual:

- key country characteristics that have a strong relevance to the future KTP – from politics to economics to sociocultural elements to the health system;
- health policy domains where the demands and needs for evidence are high, counterbalanced with an assessment of how local research and EIP capacity can potentially support decision-maker needs;
- available HIS resources, indicators, data sources, data management, data quality and dissemination;
- existing mechanisms and relationships that connect health system decision-makers and health researchers;
- the interests, behaviours, intentions and influence of different actors in relation to present and future EIP actions; and
- potential priority themes for the future KTP to address.

The report should conclude with some action-oriented recommendations for taking the KTP development work further, grounded in the findings of each chapter. These recommendations will be key to the development of concrete scenarios that will underpin the establishment of a future KTP.

Editorial template of the report

The report should adhere to the following stylistic guidelines:

- a total length of between 20 and 30 pages;
- 12-point font;
- A4 pages with margins of 1" (top, bottom, left, right);

- inclusion of page numbers;
- inclusion of a header indicating the title;
- line spacing of 12 points.

The report will be divided into the following twelve sections:

1. **Title page**, giving the title of the exercise, the author(s), the date, and all relevant logos, including that of WHO Europe;
2. **Table of Contents** with a suggested length of **one page**;
3. **Acknowledgements** that clearly state who participated in developing the different stages of the report, and offering thanks to specific reviewers and other sources of technical assistance (no more than **one page**);
4. **Executive summary** that outlines the general intention of the SA along with some of its specific findings and recommendations. This may also be used as a stand-alone document. It should include a background (rationale for the SA), a brief description of methods (when, where, how the SA was undertaken), a summary of results, and a list of formal recommendations for taking the work further (no more than **two pages**);
5. **I. Introduction** – describing the reason for the SA, its purpose, background and methods (no more than **2 pages**);
6. **II. General country context** – describing general observations about the country (related to politics, economics, sociocultural aspects, the media, civil liberties) that have strong and specific implications for the future KTP (no more than **3 pages**);
7. **III. The health system** – describing the health system in general, including major health system actors and points of high relevance for the future KTP (no more than **4 pages**);
8. **IV. The national health information system** – describing the HIS, including dissemination of information and governance, and points of importance for the future KTP (no more than **4 pages**);
9. **V. The national health research system** – describing the NHRS, including major NHRS actors and points of importance for the future KTP (no more than **4 pages**);
10. **VI. Evidence-informed policy processes** – providing general observations of the country's EIP processes, major actors, and top EIP issues for the future KTP (no more than **5 pages**);
11. **VII. Conclusions, recommendations and next steps** – an analysis of the direction in which and how the KTP planning process should proceed, including specific recommendations for different target audiences (e.g. researchers, policy-makers, KTP designers) and specific issues that require further deliberation or resolution (no more than **4 pages**);
12. **References** – the paper should use the Vancouver style and a numerical system for referencing throughout. There is no prescription for the length of this section, but all facts and opinions should be fully referenced.

It is recommended that sections II through VI are complemented by summary text boxes capturing the key messages of each section. In section VII, a textbox outlining the major opportunities provided by the establishment of a KTP and major challenges to a KTP may add clarity to the discussion.

The summary tables of sections 3.1 through 3.5 and the SWOT analysis of Chapter 4 should be added as annexes to the report.

Next steps

The results of the SA will be presented, discussed and validated during a stakeholder consultation. The additional deliberations and recommendations of the stakeholders will feed into a final SA report, based on which the SA team will prepare two to three scenarios about the future establishment of a KTP, including a critical appraisal of each (*see* EVIPNet Europe: developing viable scenarios for knowledge translation platforms) *(2)*. These scenarios will be presented and used with local decision-makers and local actors willing to engage in further development of the EIP agenda.

ANNEX 1. TABLES TO BE FILLED IN BY THE USER

TABLE 3B. QUESTIONS ON THE POLITICAL STRUCTURE OF THE COUNTRY[5]

Questions	Answers	Sources
Institutions: formal and informal rules, norms, precedents, and organizational factors that structure political behaviour		
1. What are the characteristics of current government structures? 1a. Is it unitary (one legislature within which policy development takes place to govern the entire country) or (con)federal state (with a number of provincial/regional/state legislatures)? 1b. What is the frequency of turnover of government(s) and what are the reasons (voluntary or involuntary)? 1c. What type of political structure prevails in the country (single party/coalition political parties; minority/majority)? 1d. To what extent is decision-making authority concentrated or supported by advisory boards and adjacent organizations (e.g. involvement of parliamentary task forces, external agencies, civil society or expert advisory groups, etc.)? 1e. What obligations or incentives are in place in decision-making bodies to prompt the use of research evidence (e.g. requests for systematic analyses of problems and grounding of recommendations in research and evidence, etc.)? 1f. What is the proportion of the national budget spent on generating research evidence across all sectors? If no data can be obtained on budget, explain the use of research evidence in policy-making overall. 1g. Are government staff members (administrative or technical staff) in general academically trained? If not, what is their typical training background? 1h. Is there any capacity for policy analysis (understanding the determinants of policy processes, and competencies to design, implement and evaluate policy interventions)?		
2. What are the characteristics of the civil service? 2a. Is the civil service an important employer in the country? In absolute and relative terms? Are there high or low rates of turnover and internal role transitions of the civil service (i.e. civil servants do not stay in their roles for long periods of time)? 2b. What is the level of (academic) skills and professional backgrounds of civil service staff members? 2c. Is the State's role complemented by private organizations (for profit or non-profit) for delivering public services?		

