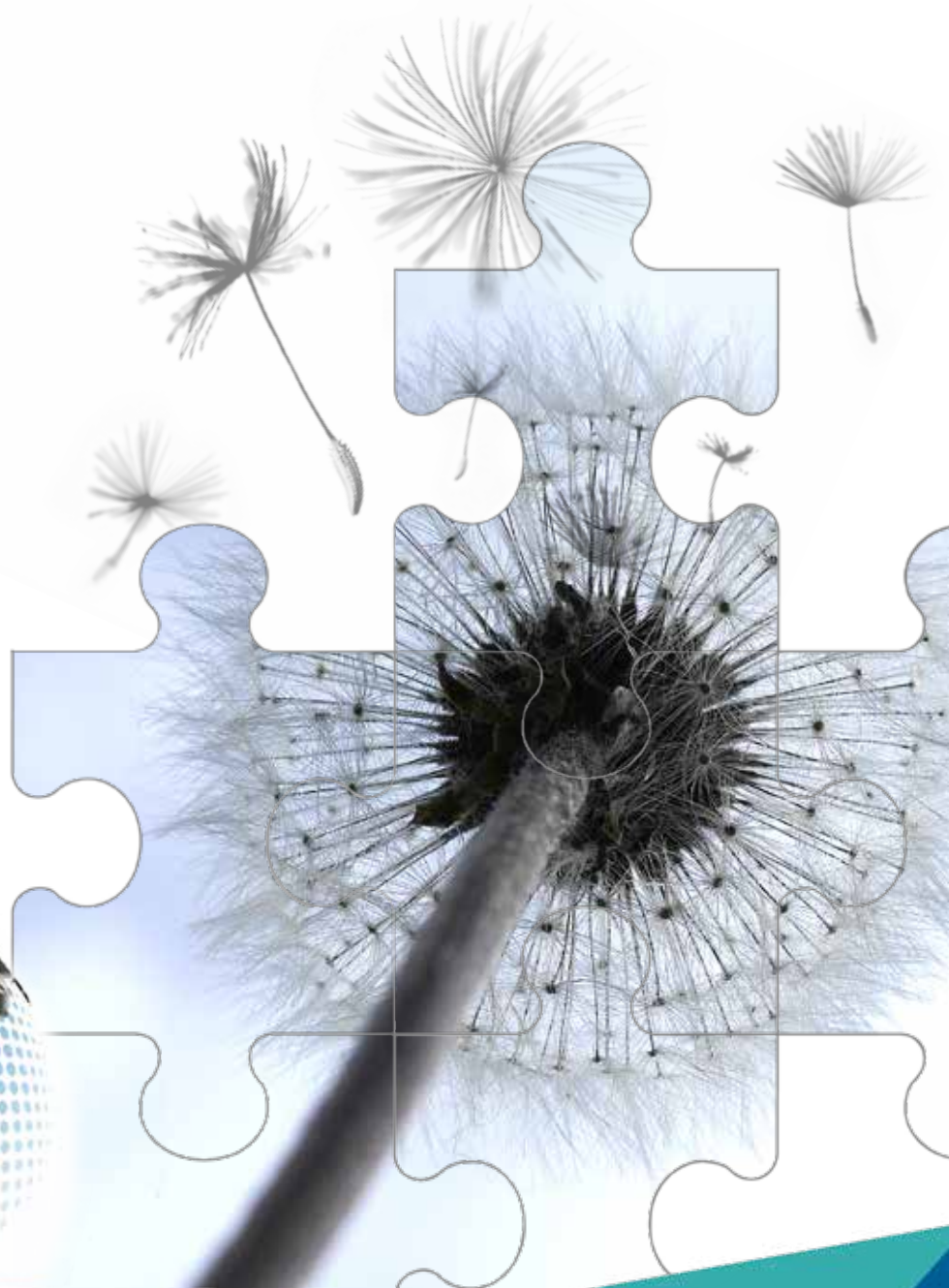


# EVIDENCE BRIEFS FOR POLICY. USING THE INTEGRATED KNOWLEDGE TRANSLATION APPROACH GUIDING MANUAL



**EVIDENCE BRIEFS FOR POLICY.  
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KNOWLEDGE  
TRANSLATION APPROACH  
GUIDING MANUAL**



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# Evidence Briefs for Policy. Using the Integrated Knowledge Translation Approach. Guiding Manual.

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# CONTENTS

List of illustrations .....	VII
List of abbreviations .....	IX
About the manual .....	1
<b>Section 1. What to consider before getting started with the integrated knowledge translation approach .....</b>	<b>9</b>
1.1 Informal coordination between parties .....	10
1.2 Establishing official collaboration .....	11
1.2.1 Goals and objectives of the collaboration .....	11
1.2.2 Duties of all parties .....	12
1.2.3 EBP team leads for collaboration and follow-up .....	13
1.2.4 Communication terms .....	17
1.2.5 Timeline for collaboration .....	18
1.2.6 Outlining the monetary terms .....	18
<b>Section 2. Technical support and coaching for the integrated knowledge translation approach .....</b>	<b>20</b>
2.1 The pre-EBP writing-preparations phase .....	21
2.1.1 Priority-setting .....	21
2.1.2 Identifying the EBP team .....	22
2.1.3 Identifying the EBP steering committee .....	27
2.1.4 Brief description and mapping of the policy and political contexts .....	29
2.1.5 Stakeholder mapping (key informants, dialogue invitees) .....	31
2.1.6 Work plan and timeline for deliverables .....	34
2.2 Writing the EBP: the development phase .....	40
2.2.1 The problem tree .....	41
2.2.2 EBP ToR .....	44
2.2.3 Conducting key informant consultations .....	45
2.2.4 Search strategy .....	47
2.2.5 How to critically appraise evidence .....	56
2.2.6 How to synthesize the critically appraised literature .....	65
2.2.7 How to frame the problem .....	67
2.2.8 How to frame the options to address a problem .....	74
2.2.9 How to identify implementation considerations for an option .....	78
2.2.10 How to develop the full EBP .....	81
2.2.11 Using the EBP template .....	84
2.2.12 Identifying merit-/peer-reviewers .....	84
2.2.13 Translation, proofreading and formatting .....	85

---

<b>2.3</b>	<b>Post-EBP uptake phase</b>	<b>91</b>
2.3.1	Policy dialogue	91
2.3.2	Dialogue summary	98
2.3.3	Advocacy plan	101
2.3.4	Communication plan	105
2.3.5	Press tracing and media analysis	108
2.3.6	Post-dialogue survey	110
2.3.7	Policy tracing	111
<b>Section 3.</b>	<b>Evaluation</b>	<b>116</b>
<b>3.1</b>	<b>EBP evaluation form</b>	<b>117</b>
<b>3.2</b>	<b>Policy dialogue evaluation form</b>	<b>120</b>
<b>3.3</b>	<b>Evaluation from both sides</b>	<b>123</b>
<b>Annex 1.</b>	<b>Synthesizing evidence from systematic reviews</b>	<b>126</b>
<b>Annex 2.</b>	<b>EBP template</b>	<b>129</b>
<b>Annex 3.</b>	<b>EBP review feedback template</b>	<b>141</b>

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# LIST OF ILLUSTRATIONS

## Tables

Table 2.1.	A guide to the functions, tasks, background/skills and effort needed by the EBP team .....	24
Table 2.2.	Estimates of working hours for the EVIPNet Hungary team compiling the EBP for AMR, according to competences and work phases .....	26
Table 2.3.	A guide to the functions, tasks, background/skills and efforts needed by the steering committee .....	28
Table 2.4.	EBP stakeholder mapping framework .....	32
Table 2.5.	Workplan for the EBP .....	34
Table 2.6.	Types of research evidence to find the information needed for the EBP policy options .....	49
Table 2.7.	Key databases to search for systematic reviews .....	50
Table 2.8.	The appropriate sources and databases to search for research evidence .....	51
Table 2.9.	Example of developing a search strategy .....	53
Table 2.10.	Example of how the search strategy differs between the Medline and Health Systems Evidence databases .....	54
Table 2.11.	GRADE .....	61
Table 2.12.	Assessing local applicability .....	62
Table 2.13.	Critical appraisal tools for considering non-research evidence .....	63
Table 2.14.	The proposed key areas of questioning for critical appraisal of non-research evidence using the SART system .....	64
Table 2.15.	Summary of systematic reviews relevant to the policy options .....	66
Table 2.16.	Example 1: underlying factors .....	72
Table 2.17.	Example 2: underlying factors .....	73
Table 2.18.	EBP policy options .....	76
Table 2.19.	Example of EBP policy option 1 .....	77
Table 2.20.	Examples of barriers and facilitators (using Hungary as a case example) .....	80
Table 2.21.	Checklist for preparing the policy dialogue .....	94
Table 2.22.	Different advocacy and communicattions .....	106

## Figures

Fig. 0.1.	The integrated knowledge translation framework .....	4
Fig. A.	Framework for supporting countries to develop and implement an integrated knowledge translation approach .....	6
Fig. 2.1.	A visual example of an EBP timeline .....	37
Fig. 2.2.	The building blocks of a problem tree .....	42
Fig. 2.3.	An example of the problem tree on AMR developed for an EBP by EVIPNet Hungary .....	43
Fig. 2.4.	Example of how the Boolean operator AND identifies concepts .....	52
Fig. 2.5.	Example of how the Boolean operator OR identifies concepts .....	52
Fig. 2.6.	The evidence hierarchy pyramid .....	56
Fig. 2.7.	AMSTAR 2 Tool checklist .....	58

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Fig. 2.8.	Seating plan for the policy dialogue .....	97
Fig. 2.9.	Stakeholder power analysis matrix .....	102
Fig. 2.10.	Example of a stakeholder power analysis of sugar-sweetened beverages in schools .....	103

## Boxes

Box 2.1.	Priority-setting criteria of the K2P Center .....	23
Box 2.2.	Search strategy in the Health Systems Evidence databas .....	54
Box 2.3.	Example of amending the AMSTAR quality score into categories .....	61
Box 2.4.	Post-dialogue survey example .....	110



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## LIST OF ABBREVIATIONS

AMR	antimicrobial resistance
AMSTAR	A MeaSurement Tool to Assess systematic Reviews
ASP	antibiotic stewardship programme
CASP	Critical Appraisal Skills Programme
CCNC	Canadian Cochrane Network and Centre
CIHR	Canadian Institutes of Health Research
EBP	evidence brief for policy
ECDC	European Centre for Disease Prevention and Control
EHII	European Health Information Initiative
EIP	evidence-informed policy(-making)
EU	European Union
EVIPNet	Evidence-informed Policy Network
GP	general practitioner
GRADE	Grading of Recommendations Assessment, Development and Evaluation
GRADE CERQual	GRADE Confidence in the Evidence from Reviews of Qualitative Research
K2P Center	Knowledge to Policy Center
KTP	knowledge translation platform
M&E	monitoring and evaluation
MeSH	Medical Subject Heading
MoU	Memorandum of Understanding
NCD	noncommunicable disease
NGO	nongovernmental organization
NNLM	National Network of Libraries of Medicine
NRSI	Non-Randomized Studies of Interventions
NSSF	National Social Security Fund (Lebanon)
POCO	P(People)-O(Option)-C(Comparison)-O(Outcome)
PPD	Program in Policy Decision-making
PROGRESS groupings	Place of residence Race/ethnicity/culture/language Occupation Gender/sex Religion Education Socioeconomic status Social capital
QES	qualitative evidence synthesis
RCT	randomized controlled trial
RoB	risk of bias
ROBINS-I	Risk of Bias In Non-randomized Studies - of Interventions
SART	source–accuracy–relevance–timeliness
SDGs	Sustainable Development Goals
SWOT	strengths, weaknesses, opportunities and threats
ToR	terms of reference
QES	qualitative evidence syntheses
UNICEF	United Nations Children’s Fund



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**UNHCR**  
**UNFPA**  
**WHO**  
**5Ws**

United Nations Refugee Agency  
United Nations Population Fund  
World Health Organization  
what, when, where, why, who

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# ABOUT THE MANUAL

This manual targets Member countries of EVIPNet Europe aiming to develop evidence briefs for policy (EBPs) and organize related policy dialogues to promote evidence-informed policy-making (EIP). Although the manual is contextualized to the WHO European Region, this tool nonetheless provides useful guidance to any institution or organization interested in developing EBPs.

## Objectives of the manual

The objectives of the manual are:

- to understand what an EBP is and have the ability to explain to third parties the purpose and comparative advantages of an EBP;
- to understand and master the process of preparing for an EBP before its development;
- to understand and learn how to develop and evaluate an EBP;
- to understand how to prepare for and gain skills in conducting a policy dialogue, and then facilitate and evaluate it;
- to acquire skills in developing strategies for the uptake of the EBP, including advocacy and media engagement to influence policy decisions.

## What the manual includes

It includes:

1. details on the steps required throughout the continuum of preparing, developing and evaluating an EBP, which also comprise the steps leading to policy influence (including policy dialogue);
2. templates for the entire process;
3. clear guidelines on how to fill in the templates. This includes (where relevant):
  - general guidelines;
  - examples based on previous experiences;
  - tips, and “dos” and “don’ts”;
  - other supporting resources.

## How to use the manual

The manual provides hands-on guidance on developing EBPs. EVIPNet country teams<sup>1</sup> and EBP teams can refer to this manual at any stage in the process of preparing for, developing and moving forward with their EBPs. The templates, along with the step-by-step guidance and tips, make it easy

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<sup>1</sup> A country team (in many cases called a knowledge translation platform [KTP], once fully institutionalized) plans, implements, monitors and evaluates the knowledge translation work at country level, with the support of EVIPNet Europe. The EBP team is set up for a temporary period of time. It involves members of the country team, but also expands beyond this to involve content experts related to the specific topic that the EBP addresses.

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The authors wish to thank all other contributors to this manual, including Ms. Racha Fadlallah, Mrs Diana Jamal, Ms Clara Abou Samra and Ms Rayane Naserddine from the K2P Center. The authors are also grateful for the valuable comments provided by the peer and merit-reviewers and the additional review and feedback from Tomas Pantoja, Assistant Professor at the Department of Family Medicine of the Pontificia Universidad Católica de Chile in Santiago, Chile; editor with the Cochrane Effective Practice and Organisation of Care Group.

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3. The Evidence-Informed Health Policy Making Unit at the Ministry of Health in Chile. The team included:
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- Balázs Babarczy, Analyst, Department for Epidemiology and Infection Control, National Public Health Center, Hungary.

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for country teams and the EBP team to follow. However, this guide is only one stage in the process of receiving support for the preparation of EBPs. Multiple workshops/webinars should be provided for countries throughout the process to ensure the development of an effective and rigorous EBP. The WHO Secretariat of EVIPNet Europe and its partners should ideally provide these capacity-building activities, which should be supplemented by continuous mentoring, coaching and individualized discussions with the country teams to ensure the development of EBPs that are rigorous, evidence-informed and responsive to local needs.

## Introduction to evidence-informed health policy-making

Governments around the world are responsible for maintaining health and providing equitable access to high-quality health care to their people. However, a large number of people worldwide still cannot obtain the health services they need. Evidence plays an important part in strengthening health systems, improving population health and accelerating the attainment of the Sustainable Development Goals (SDGs) (Jha et al., 2016; Hatt et al., 2015; Langlois et al., 2016). It can inform critical health system decisions, including who delivers health services and how these services are financed and organized (Gilson et al., 2011; Koon et al., 2013). Evidence-informed health policy-making (EIP) is an approach that aims to ensure that policy-making is well-informed by the best available evidence. It includes systematic and transparent processes for articulating global and local evidence as a valuable subsidy for decision-making (Oxman et al., 2009).

Recognizing the need to scale up national efforts to close the gap between research and policy, the WHO Regional Office for Europe launched EVIPNet Europe in October 2012 under the umbrella of the WHO European Health Information Initiative (EHII). EVIPNet Europe is hosted by the WHO Regional Office for Europe's Division of Information, Evidence, Research and Innovation, and is one of the key strategic areas included in the Action plan and resolution to strengthen the use of evidence, information and research for policy-making in the WHO European Region (WHO Regional Office for Europe, 2016).

EVIPNet Europe is part of the global WHO EVIPNet initiative that promotes EIP, defined as the systematic and transparent use of health research evidence in policy-making (Oxman et al., 2009). WHO EVIPNet is present in all WHO regions and is coordinated both at the regional and global levels. At country level, EVIPNet encourages the development of national teams, which comprise policy-makers, researchers and representatives from civil society. These actors facilitate policy development and implementation through the use of the best global and local evidence available.

## Knowledge translation

Knowledge translation is the science and practice of strengthening the research–policy and practice interface. WHO defines knowledge translation as: “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” (WHO, 2004). Knowledge translation is defined by the Canadian Institutes of Health Research (CIHR) as “a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically-sound application

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of knowledge to improve health, provide more effective health services and products and strengthen the health care system” (CIHR, 2018).

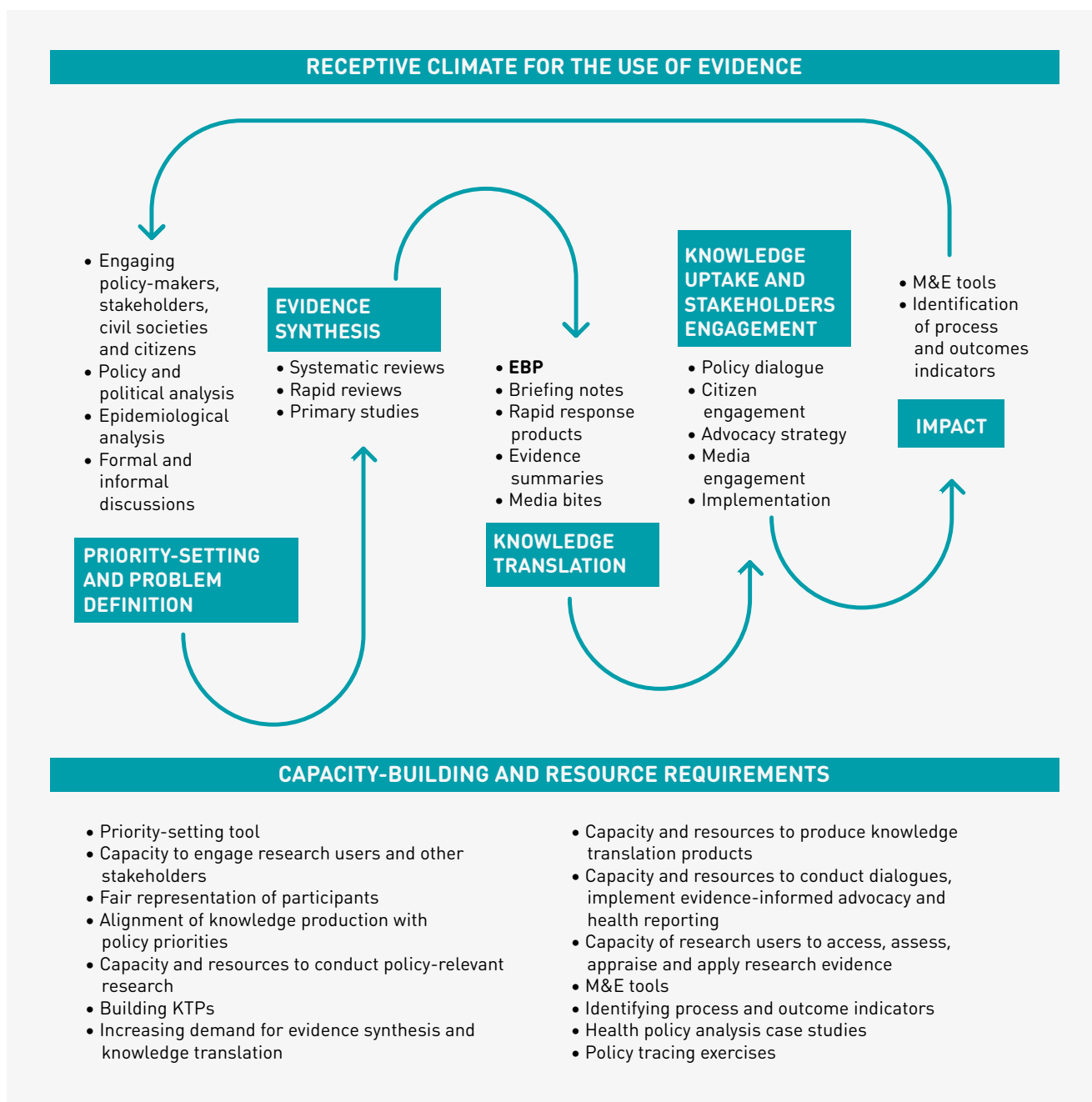
Studies on knowledge transfer and translation have shown that policy-makers prefer brief and user-friendly summaries of evidence (Hyder et al., 2011; Oliver et al., 2014; El-Jardali et al., 2012) that highlight the key messages and address considerations related to quality, local applicability and equity. Examples of knowledge translation tools that are policy-maker friendly and used by EVIPNet Europe include EBPs, rapid response synthesis, evidence summaries and media (sound) bytes.

EBPs are a relatively new, innovative approach to packaging research evidence for policy-makers; however, they are already the most widely used tool. EBPs are prepared by synthesizing and contextualizing the best available evidence about a problem, viable solutions to address it, and key implementation considerations, through the involvement of content experts, policy-makers and stakeholders (Lewin et al., 2012). EBPs should be seen as being part of an integrated knowledge translation approach (see Fig. 0.1) to catalyse EIP and improve health outcomes (El-Jardali & Fadlallah, 2015). Such an approach is characterized by:

- (1) being impact oriented;
- (2) starting with priority-setting of the health problems/issues;
- (3) enabling evidence synthesis, such as developing systematic reviews, and;
- (4) moving onto packaging the evidence via knowledge translation tools such as EBPs; as well as
- (5) working on knowledge uptake via citizen engagement, advocacy and policy dialogues to increase the likelihood of policy influence and improved health outcomes.

Policy dialogues are important cornerstones of the knowledge translation approach and supplement the EBP. Policy dialogues facilitate deliberations around the research evidence, support the contextualization of the research evidence and enhance the possibility of research uptake by further engaging high-level stakeholders who are most likely to take action (Lavis et al., 2009; Yehya & El-Jardali, 2015; Damani et al., 2016).

FIG. 0.1. THE INTEGRATED KNOWLEDGE TRANSLATION FRAMEWORK



Note. M&E: monitoring and evaluation

Source: adapted from the integrated knowledge translation framework presented by El-Jardali & Fadlallah (2015).



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Fig. A depicts a framework that outlines the full spectrum of the steps needed to support countries in developing an EBP and implementing an integrated knowledge translation approach. The manual is based on this colour-coded framework: each of the steps is explained in detail in the relevant sections.

The framework (Fig. A) starts off with establishing official collaboration between EVIPNet Europe and the Network Member country for developing an EBP, and providing initial capacity-building via training workshops and webinars (Section 1).

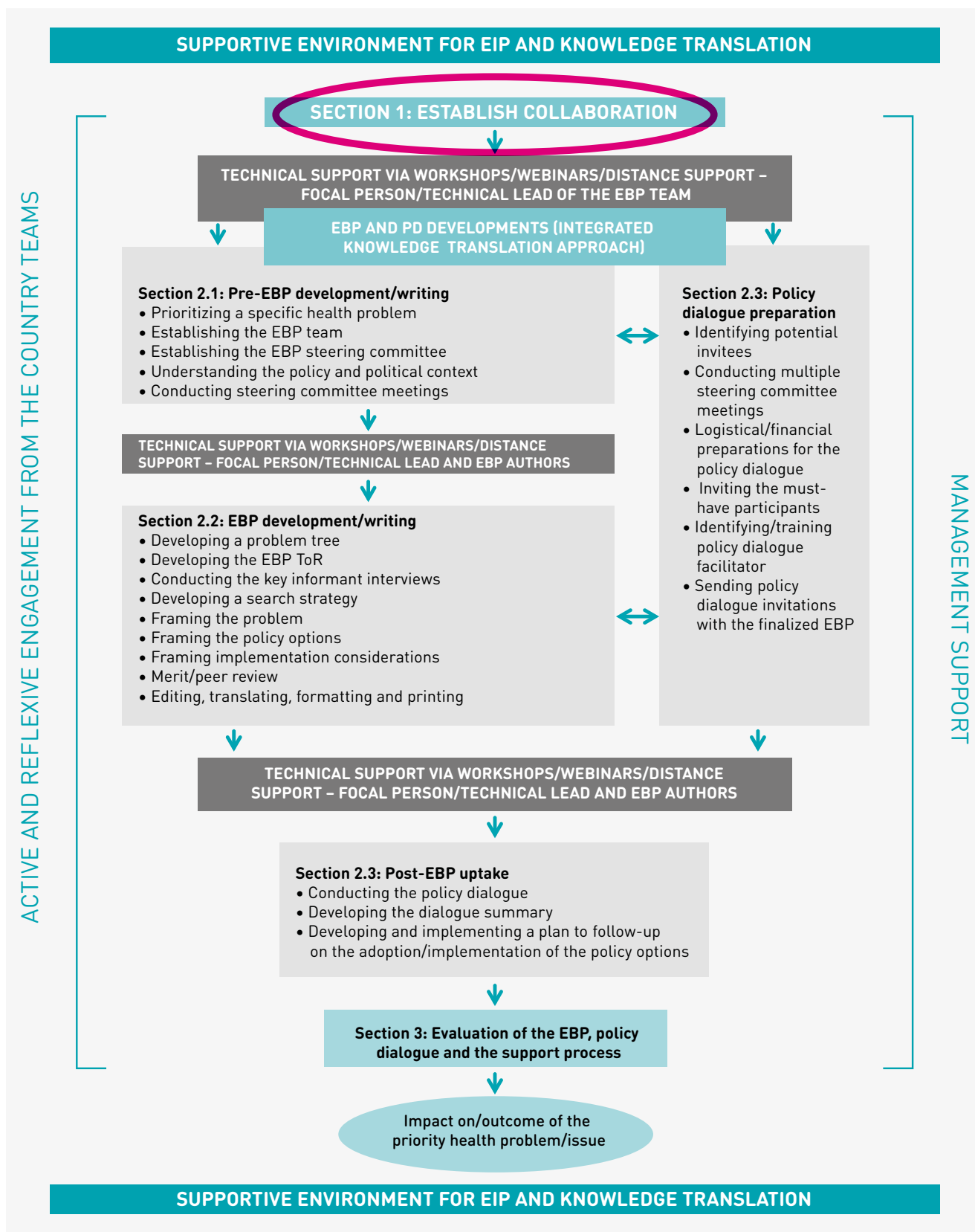
Section 2 describes how country teams can prepare for developing the EBP (e.g. by creating the EBP team and steering committee, conducting priority-setting exercises, etc). At its core, Section 2 provides detailed guidance on how to develop the EBP, including key tools, methods and approaches required at each step of developing the EBP. The section ends with an outline of the activities needed to promote uptake of the EBP in policy (via policy dialogues, dialogue summaries, advocacy, communication plan, and policy and media tracing).<sup>2</sup>

In Section 3, the manual concludes with the evaluation methods and templates for the entire knowledge translation process to assess the degree to which the desired public health outcomes and impacts have been achieved.

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<sup>2</sup> Fig. A will appear again at the end of each section, depicting the next stage of the process.

FIG. A. FRAMEWORK FOR SUPPORTING COUNTRIES TO DEVELOP AND IMPLEMENT AN INTEGRATED KNOWLEDGE TRANSLATION APPROACH



Note. M&E: monitoring and evaluation

Source: adapted from the integrated knowledge translation framework presented by El-Jardali & Fadlallah (2015).

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## SECTION 1

# WHAT TO CONSIDER BEFORE GETTING STARTED WITH THE INTEGRATED KNOWLEDGE TRANSLATION APPROACH

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## KEY MESSAGES

- Member countries should have a receptive climate for EIP to initiate knowledge translation work.
- Defining the duties and responsibilities of those collaborating will facilitate cooperation and allow for more structured, efficient and effective work.

This section describes the first steps required to initiate collaboration between the WHO Secretariat of EVIPNet Europe and the Member country that would like to develop an EBP. On the one hand, Network Member countries should have a receptive climate for EIP and knowledge translation processes. On the other hand, it is crucial that the duties and timelines for the collaborative work are defined and agreed upon ahead of time to ensure smooth and timely project implementation.

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### 1.1 INFORMAL COORDINATION BETWEEN PARTIES

Before starting the process of implementing the integrated knowledge translation approach to developing an EBP, a few key considerations should be in place.

1. First and most important is a supportive environment for EIP and knowledge translation processes, i.e. that countries are aware of the comparative advantage of knowledge translation and prepared to move forward with its implementation. Further advocacy on the demand for evidence synthesis and knowledge translation can improve a country's receptiveness. An assessment of the EIP context, as suggested by EVIPNet Europe's Situation analysis manual, is a good starting point (EVIPNet Europe, 2017) to analyse the EIP climate of a country.
2. The country/institution that will implement the EBP project needs to have the capacity to initiate the process. This includes having the human resources ready to be trained on EBP development. Furthermore, time, commitment and the basic financial resources need to be secured.
3. In addition, it is essential that the countries/institutions have a general idea about the priority health problem(s) requiring the development of an EBP that is aligned with policy priorities in the country. At this stage, it might be enough to know the general theme or the overarching issue that is to be tackled (e.g. antimicrobial resistance [AMR]). Some countries/institutions, however, might already have a clear, detailed definition of the problem they wish to address via knowledge translation (e.g. inappropriate prescribing of prophylactic antibiotics following surgery in hospitals). In either case, countries should not come with preconceived ideas about what to do to change the situation (that is, the solution or policy options), since those are to be identified through evidence from the EBP and stakeholder engagement.

Whenever the before-mentioned critical elements are established, the EVIPNet Europe Member country and WHO can move forward in preparing for official collaboration.

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## 1.2 ESTABLISHING OFFICIAL COLLABORATION

Once the EVIPNet Europe Member country and WHO have informally agreed to collaborate on developing an EBP, more formal cooperation methods can be established. Providing a clear understanding and spelling out the respective tasks and responsibilities will facilitate cooperation and allow for more structured, efficient and effective work. The following subsections provide examples for the EVIPNet Europe Member country of the issues that should be discussed during the collaboration phase, and which may form the basis of formal terms of reference (ToR) or a memorandum of understanding (MoU).

### 1.2.1 Goals and objectives of the collaboration

**The ultimate goal** of the support/collaboration is to promote EIP in countries.

**Specific objectives** of this collaboration

To sustainably build the capacity of countries in knowledge translation in order to support the formulation and adoption of EIP.

**Expected outcomes** of this collaboration

For the EVIPNet Europe Member country and the involved institutions/actors, the expected outcomes are:

- to understand and master the process of preparing, developing and evaluating an EBP;
- to understand and gain skills in preparing for a policy dialogue, as well as facilitating and evaluating it;
- to understand and gain skills in developing an uptake plan for the EBP;
- to create or facilitate an environment/culture supportive of EIP and knowledge translation.

**Expected outputs** from this collaboration

The collaborative work is expected to enable:

- the development of skilled and competent individuals within the EVIPNet Europe Member country to develop EBPs to support policy decisions;
- the development of EBPs based on systematic and transparent processes that are evidence informed, contextualized and engaging, to guide the development of public health policies, programmes and/or strategies;
- the implementation of an uptake plan for the EBP, including a policy dialogue and its summary.



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## 1.2.2 Duties of all parties

The WHO Secretariat of EVIPNet Europe will support the establishment of a team that will be in charge of developing the EBP. Overall, the capacity-building and support process includes:

- at least one face-to-face workshop (or at least three webinars) on the process of preparing for, developing and evaluating an EBP and implementation plan;
- individualized calls/meetings to follow up on the process and address challenges;
- coaching on and distance support for the EBP country teams' drafts, including providing comments, suggestions and/or changes to the drafts until these are ready for publication.

The subsections that follow provide a general idea of the responsibilities of the different parties involved in the EBP development and support processes.

### The EBP country team

The EBP team should:

- be actively engaged in the process of identifying priority public health issues/problems to tackle via the EBP;
- observe the agreed terms and conditions of the collaboration, including the agreed workplan and timelines;
- attend all organized webinars/workshops and one-on-one coaching sessions;
- be proactive in identifying and discussing the challenges, barriers and issues that might affect the process of developing the EBP or of maintaining the MoU.

### Methodological support by WHO and its partners

Methodological support includes support from experts in the fields of knowledge translation and/or EIP to ensure methodological rigour of the EBP, such as how the evidence was synthesized and the EBP developed. This type of technical support is provided all along the knowledge translation process. It consists of:

- advising on the country's readiness to tackle a certain public health issue/problem via knowledge translation/EBPs, in terms of the team's capacity to initiate a knowledge translation process;
- delivering webinars, face-to-face workshops and one-on-one coaching for EBP teams aligned with and in response to the capacity-building needs of the country;
- providing guidance on the entire knowledge translation process, along with the tools and methods for the EBP team to initiate, prepare for, develop, publish and evaluate the EBP;
- advising on how to progress the EBP over the knowledge translation continuum, including the uptake process, via advocacy, communication and policy dialogues;
- monitoring progress and following up with the EBP country team(s) according to the timeline and workplan;
- reviewing the final EBP from a methodological perspective;
- identifying where support to an EBP cohort is needed – promoting networking, exchange of experiences and good practices, as well as peer support among participating countries (e.g. through interaction via Yammer®, the EVIPNet Europe online platform).

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## Content-technical support by WHO and its partners

Support for developing subject-specific content includes support from experts in the field of the EBP topic (e.g. an infectious disease specialist if the topic of the EBP is AMR), and its role is to ensure scientific soundness and rigour in problem description and the potential policy options. This support function involves:

- specifically advising on refining the problem statement, problem tree and description of the problem;
- regularly reviewing the EBP at different stages of the process, starting with the EBP ToRs;
- helping to identify relevant research evidence and tacit knowledge on the described problem and/or the policy options, best practices and their implementation considerations;
- assisting in identifying local/international content experts and other relevant stakeholders to engage them in the process;
- reviewing the final EBP from the perspective of subject-specific content.

## Management support by WHO

While the WHO Secretariat of EVIPNet Europe leads the management support, the involvement of WHO country offices and, in particular, the WHO Representative, is vital throughout the EBP development process to ensure that it is of high quality and completed in a timely manner. Management support includes:

- overseeing the development and implementation of the collaborative work (e.g. MoU/ToR);
- helping to source financial support for the EBP process;
- organizing webinars and workshops;
- monitoring progress and following up with all involved parties according to the timeline and workplan;
- assisting in finding solutions to the barriers that might arise throughout the process of developing the EBP;
- raising overall awareness of and advocating for the EBP among national stakeholders;
- helping to identify merit- and peer-reviewers;
- leading the WHO clearance and publication process of the EBP.

### 1.2.3 EBP team leads for collaboration and follow up

For each EBP team, both a content and a methodological lead person should be identified, the latter also being the overall focal person of the team. Examples are given below of the ToR for a focal person and a content expert lead to demonstrate what responsibilities and qualifications are expected from these actors.

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# SPECIFICATIONS OF EVIPNET EUROPE FOCAL PERSON/LEAD FOR EBP DEVELOPMENT (WHO REGIONAL OFFICE FOR EUROPE)<sup>3</sup>

**ToR:** the EBP team focal person/lead – to be chosen by the governing body – should have the following experience/expertise for the key tasks noted here.

## 1. Methods

EBP development activities for the EBP team focal person include:

- leading the development of the protocol/ToR of the EBP;
- ensuring the technical accuracy and political sensitivity of the EBP;
- coordinating the mapping of key stakeholders (e.g. for the key informant interviews and merit-review process), and leading or supporting the key informant consultations;
- identifying suitable EBP team members based on the required skills and expertise;
- leading and coordinating problem-framing, and identifying the options and considerations for implementation;
- ensuring access to databases and literature;
- coordinating the process of searching for and appraising the literature;
- drafting the EBP and/or overseeing and guiding the writing process;
- reviewing the EBP to ensure quality of content.

## 2. Leadership and organization

In collaboration with the content lead, the EBP team focal person will:

- oversee and monitor the EBP development process, and alert the steering committee and WHO in case of delays;
- lead and coordinate the EBP team (including clearly communicating responsibilities and providing clear instructions about tasks);
- support EBP team members in managing their tasks, including:
  - planning and coordinating collaboration with the team, steering committee, and merit reviewers;
  - coordinating the merit-review process and revision(s) of the EBP according to timelines;
  - overseeing the budget;
  - managing partnership agreements and/or contracts;
  - preparing project reports (as required);
  - coordinating the publication process in collaboration with the WHO Secretariat (including copyediting, translation, design, printing and dissemination).

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<sup>3</sup> Unpublished template developed by WHO Regional Office for EVIPNet Europe. Note that there is significant overlap in some of the leadership and organization-related tasks of the EBP team focal person/content lead and the content expert/lead; both actors should be fully responsible for and involved in leading the process.

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### 3. Communication

The EBP team focal person/lead:

- regularly communicates with the EVIPNet Europe Secretariat and their team, the WHO Country Office and the steering committee;
- develops and/or coordinates the development of a communication strategy, including steps for the dissemination of the EBP results;
- communicates with the media and advocates for the EBP as appropriate;
- monitors communication activities.

### 4. Knowledge and skills

Ideally, the focal person would have some key characteristics, including:

- knowledge of EVIPNet Europe and an understanding of the methods of EBP development;
- a good understanding of the knowledge translation and policy processes;
- previous experience in evidence synthesis;
- strong leadership, organizational and project management skills;
- previous experience in coordination and people management, in particular, of interdisciplinary teams;
- good interpersonal and communication skills;
- excellent English-writing and speaking skills (fluent).

### 5. Educational background

The EBP team focal person should be educated in at least one of the following areas:

- public health
- public administration
- health system governance
- health system/policy analysis.

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# SPECIFICATIONS OF THE CONTENT EXPERT LEAD FOR EBP DEVELOPMENT (WHO REGIONAL OFFICE FOR EUROPE)<sup>4</sup>

**ToR:** the content expert/lead should have the following experience/expertise for the key tasks noted here (using the example of an AMR content expert).

## 1. Methods

EBP development activities for the content expert include:

- contributing to mapping of the key stakeholders (e.g. for the key informant interviews and merit-review process) and leading or supporting the key informant interviews;
- identifying suitable EBP team members based on the required skills and expertise;
- overseeing the technical soundness and relevance of problem framing, and identifying the options and implementation considerations;
- contributing to the process of searching for the relevant literature and supporting the development of the literature search strategy;
- drafting the EBP, together with the EBP team focal person, drawing on input from the team members;
- reviewing the EBP to ensure the quality of the content;
- ensuring liaison with relevant institutes and partners in the field in question (e.g. to supply country-specific data on AMR and use of medicines).