5 Based on references (*15,21,22*). *See* end of Table 3b for details.

3. What are the characteristics of the policy-making stakeholders (i.e. professional associations, civil society organizations, NGOs and the public)? 3a. How are stakeholders organized and supported in order to contribute to the policy-making process? What type of stakeholders is better supported and organized compared to others? 3b. What is the influence of third-party payers (e.g. insurers, public and/or private) in the policy-making process? 3c. Are structures in place to coordinate stakeholders' activities (e.g. coalitions, networks)? 3d. Do stakeholders engage in and what is their capacity for policy analysis (understanding the determinants of policy processes and competencies to design, implement and evaluate policy interventions)?		
Interests: interests of stakeholders that could influence the policy process and the power relationships between stakeholders		
4. What types of influence do key stakeholders have over policy-making? Please provide specific examples. 4a. What is the extent to which civil freedoms exist? How can important and interested stakeholders (e.g. professional associations, civil society organizations, NGOs, the public, donors/international organizations/ supranational structures) engage in the policy process? Are there formal and significant roles for interested stakeholders outside of government?		
Ideas: societal values that characterize the policy arena and actors		
5. What are the general prevailing values with regard to the use of research evidence? 5a. Does the public value the role of research evidence as an input to policy-making? 5b. Do ministries or governments directly support the generation and/or synthesis of research evidence as part of the overall governance culture? 5c. Is civil society participation valued within the country?		

External factors: country-specific factors affecting policy-making		
6. How do external factors (e.g. social, economic, military, media characteristics) influence policy-making in the country? 6a. Is there an impact of linguistic and cultural groups in the country on policy-making? 6b. How important is the role of the media and what freedom does the media have to report on political processes? 6c. How is the socioeconomic condition of the country (e.g. GDP growth rate/capita, employment rate, poverty rate, public debt, health spending and its distribution (public/private) and how does it affect policy-making processes? 6d. Has the country been subject to economic/political/military crisis that has had an impact on political developments and policy-making processes in the country?		

Sources

- Lavis JN, Rottingen JA, Bosch-Capblanch X, Atun R, El-Jardali F, Gilson L, et al. Guidance for evidence-informed policies about health systems: linking guidance development to policy development. PLoS Medicine. 2012;9(3):e1001186 *(14)*.
- Lavis JN, Permanand G, Catallo C; BRIDGE Study Team. How can knowledge brokering be better supported across European health systems? Copenhagen: European Observatory on Health Systems and Policies; 2013 *(22)*.
- Moat KA, Lavis JN, Abelson J. How contexts and issues influence the use of policy-relevant research syntheses: a critical interpretive synthesis. Milbank Q. 2013;91(3):604–48 *(23)*.

TABLE 5B. HEALTH SYSTEM REVIEW

Questions	Answers	Sources
1. Health system – general		
1a. *Health system governance*. What are the major governance and organizational structures of the health system? Specify especially the characteristics and extent of centralization and decentralization of the health system and its governance.		
1b. *Health system stakeholders*. Who are the major stakeholders involved in the development of the health system and how do they engage in (or resist) the uptake of research evidence in health system policy-making?		
1c. *Non-State actor involvement*. What is the role of the State compared to the role of non-State actors in delivering health care? Does this role differentiation affect the use of research evidence in policy-making or implementation processes?		

1d. *Major health system challenges in provision of care*. What are the major issues currently faced in adequate provision of care for the population?		
1e. *Demography*. Are there any demographic factors that are particularly important to consider?		
1f. Which types of diseases (acute vs chronic) are most prevalent in the country and how are they distributed among particular populations?		
1g. Are there any minority groups for which health is a particular challenge?		
2. Health system reforms		
2a. What past or ongoing health system reforms mark the organization of the health system? How was research evidence used in these reforms?		
2b. Who are the major actors leading the implementation of the reforms and what is their attitude towards the use of research evidence?		
2c. Does the health system promote innovation, change and reforms that make the system adapt to changing needs? If so, who are the key actors promoting or hampering this process. Is there a strategy that enhances the use of research evidence?		
2d. How transparent are these reforms? What accountability mechanisms are in place to monitor the reforms?		
3. Service delivery		
3a. *Comprehensiveness*. Does the health system cover the range of population health needs? What is the quality of the provided services? What are the major quality challenges that have to be tackled? Does the country use scientifically grounded (clinical) guidelines to improve the quality of health services?		
3b. *Accessibility* (entry points). In general, does the population have adequate access to medically necessary services? Are there adequate facilities and equipment with which to deliver health services in the country and are these accessible to all?		
3c. *Accessibility barriers*. What are the known barriers that prohibit access to the health services? Are these barriers specific for particular groups?		
3d. *Human resources*. Is the supply and distribution of health-care professionals in the country sufficient to meet the needs of the population? Are there any problems with regard to qualifications and competencies of the health workforce?		
4. Health financing		
4a. *Revenue collection (financing mechanisms)*. What are the mechanisms that generate national health-care revenues? What agents are responsible for collecting the revenues?		

4b. *Revenue collection (health insurance)*. What is the prominent health insurance scheme? What is the proportion of uninsured or underinsured people of all ages in the country? What percentage of employers offer health insurance to employees? What is the scope of the services covered in the insurance plan? Are there gaps in the coverage?		
4c. *Setting health-care prices.* Who is responsible for setting the health-care prices and packages?		
4d. *Purchase and funding of health services.* What are the prominent payment methods for the individual health professionals and organizations that provide care? Do the financial incentives enhance or hamper the uptake of evidence?		
5. Governance and leadership		
5a. *Legislative framework(s).* What are the major legislative arrangements that govern how individuals and organizations function within the health system?		
5b. *Strategic policy direction (strategic framework).* Does a recent strategic national vision to achieve better health system outcomes exist? What are its main directions? Is there a role specified for health research and/or EIP processes?		
5c. *Accountability and oversight: policy authority.* Is the decision-making authority for the health system centralized or decentralized? How does this centralization or decentralization affect (a) coordination and communication, and (b) uptake of research evidence in health system decision-making? Are there means of holding all health system actors (public and private, providers, payers, producers of other resources, stewards) accountable for their actions? What corruption protection mechanisms are in place?		
5d. *Accountability and oversight: professional authority.* What educational or training requirements are in place for each of the health professions? Who is responsible for the oversight of each of the health professions?		
5e. *Accountability and oversight: monitoring and evaluation.* To what extent are research-based evaluations of health system components being done, by whom, and are they influencing policy or practice? Are there mechanisms in place to prompt periodic transparent reviews of the health system and the range of governance, financial and service delivery arrangements to ensure they are aligned with strategic health sector goals?		
5f. *Coalition-building and participation (whole-of-society approach).* Is health considered a cross-sectoral topic? Do any line ministries have a direct role or influence in health policy-making processes? If so, does this affect the uptake of evidence? What is the involvement/participation of patients and the general public in the decision-making process? Does this affect the use of research evidence in policy-making?		