## 2. Leadership and organization

In collaboration with the EBP team focal person, the content expert lead will:

- oversee and monitor the EBP development process, and alert the steering committee and WHO in case of delays;
- lead and coordinate the EBP team (including clearly communicating responsibilities and providing clear instructions about tasks);
- support EBP team members in managing their tasks, including:
  - planning and coordinating collaboration with the team, steering committee, and merit reviewers;
  - coordinating the merit-review process and revision(s) of the EBP according to timelines;
  - overseeing the budget;
  - managing partnership agreements and/or contracts;
  - preparing project reports (as required);
  - coordinating the publication process in collaboration with the WHO Secretariat (including copyediting, translation, design, printing and dissemination).

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<sup>4</sup>Unpublished template developed by the WHO Regional Office for EVIPNet Europe. Note that there is significant overlap in some of the leadership and organization-related tasks of the EBP team focal person/content lead and the content expert/lead; both actors should be fully responsible for and involved in leading the process.

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### 3. Communication

The content expert lead:

- regularly communicates with the (AMR) programme, the EVIPNet Europe Secretariat and its team, the WHO Country Office and the steering committee;
- develops and/or coordinates the development of a communication strategy, including steps for dissemination of the EBP results, in collaboration with the EBP team focal person;
- communicates with the media and advocates for the EBP as appropriate;
- monitors communication-related activities.

### 4. Knowledge and skills

Preferably, the content expert would have some key characteristics, including:

- expert knowledge about the issue (e.g. national AMR response), key actors and data availability;
- knowledge of EVIPNet Europe and an understanding of the methods of EBP development;
- a good understanding of the knowledge translation and policy processes;
- previous experience in evidence synthesis;
- strong leadership, organizational and project management skills;
- previous experience in coordination and people management, in particular, of interdisciplinary teams;
- good interpersonal and communication skills;
- excellent English-speaking skills (fluent).

### 5. Educational background

The content expert lead should be educated in either of the following area:

- medicine
- health sciences.

#### 1.2.4 Communication terms

To ensure effective capacity-building of the EBP teams, training sessions should be conducted on each step of the EBP development process (see Fig. A). Furthermore, the EBP writing processes will be technically assisted through:

- (a) regular (virtual) meetings to monitor progress and discuss specific needs and challenges that may arise;
- (b) individualized coaching and mentoring to facilitate the EBP writing process;
- (c) written feedback on draft versions of the EBP.

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Setting clear timelines and agreeing on the means of communication should occur early in the process. One-on-one meetings/workshops remain the best method of communication. However, if this is not possible, other means of communicating should be identified. Some examples include:

- platforms for webinars, such as WebEx, Go To Meeting, etc.;
- platforms for one-on-one coaching, such as Skype, Huddle, WhatsApp, WebEx, etc.;
- platforms for sharing documents, such as Dropbox, Yammer, email, etc.

Some of these platforms are free, but others might have to be purchased. Identifying communication methods early on can help in potentially including an item in the budget to facilitate communication.

### 1.2.5 Timeline for collaboration

Clear timelines should be agreed upon before starting to collaborate. The expected timeline for the support process can be in the range of 6–12 months. Detailed timelines are discussed in Subsection 2.1.6.

### 1.2.6 Outlining the monetary terms

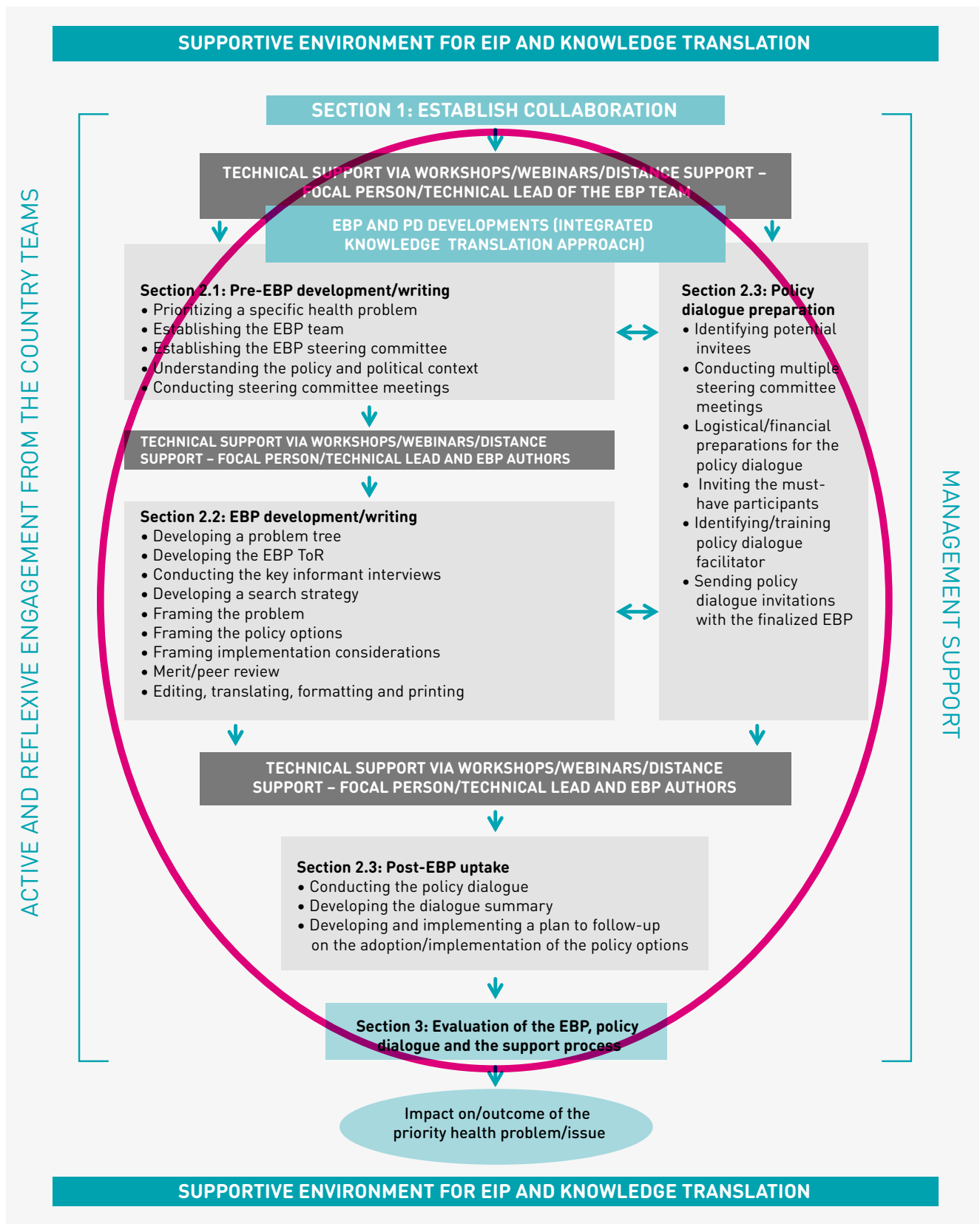
To be agreed on a case-by-case basis.

## List of references

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FIG. A. FRAMEWORK FOR SUPPORTING COUNTRIES TO DEVELOP AND IMPLEMENT AN INTEGRATED KNOWLEDGE TRANSLATION APPROACH



Note. M&E: monitoring and evaluation

Source: adapted from the integrated knowledge translation framework presented by El-Jardali & Fadlallah (2015).

## SECTION 2

# TECHNICAL SUPPORT AND COACHING FOR THE INTEGRATED KNOWLEDGE TRANSLATION APPROACH

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## 2.1 THE PRE-EBP PHASE: PREPARATIONS FOR WRITING

This section describes all the steps that precede the writing of the actual EBP. Before starting the process, technical training will be provided to countries developing EBPs for the first time.

The process of preparing to develop an EBP is very important (before starting to write the actual EBP). This phase includes identifying the EBP team and steering committee, with the right expertise in developing the EBP. It also ensures a proper understanding of the problem, the political and policy contexts and the main stakeholders around the issue, as well as facilitating the development of the EBP ToR for the next stage. Completing these steps before getting started on the EBP is essential for ensuring a high-impact EBP that is evidence informed and based on the local context.

This phase might take a few weeks to a few months, depending on how fast the EBP team and the steering committee can be convened and start meeting regularly. It also depends on the total timeline of the knowledge translation project.

### KEY MESSAGES

- Before initiating the writing process of the EBP, multiple steps are needed to ensure a high-impact EBP that is evidence informed and based on the local context.
- Priority-setting exercises should be conducted to identify the specific public health challenge to be addressed by the EBP. This problem should be further broken down to its main contextual underlying factors.
- The EBP team and steering committee, with the right mixture of expertise, are crucial to the success of the knowledge translation process.
- Adequate knowledge of the context can help shape the EBP itself, the choice of stakeholders involved, the deadlines set for the project, the communication plan, and the uptake plan.
- Defining the project timeline and workplan with clear division of tasks among the team members early on ensures smooth and timely development of the EBP.
- Engaging key stakeholders related to the public health challenge from the beginning can enable the opportunity to learn from their tacit knowledge. It further gives them a sense of ownership of the initiative and increases their buy-in and the likelihood of the policies being adopted.

### 2.1.1 Priority-setting

Prioritizing the problem is a very important first step of the EBP development process. Given the limited resources, the EBP should tackle a high-priority issue to maximize impact and use resources wisely (Uneke et al., 2013). Furthermore, engaging policy-makers and stakeholders in prioritizing topics increases the likelihood of uptake of the evidence, as well as the buy-in of policy-makers and stakeholders (COHRED, 2006; Lavis, Lomas, et al., 2006). Once the EBP team is identified and discussions have started, further focus might be necessary to frame the problem appropriately. While

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this section is relevant at the beginning of the process, more specific problem-framing might also be needed at later stages of the journey towards integrated knowledge translation.

Priority topics can be identified through a range of methods.

### 1. Formal priority-setting exercise

- A priority-setting exercise (i.e. in the form of a meeting) should be carried out to formally convene relevant policy-makers and stakeholders to clarify priority topics and identify research, data and evidence needs (El-Jardali et al., 2010).
- The planning of a priority-setting exercise comprises a number of steps.
  - The first step is to conduct a review of the literature and technical data from ministries and other government agencies, websites of international organizations and scholarly databases. This step helps to define the scope, focus and time frame for the exercise.
  - The second step is to invite and secure the participation of the most relevant stakeholders, ensuring appropriate representation by conducting a comprehensive stakeholder mapping exercise focusing on the broader topic (see Subsection 2.1.5). The stakeholders invited for the priority-setting exercise might be slightly different from those invited to the policy dialogue in later stages of the process, depending on what specific problem is chosen for working on from the broader topic (e.g. AMR at the national level in general, versus antibiotic prescription only in the veterinary field).
  - The next step is to collect data on the priorities of different policy-makers and stakeholders and identify cross-cutting priorities.
  - The final step is to validate and rank the identified priorities based on a number of criteria, such as the magnitude and severity of the problem, relevance, urgency, applicability, feasibility and originality.

### 2. Informal discussions and consultations/direct requests

- Priorities can also be identified through informal discussions, personal meetings and encounters with policy-makers and stakeholders, even when the topic at hand is not the purpose of the discussion.
- Direct requests can be received from policy-makers and stakeholders on a specific policy priority (i.e. commissioned work).

### 3. Focusing event

- Priorities can also be identified by an event that suddenly focuses attention, such as a crisis or an outbreak, and/or subsequent media/press tracing that requires a response (e.g. a child dying from a medical error or a disease outbreak) (Kingdon, 1984).

See Box 2.1 for the priority-setting criteria established by the K2P Center to assess a topic's readiness to enter the EBP process.

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## BOX 2.1. PRIORITY-SETTING CRITERIA OF THE K2P CENTER

In order to identify whether the chosen issue is a priority, the K2P Center has established a set of 14 criteria for consideration when selecting priority topics, in the form of yes/no questions. The answer should be yes to all of these questions to be considered material for an EBP; otherwise, the issue would not be ready to pass through the policy cycle. Meeting all these criteria might also mean that the EBP can lead to health benefits, improvements in health equity or other positive impacts.

The political and policy context-mapping exercise can help achieve a comprehensive understanding of the issue in order to answer the below questions.

1. Is the topic important?
2. Has the topic already been recognized as a policy challenge?
3. Has the topic already been integrated in the policy cycle?
4. Is there public interest in the topic?
5. Is there sufficient local evidence?
6. Are viable options available to address the topic?
7. Is there an opportunity for change?
8. Is there important uncertainty about the topic and potential solutions?
9. Is relevant research evidence available?
10. Is there interest in informed deliberation about the problem and potential solutions?
11. Does the topic have national and regional relevance?
12. Is it feasible for the organization/institution to track the outputs, outcomes and impacts of the use of evidence in policy?
13. Can long-term versus short-term wins be identified by addressing this priority topic?
14. Is the topic clear and well-defined?

Source: K2P Center (2014).

### 2.1.2 Identifying the EBP team

Identifying the right mixture of expertise for the EBP team is crucial to the success of the EBP. The focal person and the content expert recruited at the earliest stage of the knowledge translation process (see Section 1.2) should ideally take the lead in choosing and recruiting the EBP team. This team will be responsible for developing the EBP, conducting the key informant consultations, preparing for the policy dialogue and supporting the knowledge uptake plan for the EBP. A preliminary stakeholder mapping exercise can help to identify the EBP team members (see Subsection 2.1.5), especially the methodological and content experts in the field. Some countries/institutions/organizations might have an extensive list of personnel/resources allocated for developing the EBP and organizing the policy dialogue. Table 2.1 is intended to give a general overview of the team members to be involved in developing the EBP, including:

- their tasks and their suggested backgrounds, knowledge and skills;
- the approximate time investment required, with possible incentives identified.

The EBP team consists of members with different backgrounds and expertise. Note that while Table 2.1 is structured by functions, it is recommended to focus on the tasks listed. In some EBP teams, for example, the methodological lead may at the same time serve as the administrative lead.

**TABLE 2.1. A GUIDE TO THE FUNCTIONS, TASKS, BACKGROUND/SKILLS AND EFFORT NEEDED BY THE EBP TEAM**

EBP TEAM			
FUNCTION	TASK	BACKGROUND AND KNOWLEDGE/ SKILLS	EFFORT AND INCENTIVES
<b>Method- ological (EBP) lead</b>	<ol style="list-style-type: none"> <li>1. Leadership/management <ul style="list-style-type: none"> <li>▪ Oversees and monitors the EBP development process, and alerts the steering committee and WHO in case of delays</li> <li>▪ Leads the EBP team (clearly communicates about responsibilities and provides clear instructions about tasks)</li> <li>▪ Ensures that the EBP team has good access to databases and literature</li> </ul> </li> <li>2. Technical oversight <ul style="list-style-type: none"> <li>▪ Leads the development of the protocol/ ToR/outline of the EBP</li> <li>▪ Ensures the technical accuracy and political sensitivity of the EBP</li> <li>▪ Leads the development of the policy and political context-mapping exercise</li> </ul> </li> <li>3. Engagement and communication <ul style="list-style-type: none"> <li>▪ Maps key stakeholders (e.g. for the key informant interviews and merit-review process) and leads the conduct of interviews</li> <li>▪ Regularly communicates with the WHO Secretariat of EVIPNet Europe and its partners, the WHO Country Office and the steering committee</li> <li>▪ Communicates with the media and advocates for the EBP as appropriate</li> </ul> </li> </ol>	<p>Background</p> <ul style="list-style-type: none"> <li>▪ Public health, public administration, health system governance and/or health system/policy analysis</li> </ul> <p>Knowledge/skills</p> <ul style="list-style-type: none"> <li>▪ Expertise in knowledge translation science, especially in developing EBPs and in formulating problem statements and options</li> <li>▪ Finding, assessing and synthesizing evidence</li> <li>▪ Experience working in an interdisciplinary, international team context</li> <li>▪ Leadership, organizational, coordination, people management, and interpersonal skills</li> <li>▪ English language proficiency</li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>▪ 6 hours/week over 8 months</li> </ul> <p>Incentives</p> <ul style="list-style-type: none"> <li>▪ Financial</li> <li>▪ Co-authorship</li> </ul>
<b>Adminis- trative lead</b>	<ol style="list-style-type: none"> <li>1. Administration <ul style="list-style-type: none"> <li>▪ Oversees budget</li> <li>▪ Manages partnership agreements and team ToR/contracts</li> <li>▪ Supports publication process (including copy-editing, translation, design, printing and dissemination)</li> </ul> </li> <li>2. Coordination/planning <ul style="list-style-type: none"> <li>▪ Supports EBP team members in managing their tasks and following up on timelines</li> <li>▪ Plans and coordinates collaboration work with the team, steering committee, and merit-reviewers</li> <li>▪ Coordinates the merit-review process and revision(s) of the EBP according to the agreed timelines</li> <li>▪ Supports in the preparations for the policy dialogue</li> </ul> </li> <li>3. Documentation <ul style="list-style-type: none"> <li>▪ Prepares project reports</li> <li>▪ Keeps track of the meeting minutes</li> </ul> </li> </ol>	<p>Background</p> <ul style="list-style-type: none"> <li>▪ Administration</li> </ul> <p>Knowledge/skills</p> <ul style="list-style-type: none"> <li>▪ Organization, communication, administrative, people management and interpersonal skills</li> <li>▪ Working in an interdisciplinary/ international team</li> <li>▪ English language proficiency</li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>▪ 18 hours/week over 7 months</li> </ul> <p>Incentive</p> <ul style="list-style-type: none"> <li>▪ Financial</li> </ul>

EBP TEAM			
FUNCTION	TASK	BACKGROUND AND KNOWLEDGE/ SKILLS	EFFORT AND INCENTIVES
<b>Evidence synthesis and writing lead</b>	<ol style="list-style-type: none"> <li>Evidence synthesis <ul style="list-style-type: none"> <li>Leads literature searches, conducts quality appraisal and prepares evidence tables (including developing the search strategy)</li> </ul> </li> <li>Engagement <ul style="list-style-type: none"> <li>Supports the conduct of key informant interviews</li> </ul> </li> <li>Writing <ul style="list-style-type: none"> <li>Drafts the EBP and/or oversees and guides the writing process</li> </ul> </li> </ol>	<p>Background</p> <ul style="list-style-type: none"> <li>Research, public health, health system governance and/or health system/policy analysis</li> </ul> <p>Knowledge/skills</p> <ul style="list-style-type: none"> <li>Finding, assessing and synthesizing evidence</li> <li>Conducting and analysing key informant interviews</li> <li>Working in an interdisciplinary/international team</li> <li>Writing skills and experience</li> <li>English language proficiency</li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>9 hours/week over 7 months</li> </ul> <p>Incentives</p> <ul style="list-style-type: none"> <li>Financial</li> <li>Co-authorship</li> <li>Desire to make an impact and improve health/societal outcomes</li> </ul>
<b>Topic-specific expert(s)</b>	<ol style="list-style-type: none"> <li>Evidence synthesis <ul style="list-style-type: none"> <li>Reviews search strategy</li> <li>Supports the development of the problem tree, protocol/ToR/outline of the EBP</li> <li>Supports the identification of project team members, steering committees and stakeholders to be involved</li> <li>Supports the development of the policy and political context-mapping exercise</li> </ul> </li> <li>Review <ul style="list-style-type: none"> <li>Reviews the EBP for accuracy and quality of content (including recommendation of additional literature, where applicable)</li> </ul> </li> </ol>	<p>Background</p> <p><i>Depends on the topic, e.g.</i></p> <ul style="list-style-type: none"> <li>Medicine/epidemiology/ economics</li> </ul> <p>Knowledge/skills</p> <ul style="list-style-type: none"> <li>Strong thematic knowledge depending on the topic (scientific and tacit knowledge)</li> <li>Knowledge of existing data and evidence (national/global level)</li> <li>English language proficiency</li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>4 hours/week over 3 months</li> </ul> <p>Incentives</p> <ul style="list-style-type: none"> <li>Financial</li> <li>Co-authorship</li> <li>Desire to make an impact and improve health/societal outcomes improve health/societal outcomes</li> </ul>
<b>External support (WHO Country Office)</b>	<ol style="list-style-type: none"> <li>Engagement <ul style="list-style-type: none"> <li>Brokers between the EBP team, the Ministry of Health and local stakeholders</li> <li>Supports stakeholder mapping and engagement</li> <li>Helps establish contact/contracts with experts</li> <li>Supports in the policy and political context-mapping exercise</li> </ul> </li> <li>Monitoring of work <ul style="list-style-type: none"> <li>Monitors the progress of work and follows up on timelines</li> <li>Reviews the EBP from a local policy context angle</li> </ul> </li> <li>Communication/advocacy <ul style="list-style-type: none"> <li>Promotes the work to other stakeholders</li> </ul> </li> </ol>	<p>Background</p> <ul style="list-style-type: none"> <li>WHO Country Office staff member</li> </ul> <p>Knowledge/skills</p> <ul style="list-style-type: none"> <li>Health system governance</li> <li>Health system and health policy (analysis): <ul style="list-style-type: none"> <li>of the local context</li> <li>of (and contact with) local key stakeholders</li> </ul> </li> </ul>	<p>Effort</p> <ul style="list-style-type: none"> <li>1 hour/week over 8 months</li> </ul> <p>Incentive</p> <ul style="list-style-type: none"> <li>Acknowledgement of WHO/ Country Office support in EBP publication</li> </ul>

In many contexts, the number of people involved will vary. In some contexts, the team can be much larger (see, for example, Table 2.2), while in other contexts it can be much smaller and the tasks performed much more streamlined. The decision on the team size could be based on the nature of the problem/issue chosen in the EBP, the availability of and accessibility to experts, the budget, and the deadlines for finalizing the knowledge translation process. As a rough guideline, the EBP team needs to include at least one member with expertise in each of these areas:

- methods of writing (an EBP);
- knowledge translation science;
- administration;
- evidence research, appraisal and synthesis;
- expertise in subject-specific content (on the topic that is being addressed in the EBP);
- communications.

### Example

The EVIPNet Hungary team of 2016-2017 working on an EBP on antibiotic use and AMR (furthermore referred to as “EVIPNet Hungary team”) consisted of nine members, with six content experts in the field of antibiotic use and AMR, and three people taking the lead for coordination, providing the policy input and support for the whole process (Table 2.2).

**TABLE 2.2. ESTIMATES OF WORKING HOURS FOR THE EVIPNET HUNGARY TEAM COMPILING THE EBP FOR AMR, ACCORDING TO COMPETENCES AND WORK PHASES**

	<b>Epidemiologists (3)</b>	<b>Pharmacologists (2)</b>	<b>Infectious disease specialist (1)</b>	<b>Policy &amp; support (3)</b>	<b>Total (hours)</b>
<b>Literature search</b>	20 hours	–	8 hours	48 hours	<b>76</b>
<b>First draft</b>	178 hours	20 hours	8 hours	–	<b>206</b>
<b>Adjusting after reviews</b>	96 hours	–	2 hours (consultation)	48 hours	<b>146</b>
<b>Key informant interviews</b>	10 hours	–	–	40 hours	<b>50</b>
<b>Development of the second draft</b>	50 hours	20 hours	–	50 hours	<b>120</b>
<b>Adjustments after peer and merit review</b>	100 hours	10 hours	–	100 hours	<b>200</b>
<b>Correction of the edited English version and the Hungarian translation</b>	10 hours	–	–	20 hours	<b>30</b>
<b>Coordination</b>	–	–	–	96 hours	<b>96</b>
<b>TOTAL (HOURS)</b>	<b>464</b>	<b>50</b>	<b>18</b>	<b>402</b>	<b>934</b>

Note. Sums for any given category of experts

Source: Estimated by the EVIPNet Hungary team.



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## TIPS

To ensure the efficiency of the work, a suite of actions should be carried out, including:

- ensuring the multidisciplinary and multisectoral composition of the EBP team, not forgetting those with a sound understanding of policy processes;
- developing the ToR for the team members, in close coordination with them and keeping in mind their competing roles and responsibilities;
- clarifying the team members' responsibilities and deadlines early on in the process (and always having an updated workplan available);
- setting a clear timeline for the tasks and sticking to it (e.g. establishing good managerial practices);
- establishing and maintaining team spirit by continuing to remind them of the ultimate goal for their hard work;
- arranging for regular meetings of the authors of the EBP;
- remaining aware of potential conflicts of interest among the EBP team (as such, it is preferable to ask for a conflict of interest declaration to be submitted by the team) – transparency and disclosure of any potential conflict of interest are key to the success of the EBP.
  - If any conflict of interest arises, it should be discussed with the team and steering committee to decide how to handle it:
    - if the conflict of interest is high risk ➤ stop the collaboration;
    - if medium/low risk ➤ manage the conflict of interest.

### 2.1.3 Identifying the EBP steering committee

The EBP steering committee supports the different steps of the EBP development process. The EBP requires a steering committee that consists of 5–7 multisectoral, multidisciplinary and high-level key stakeholders from among the government, policy-makers, researchers and other key stakeholders who are knowledgeable enough about the topic and can contribute to the process of developing the EBP and organizing the policy dialogue. The steering committee members should also have a strong understanding of the underlying politics around the issue/problem; as such, they can provide the proper guidance to ensure the EBP's success. The steering committee members are the key stakeholders who must be included from the early stages of the EBP development process to oversee it closely. The committee should be in close contact with the leaders of the EBP team.

Table 2.3 describes:

- the steering committee's tasks and the members' suggested backgrounds, knowledge and skills;
- the approximate time investments required, with possible incentives identified.

**TABLE 2.3. A GUIDE TO THE FUNCTIONS, TASKS, BACKGROUND/SKILLS AND EFFORTS NEEDED BY THE STEERING COMMITTEE**

EBP STEERING COMMITTEE			
Function	Task	Background/ knowledge/skills	Effort and incentives
<b>Policy-maker(s)</b>	<ol style="list-style-type: none"> <li>1. Guidance on management of the EBP process                             <ul style="list-style-type: none"> <li>• Advises on the project plan and timelines (including the funding, budget, contracts, stakeholder mapping and interviews)</li> </ul> </li> <li>2. Guidance of EBP content development                             <ul style="list-style-type: none"> <li>• Reviews the protocol/ToR/outline for the EBP, in particular, refining the problem</li> <li>• Reviews the political and policy context-mapping exercise</li> <li>• Reviews the EBP and all other outputs</li> <li>• Reviews EBP evaluations</li> </ul> </li> <li>3. Guidance on the stakeholder engagement and the EBP uptake process                             <ul style="list-style-type: none"> <li>• Identifies key informants to provide feedback on the EBP (and its protocol/ToR/outline)</li> <li>• Identifies key stakeholders to be involved in the policy dialogue and the communication plan</li> <li>• Advises on the EBP uptake process</li> <li>• Supports in the identification of additional funding sources for the uptake of the EBP</li> </ul> </li> </ol>	High-level government policy-makers, bureaucrats	<b>Effort</b> <ul style="list-style-type: none"> <li>• One joint teleconference/ month (sometimes bi-weekly during crucial points in the process) over 6–7 months</li> </ul> <b>Incentive</b> <ul style="list-style-type: none"> <li>• Acknowledgement in the publication</li> </ul>
<b>Stakeholder(s)</b>		High-level stakeholder groups (e.g. professional associations, unions, large health-care delivery organizations)	

Source: adapted from approaches used by the McMaster Health Forum.

## TIPS

- At least one meeting per month should be arranged, or even more around key events. If face-to-face meetings are not possible, teleconferences are an option.
- One EBP team member should be assigned to coordinate the steering committee meetings.
- Minutes of the steering committee meetings should be taken and shared.
- In some cases, and depending on the topic at hand, the EBP team members could serve as the steering committee as well. Such cases can occur when few stakeholders are involved in a certain issue and most of them have been engaged with by/as EBP team members.
- All actors involved should be aware of potential conflicts of interest among the members of the steering committee. It is preferable to ask them to submit a conflict of interest declaration – transparency and disclosure of any potential conflict of interest are key to the success of the EBP:
  - If any conflict of interest arises, it should be discussed with the team and steering committee to decide how to handle it:
    - if the conflict of interest is high risk ➤ stop the collaboration;
    - if medium/low risk ➤ manage the conflict of interest.

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## 2.1.4 Brief description and mapping of the policy and political contexts

It is essential to understand the policy and political contexts around the health problem or issue identified before starting to develop the EBP. This step is very important in understanding the context and thus designing the proper response. Knowledge of the context can help shape the EBP itself, the choice of stakeholders to be involved, the deadlines set for the project, the communication plan, and the uptake plan. Below are some guiding questions that can support structuring of the thinking process about the history of the problem and the political context around it, including what has been done so far, what was successful, and what is still missing and why. This can further narrow the problem/issue of focus in the EBP and will help to understand the key stakeholders who might be for or against the policy being discussed. Stakeholders who have previously worked on similar goals related to the health problem in question should be collaborated with, and those who were opposing any such previous work should be monitored for possible actions that might hinder the ongoing work towards the EBP and/or the knowledge translation approach. The questions detailed in the subsections that follow can further identify the possible contextual windows of opportunity, and as such, allow a timeline to be set for the EBP to be completed (e.g. elections, international days, the issuance of a law that should be stopped, an outbreak that has happened, etc.).

It is worth noting, however, that the full and comprehensive policy and political context-mapping exercise requires extensive time and resources, along with a policy specialist to undertake it. The guiding questions below represent a tool that can be used to briefly outline the key areas that should be kept in mind when thinking about the context. The EBP team and/or the EBP steering committee can answer these questions, and their varied expertise can help to establish a better understanding of the problem.

### The guiding questions

1. **What is the problem or health issue(s)?**
  - What is the specific aspect of this health issue/problem to be tackled?
2. **What progress has been made on the issue/problem so far in your country?**
  - What brought the issue/problem into focus? Were there any focusing events?
  - Are there any previous policies, laws, decisions or interventions around it?
  - If yes, outline them and describe who was involved and how these were developed.
3. **Is the issue/problem currently within the policy/political agenda?**
  - Do policy-makers intend to address the issue/problem?
    - If not, then (i) should it be on the policy/political priority agenda; and (ii) what would it take to get it onto the agenda?
  - How high is it among their priorities?
4. **Is there a window of opportunity that can be used to start discussions/find solutions for the issue/problem in question?**
5. **Referring to the present problem and the possible solutions, what is required to reach the health policy objectives? (E.g. a law, a decision, an intervention, a strategy or institutional policy)**

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**6. Depending on the answer to question 5, how are strategies/laws/decrees developed and passed in the country?**

- What is the legislative process in the country?
- What is the governance structure and the status of transparency, accountability, resources and regulatory quality in the country?

**7. Who are the stakeholders involved in this issue/problem?**

- Who are the key decision-makers, policy-makers and influencers?
- Who might influence those categories (influencers of influencers)?
- Are there any civil society groups that might influence actions for/against the issue?
- Where do citizens stand on this issue?

**8. What is the power interplay among and between these stakeholders?**

- Who supports change on this issue?
- Who opposes change on this issue?
- What is the level of power of each: low, neutral or high?
- Are any of them allies? Is there any institutional conflict between any of them?
- Who would be critical to have on one's side in order to reach the identified objective(s)?
- Whose actions would it be critical to monitor to ensure that they are not working against the objective(s)?

These questions can help to identify the stakeholders who should be involved in the preparation, advising and deliberations of the EBP. It is worth noting that not all of the stakeholders mentioned in the last two questions should necessarily be involved; only the key stakeholders who can have a beneficial output and play a significant role in the process should be engaged from the beginning.

## TIPS

- At least one meeting should be convened with the steering committee and the EBP team to answer the questions outlined.
- Understanding the context is an iterative process that would be more efficiently conducted within a multidisciplinary team at multiple times throughout the development of the EBP.
- Although most of these questions will mainly serve to inform and guide the work of developing an EBP in general, this exercise can inform the later section related to describing the context and background of the EBP.

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## 2.1.5 Stakeholder mapping (key informants, policy dialogue invitees)

Stakeholder mapping is an important step before the development of an EBP. While this step is added here, stakeholder mapping is an iterative process that should be refined before each major stage of the knowledge translation continuum. Nonetheless, the list of stakeholders to be included as key informants and dialogue participants should be identified by the multidisciplinary steering committee and the EBP team through multiple meetings. The added value of multidisciplinary can be seen here, as those who are experts in the policy arena, for example, can identify all those who are involved in the policy aspect of the problem/issue in question. Similarly, researchers can identify other researchers. Stakeholders are identified from various stakeholder groups, such as decision-makers and policy-makers, national and international organizations, researchers in the field and other influencers. The definition of the scope of the EBP can help inform the choice of relevant stakeholders. Also, the stakeholder analysis conducted in the policy and political mapping stage can be of significant use here.

The choice of the stakeholders to be engaged as key informants/dialogue participants relies on:

1. their degree of involvement/knowledge about the problem and its relevant solutions;
2. their ability to engage constructively in the discussions and to articulate the problem and its possible solutions;
3. their ability to champion the actions recommended in the EBP.

The benefits of engaging stakeholders early on include:

1. ***learning from their tacit knowledge, i.e.***
  - about relevant programmes/policies
  - about other stakeholders (their roles, positions and influence over the issue)
  - about what works and what does not in the context, as opposed to relying only on international research evidence;
2. ***giving them a sense of ownership of the initiative and increasing their buy-in and the likely adoption of the policies in the future;***
3. ***sustainable implementation of the policies/interventions;***
4. ***getting more advocates on board;***
5. ***increasing the area/scope of coverage for the implementation phase.***

Table 2.4 shows a framework that can be used for stakeholder mapping. The list is not exhaustive; however, it can be useful in organizing the process of identifying policy-makers and relevant stakeholders.

**TABLE 2.4. EBP STAKEHOLDER MAPPING FRAMEWORK**

SPECIFIC ROLE CATEGORY	EXAMPLES OF DESCRIPTIVE POSITION TITLES	NAME	KEY INFORMANT AND/OR POLICY DIALOGUE PARTICIPANT
Directors in the Ministry of Health responsible for health policy decisions	Minister of Health or Deputy Minister/ Undersecretary/Secretary-General		
	Advisors and members of councils (e.g. quality councils, specialty councils, general medical commissions)		
	Head of Finance and Administration (e.g. budget and expenditure)		
	Head of Health Policy and Planning (e.g. in the areas of health information, health economics, project management)		
	Head of Health Human Resources (e.g. personnel, medical professionals, education and training)		
	Head of Primary Health Care (e.g. quality, private hospitals, regional health services, outpatient clinics)		
	Head of Public Health Programme (e.g. school health, occupational health, reproductive health, health promotion, maternal health, health media)		
	Head of Pharmaceuticals and Laboratories (e.g. microbiology, radiology, chemistry, pathology laboratories, drug control)		
Other health-related ministries	Directors in other health-related ministries (e.g. Ministry of Education, Ministry of Finance, Ministry of Social Affairs, Ministry of Labour)		
Manager nongovernmental organization (NGO) in a major city (e.g. United Nations)  Most senior director responsible for strategy or planning or policy within an NGO (e.g. Director, Vice-President)	International nongovernmental organizations (NGOs)		
	National NGOs/civil society actors (when available)		
Staff/member of a health professional association or group  Most senior manager/ director (i.e. non-elected representative) in charge of strategy or planning or policy	Presidents of national medical associations (e.g. physicians, dentists, laboratory technicians, physiotherapists)		
	President of national nursing association		
	President of national pharmacists' association		
	President of national hospital association		

SPECIFIC ROLE CATEGORY	EXAMPLES OF DESCRIPTIVE POSITION TITLES	NAME	KEY INFORMANT AND/OR POLICY DIALOGUE PARTICIPANT
Director in a donor agency (e.g. European Community), international organization (e.g. WHO)	A United States-based donor agency		
	A Europe-based donor agency		
Most senior manager within the WHO Country Office	WHO		
Manager in a health-care institution (e.g. hospital, primary health care centre)	Most senior manager in a health-care institution		
Researchers	Researcher in a national research institution		
	Researcher in a university		
	Researchers in health committees of the legislative power		
	Researcher in other institutions		

Source: adapted from Lavis, Hammill, et al., 2006; El-Jardali et al., 2010.

## TIPS

- There is no one formula for or method of identifying stakeholders; each country and each issue have their own specificities.
- Which stakeholders will serve as key informants and which will serve as dialogue participants or both should be identified.
- The number of researchers, policy-makers and other stakeholder groups should be balanced to allow for equitable contribution.
- Around 10–15 stakeholders should be chosen as key informants.
- Around 18–24 participants should be chosen as dialogue participants.
- If more stakeholders need to be invited, the possibility of engaging them in different subgroup dialogues should be assessed.
- When moving forward with the process of developing the EBP, the stakeholder list might change, new stakeholders might be identified, while others might not be relevant any more.
- In some contexts, politically elected leaders are not the expert policy-makers. For example, a Director-General of a Ministry of Health may have more expertise than the minister and can ensure the continuity of efforts among the succession of different ministers. As such, policy-makers, rather than politically elected leaders, should be chosen as experts, unless a specific politically elected leader is championing the initiative.

## 2.1.6 Workplan and timeline for deliverables

### Workplan

A workplan and a timeline are essential to ensuring that the deliverables are finalized on time. These are also important tools for internal and external coordination and communication of work with the advising institutions, so that everyone can plan ahead and know their roles and the deadlines involved. The workplan template (Table 2.5) covers the process of developing the EBP itself, whereas the timeline template (see Fig. 2.1 for an example) covers the entire process, including the preparations before and after the EBP, such as the policy dialogue.

These documents should be compiled with the EBP team and reviewed by the steering committee. The deadline should respect the deadlines approved by all parties in the potential contractual arrangements. A useful strategy is to set the timeline by starting from the policy dialogue date and working backwards.

One team member should be responsible for following up on the deadlines around deliverables with the steering committee and the EBP team. This person should also update these documents regularly.