TABLE 8B. HEALTH INFORMATION SYSTEM REVIEW

Questions	Answers	Sources
1. Resources (policy and planning; HIS institutions, human resources, and financing; HIS infrastructure)		
1a. Is there an up-to-date legislation providing the legal framework for all relevant components of the national HIS, such as vital registration, notifiable diseases and private sector data, including social insurance, confidentiality and fundamental principles of official statistics? Ideally, this legal framework also covers an evidence-informed policy cycle.		
1b. Is there a comprehensive, written HIS and/or eHealth strategic plan in active use and it is implemented at the national level? What are its key components? Does it include intersectoral approaches, such as, among others, ministries for health, information and technology?		
1c. Has the Ministry of Health (MoH) established a multisectoral HIS coordination mechanism to other main HIS stakeholders in the country (e.g. a task force on health statistics)? Does this coordination mechanism have a clear role and mandate?		
1d. Is there a routine system in place for monitoring the performance of the HIS, its various subsystems and eHealth?		
1e. Do the institutions with official roles in the HIS (e.g. the MoH, national statistical office, national public health institute, subnational health authorities) have adequate and sustainable capacity in core health information sciences (epidemiology, demography, statistics, information and communication technology [ICT], knowledge integration [including forecasting], health reporting and KT)?		
1f. Do the institutions with official roles in the HIS (e.g. the MoH, national statistical office, national public health institute, subnational health authorities) have adequate and sustainable resources for their health information activities?		
1g. Is adequate ICT infrastructure (e.g. computers, data management software, internet access) and adequate ICT support in place at the national level, at relevant subnational levels and at hospital/provider level?		
2. Indicators		
2a. Have national minimum core indicators been identified for national and subnational levels covering all categories of health indicators (e.g. determinants of health, health system inputs, outputs and outcomes [health systems performance assessment], health status, health inequalities)?		
2b. Is there regular reporting on the set(s) of core indicators and are they regularly evaluated for usefulness and completeness, together with policy-makers and other end users?		

2c. Is there adequate alignment between the core indicators used at national and at subnational levels, and between the core indicators used by the different subnational health authorities?		
3. Data sources		
3a. What are the main data sources in your country, including the census, civil registration and vital statistics (CRVS), population-based surveys, health and disease records, health service records, resource records?		
3b. For each of these data sources, does the country have adequate capacity: (i) to implement data collection; (ii) to process the data; (iii) analyse the data; and (iv) disseminate the analyses and (micro)data?		
3c. In addition for CRVS, is there (i) high coverage of deaths registered through CRVS, (ii) high coverage and quality of cause of death information recorded on the death registration form.?		
3d. In addition to population-based surveys, do the health and statistical constituencies in the country work together closely on survey design, implementation, and data analysis and use?		
3e. In addition to health and disease records (including disease surveillance systems), is there adequate capacity: (i) to diagnose and record cases of notifiable infectious diseases; (ii) to report and transmit timely and complete data on these diseases; and (iii) to analyse and act upon the data for outbreak response and planning of public health interventions?		
3f. In addition to health and disease records (including disease surveillance systems), is/are there (i) a high level of implementation of the International Statistical Classification of Diseases and Related Health Problems, 10th Revision (ICD-10) for reporting hospital discharge diagnoses; (ii) adequate and sustainable resources available for operating the national cancer registry and other registries according to international standards?		
3g. In addition to health service records, is there (i) a comprehensive electronic health service-based information system that brings together data on discharge diagnoses, procedures, and other treatments and services provided and their costs from all public and private facilities? (ii) Is support provided to the electronic health service-based information system by a cadre of trained health information staff, both at the central level and at the level of facilities, and regular training to keep the staff's knowledge up to date and to guarantee that a sufficiently large pool of trained staff is provided? (iii) Is there a mechanism in place for verifying the completeness and consistency of data from facilities and for feeding this information back to the facilities?		

3h. In addition to resource records, is there (i) a national database of public- and private-sector health facilities with complete coverage, (ii) a national human resources database that tracks the number of health professionals by major professional category working in either the public or the private sector with complete coverage, (iii) a national database that tracks the annual numbers graduating from all health-training institutions with complete coverage, (iv) availability of financial records on general government expenditure on health and its components (e.g. by the MoH, other ministries, social security, regional and local governments, and extrabudgetary entities), and on private expenditure on health and its components (e.g. household out-of-pocket expenditure, private health insurance, nongovernmental organizations, firms and corporations)?		
3i. Are there adequate human resources and equipment for maintaining and updating the various resource databases, and for producing and disseminating outputs based on these databases?		
3j. Are the routine data collections adequate in periodicity and timeliness, and do they meet the demands of the end users (e.g. health facility managers, health insurance companies)? Are the data collections regularly assessed for completeness and quality?		
3k. Are data from the electronic health service-based information system readily available for public health monitoring (that is, policy support) and research purposes, and are they actually being used for such secondary purposes?		
4. Data management		
4a. Is there a written set of procedures for data management, including data collection, storage, cleaning, quality control, metadata requirements, analysis and presentation for target audiences that are implemented throughout the country? Briefly describe.		
4b. Is the HIS unit at the national level running an integrated "data warehouse", containing data from all data sources (at national and subnational levels) and/or are there linkages between relevant health-related databases (both population-based and facility-based sources, including all key health programmes)? Does it have a user-friendly reporting utility accessible to various user audiences? Is an integrated data analysis being performed? Briefly describe.		
5. National HIS data quality/information products		
5a. Do policy-makers at the national as well as at the relevant subnational levels have access to all the information they need to support their policy decisions, i.e. there are no major information gaps? In particular, are all data and information necessary for monitoring the targets of the national health strategy available?		

5b. Is the data collection method for core indicators in line with national and international standards and recommendations? Can the country meet all data delivery requirements from the international organizations of which it is a member and with which it is collaborating? Are there recent publications that tackle the question of data quality in health?		
5c. Are the timeliness and periodicity with which the data for official indicators are collected, computed and reported adequate and meet the needs of policy-makers?		
5d. Is there high consistency over time of datasets from major data sources used for computing official indicators? Is the coverage of these data sources high?		
5e. Can official indicators be disaggregated by demographic characteristics (e.g. sex, age), socioeconomic status (such as income, occupation, education) and locality (e.g. urban/rural, major geographical or administrative region), and do in-country adjustments use transparent, well established methods?		
6. Dissemination and use		
6a. Do senior managers and policy-makers demand complete, timely, accurate, relevant and validated HIS information, and know how to interpret and use it?		
6b. Are the integrated health reports, including information on the core indicators and their disaggregation, publicly distributed regularly to all relevant parties?		
6c. Are integrated health information reports on the core indicators and their disaggregation demonstrably used in national and subnational policy-making processes ▪ in the planning, agenda-setting or problem definition processes, e.g. for annual integrated development plans, medium-term expenditure frameworks, long-term strategic plans and annual health sector reviews? ▪ to set resource allocation in the annual budget for health at national or subnational level? ▪ to advocate equity and allocation of increased resources to disadvantaged groups and communities (e.g. by documenting their disease burden and poor access to services)? ▪ by care providers at any level (national, regional/provincial, district, hospital and health centre) for health service delivery management, continuous monitoring and periodic evaluation?		
6d. Are there adequate mechanisms for KT (e.g. resources, tools, networks and platforms to structurally support the uptake of health information in evidence-informed policy-making) in place and functioning well?		
6e. Is information on health risk factors systematically used to advocate adoption of lower-risk behaviours by the general public or targeted vulnerable groups?		

TABLE 11B. DIMENSIONS OF THE NHRS

Questions	Answers	Sources
1. Stewardship of health research		
1a. Strategic policy directions (strategic framework). Is there an explicitly stated vision, mission and set of goals for the NHRS? How and to what extent does health research in the country address issues regarding health system policy needs?		
1b. Research priority-setting. Is there a list of explicit national health system research priorities? How are they identified?		
1c. Oversight. Does any agency (ministry, institution or organization) manage or govern the NHRS? Are there national laws, regulations, policies or guidelines on ethical conduct of research on human subjects and other related areas in the country? Do they adhere to international guidelines?		
1d. Partnerships and coalitions Are efforts at health research networking and partnerships (nationally and internationally) promoted? What types of health research partnerships or networks exist in the country and internationally? Are there genuine opportunities to present and openly discuss research data in local, national and international communities?		
2. Funding sources for health research		
2a. Funding sources. Who are the key national funders and funding agencies of health research (public and private)? What are the current levels of health systems research funding versus funding of other health research areas?		
3. Organizational infrastructure and characteristics of health research		
3a. Organizational structures. What is the total number and health research staffing levels of organizations, departments or research groups actively involved in generating health research evidence? Are they in the public, private or NGO sectors?		
3b. Research infrastructure. Do researchers typically have adequate access to information and research evidence through physical and electronic resources? Are there reliable health information systems in the country? What are the reported gaps and problems? What is the availability of and access to information technology for health researchers?		
3c. Human resources. What types of training and education programmes relevant for health systems research are currently offered in the country and what are the areas covered? Is there a viable career structure and funding to attract and retain the most talented individuals?		

3d. *Research competencies.* What are the domains of expertise prominently represented in the country (e.g. clinical research, health systems and policy research, health services research)? What research traditions exist in the country (e.g. quantitative research, qualitative research, mixed methods)? Are there any historic factors influencing the type of research competencies in the country? To what extent is research on health system priorities and EIP valued and regarded as important within the research community? Is it acted upon and, if so, how often?		
4. Producing and using research		
4a. *Scientific outputs.* Are the country's research findings typically published in peer-reviewed journals? Are these journals well regarded domestically/ internationally?		
4b. *Research utilization.* Who are the typical target audiences for research findings and other research outputs? Are there specific activities or mechanisms that translate and communicate research to inform health policy, strategies, practices and public opinion?		

TABLE 13B. EXISTING EIP EFFORTS

Questions	Answers	Sources
1. Policy analysis		
1a. Are there any: ▪ government agencies, parastatals or ministry departments ▪ nongovernment organizations that specialize in policy analysis? What is their mandate/what are their activities?		
1b. For the health policy-making process and implementation, are there any incentives or requirements stipulating the use of research evidence and practice?		
2. Knowledge brokering and translation		
2a. Are there any: ▪ government agencies, parastatals or ministry departments ▪ nongovernment organizations that specialize in or perform KB/KT activities for health policy? What is their mandate/what are their activities?		
2b. Are there any policies, programmes or projects within the health system that are supported by KB/KT efforts?		

TABLE 14B. EIP IN HEALTH: DETAILED DESCRIPTION OF ACTORS AND PROGRAMMES

Questions	Answers	Sources
1. Mandate		
1a. What is the actor's name and mandate?		
2. Activities to promote KT		
2a. What are the actor's major activities and mechanisms in fostering the use of evidence in policy-making? (*See* Textboxes 2 and 3 for examples.)		
3. Knowledge translation capacity		
3a. What is the actor's technical capacity in KT/KB? 3b. What is the actor's resource capacity in terms of ▪ financial resources: how is the actor funded? ▪ human resources: how large is the staff and what types of competencies does the staff possess (functions, BA, MSc, PhD and disciplines, e.g. public health, health economics, social sciences, clinical sciences)?		
4. Policy engagement		
4a. How is the actor involved in the health policy-making process? What type of health policy does the actor typically focus on?		
5. Interactions/networks/alliances		
5a. With whom does the actor mainly work and what is the nature of the actor's relations? E.g. providing information, coordinating different research disciplines and policy-making; connecting with the international (research) community on health systems; co-producing research evidence, etc. 5b. Does the actor have a strong convening power on other health system/ policy/research actors?		
6. Openness to collaborate with the future KTP		
6a. How willing is the actor to further invest and engage in this particular field of bridging the research–policy gap for hosting and/or collaborating with the KTP? 6b. What would be the actor's technical and resource capacity to host and/or collaborate with the KTP?		