TABLE 2.5. WORKPLAN FOR THE EBP

TASK	PERSON RESPONSIBLE	TARGET DATE	COMMENTS
Agree on the team to prepare the EBP for authorship			
Problem description and diagnosis		Requires approximately 2–3 full working weeks	
<ul style="list-style-type: none"> <li>▪ Outline problem and information needs</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Identification and appraisal of evidence and other information</li> </ul>			
<ul style="list-style-type: none"> <li>▪ First draft describing the problem</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Internal review and revision of problem description</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Submission of draft version for review</li> </ul>			
Policy options		Requires approximately 2–3 full working weeks	
<ul style="list-style-type: none"> <li>▪ Identification of potential programmes or services and health systems arrangements to address problem and information needs (particularly systematic reviews)</li> </ul>			
<ul style="list-style-type: none"> <li>▪ Identification and appraisal of evidence and other information</li> </ul>			



TASK	PERSON RESPONSIBLE	TARGET DATE	COMMENTS
<ul style="list-style-type: none"> <li>Agreement on policy options (single elements or bundles of relevant programmes or services and health systems arrangements)</li> </ul>			
<ul style="list-style-type: none"> <li>First draft describing policy options</li> </ul>			
<ul style="list-style-type: none"> <li>Internal review and revision of policy options</li> </ul>			
<ul style="list-style-type: none"> <li>Submission of draft version for review</li> </ul>			
Implementation strategies		Requires approximately 2–3 full working weeks	
<ul style="list-style-type: none"> <li>Identification of barriers to implementing policy options, strategies to address these barriers, and information needs (particularly systematic reviews)</li> </ul>			
<ul style="list-style-type: none"> <li>Identification and appraisal of evidence and other information</li> </ul>			
<ul style="list-style-type: none"> <li>First draft describing implementation strategies</li> </ul>			
<ul style="list-style-type: none"> <li>Internal review and revision of implementation strategies</li> </ul>			
<ul style="list-style-type: none"> <li>Submission of draft version for review</li> </ul>		Can be done alongside the previous steps Allow 10 working days	
Completion of the full EBP		Requires approximately 2–4 full working weeks (depending on the extent of the feedback from the external review)	
<ul style="list-style-type: none"> <li>Draft title, cover page, key messages, executive summary, references, description of methods, acknowledgements (including funders), conflicts of interest</li> </ul>			
<ul style="list-style-type: none"> <li>External review of the draft EBP</li> </ul>		Allow 10 working days	
<ul style="list-style-type: none"> <li>Revision of the full EBP</li> </ul>			
Policy dialogue, and informing and engaging stakeholders <sup>5</sup>		Approximately 5–6 months before the policy dialogue date	
<ul style="list-style-type: none"> <li>Agree on a team that will plan policy dialogue</li> </ul>			
<ul style="list-style-type: none"> <li>Decide on objectives of policy dialogue</li> </ul>			
<ul style="list-style-type: none"> <li>Decide when policy dialogue will take place</li> </ul>			
<ul style="list-style-type: none"> <li>Plan how to inform and engage stakeholders</li> </ul>			

<sup>5</sup> See Subsection 2.3.1 Policy dialogue.

TASK	PERSON RESPONSIBLE	TARGET DATE	COMMENTS
<ul style="list-style-type: none"> <li>Agree on a team to plan and monitor efforts to inform and engage stakeholders</li> </ul>			
<ul style="list-style-type: none"> <li>Decide which key stakeholders should be informed and engaged in preparing and using the EBP</li> </ul>			
Evaluation and publication of the EBP		Requires approximately 2–3 full working weeks	
<ul style="list-style-type: none"> <li>Finalize and publish EBP</li> </ul>			
<ul style="list-style-type: none"> <li>Monitor and evaluate EBP</li> </ul>			
<ul style="list-style-type: none"> <li>Monitor and evaluate policy dialogue</li> </ul>			
<ul style="list-style-type: none"> <li>Evaluate SURE guides</li> </ul>			

Source: adapted from SURE guides (The SURE Collaboration, 2011) and approaches developed with input from the McMaster Health Forum.

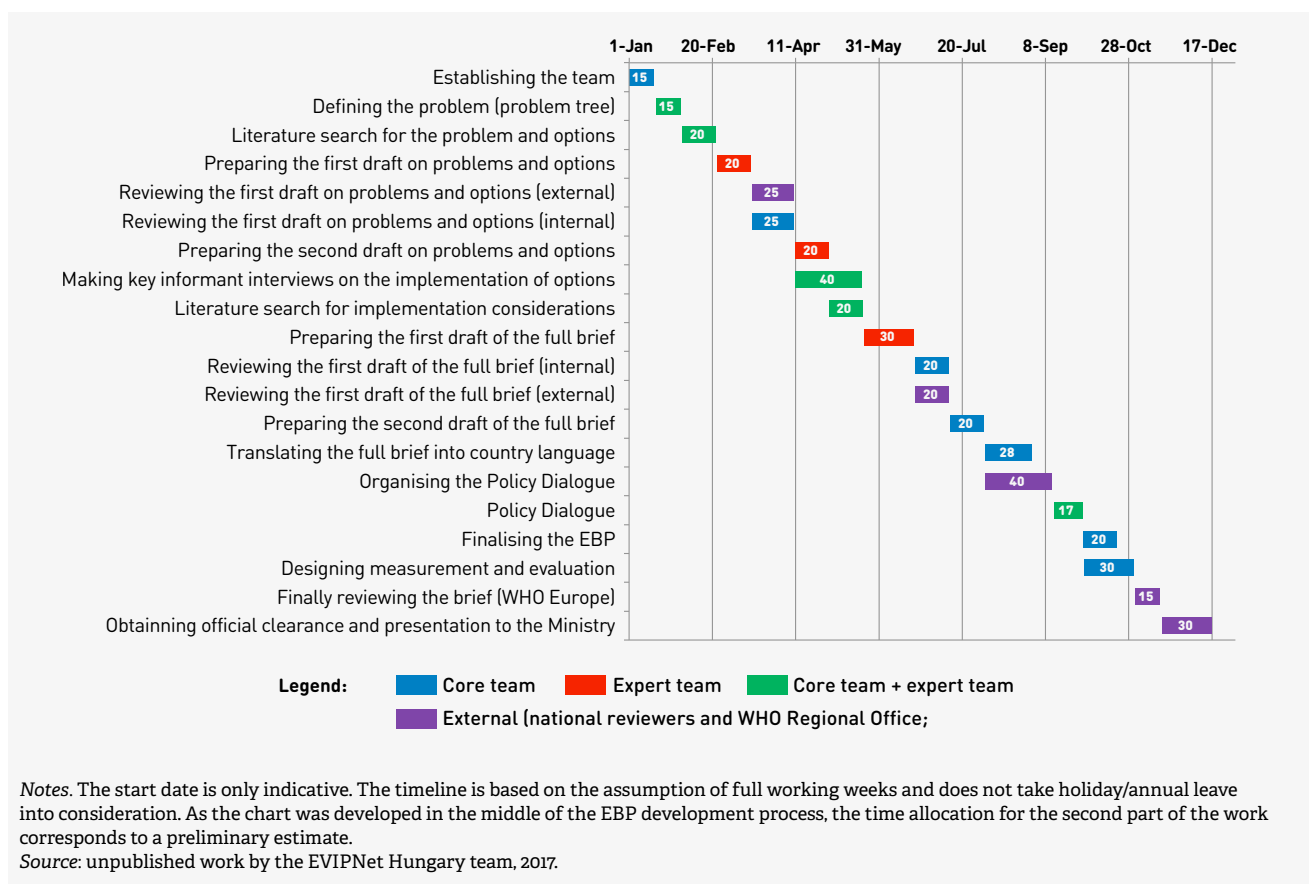
## Timeline

Aside from the workplan for the process of developing the EBP itself, a timeline should be developed for the full project. An average EBP and policy dialogue process takes somewhere in the range of 7–8 months.

The timeline should be individualized for each knowledge translation project. As a guideline, the following main milestones and time frames are to be considered when developing the full timeline for the knowledge translation project:

1. the timeline agreed on in the potential contractual arrangements;
2. the time needed to establish the EBP team and the steering committee;
3. if relevant, the time to identify funders and partners;
4. meetings of the steering committee (and the time required to respond to their comments);
5. the time needed for methodological/technical review by WHO;
6. any planned holidays;
7. conducting key informant consultations;
8. the time needed to actually write the EBP;
9. the date of the policy dialogue.

FIG. 2.1. A VISUAL EXAMPLE OF AN EBP TIMELINE



## TIPS

- If the EBP is an input into a policy dialogue, start the timeline by establishing (to the extent possible) the date of the and work backwards from there.
- Set the timeline and workplan with the EBP team members to ensure that the deadlines are feasible for them.
- Assign a team member/lead to maintain and update the workplan and timeline.
- The workplan and timeline might change as the project moves forward. These should be regularly updated and communicated with all the involved parties.
- As the timeline evolves, it should be ensured that all team members and consultants will still be available and willing to continue working on the EBP.

Fig. 2.1 shows a sample timeline that was developed by the EVIPNet Hungary team based on the experience of developing the first part of their EBP on antibiotic use and AMR.

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## 2.2 WRITING THE EBP: THE DEVELOPMENT PHASE

The steps conducted in the pre-EBP phase inform the development and writing of the EBP.

- The team has been established, with clear goals, timelines, and an understanding of the issue and its context.

The next step is to move forward with the process of developing the actual EBP.

- The problem has to be broken down to its contextual underlying factors by means of a problem tree.
- The EBP ToR and key informant consultations, conducted according to the ToR, should inform the EBP sections with evidence and tacit knowledge.
- The literature should be searched for relevant high-quality local, regional and international literature around the issue before work commences on the draft EBP.
- The EBP requires a clear problem statement and definition that frames it in an engaging way, capturing the interest and attention of all the relevant stakeholders.
- Options/elements to address the issue should be outlined with the relevant details needed to support evidence-informed decision-making. These options should be studied in terms of their implementation considerations, addressing the possible barriers to effective implementation.

### KEY MESSAGES

- An initial EBP outline or ToR should be shared with key stakeholders to further dissect the problem and to enable their feedback on the comprehensibility and relevance of the policy options.
- A search strategy should be conducted to retrieve all relevant local, regional and international evidence on the problem, underlying factors and policy options. More refined search strategies could be applied to different sections of the EBP, as long as this is reported on throughout the process. The EBP is then developed, while ensuring that:
  - the framing of the problem is evidence informed, contextualized and engaging, with a focus on health outcomes;
  - the options are evidence informed, objective, context specific and feasible, fit in with the local values and framework and are acceptable in terms of budget impact;
  - the implementation barriers and facilitators are identified at the various levels (system, organization, and for professionals and the public);
  - a graded entry format is used, with one page of key messages, three pages for an executive summary and a maximum of 25 pages for the full EBP;
  - the EBP is written in a simple, clear, focused and objective way.

It is important to note that recommendations should never be provided in an EBP.

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## 2.2.1 The problem tree

Once the topic has been identified, and its local political and policy context understood, a clear description of its extent, consequences and underlying factors should be composed. Time should be invested in developing the problem tree because a clearly defined problem tree helps:

- to clarify the real problem, its consequences, and its direct and indirect underlying factors;
- to frame the problem;
- to identify possible stakeholders;
- to focus the search on the elements/options for the solutions;
- to identify potential barriers to implementation.

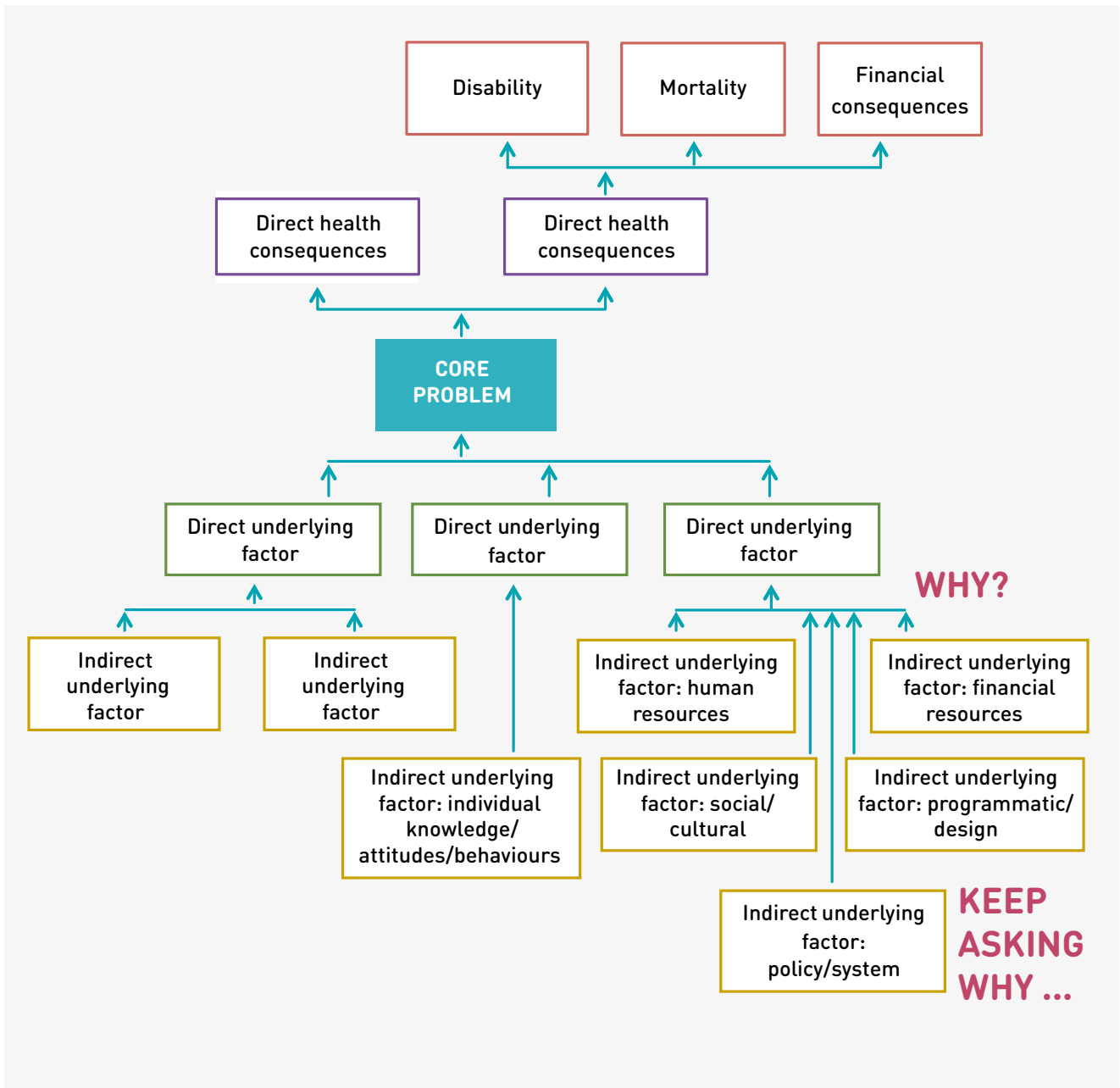
A problem tree comprises (see Fig. 2.2 and Fig. 2.3):

- a core problem positioned in the centre of the tree;
- direct and indirect consequences of the problem, to be added above the core problem (financial and health outcomes, mortality, morbidity, disability, etc.);
- a list of the direct and indirect underlying factors of the problem, added beneath the core problem. The direct underlying factors will then be segregated into smaller building blocks, delineating what might cause them. Indirect underlying factors can be segregated as (among others): individual-level knowledge/attitudes/behaviours; human resources; social/cultural factors; programmatic design; and policy/system factors.

### TIPS

- Developing the problem tree is an iterative process that requires much discussion.
- The problem tree should be developed with a multisectoral team that includes experts from various backgrounds, highlighting different angles of the problem.
- It is worthwhile considering arranging for a stakeholder consultation meeting or a focus group with experts to ask them about the underlying factors.
- Direct underlying factors might have overlapping and common indirect underlying factors; therefore, it is advised to use arrows and/or position factors according to the highest relevance (see Fig. 2.3).
- The team should choose and use terms and phrases correctly and in full (e.g. an underlying factor can be “lack of trained human resources”, rather than just “human resources”).
- All the recognized local and international underlying factors should be reported on.
- Both the direct and indirect underlying factors in the policy options should be addressed.
- The team should focus on one underlying factor in the EBP, or compile a more comprehensive EBP tackling all underlying factors.

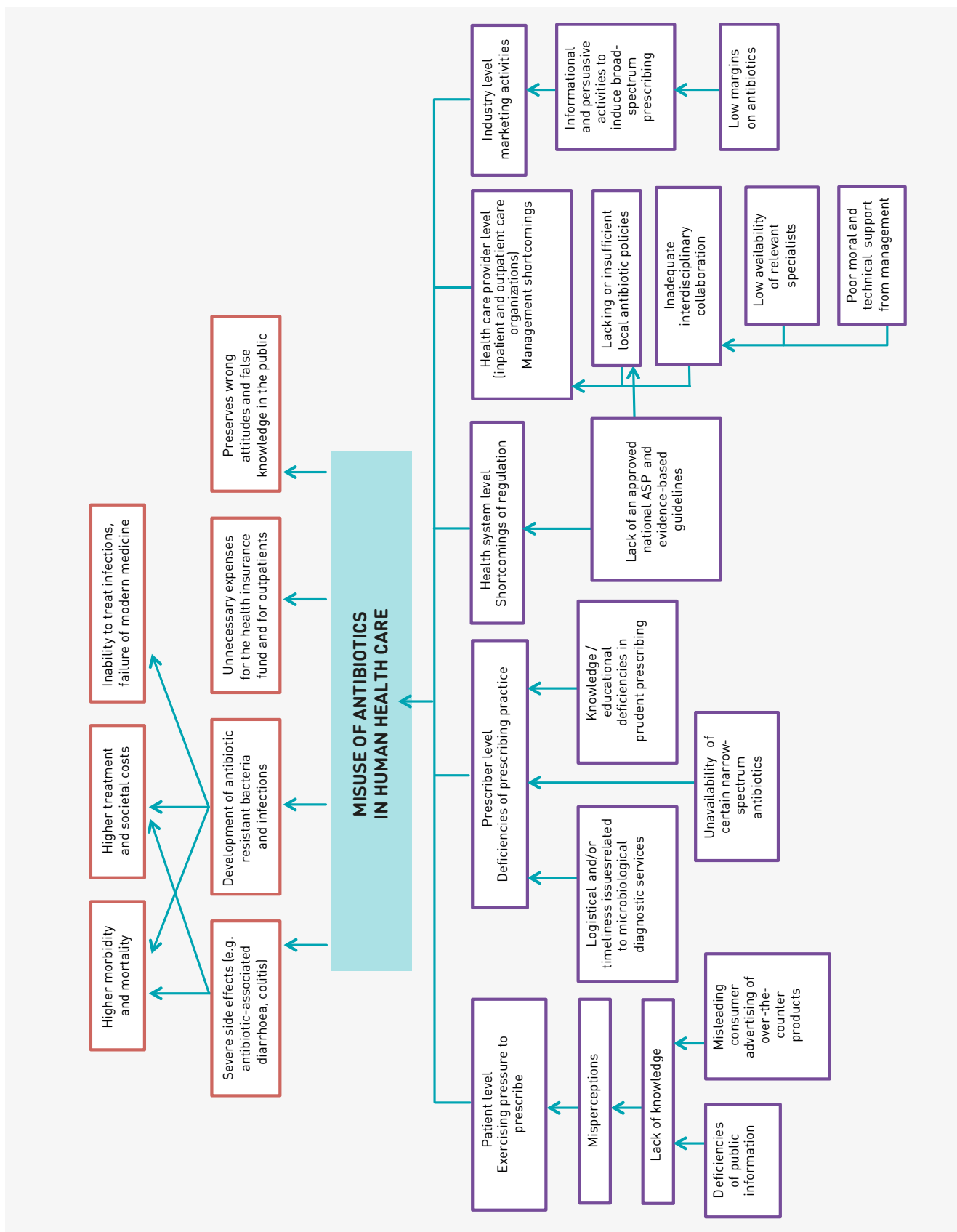
FIG. 2.2. THE BUILDING BLOCKS OF A PROBLEM TREE



Notes. This problem tree is based on the EVIPNet Hungary local context. The section on consequences is not included here.  
 Source: adapted from a presentation made by EVIPNet Hungary national champion Mr Balázs Babarczy (see Hajdu et al., 2018).