7. General perception of the actor		
7a. Is the actor generally perceived as ▪ being autonomous/neutral/independent ▪ playing an important role in/supporting policy-making ▪ a respected, credible actor, trusted by other stakeholders ▪ benefiting from political support ▪ a credible communicator?		
8. Lessons learned		
8a. What major lessons emerge from this actor with direct implications for a future KTP?		

TABLE 16B. OVERVIEW OF THE LINKS BETWEEN FACTORS IDENTIFIED IN THE SA AND THE FUTURE FOR EIP

Questions		Answers	Sources
Context and climate for EIP (e.g. what types of evidence and resources exist, and what types of efforts are already pursued)	Who produces scientific research evidence on public health, health systems and/or health services topics?		
	Is there a database housing local research evidence?		
	Is there access to reliable/updated national statistics?		
	Who can/will synthesize existing knowledge and evidence?		
	Does any group/institution actively synthesize the best available local evidence with the best available global evidence (e.g. systematic reviews)?		
	Does any group/institution actively summarize the findings from the best available evidence to make them easier to use by health system policy-makers and stakeholders?		
	Does any group/institution convene policy-makers and stakeholders in deliberative processes, so that the evidence can be considered alongside their full range of views, experiences and tacit knowledge?		

Actors with influence over EIP (e.g. who are the key champions and can support EIP)	Who are the major decision-makers in the health system to take into account when launching or enhancing KTP and EIP?		
	Which are the major civil society organizations in the health system, and should or can they be involved?		
	Who has access to and influence over health system stakeholders (researchers, policy-makers, civil society) in order to facilitate collaborations and partnerships?		
	Who brokers the needs of decision-makers with the priorities of those generating and synthesizing research evidence?		
	What actors or institutions need to be involved in order to mobilize necessary KTP resources (e.g. human, financial)?		
	Who can/will communicate and advocate for the KTP?		
	Which are the major research institutes focused on disciplines relevant to the health systems strengthening that can contribute to the establishment of a KTP and EIP efforts in the country?		

ANNEX 2. DETAILED TABLES OF THE ORGANIZATIONAL CHARACTERISTICS OF KEY PLAYERS

These tables are intended to be used as supportive tools. They will help the implementation team to develop a more comprehensive answer to the key questions in this Manual, because they will enable a systematic and thorough approach to mapping the full range of actors (e.g. policy-makers, stakeholders, researchers) who will either be engaged in, or have a stake in developments related to the establishment of EIP processes and KTP within a country. Filling in these tables should, however, not consume essential time and resources that should be spent on reaching the objectives of the SA. Much of this content overlaps with insights gained while completing the Manual's deliverables, and users interested in developing a more comprehensive understanding of the key actors should do so only after these deliverables have been met.

THE MINISTRY OF HEALTH

Background

Understanding the structure and role of the MoH is important for the future KTP.

An MoH is a complex stakeholder; some elements within an MoH may be barriers to specific EIP efforts, while others may be facilitators. In some countries, there is more than one ministry that has an impact on health systems policy-making (e.g. federal states, or different ministries with health system responsibilities). SA teams should focus on the ministry that the KTP is *most* likely to work with, given the potential mandate of the KTP.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

TABLE 20. THE MINISTRY OF HEALTH

Question	Category	Answers	Sources
How formal is the structure of the Ministry of Health (MoH)? Please provide an organogram of the MoH.	Bureaucratic structures and processes		
Is there a separate department of research at the MoH? If so, what is its mandate?	Bureaucratic structures and processes/ organizational mandate and role/financial capacity		
What research skills do MoH staff have, and what types of research are routinely conducted?	Human resources capacity		
Does the Ministry fund any research?	Organizational mandate and role/financial capacity		
Is there a separate department for monitoring and evaluation? If so, what is its mandate?	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
Is there a department of policy and planning? If so, what is its mandate?	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
Is the MoH well-resourced financially? Please provide an idea of the budget.	Organizational mandate and role/financial capacity		
In what ways does the MoH formally and informally connect with other line ministries? How is the interaction with other ministries when it comes to health systems decision-making?	Organizational culture		
How does the MoH set health policy priorities in its agenda?	Organizational culture/ bureaucratic structures and processes		
Does the MoH participate in any agenda-setting or priority-setting exercises for research?	Organizational culture		
Does the MoH have policies or regulations in place stipulating the use of research in its decision-making?	Organizational culture/ bureaucratic structures and processes		

How in general would you characterize the skill sets of staff at the MoH? Is MoH staff in general well supported, both logistically as well as technically? Is there a high turnover of MoH staff? Does the MoH have strong in-house comprehension skills for research evidence (e.g. ability to understand a systematic review)?	Human resources capacity		
Do higher levels of staff within the MoH (e.g. vice ministers) routinely request research evidence or use research evidence in their work?	Organizational culture		
Does the MoH have its own database of health research? Does it provide its staff with access to other health research databases?	Bureaucratic structures and processes		
Does the MoH have active connections with the health research funder? With research universities? Describe the nature of the relationship (e.g. identifying priority topics for funding or study).	Organizational culture/ bureaucratic structures and processes		
Does the MoH participate in any international partnerships and/or international research projects?	Bureaucratic structures and processes		
Are there any other issues or elements of importance?			

CIVIL SOCIETY ORGANIZATIONS

Background

In many countries, civil society organizations (CSOs) play a prominent role in health system choices and development. A CSO refers to the wide array of NGO and not-for-profit organizations that have a presence in public life, expressing the interests and values of their members or others, based on ethical, cultural, political, scientific, religious or philanthropic considerations. CSOs may be community groups, NGOs, labour unions, indigenous groups, charitable organizations, faith-based organizations, professional associations and foundations.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

As a first step, list all major CSOs in the country. Second, decide on the best way forward: whether it would make sense to develop a separate table (e.g. Table 21 for each of the major CSOs or if just one common table for all CSOs would suffice (the latter may be the case for countries with a weak tradition of the CSO sector).

TABLE 21. CIVIL SOCIETY ORGANIZATIONS

Question	Category	Answers	Sources
How would you characterize the role of civil society in the health system? What specific roles does it play?	Organizational mandate and role/financial capacity/organizational culture		
What are the major CSOs in the health system? Indicate specific roles/activities (in particular, in view of accountability measures, governance and decision-making)	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
Are civil society groups well-resourced financially? Who funds them?	Organizational mandate and role/financial capacity		
If CSOs deliver health services, describe their exact role and function, and their funding base. How connected is this service delivery to the MoH's service delivery?	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
How free are civil society groups to report on accountability measures or findings?	Organizational culture		
Do CSOs produce any research evidence related to public health or health systems issues?	Organizational mandate and role/financial capacity		
How in general would you characterize skill sets of staff at CSOs? How would you describe staff turnover? Are their staff members in general well supported?	Human resources capacity/organizational culture		
Are there any CSOs or think tanks involved in producing health research? In synthesizing research? In disseminating research?	Bureaucratic structures and processes		
If so, how do core health system actors perceive the quality of that research (e.g. objective, poor methodologies, etc.)? Is the research partisan?	Bureaucratic structures and processes		
Do CSOs use health research evidence as part of their advocacy efforts? Describe.	Bureaucratic structures and processes		

Do CSOs have active connections with the MoH, the health research funder and/or research universities (e.g. around the use of research)? Describe.	Bureaucratic structures and processes		
Do CSOs have strong in-house comprehension skills for research evidence (e.g. able to understand a systematic review)?	Bureaucratic structures and processes		
Do CSOs participate in any international partnerships and/or international research projects?	Bureaucratic structures and processes		
Do CSOs actively network on health research issues?	Organizational culture		
Are there any other issues or elements of importance?			

THE (PRIVATE AND PUBLIC) NON-PROFIT SECTOR

Background

In most countries, non-profit organizations play a significant role in the health system, such as patient's rights groups or professional unions/associations.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

In Table 22, list all major actors and consider whether it would make sense to have a separate table for each of the major actors or if a generic table for the not-for-profit sector in general would suffice.

TABLE 22. THE (PRIVATE AND PUBLIC) NON-PROFIT SECTOR

Question	Category	Answers	Sources
How would you characterize the role of the non-profit sector in the health system? What specific roles does it play?	Organizational mandate and role/financial capacity		
How would you characterize the role of the not-for-profit sector in health system decision-making?	Organizational mandate and role/financial capacity		

What specific issues (e.g. provision of medicines, alternative for-fee health services) does the private sector typically focus on?	Organizational mandate and role/financial capacity		
Are there any other elements or details that might influence the future KTP?			

THE (PRIVATE AND PUBLIC) FOR-PROFIT SECTOR

Background

In most countries, for-profit businesses play a significant role in the health system. It may be the domestic or global private sector, and may provide health services or products or participate actively in health financing. The private for-profit sector may have a strong role in setting health policy.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

In Table 23, list all major actors and consider whether it would make sense to have a separate table for each of the major actors or if a generic table for the private for-profit sector in general would suffice.

TABLE 23. THE (PRIVATE AND PUBLIC) FOR-PROFIT SECTOR

Question	Category	Answers	Sources
How would you characterize the role of the for-profit sector in the health system? What specific roles does it play?	Organizational mandate and role/financial capacity		
How would you characterize the role of the for-profit sector in health system decision-making? In decision-making by the MoH?	Organizational mandate and role/financial capacity		
What specific issues (e.g. provision of medicines, alternative for-fee health services) does the private sector typically focus on?	Organizational mandate and role/financial capacity		
Any other elements or details that might influence the future KTP?	Organizational mandate and role/financial capacity		

EXTERNAL ACTORS

Background

In many countries, there are external actors (e.g. a bilateral donor such as the Department for International Development [DFiD] or United States Agency for International Development [USAID], the World Bank, private foundations and philanthropies, etc.) who exert a strong influence on the health system.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

In Table 24, list all major actors and produce a separate table for each major actor.

For example, if the Global Fund to Fight AIDS, Tuberculosis and Malaria, the World Bank and the Bill & Melinda Gates Foundation are judged to be three external actors that have high relevance for and influence on the health system, ask and answer the questions in Table 24 for each of these three actors.

WHO plays a major role in supporting the MoH in developing national health policies and action plans in support of Health 2020, and should be one of the external actors assessed in Table 24.

TABLE 24. EXTERNAL ACTORS

Question	Category	Answers	Sources
How would you characterize the role of the external actor in the health system? What specific role or roles does it play?	Organizational mandate and role/financial capacity		
Does the external actor transfer financial resources directly to the MoH or national government?	Organizational mandate and role/financial capacity/ bureaucratic structures and processes		
Does the external actor deliver any health services? Describe their exact role and function. How connected is this service delivery to the MoH's service delivery?	Bureaucratic structures and processes/ organizational mandate and role/financial capacity		
What role does the external actor play in the decision-making processes of the MoH? How influential is it?	Organizational mandate and role/financial capacity/ bureaucratic structures and processes		

Does the external actor produce any research evidence related to health sector performance? To specific service delivery issues?	Organizational mandate and role/financial capacity		
Does the external actor provide any support to staff (e.g. capacity-building, staff secondment) of the MoH or to other actors in the health system?	Human resources capacity		
Are there any external actors involved in funding, producing, synthesizing and/or disseminating health research in the country?	Bureaucratic structures and processes		
Describe how external actors (e.g. a funding agency based in another country) fund health research undertaken in the country. Are these projects undertaken by foreigners? Do they involve partnerships with local institutions or individuals? How are the findings disseminated or taken up locally?	Bureaucratic structures and processes/ organizational mandate and role/financial capacity		
How do core health system actors perceive the quality of research undertaken or funded by external actors? Are there any power conflicts?	Organizational culture		
Do the external actors participate in any local health research prioritization processes?	Bureaucratic structures and processes/ organizational mandate and role/financial capacity		
Does externally funded research go through national ethics review processes?	Bureaucratic structures and processes		
Where are the findings from externally funded research typically published?	Bureaucratic structures and processes		
Do external health research funders participate in any mechanisms designed to connect with local policy-making processes?	Organizational mandate and role/financial capacity/ bureaucratic structures and processes		
Are there any other issues or elements of importance?			