FIG. 2.3. AN EXAMPLE OF THE PROBLEM TREE ON ANTIBIOTIC USE AND AMR DEVELOPED FOR AN EBP BY THE EVIPNET HUNGARY TEAM



Notes. This problem tree is based on the EVIPNet Hungary local context.

Source: adapted from a presentation made by EVIPNet Hungary national champion Mr Balázs Babarczy (see Hajdu et al., 2018).

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## 2.2.2 EBP ToR

The EBP ToR serve as an outline for the full EBP, based on all the prior steps. This ToR will inform the key informant consultations and discussions to ensure that the EBP is on track and that implementation of the policy options/elements is possible in the context.

Developing this TOR requires a thorough understanding of the problem, its underlying factors, the political and policy context, and the evidence-informed policy options. As such, developing the ToR will be possible only after the political and policy context mapping, after the problem tree has been developed, and after multiple meetings with the EBP team, steering committee and key informants.

Here is a template for the EBP ToR, adapted from the McMaster Health Forum templates (2017).

### **EBP about XXX**

#### **ToR for the EBP**

The purpose of this document is:

- to serve as a protocol for the EBP;
- to provide a resource to structure the key informant consultations (asking them to get involved by reacting to particular sections and/or content); and
- to help develop content for the first draft of the EBP (which can be copied and pasted directly into an EBP draft once this document is relatively well developed).

A first step is to decide on the provisional title of the EBP (tip: try to start with an active verb in the progressive tense, such as “strengthening” or “improving”).

*Source:* adapted from approaches used by the McMaster Health Forum.

## 2.2.3 Conducting key informant consultations

The following questions can be used as a template for defining the scope of the EBP by means of the key informant interviews.

### 1. What is known (or is important) about the context within which the evidence brief is being prepared?

QUESTION(S)	PROVISIONAL/DRAFT RESPONSES
What important political or policy issues should be considered within the context of this EBP?	▪
What concepts should be defined and what definitions should be used?	▪
What should the evidence brief address?	▪
What should the evidence brief not address?	▪

### 2. Are there any equity considerations that are important to consider?

QUESTION(S)	PROVISIONAL/DRAFT RESPONSES
What group(s) should be given particular attention in the evidence brief because the problem, policy options or implementation considerations disproportionately affect(s) them?	▪

### 3. What is the problem?

QUESTION(S)	PROVISIONAL/DRAFT RESPONSES
How does the problem relate to a risk factor, disease or condition?	▪
How does the problem relate to a programme, service or drug currently being used?	▪
How does the problem relate to the current health system arrangements within which programmes, services and drugs are provided?	<ul style="list-style-type: none"> <li>▪ Delivery arrangements</li> <li>▪ Financial arrangements</li> <li>▪ Governance arrangements</li> </ul>
How does the problem relate to the current degree of implementation of the course of action already agreed upon (e.g. a policy)?	▪

#### 4. Policy or programmatic options to address the problem

QUESTION(S)	PROVISIONAL/DRAFT RESPONSES
What are three viable policies or programmatic options to address the problem?	<ul style="list-style-type: none"> <li>▪ Option 1: Elements of this option might include:</li> <li>▪ Option 2: Elements of this option might include:</li> <li>▪ Option 3: Elements of this option might include:</li> </ul>

#### 5. Implementation considerations

QUESTION(S)	PROVISIONAL/DRAFT RESPONSES		
	OPTION 1	OPTION 2	OPTION 3
What are the potential barriers that could influence the successful implementation of these policies or programmatic options?	<ul style="list-style-type: none"> <li>▪ Patient/individual</li> <li>▪ Provider</li> <li>▪ Organization</li> <li>▪ System</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient/individual</li> <li>▪ Provider</li> <li>▪ Organization</li> <li>▪ System</li> </ul>	<ul style="list-style-type: none"> <li>▪ Patient/individual</li> <li>▪ Provider</li> <li>▪ Organization</li> <li>▪ System</li> </ul>

#### 6. Potential windows of opportunity for implementing the options

TYPE	OPTION 1	OPTION 2	OPTION 3
General			
Option-specific			

Another common technique to engage stakeholders in the production of the EBP is structured brainstorming, whereby a group of stakeholders with relevant expertise on the topic meet and brainstorm ideas together to improve the EBP, find solutions, and focus attention on the promising aspects of the EBP (The SURE Collaboration, 2011). This process is not a mandatory step; nonetheless, it could be a valuable complement to the key informant consultations.

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## TIPS

- The interviewer should ideally have skills and experience in semi-structured interviews.
- The stakeholders might have a busy schedule, so enough time within the EBP timeline should be accounted for to conduct the interviews.
- Stakeholders should have read the EBP ToR ahead of time in order to provide quick and constructive feedback during the interview. If the stakeholder has not read the ToR beforehand, they should be given enough time during the interview to read it.
- The participant should be asked to provide written/track-changes comments on the EBP ToR.
- At the time of the key informant interview: the questions should be printed out, the interview should be conducted in a timely manner, with notes taken of everything said during the interview. Participants should be asked if the interview can be recorded.
- It is worth remembering that the key informant interviews can also help in identifying the position of each stakeholder relating to the issue/problem. It can give a sense of who is for, who is against and who has little to contribute regarding the issue. Accordingly, the list of relevant stakeholders should be adjusted.
- It is important to try to sense if the stakeholder is withholding information during the interview. This can happen when stakeholders want to keep some information confidential, or they have not fully understood what an EBP is, or the roles of those involved in it (including theirs). This should all be explained before starting the interview.
- Not all comments will necessarily be feasible/appropriate to the scope of the EBP; when in doubt, this should be discussed with the team.

### 2.2.4 Search strategy

After identifying the priority issue and narrowing it down, a comprehensive literature search should be conducted to identify the best available evidence about the problem, the options to address it and the implementation considerations. The literature search is an iterative process that can be conducted at multiple times throughout the development of the EBP. Certain steps apply, as outlined here.

- The first literature search might be conducted to understand the problem better, narrow it down, develop the EBP ToR (refer to Subsection 2.2.2), and identify the general policy options.
- The second literature search might be conducted at a later stage, while developing the full description of the policy options to identify all relevant details specific to this option (refer to Section 2.2 on writing the EBP).

This will include taking into consideration the following elements:

- what evidence to search for;
- where to search;
- how to search for peer-reviewed evidence;
- how to search for the grey literature;
- how to screen the evidence;
- how to critically appraise the included literature (e.g. systematic reviews);

- 
- how to critically appraise the included literature (local evidence);
  - how to synthesize the critically appraised literature.

### The evidence to search for

Depending on whether the literature will be used to better understand the problem or to assess policy options, the type of evidence needed will be different. Commonly, local data are used to clarify the problem, whereas global research evidence is necessary to assess each option selected. Also, observational studies and qualitative data could be used to clarify the problem, show the magnitude of the problem, or the stakeholders' perspective on the policy issue. Then, a literature search will be conducted to gather the following types of data or evidence.

1. Local data are essential to contextualize the problem and establish its magnitude and its underlying factors. Local data can be obtained from published reports and indicators of relevant governmental bodies (e.g. ministries and departments of health) and national, regional and international organizations (e.g. WHO, the United Nations High Commissioner for Refugees [UNHCR], United Nations Population Fund [UNFPA]). In addition, local data can be found in published peer-reviewed studies from the country of interest. Examples of local data include: disease burden, risk factor prevalence, availability of resources, existing health system arrangements, etc. Systematic reviews of local data can also be found, including barriers to implementation.
2. Global research evidence can be found in the form of systematic reviews, which provide the highest quality of research evidence. Systematic reviews are increasingly considered as a key source of information in policy-making, particularly in terms of determining the effectiveness of options/solutions, factors that modify those effects, and implementation considerations. In the event that systematic reviews are lacking about a specific topic, high-quality primary studies can be considered. Different types of research evidence are needed to inform the EBP policy options (see Table 2.6). Whereas the impact of health policy and health systems interventions are commonly addressed by quantitative data from randomized controlled trials (RCTs), qualitative research is also of crucial importance for several contexts. For example, qualitative evidence could be useful for health policy questions, such as identifying values and preferences of the population regarding a specific intervention, assessing strategic barriers to implementing a specific policy or programme, or validating the feasibility of implementing a certain intervention. More details about the policy options and the questions are provided in Subsection 2.2.8 How to frame the options to address a problem.

**TABLE 2.6. TYPES OF RESEARCH EVIDENCE TO FIND THE INFORMATION NEEDED FOR THE EBP POLICY OPTIONS**

<b>QUESTION (SEE SUBSECTION 2.2.8)</b>	<b>TYPE OF RESEARCH EVIDENCE</b>
Which benefits are important for those who will be affected and which benefits are likely to be achieved with each policy option/element?	Systematic reviews of effectiveness studies  RCTs
Which harms are important for those who will be affected and which harms are likely to arise with each policy option/element?	Systematic reviews of: <ul style="list-style-type: none"> <li>▪ effectiveness studies</li> <li>▪ observational studies</li> </ul>
What are the costs of each policy option/element and is there local evidence about their cost–effectiveness?	Economic evaluations
What adaptations might be made to a given policy option/element and might they alter its benefits, harms and costs?	Systematic reviews of qualitative studies
Which stakeholders’ views and experiences might influence the acceptability of a policy option/element and its benefits, harms and costs?	Systematic reviews of qualitative studies  Observational studies  Qualitative studies  Tacit knowledge identified through key informant consultations

## Where to search

Table 2.7 presents some key databases to search for systematic reviews.

**TABLE 2.7. KEY DATABASES TO SEARCH FOR SYSTEMATIC REVIEWS**

DATABASE	DESCRIPTION	WEBSITE	DETAILS
Health Systems Evidence	Systematic reviews addressing health systems arrangements and implementation strategies	<a href="http://www.healthsystemsevidence.org">www.healthsystemsevidence.org</a>	<ul style="list-style-type: none"> <li>▪ Log in (or register)</li> <li>▪ Click on “Advanced search”</li> <li>▪ Copy and paste the search into the field (or select an appropriate health system arrangement in the taxonomy)</li> <li>▪ Use the “Filter documents by” navigation to filter by type of document, country, date, sector and health system arrangement</li> </ul>
Health Evidence	A database of systematic reviews evaluating the effectiveness of public health interventions	<a href="http://www.healthevidence.org/">http://www.healthevidence.org/</a>	<ul style="list-style-type: none"> <li>▪ Copy and paste the search into the “Search” field</li> <li>▪ Use the “Advanced search” option to implement a detailed search strategy</li> </ul>
The Cochrane Library	Systematic reviews addressing clinical programmes and services or drugs	<a href="http://www.cochranelibrary.com/">http://www.cochranelibrary.com/</a>	<ul style="list-style-type: none"> <li>▪ Copy and paste the search into the open search field in the top right corner</li> <li>▪ Use the “Advanced Search” function for a detailed search with specific parameters</li> </ul>
PubMed	Quantitative and qualitative studies addressing clinical and public health programmes and services	<a href="https://www.ncbi.nlm.nih.gov/pubmed/">https://www.ncbi.nlm.nih.gov/pubmed/</a>	<ul style="list-style-type: none"> <li>▪ Select “Advanced”</li> <li>▪ Click “Edit” and copy and paste the search into the field</li> <li>▪ Select “Search”</li> <li>▪ Click on “Customize” in the top left corner</li> <li>▪ Tick “Systematic Reviews” to limit to systematic reviews</li> <li>▪ For qualitative studies</li> <li>▪ Click on “Topic-Specific Queries”</li> <li>▪ Select “Health Services Research (HSR) Queries”</li> <li>▪ Tick “Qualitative research” from the list of categories</li> </ul>



## How to search the literature: electronic database search

Table 2.8 presents the databases to search for each type of systematic review and other primary studies.

**TABLE 2.8. THE APPROPRIATE SOURCES AND DATABASES TO SEARCH FOR RESEARCH EVIDENCE**

TYPE OF POLICY OPTION (OR ELEMENT)	DATABASE	TYPE OF RESEARCH EVIDENCE
If the option involves health system arrangements or implementation strategies	Health Systems Evidence*	<ul style="list-style-type: none"> <li>▪ Systematic reviews of effects (benefits and possibly harms)</li> <li>▪ Systematic reviews addressing other questions (harms, process evaluations and acceptability)</li> <li>▪ Economic evaluations (cost-effectiveness)</li> </ul>
If the option involves public health programmes and services	Health Evidence*	<ul style="list-style-type: none"> <li>▪ Systematic reviews of effects (benefits and possibly harms)</li> <li>▪ Systematic reviews of effects (benefits and harms)</li> </ul>
	Cochrane Public Health*	
	Cochrane Library*	<ul style="list-style-type: none"> <li>▪ Economic evaluations (cost-effectiveness)</li> </ul>
	PubMed	<ul style="list-style-type: none"> <li>▪ Systematic reviews of qualitative studies</li> <li>▪ Qualitative studies</li> </ul>
If the option involves clinical programmes and services or drugs	Cochrane Library*	<ul style="list-style-type: none"> <li>▪ Systematic reviews of effects (benefits and possibly harms)</li> <li>▪ Economic evaluations (cost-effectiveness)</li> </ul>

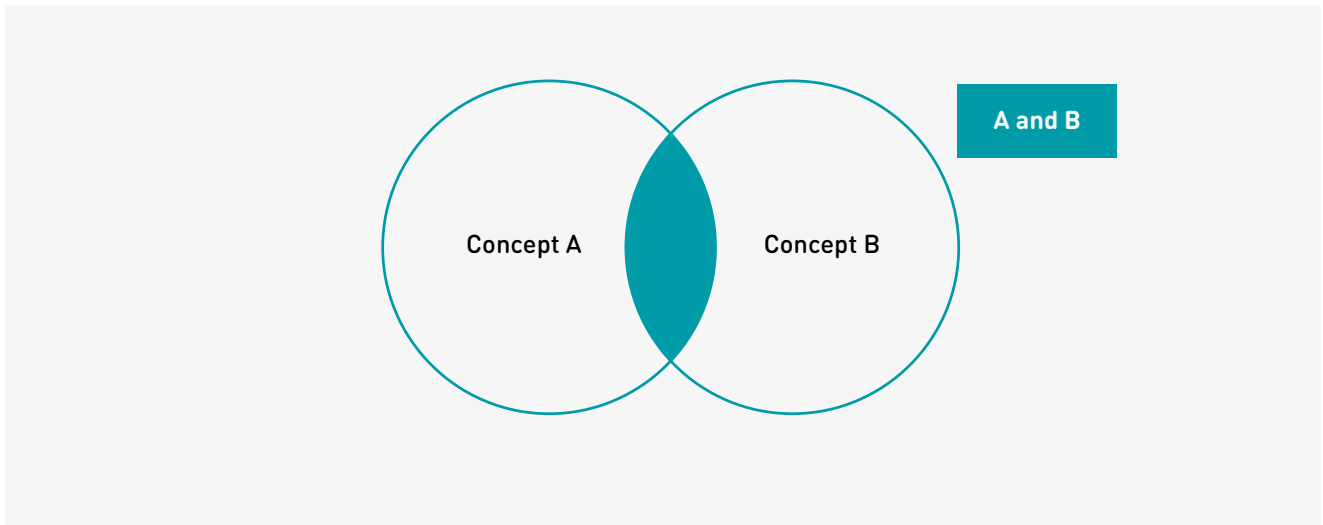
\* Specialized sources of systematic reviews

Electronic databases can mainly be searched for peer-reviewed (primary research) articles. The specific procedures set out below provide details on how to develop a search strategy.

1. The problem statement should be first split into two or three concepts.
2. Search terms (and related Medical Subject Heading [MeSH] terms) are generated for each concept. Search terms can be identified through consultation with content experts, by using search strategies used in previous studies, as well as in relevant articles on the topic.
3. Truncations can be used to capture word variations, such as \* and ? to find different forms of a word. For example, “prescri\*” can be used to capture the words prescribing, prescribe, prescribed and prescription. The truncation ? in the middle of a word can also be used to capture multiple word forms; for example, “organi?ation” can be used to capture the words organization and organisation.
4. Concepts can be combined using Boolean operator “(AND)” (see Fig. 2.4) and search terms within each concept can be found using Boolean operator “(OR)” (see Fig. 2.5).

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FIG. 2.4. EXAMPLE OF HOW THE BOOLEAN OPERATOR AND IDENTIFIES CONCEPT



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FIG. 2.5. EXAMPLE OF HOW THE BOOLEAN OPERATOR OR IDENTIFIES CONCEPTS

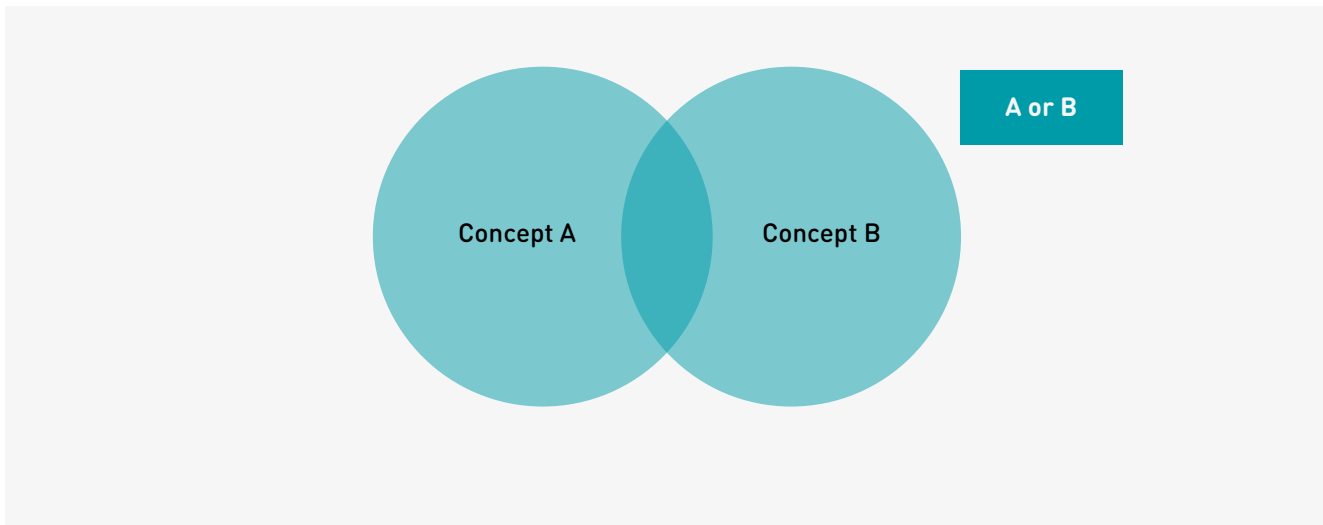


Table 2.9 provides an example of how to develop a search strategy.