HEALTH RESEARCH FUNDER

Background

Health research is in most countries is funded by a range of institutions, including governmental agencies, ministries, charities (such as the Wellcome Trust), for-profit organizations, and others.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

In Table 25, list all major actors and produce separate tables (either for each major actor or as a minimum for each type of funder, i.e. government science department, charities, for-profit organizations).

TABLE 25. HEALTH RESEARCH FUNDER

Question	Category	Answers	Sources
How much of the health research funder's budget is spent on supporting public health or health systems research?	Bureaucratic structures and processes		
How does the health research funder determine priorities or what types of research to fund?	Bureaucratic structures and processes		
How does the health research funder review project proposals?	Bureaucratic structures and processes		
Is the health research funder an autonomous entity or is it an arm of the government?	Bureaucratic structures and processes		
How does the health research funder connect to the MoH? Is there a mechanism whereby the MoH can communicate its research needs to the funder?	Bureaucratic structures and processes		
Does the health research funder have partnerships with international institutions or networks? Describe.	Organizational mandate and role/financial capacity		
Does the health research funder fund any multidisciplinary research? Any explicitly policy-oriented research?	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
How are the decisions of the health research funder held accountable?	Bureaucratic structures and processes		

How in general would you characterize staff skill sets of the health research funder (i.e. are they attracting top talent)? How would you describe staff turnover? Are its staff members in general well supported?	Human resources capacity/organizational culture		
Are there any other issues or elements of importance?			

HEALTH RESEARCH ORGANIZATIONS (ACADEMIC AND NON-ACADEMIC)

Background

In most countries, the institutional landscape of research institutions and universities is vast. Identifying suitable research institutions is paramount for future work of the KTP.

Methods

- Desk research that consists of a combination of the published and grey literature, and consultation of Internet sources
- Key informant interviews, if necessary, to fill in gaps in understanding.

In Table 26, list all the major actors and produce separate tables for the most important ones. The table is suited for academic institutions. Please adapt the table to non-academic research institutions if applicable.

TABLE 26. HEALTH RESEARCH AT THE UNIVERSITY LEVEL

Question	Category	Answers	Sources
Which universities train health researchers? What training programmes, disciplines and methods do they offer?	Organizational mandate and role/financial capacity		
What is the quality of the training?	Organizational culture		
Which universities (or their departments) are structurally performing public health or health systems-related research?	Organizational mandate and role/financial capacity		
Are these universities public or private? A combination?	Organizational mandate and role/financial capacity		
Do tenured staff at universities (or departments) have funded research projects?	Bureaucratic structures and processes		

Does research staff systematically engage in scientific peer-reviewed publications?	Bureaucratic structures and processes		
In what ways do these universities (or departments) connect to the MoH and other core health sector actors to support health systems development?	Bureaucratic structures and processes		
Do these universities (or departments) employ specific mechanisms to connect with research users?	Bureaucratic structures and processes/ organizational mandate and role/financial capacity		
Do these universities (or departments) engage in multidisciplinary research supporting health systems development?	Bureaucratic structures and processes		
Do these research universities (or departments) have international partnerships and/or international research projects?	Organizational mandate and role/financial capacity/bureaucratic structures and processes		
How do the research universities (or departments) network with other universities either domestically or internationally?	Bureaucratic structures and processes		
How in general would you characterize staff skill sets at the universities (i.e. are they attracting top talent)?	Organizational culture/ human resources capacity		
How would you describe staff turnover? Are its staff members in general well supported?	Human resources capacity		
Are there any other issues or elements of importance?			

ANNEX 3. BRIEF EVALUATION OF THE TOOLS USED

Situation analysis teams should critically appraise the content (approaches and concepts) provided in this Manual. The aim of this evaluation form (Table 27) is to improve the content and usability of the Manual in the future.

TABLE 27. BRIEF EVALUATION OF THE TOOLS USED IN THE SITUATION ANALYSIS MANUAL

Question	Answers
What are three things that you especially liked about the Manual, with a particular focus on how it helped to deepen your understanding of how your country can move forward in establishing a KTP to support EIP?	
What are three things that you think could be improved in the Manual that would strengthen its ability to deepen your understanding of how your country can move forward in establishing a KTP to support EIP?	
Do the questions addressed in each of the sections of Chapter 3 allow you to collect data that contribute to a better understanding of the conditions in which a KTP (and EIP) can be established?	
What are the strengths and weaknesses of (a) the information found; (b) the quality of the data you obtained after completing the sections of Chapter 3?	
How would you improve (both on the usability of the instruments and the way the questions were formulated) the collection of data suggested and the descriptive analysis approach suggested in Chapter 3?	
How would you improve (both the usability of the SWOT framework and the ways in which the Manual suggested you draw on your descriptive data) the approach to conducting an interpretive analysis that draws on your descriptive analysis in Chapter 4?	
Did you feel there were pieces of information or tools that were absent in the Manual and were necessary to assess the context in which a KTP could be established?	

ANNEX 4. GLOSSARY OF KNOWLEDGE TRANSLATION TERMS

TABLE 28. GLOSSARY OF KNOWLEDGE TRANSLATION TERMS FOR EVIPNET EUROPE

Term	Definition(s)
actors (also called stakeholders)	Actors or stakeholders refer to individuals, groups, organizations and/or networks that have a stake or vested interest in a specific issue. Their roles, rights and/or ownership related to an issue are critical for the implementation and success of any policy or policy change *(5)*. In the context of EVIPNet, actors or stakeholders refer to, but are not limited to, policy-makers, researchers, civil society and funders who share the goal of improving the performance of the health system and health outcomes through evidence-informed policy-making. (*See* Introduction)
best available evidence	This refers to a synthesis of high-quality evidence from global databases (e.g. systematic reviews), which is combined with local evidence to design context-specific solutions *(23,24)*. It can also be complemented with tacit knowledge, especially when explicit knowledge from local contexts is of poor quality or is not available *(25)*.
clearinghouse	A clearinghouse is a continuously updated repository of documents, serving as a "one-stop shop" for users seeking reliable and relevant research evidence on a given topic. They typically contain systematic reviews that are of high quality and optimally packaged for policy-makers and other stakeholders, and may also house other types of documents relevant to the subject area *(26,27)*.
colloquial evidence	*See* "tacit knowledge"
context-free evidence	Context-free and context-sensitive evidence are types of explicit knowledge. Context-free evidence is from systematic and methodologically rigorous clinical research *(28)* such as medical effectiveness or biomedical research *(29,30)*.
context-sensitive evidence	Context-sensitive evidence is a type of explicit knowledge that is context-based and operational or relevant to a particular setting *(28–30)*.
evidence	Evidence refers to "findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care" *(31)*. Evidence is a combination of explicit and tacit knowledge *(29,32)*. The term "evidence" is often used synonymously with "knowledge".

Term	Definition(s)
evidence brief for policy	Evidence briefs for policy – also known as policy briefs – provide direct support to policy-making by packaging the research evidence in a way that it is accessible, relevant, easy to use and applicable at the local level *(33)*. They start with the priority policy issue (not the research evidence). Thereafter, they use the best available evidence to clarify the problem and its causes, and identify and frame policy options to address the problem *(34)*. They often feature issues related to governance, financing and delivery, along with important implementation considerations.
evidence-informed health policy-making	Evidence-informed health policy-making is an approach to policy decisions that aims to ensure that decision-making is well informed by the best available research evidence. It is characterized by the systematic and transparent access to, and appraisal of, evidence as an input into the policy-making process *(23,35)*.
evidence synthesis	An evidence synthesis is a core mechanism of knowledge translation and refers to a process of summarizing information from a wide range of research findings in a rigorous, systematic and transparent manner to repackage a large body of evidence *(36,37)*. Evidence synthesis products include systematic reviews, summaries of systematic reviews and evidence briefs for policy. This term is used interchangeably with "knowledge synthesis".
exchange effort	This is one of the four models of knowledge translation and refers to the interactions, partnerships and joint actions between researchers, policy-makers and other stakeholders to increase shared understanding and ownership of the use of research in decision-making. Exchange efforts might include undertaking collaborative research projects and convening policy dialogues *(36,38)*.
explicit knowledge	This refers to structured, verifiable and replicable evidence. Explicit knowledge can be categorized in two ways. One is to describe it as either context-free or context-sensitive evidence *(29,39)*. Another way is to rank explicit knowledge according to the scientific rigour or data collection methodology and strength of evidence, which can be displayed as a hierarchy of evidence from the strongest to the weakest *(32,40)*.
health information	This refers to information "generated by both population-based (e.g. surveys, censuses and civil registration) and institution-based (e.g. service records, individual records) data sources", providing support to decision-making at all levels of the health system *(17)*. Health information includes "descriptions of health status and mortality of populations over time, analysis of causation of health problems, quantification of associations between health outcomes and risk or protective factors, and assessment of the effectiveness of public health interventions."
integrated effort	This effort brings together push, user-pull and exchange efforts (*see* definitions in this glossary) for knowledge translation *(38,41)*. An example is a knowledge translation platform.

Term	Definition(s)
knowledge	*See* "evidence".
knowledge broker	This is often a senior, well-connected and respected individual or an organization whose core function is to connect people to exchange knowledge *(23)*. A broker brings stakeholders together, builds relationships, cements coalitions and alliances, and helps to build new skills and capacities *(42)*.
knowledge brokering	This refers to activities that facilitate the transfer of knowledge between stakeholders, including policy-makers, researchers and civil society *(36)*. The goal of knowledge brokering is to build and maintain partnerships or networks for knowledge translation and promote mutual understanding about each other's roles and cultures *(43)*.
knowledge synthesis	*See* "evidence synthesis".
knowledge translation	This refers to "the exchange, synthesis, and effective communication of reliable and relevant research results. The focus is on promoting interaction among the producers and users of research, removing the barriers to research use, and tailoring information to different target audiences so that effective interventions are used more widely" *(44,45)*.
knowledge translation platform (KTP)	A KTP promotes and creates an environment that supports both research use in policy-making and policy needs in research design *(46)*. It may be a formal organization, department or network, focusing on bringing actors together, synthesizing explicit and tacit knowledge, and leading networking in knowledge translation *(47)*. A KTP leads the development of evidence briefs for policy and policy dialogue exercises, offers rapid response services, conducts priority-setting exercises and performs clearinghouse functions.
policy brief	*See* "evidence briefs for policy".
policy dialogue	These dialogues allow the best available research evidence to be considered among the real-world factors influencing the policy-making process *(48)*. They are informed by an evidence brief for policy, which is subsequently considered alongside tacit knowledge of local health policy-makers and stakeholders to inform future policy decisions *(23)*.
Priority-setting	Priority-setting is a knowledge translation mechanism used in shaping a policy and/or research agenda. It is a transparent and explicit process for guiding decisions on how resources should be used among competing issues and agenda items *(49)*. Priority-setting brings together stakeholders, including policy-makers, researchers and civil society *(50)*, and is led by a KTP in the context of EVIPNet.
push effort	A push effort describes the tailoring and targeting of key messages from research evidence to make it more accessible and easier to use for policy-makers *(38,51)*.

Term	Definition(s)
rapid response service	A rapid response service responds to a question or issue arising from a policy-maker, producing a synthesis of research evidence on a timescale of hours to days to weeks *(52,53)*.
research use	Research evidence can be used in an instrumental, conceptual, symbolic or strategic way *(54–56)*.
situation analysis	EVIPNet Europe conducts situation analysis as the first step towards establishing a KTP at a national level. It facilitates understanding of the national context, the health system and health research system, and any existing evidence-informed policy-making processes. It provides information on opportunities and barriers in organizing and establishing a KTP *(4)*.
tacit knowledge	This refers to knowledge comprising expertise, opinions, traditions and beliefs that complement explicit knowledge. It is particularly critical where the evidence is inconclusive, lacking or non-existent *(32,40)*. Tacit knowledge is also referred to as "colloquial evidence" *(30)*.
User-pull effort	This effort is made by users of research or policy-makers who demand research evidence from the research community. It can take the form of one-stop shops, which provide access to high-quality and relevant research evidence *(38,51)*.

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THE WHO REGIONAL OFFICE FOR EUROPE

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health.

The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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