**TABLE 2.9. EXAMPLE OF DEVELOPMENT OF A SEARCH STRATEGY**

<p><b>The problem</b></p> <p>Inappropriate prescribing of antibiotics</p>
<p><b>Concepts</b></p> <p><u>Concept A</u>: Antibiotics</p> <p><u>Concept B</u>: Inappropriate prescribing</p>
<p><b>Search terms for each concept ( * can be used )</b></p> <p><u>Concept A</u>: Antibiotic* (for antibiotic and antibiotics), antimicrobial*, antibacterial, anti-bacterial</p> <p><u>Concept B</u>: prescri* (for prescribing, prescribe, prescribed, prescription), us* (for use, using, usage), administ* (for administering, administration, administer)</p>
<p><b>Combine concepts using Boolean operators:</b></p> <p>(Antibiotic* <u>OR</u> antimicrobial* <u>OR</u> antibacterial <u>OR</u> anti-bacterial) <u>AND</u> (prescribing <u>OR</u> prescribe <u>OR</u> prescribed <u>OR</u> prescription <u>OR</u> use <u>OR</u> administration <u>OR</u> administering <u>OR</u> administer)</p>
<p><b>Problem statement</b></p> <p>Limited coordination between organizations, agencies and bodies providing or financing health services in humanitarian crises.</p>
<p><b>Concepts</b></p> <p>Concept A: humanitarian crisis</p> <p>Concept B: coordination</p> <p>Concept C: organizations, agencies and bodies</p>
<p><b>Search terms for each concept</b></p> <p><b>Concept A:</b> disaster, war, conflict, tsunami, earthquake, volcano, hurricane, cyclone</p> <p><b>Concept B:</b> coordination, cooperation, co-operation, collaboration</p> <p><b>Concept C:</b> organizations, agencies, bodies, foundations, united nations, red cross, relief work</p>
<p><b>Combine concepts using Boolean operators</b></p> <p>(disaster* <u>OR</u> war <u>OR</u> wars <u>OR</u> conflict* <u>OR</u> tsunami <u>OR</u> earthquake* <u>OR</u> volcano* <u>OR</u> hurricane* <u>OR</u> cyclone*) <u>AND</u> (Coordination <u>OR</u> cooperation <u>OR</u> collaboration <u>AND</u> (Organi?ation* <u>OR</u> agencies <u>OR</u> bodies <u>OR</u> foundation* <u>OR</u> united nations <u>OR</u> red cross <u>OR</u> relief work)</p>

- The search strategy should be designed differently for each of the databases, as each database has special features. For example, the Medline and PubMed databases have controlled MeSH terms and allow search fields (title and abstract), while the Health Systems Evidence database does not, and the Health Systems Evidence database has health systems arrangements filters, while other databases do not.

Table 2.10 provides examples of search strategies for the Health Systems Evidence database and the PubMed (Medline) database.

**TABLE 2.10. EXAMPLE OF HOW THE SEARCH STRATEGY DIFFERS BETWEEN THE MEDLINE AND HEALTH SYSTEMS EVIDENCE DATABASES**

<b>Medline search strategy</b>	
Database: Ovid MEDLINE(R) <1946 to August 02, 2019>	
Search strategy:	
1	exp Anti-Bacterial Agents/ (702860) =====> MeSH TERM
2	(antibiotic* or antibacterial* or anti-bacterial* or antimicrobial* or anti-microbial*).ti,ab. (467671) =====> FREE SEARCH TERMS
2	1 or 2 (933019)
3	limit 3 to "systematic review" (4265)
<b>Health Systems Evidence search strategy</b>	
(Antibiotic* OR antimicrobial* OR anti-microbial* OR antibacterial OR anti-bacterial) filtered by Domain "Governance Arrangement"	
124 results (31 July 2019)	

- The search strategy (or the keywords) used for each of the websites and databases searched are to be developed and validated in consultation with an information specialist or a librarian.
- The final search strategy applied in each electronic database or website should be saved in a separate Word document, including the date of the search and number of hits. Box 2.2 provides an example of a saved search strategy from the Health Systems Evidence database.

### **BOX 2.2. SEARCH STRATEGY IN THE HEALTH SYSTEMS EVIDENCE DATABASE (23 AUGUST 2017)**

- Go to <https://www.healthsystemsevidence.org>.
- Type the following keywords in the search field: (Antibiotic OR antimicrobial OR antibacterial OR anti-bacterial) AND (prescrib\* OR prescription OR use OR administration OR administering OR administer).
- Filter documents by type and choose "systematic reviews of effects" and "systematic reviews addressing other questions".
- Document the number of hits.

- 
- 8 The results of each electronic database or website search should be saved and exported to a reference software system (such as EndNote), or simply saved in Excel, where duplicates can be removed.

### **How to search the literature: grey literature search**

- “Grey literature” is the term for information that is “produced on all levels of government, academics, business, and industry in print and electronic formats but which is not controlled by commercial publishers” (NYAM, 2003). Grey literature includes documents that have not been formally published in a peer-reviewed format. It includes unpublished research, government or organizations’ reports, theses, dissertations, conference proceedings or abstracts, technical reports and policy briefs.
- A search should be carried out of the resources and websites that make the most sense for the review question. Some databases that can be searched for the grey literature include: OpenGrey, Grey Literature Report, POPLINE, ProQuest Dissertations and Theses, and Google.
- As searching the grey literature can be difficult and time-consuming, it will be searched only when the topic necessitates it, or when there is insufficient evidence on the topic in peer-reviewed articles.

The specific procedures set out in the subsections that follow provide further details on how to develop a search strategy.

### **How to screen and select citations: title and abstract screening**

After establishing the search strategy and carrying out the searches, the results should be analysed. Depending on the number of hits, different courses of action are required, followed by screening steps to select studies.

- If a small number of hits (less than 100) was identified, the results should be checked for relevance and to establish whether the search strategy was sensitive enough.
  - If irrelevant studies were identified, the search strategy should be revised.
- If a large number of hits was identified, the first 3–4 pages should be checked for relevant systematic reviews, or the results exported to EndNote and the title and abstract of all the exported results scrolled through to verify.

### **After finalizing the literature search:**

- title and abstract screening should be carried out for all the hits as the first step in selecting relevant studies.
  - A reference management system such as EndNote or RefWorks can be used to conduct the title and abstract screening.
  - Studies that are identified as being relevant to the topic of interest should be saved as a .pdf in a separate file.

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## 2.2.5 How to critically appraise evidence

### How to critically appraise systematic reviews

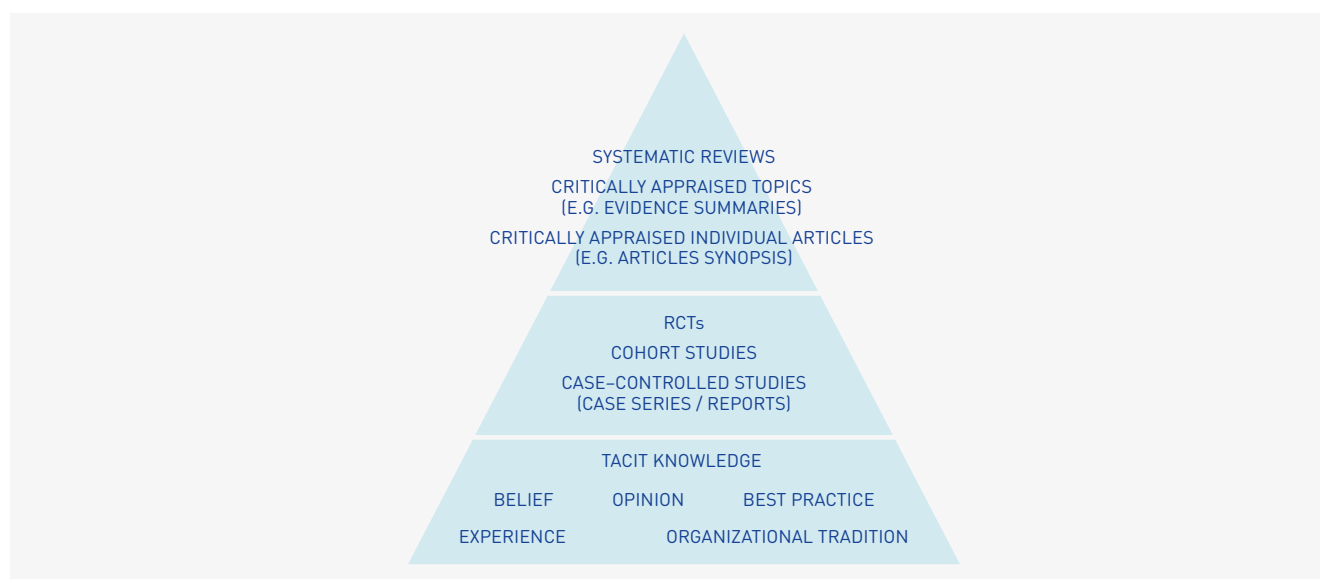
After all the relevant literature available regarding the problem has been identified through the systematic searches conducted, along with the options to address the problem and the implementation considerations, the next step is getting an accurate understanding of the quality of the included evidence. This is important for future decision-making and to inform judgements regarding the use of such interventions for health systems strengthening. Decision-makers could be health-care professionals, patients and – in the case of EBPs, more importantly – policy-makers and citizens. The harms and benefits of different policy strategies need to be weighed against other alternative policy options. To do this effectively, the advantages and disadvantages of the different policy options need to be considered, based on the quantity and the quality of the evidence supporting them, to enable decision-making (Lewin et al., 2012; Lewin et al., 2009).

### The importance of understanding the quality of the evidence

Systematic reviews can be the top of the evidence hierarchy (Fig. 2.5), whereby there are explicit methods of searching for, including, appraising and synthesizing evidence. The underlying evidence can vary from RCTs to observational studies or qualitative studies (Djulbegovic & Guyatt, 2017; Murad et al., 2016). However, it is important to consider that not all systematic reviews are necessarily of the same quality, or they may not exactly capture directly the problem at hand; indeed, they may be from a different context that is not entirely transferable to the relevant context for the EBP. Moreover, one would need to consider that such hierarchy cannot be absolute because the value of evidence is interlinked with levels of synthesis and trust. Sometimes, the best evidence on contextual aspects can be individual studies or reports (Murad et al., 2016).

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FIG. 2.6. THE EVIDENCE HIERARCHY PYRAMID



Source: Campbell, 2012.

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## Available tools and approaches for appraising the methodological quality of a systematic review and the quality of a body of evidence

It is therefore important to assess both the quality of the evidence and the applicability of the findings presented by systematic reviews. Quality could simply refer to the strength or validity of a study or it could be considered in light of a relatively new concept of 'quality of evidence' (Guyatt 2008). We distinguish the concept of 'reliability' (credibility) in a systematic review that refers to the extent to which we can be sure that the review provides an accurate summary of the best available evidence (also called methodological quality) from the concept of 'quality of the evidence' (confidence/certainty) that refers to the extent to which we can be sure that an estimate of the effect/impact is correct (Hulcrantz 2017).

The most commonly used tool for assessing the methodological quality of systematic reviews is AMSTAR (A MeaSurement Tool to Assess systematic Reviews) tool (Shea et al 2007, 2009). AMSTAR is the recommended tool for EBP development because it is relatively easy to use. Furthermore, systematic reviews retrieved from the Health Systems Evidence database have been appraised using this tool (AMSTAR). However, critiques and feedback from users and recent developments in the science of systematic reviews have prompted the development of a new version of the instrument: AMSTAR 2 (Shea et al., 2017a, 2017b; see Fig 2.7).

Although the use of the AMSTAR original version seems still reasonable, teams should move to the use of AMSTAR 2<sup>6</sup> to assess the methodological quality of systematic reviews once they receive the needed training in the use of the tool.

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<sup>6</sup> AMSTAR 2 retained ten domains from the original tool, with some changes to the wording of the items and with a more detailed coverage of two of them which better accommodates for non-randomised studies. Four new domains were added and additionally a 'partial yes' response category was added. In total AMSTAR 2 includes 16 items compared with the 11 included in the original version.

FIG. 2.7. AMSTAR 2 TOOL CHECKLIST

---

**1. Did the research questions and inclusion criteria for the review include the components of PICO?**

For Yes:

- Population
- Intervention
- Comparator group
- Outcome

Optional (recommended)

- Timeframe for follow up

Yes  
 No

---

**2. Did the report of the review contain an explicit statement that the review methods were established prior to the conduct of the review and did the report justify any significant deviations from the protocol?**

For Partial Yes:  
The authors state that they had a written protocol or guide that included ALL the following:

- review question(s)
- a search strategy
- inclusion/exclusion criteria
- a risk of bias assessment

For Yes:  
As for partial yes, plus the protocol should be registered and should also have specified:

- a meta-analysis/synthesis plan, if appropriate, and
- a plan for investigating causes of heterogeneity
- a plan for investigating causes of heterogeneity

Yes  
 Partial Yes  
 No

---

**3. Did the review authors explain their selection of the study designs for inclusion in the review?**

For Yes, the review should satisfy ONE of the following:

- Explanation for including only RCTs
- OR Explanation for including only NRSI
- OR Explanation for including both RCTs and NRSI

Yes  
 No

---

**4. Did the review authors use a comprehensive literature search strategy?**

For Partial Yes (all the following):

- searched at least 2 databases (relevant to research question)
- provided key word and/or search strategy
- justified publication restrictions (e.g. language)

For Yes, should also have (all the following):

- searched the reference lists / bibliographies of included studies
- searched trial/study registries
- included/consulted content experts in the field
- where relevant, searched for grey literature
- conducted search within 24 months of completion of the review

Yes  
 Partial Yes  
 No

---

**5. Did the review authors perform study selection in duplicate?**

For Yes, either ONE of the following:

- at least two reviewers independently agreed on selection of eligible studies and achieved consensus on which studies to include
- OR two reviewers selected a sample of eligible studies and achieved good agreement (at least 80 percent), with the remainder selected by one reviewer.

Yes  
 No

---

**6. Did the review authors perform data extraction in duplicate?**

For Yes, either ONE of the following:

- at least two reviewers achieved consensus on which data to extract from included studies
- OR two reviewers extracted data from a sample of eligible studies and achieved good agreement (at least 80 percent), with the remainder extracted by one reviewer.

Yes  
 No

---

**7. Did the review authors provide a list of excluded studies and justify the exclusions?**

For Partial Yes:

- provided a list of all potentially relevant studies that were read in full-text form but excluded from the review

For Yes, must also have:

- Justified the exclusion from the review of each potentially relevant study

Yes  
 Partial Yes  
 No



**8. Did the review authors describe the included studies in adequate detail?**

For Partial Yes (ALL the following):

- described populations
- described interventions
- described comparators
- described outcomes
- described research designs

For Yes, should also have ALL the following:

- described population in detail
- described intervention in detail (including doses where relevant)
- described comparator in detail (including doses where relevant)
- described study's setting
- timeframe for follow-up

- Yes
- Partial Yes
- No

**9. Did the review authors use a satisfactory technique for assessing the risk of bias (RoB) in individual studies that were included in the review?**

**RCTs**

For Partial Yes, must have assessed RoB from

- unconcealed allocation, and
- lack of blinding of patients and assessors when assessing outcomes (unnecessary for objective outcomes such as all-cause mortality)

For Yes, must also have assessed RoB from:

- allocation sequence that was not truly random, and
- selection of the reported result from among multiple measurements or analyses of a specified outcome

- Yes
- Partial Yes
- No
- Includes only NRSI

**NRSI**

For Partial Yes, must have assessed RoB:

- from confounding, and
- from selection bias

For Yes, must also have assessed RoB:

- methods used to ascertain exposures and outcomes, and
- selection of the reported result from among multiple measurements or analyses of a specified outcome

- Yes
- Partial Yes
- No
- Includes only RCTs

**10. Did the review authors report on the sources of funding for the studies included in the review?**

For Yes

- Must have reported on the sources of funding for individual studies included in the review. Note: Reporting that the reviewers looked for this information but it was not reported by study authors also qualifies

- Yes
- No

**11. If meta-analysis was performed did the review authors use appropriate methods for statistical combination of results?**

**RCTs**

For Yes:

- The authors justified combining the data in a meta-analysis
- AND they used an appropriate weighted technique to combine study results and adjusted for heterogeneity if present.
- AND investigated the causes of any heterogeneity

- Yes
- No
- No meta-analysis conducted

**For NRSI**

For Yes:

- The authors justified combining the data in a meta-analysis
- AND they used an appropriate weighted technique to combine study results, adjusting for heterogeneity if present
- AND they statistically combined effect estimates from NRSI that were adjusted for confounding, rather than combining raw data, or justified combining raw data when adjusted effect estimates were not available
- AND they reported separate summary estimates for RCTs and NRSI separately when both were included in the review

- Yes
- No
- No meta-analysis conducted

**12. If meta-analysis was performed, did the review authors assess the potential impact of RoB in individual studies on the results of the meta-analysis or other evidence synthesis?**

For Yes:

- included only low risk of bias RCTs
- OR, if the pooled estimate was based on RCTs and/or NRSI at variable RoB, the authors performed analyses to investigate possible impact of RoB on summary estimates of effect.

- Yes
- No
- No meta-analysis conducted

**13. Did the review authors account for RoB in individual studies when interpreting/ discussing the results of the review?**

For Yes:

Included only low risk of bias RCTs  Yes

OR, if RCTs with moderate or high RoB, or NRSI were included the review provided a discussion of the likely impact of RoB on the results  No

---

**14. Did the review authors provide a satisfactory explanation for, and discussion of, any heterogeneity observed in the results of the review?**

For Yes:

There was no significant heterogeneity in the results  Yes

OR if heterogeneity was present the authors performed an investigation of sources of any heterogeneity in the results and discussed the impact of this on the results of the review  No

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**15. If they performed quantitative synthesis did the review authors carry out an adequate investigation of publication bias (small study bias) and discuss its likely impact on the results of the review?**

For Yes:

performed graphical or statistical tests for publication bias and discussed the likelihood and magnitude of impact of publication bias  Yes

No  No

No meta-analysis conducted  No meta-analysis conducted

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**16. Did the review authors report any potential sources of conflict of interest, including any funding they received for conducting the review?**

For Yes:

The authors reported no competing interests OR  Yes

The authors described their funding sources and how they managed potential conflicts of interest  No

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To cite this tool: Shea BJ, Reeves BC, Wells G, Thuku M, Hamel C, Moran J, Moher D, Tugwell P, Welch V, Kristjansson E, Henry DA. AMSTAR 2: a critical appraisal tool for systematic reviews that include randomised or non-randomised studies of healthcare interventions, or both. *BMJ*. 2017 Sep 21;358:j4008.

Source: the AMSTAR team (Shea et al., 2017b).

GRADE (Grading of Recommendations Assessment, Development and Evaluation) (Guyatt et al., 2008; Higgins et al., 2011; see Table 2.11) is the most used and tested approach to assess the quality of a body of evidence. GRADE has been used to assess evidence related to the effect or impact of a policy, resource use and evidence about diagnostic strategies, but recent developments allow making similar judgments for the evidence provided by systematic reviews of qualitative studies (also known as Qualitative Evidence Synthesis, QES) regarding issues such as stakeholders' views and preferences about specific interventions or policies. GRADE-CERQual (Confidence in the Evidence from Reviews of Qualitative research) is the name of this approach and has been used in a number of recent QES (Lewin et al., 2015; Lewin et al., 2018).

**TABLE 2.11. GRADE**

<b>GRADE</b>	
<ul style="list-style-type: none"> <li>▪ The GRADE approach was first established in 2008 as a response to the need for decision-makers to understand uncertainty regarding effect estimates and to help qualify confidence in those estimates.</li> <li>▪ The GRADE approach enables a simple and transparent mechanism to capture the level of confidence in the evidence and to allow recommendations to be based on the underlying evidence in a systematic, reliable and transparent manner.</li> <li>▪ The domains considered by GRADE are:               <ul style="list-style-type: none"> <li>i. <b>study limitations</b> – this allows for the evidence to be considered in light of the individual methodological problems associated with the studies included within the systematic review, as determined by the risk-of-bias tools from Cochrane (RoB and ROBINS-I);</li> <li>i. <b>inconsistency of results</b> – this allows for consideration of whether the different included studies have the same direction in the findings; that is, whether they are coherent or would give rise to opposing or different conclusions;</li> <li>ii. <b>indirectness of evidence</b> – this allows for consideration of whether the context or population are directly or indirectly relevant to the review question;</li> <li>iii. <b>imprecision</b> – this allows for consideration of whether the estimates are not only statistically significant but also clinically relevant; that is, whether the difference in the effect of the interventions is in fact meaningful.</li> <li>iv. <b>reporting bias</b> – this allows for consideration of whether there is potential for not all evidence relating to this to be published, or selectively reported upon. As the majority of unpublished studies tend to be those with no added benefit, with a negative effect or high level of adverse effects, establishing the level of reporting bias is essential for decision-making.</li> </ul> </li> </ul>	
<b>QUALITY DETERMINATION OF THE EVIDENCE USING GRADE</b>	
Quality	Description
High quality	Further research is very unlikely to change our confidence in the estimate of effect
Moderate quality	Further research is likely to have an important impact on our confidence in the estimate of effect and may change the estimate
Low quality	Further research is very likely to have an important impact on our confidence in the estimate of effect and is likely to change the estimate
Very low quality	Any estimate of effect is very uncertain
<b>GRADE CERQUAL APPROACH</b>	
<ul style="list-style-type: none"> <li>▪ Qualitative research plays an important role in understanding patient priorities and concerns, perspectives on implementing interventions, and how and why people choose to utilize health services.</li> <li>« As it would be inappropriate to reduce this kind of research results to numbers, a different tool – using a similar approach to GRADE – has been developed to take into consideration qualitative evidence synthesis (QES). GRADE CERQual was developed in 2015 to assess confidence in qualitative evidence in a transparent and systematic manner.</li> <li>« EVIPNet Europe’s forthcoming QES guide explains the different components of the evidence appraisal tool in detail.</li> </ul>	

Sources: adapted from Guyatt et al., 2008; Higgins et al., 2011; The SURE Collaboration, 2011; Tan, Stokes & Shaw, 2009; Lewin et al., 2015; Lewin et al. 2018; and EVIPNet Europe’s forthcoming Guide to qualitative evidence synthesis.

Keep in mind that when looking collectively at all relevant systematic reviews, they may use different critical appraisal tools. In such case it is useful to define a unique method of appraising the literature for use in the EBP. For example, for the AMSTAR score 0-11, the following categories of high, medium or low quality of evidence can be applied (see table 3.4), which is more in line with the GRADE or GRADE CERQual approach.

**BOX 2.3 EXAMPLE OF AMENDING THE AMSTAR QUALITY SCORE INTO CATEGORIES**

The review authors’ key findings were extracted from the identified reviews. Each review was also assessed in terms of its quality (Assessing Methodological Quality of Systematic Reviews (AMSTAR) rating of 0–11) and local applicability (proportion of studies conducted in the country). The quality of evidence was classified as follows:

Evidence quality	AMSTAR rating (points)
<b>High</b>	<b>8–11</b>
<b>Medium</b>	<b>4–7</b>
<b>Low</b>	<b>0–3</b>

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## TIPS

- An established critical appraisal tool (such as AMSTAR or AMSTAR 2) should be used to appraise the methodological quality of systematic reviews that have not been previously appraised (e.g. those identified by PubMed, etc.).
- AMSTAR is the tool used by the Health Systems Evidence database.
- The GRADE approach is broadly used to appraise the certainty of the evidence (quality of a body of evidence) presented by systematic reviews. A recent related development (GRADE CERQual) allows for similar judgments regarding qualitative evidence synthesized in Qualitative Evidence Synthesis.
- The outcomes graded by the GRADE and CERQual approaches can be allocated a rating of very low, low, moderate or high, depending on the quality of the evidence.
- If possible, two members of the EBP team should independently appraise the systematic review (if not previously appraised) and come to a consensus on the final quality rating (considering both the methodological quality and the quality of the body of evidence).

### How to critically appraise the local evidence

It is often the case that (as noted in the previous subsection) not all systematic reviews identified and included reflect the local setting in the country for which the EBP is being developed. It is therefore important to identify to what extent a systematic review that gathers international evidence is applicable and appropriate for the local context, such that any decisions made using that evidence consider its applicability as well as the strength of the evidence.

Therefore, it is necessary to contextualize the evidence and understand how it would best be implemented in the country in question; otherwise, the suggested options may fail to produce the desired results and will not be user-friendly for policy-makers, who need evidence to be context specific. Addressing five simple questions can help to determine the applicability of the evidence locally (see Table 2.12) (Lavis, Oxman, et al., 2009; Lewin et al., 2009).

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**TABLE 2.12. ASSESSING LOCAL APPLICABILITY**

#### ASSESSING LOCAL APPLICABILITY

1. Were the studies included in a systematic review conducted in the same setting or were the findings consistent across settings or time periods?
2. Are there important differences in on-the-ground realities and constraints that might substantially alter the feasibility and acceptability of a policy or programme option?
3. Are there important differences in health system arrangements that may mean an option could not work in the same way?
4. Are there important differences in the baseline conditions that might yield different absolute effects even if the relative effectiveness were the same?
5. What insights can be drawn about scaling up, implementation, and monitoring and evaluation (M&E)?

Source: Lavis, Oxman, et al., 2009.

The key issue for decision-makers remains that they need to balance these diverse evidence types together, assess the weight to place on each, and let each specific type of evidence contribute to any policy decisions made. For such evidence then to be considered alongside published and critically appraised systematic reviews, it is recommended that the local evidence is also appraised. Various tools are available for the critical appraisal of this type of evidence (taken from a scoping review); these are summarized in Table 2.13 (Sharma et al., 2015).

**TABLE 2.13. CRITICAL APPRAISAL TOOLS FOR CONSIDERING NON-RESEARCH EVIDENCE**

STUDY WITH THE CRITICAL APPRAISAL TOOL	DESCRIPTION OF THE CRITICAL APPRAISAL TOOL
Benzies et al., 2006	<p>The study considers tacit knowledge alongside other forms of evidence, including: <i>“opinions of respected authorities or that of an expert committee as indicated in published conferences or guidelines; or of those individuals who have knowledge in one particular field and are applying that knowledge to another field; or summaries of the collective wisdom or experience of others in the field; or of those individuals who have written and reviewed the guidelines, based on their experience, knowledge or the relevant literature, and discussion with their peers”.</i></p> <p>The tool considers expert input from the lower levels (IV and V) within the hierarchy-of-evidence model, after research evidence (levels I–III), therefore highlighting it as poorer-quality evidence for decision-making.</p> <p>Level I: RCTs or meta-analysis of trials with adequate size and power            Level II: RCTs that are too small to provide Level I evidence            Level III: non-randomized controlled trials or cohort studies, case series, case-control studies or cross-sectional studies            Level IV: opinion of respected authorities or that of an expert committee, as indicated in published conference proceedings or guidelines            Level Va: opinion of those individuals who have knowledge in one particular field and are applying that knowledge to another field; or summaries of the collective wisdom or experience of others in the field;            Level Vb: opinion of those individuals who have written and reviewed the guidelines, based on their experience, knowledge of the relevant literature and discussion with their peers</p>
Coad, Hardicre & Devitt, 2006	<p>This study considers a tool for critical appraisal of the grey literature. The tool suggested that when using any grey literature, one should be prepared to carefully evaluate three key areas:</p> <ul style="list-style-type: none"> <li>▪ when it was written</li> <li>▪ by whom, and</li> <li>▪ its purpose.</li> </ul>
Haig & Dozier, 2003a Wilson, 2002	<p>The study discusses a criterion for appraising the quality of the evidence obtained from websites and all electronic sources by Wilson (2002), by extending it to other forms of such evidence. Five key domains are suggested for the reviewers to critically question:</p> <ul style="list-style-type: none"> <li>▪ authority</li> <li>▪ accuracy</li> <li>▪ currency</li> <li>▪ scope</li> <li>▪ objectivity</li> </ul>



STUDY WITH THE CRITICAL APPRAISAL TOOL	DESCRIPTION OF THE CRITICAL APPRAISAL TOOL
Haig & Dozier, 2003b	<p>This is an adaptation of the DISCERN tool (DISCERN Instrument) for appraising health information in general. The tool, developed by University of Oxford and the British Library (British Library &amp; University of Oxford, 1997), was initially aimed at consumers and information providers to enable them to judge the quality of information on treatment choices. The tool asks the reviewer to consider 16 questions, all with a rating on a 5-point scale (from 1 = “No” to 5 = “Yes”).</p> <p>This study suggests that although the questions themselves may need amending, the principles and methods may have some use in appraising such evidence. Some of the questions which may be useful to consider are listed here.</p> <ul style="list-style-type: none"> <li>▪ Are the aims of the publication clear? Does it achieve its aims?</li> <li>▪ Is it relevant?</li> <li>▪ Is it clear what sources of information were used to compile the publication?</li> <li>▪ Is it clear when the information used or reported in the publication was produced?</li> <li>▪ Is it balanced and unbiased?</li> <li>▪ Does it provide details of additional sources of support and information?</li> <li>▪ Does it refer to areas of uncertainty?</li> </ul>
Rundall et al., 2007	<p>The study considers a criterion for evaluating evidence for a decision-making process and describes a set of key areas that reviewers should use to appraise information. Is it:</p> <ul style="list-style-type: none"> <li>▪ accurate?</li> <li>▪ applicable?</li> <li>▪ actionable?</li> <li>▪ accessible?</li> </ul>
Shpilko, 2005	<p>This describes the criterion for evaluating health-related information from websites using the format applied by the National Network of Libraries of Medicine (NNLM) (NNLM, 2019), within the following domains:</p> <ul style="list-style-type: none"> <li>▪ accuracy</li> <li>▪ authority</li> <li>▪ bias/objectivity</li> <li>▪ currency/timeliness</li> <li>▪ coverage.</li> </ul>

Source: Sharma et al., 2015.

Although various tools are available, most suggest similar criteria and have common features to be systematically considered for the critical appraisal of such evidence. The source–accuracy–relevance–timeliness (SART) system can be used, whereby different items can be scored as “yes”, “no”, or “unclear” using the standard Cochrane critical appraisal approach applied in their RoB tool (see Table 2.14).

**TABLE 2.14. THE PROPOSED KEY AREAS OF QUESTIONING FOR CRITICAL APPRAISAL OF NON-RESEARCH EVIDENCE USING THE SART SYSTEM**

AREA OF CRITICAL APPRAISAL (SART)	DETAILED QUESTIONS	YES	UNCLEAR	NO	COMMENTS
Source	<p>Is the source of the information credible?</p> <ul style="list-style-type: none"> <li>▪ By whom it was written/spoken and what is its purpose?</li> <li>▪ Determine to what extent one could trust the author(s).</li> <li>▪ Are there certain conflicts of interest to be noted?</li> <li>▪ Does it appear to be objective or are there any potential biases present?</li> <li>▪ Does the information present only one point of view?</li> <li>▪ Who was the sponsor/funder of the source?</li> </ul>				

AREA OF CRITICAL APPRAISAL (SART)	DETAILED QUESTIONS	YES	UNCLEAR	NO	COMMENTS
Accuracy	<p>Is the information accurate?</p> <ul style="list-style-type: none"> <li>▪ Consider how plausible the claims are, in terms of whether they could be verified by other sources or testimonies.</li> <li>▪ If they contain any footnotes or cite any references that can be checked, how reliable are they?</li> <li>▪ Are the sources cited?</li> <li>▪ Are the aims available and information presented clearly?</li> <li>▪ Are the methods used for collecting the information transparent and clearly presented?</li> <li>▪ Are there any inconsistencies present in the content?</li> </ul>				
Relevance	<p>Is the evidence with respect to the scope of the guidance relevant?</p> <ul style="list-style-type: none"> <li>▪ Consider how applicable the information really is to the question at hand.</li> <li>▪ Is all the information present or does it seem to be incomplete with respect to the question (is it discussing only part of the equation)?</li> <li>▪ Are the setting and context clearly defined and how well do they fit with the research question?</li> </ul>				
Timeliness	<p>How timely is the information?</p> <ul style="list-style-type: none"> <li>▪ How current is the information?</li> <li>▪ Are any dates associated with the information (if an electronic source, the last date when the website was updated; if testimonies, etc. how recent or old are the experiences)?</li> <li>▪ How regularly is the information updated?</li> <li>▪ Is any more recent research or information available?</li> </ul>				

Source: Sharma et al., 2015.

## TIPS

- The applicability of the systematic review evidence in the local context should be determined using the five simple questions.
- Any local evidence, data or research, if available, should always be considered alongside the systematic review evidence, especially for the implementation considerations, such that the feasibility of the different options locally have been thought through.
- The validity and relevance of the local data should be determined, taking into consideration appropriate critical appraisal tools or approaches, such as the SART system.

## 2.2.6 How to synthesize the critically appraised included literature

Policy-makers need to make choices on complex issues that are often answered by a variety of different types of evidence being considered together. After all the relevant systematic reviews for each specific option have been collated and critically appraised, they need to be considered alongside local data and other health information (such as tacit knowledge collated through key informant interviews), such that it all contributes to decision-making. This cohesive evidence, viewed together, should help inform the final body of evidence to support or refute the options or implementation considerations for policy decisions (Dixon-Woods et al., 2005; Greenhalgh, 2016).

## Approaches for mixed methods synthesis

Currently no single, agreed framework for synthesizing diverse forms of evidence has been adopted by organizations, but it is important that a systematic and transparent approach is taken.

The method of combining quantitative and qualitative evidence together has been referred to as triangulation (Jick, 1979; Mays, Pope & Popay, 2005). The types of evidence broadly fall into the following categories: interpretive (narrative and qualitative), and integrative (quantitative and Bayesian meta-/decision analysis) (see Table A1.4 in Annex 1 for more details). The approach most commonly used to combine the different sources and types of evidence together in an EBP is a narrative synthesis of different systematic reviews, qualitative research, local data and research (see the tables in Annex 1).

Keep in mind that when looking collectively at all relevant systematic reviews, they may use different critical appraisal tools, in which case it may be useful to define a unique method of appraising the literature for use in the EBP.

Currently, synthesis of the different types of sources of evidence, systematic reviews, local data and information within the EBP is done by using narrative synthesis approaches. This allows for the systematic review evidence on effectiveness to be complemented by the local context, which ensures that the EBP is meaningful at the country or local level. This is especially important for the implementation considerations that need to be grounded within the local setting.

## Incorporating the synthesis within the EBP template

Based on all the above, the references that are chosen for use in the EBP policy options should be added into Table 2.15 to summarize all the important information the EBP reader might need to consider to achieve an informed decision (further details are given in Annex 1). The table will then be added as an appendix within the final EBP.

**TABLE 2.15. SUMMARY OF SYSTEMATIC REVIEWS RELEVANT TO THE POLICY OPTIONS**

OPTION/ ELEMENT	FOCUS OF SYSTEMATIC REVIEW	KEY FINDINGS	AMSTAR OR SURE CHECKLIST (QUALITY) RATING	PROPORTION OF STUDIES THAT WERE CONDUCTED IN [INSERT COUNTRY NAME]
[Insert phrase denoting option component]	[Insert the focus of the review]	[Insert the review authors' summary of the key findings]	[Insert the AMSTAR or SURE rating]	[Insert the proportion]

Source: adapted from the EBP developed by EVIPNet Hungary on AMR (Hajdu et al., 2018).



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## TIPS

- Where possible, the evidence should be considered together, using a similar approach to the critical appraisal as used for the systematic review evidence.
- When considering different types of evidence together, mixed methods approaches can be employed (such as triangulation). Narrative synthesis is the most commonly used approach for EBPs.
- It is worth filling in the table that summarizes the systematic reviews retrieved from the options as the drafts are developed and expanded; this will make it much easier to simply copy and paste the summary table into the final EBP document.

### 2.2.7 How to frame the problem

The framing of the problem should be evidence informed, contextualized and engaging, with a focus on health outcomes. This section of the EBP should be mainly based on the local and regional literature to make it relevant to policy-makers.

The situation analysis, the problem tree and the steering committee meetings can help in framing the problem. The problem definition section of the EBP has the following subsections:

1. a clear/concise problem statement
2. description of the magnitude the problem
3. description of the consequences of the problem
4. description of the factors underlying the problem
5. description of the equity considerations related to the problem.

#### A clear problem statement

- The problem statement should be concise (maximum 3–4 sentences), describing the main problem framed within the context and including its size/scope, the main consequences and the underlying factors. The problem statement should not contain details related to the solution.
- The problem statement should not include details, but rather the broad underlying factors.
- It should be a 30–60 second description of the problem that, if heard by policy-makers, would inspire them to want to know more and to be motivated to act upon it.
- All alternative ways to describe the problem should be explored to ensure that it is framed in a way that resonates with multiple audiences.
  - As an example of alternative framings, a scenario relating to AMR can be used.
    - “Unavailability of laws that regulate the use of antibiotics in agriculture and animals” may resonate with NGOs and activists.
    - “A rise in the AMR” may resonate with public health professionals.
    - “No efforts to educate students on AMR and reasonable antibiotic use in a regular manner” may resonate with parents and stakeholders in the education system.
    - Comparing the country with other countries may resonate with politicians.

Here are some examples of problem statements (explored more fully in later subsections of this chapter).

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**Problem statement 1:** the overall problem is the inappropriate prescribing of pharmaceutical drugs, which puts patients at risk of serious adverse effects, increases drug resistance, and leads to unnecessary increased costs for patients and the community at large. The current health system arrangements do not promote rational prescribing of drugs.

**Problem statement 2:** example from EVIPNet Hungary EBP (Hajdu et al., 2018:1).

“Antibiotic misuse is a significant threat to patient safety. It implies unnecessary or ineffective treatment, potentially leads to severe side-effects, and drives the development of antibiotic-resistant bacteria, putting the general therapeutic benefit of antibiotics at risk. It also imposes an avoidable cost burden on the health-care system. The misuse of antibiotics is prevalent worldwide in both hospital and ambulatory settings.”

### Description of the magnitude the problem

While the problem statement is the short statement intended to grab the attention of stakeholders and highlight the importance of addressing this priority public health issue, a more detailed description of the problem and its magnitude is needed in order to enable discussion of all its dimensions.

The subsequent few paragraphs in the EBP should describe the local magnitude of the problem and then discuss its status in comparison with other countries.

The description of the magnitude of the problem should be based mainly on local evidence. Local evidence can be found in published research evidence, the grey literature and reports by ministries and relevant institutions and NGOs. Comparing the local magnitude of the problem across time and in comparison with its regional and international status can also provide support for highlighting the importance of acting to resolve it.

Certain questions should be considered to guide the problem description, based on the guidance provided in the SUPPORT tools (Lavis, Wilson, et al., 2009b).

#### 1. *What is the problem?*

It could be:

- a risk factor, disease or condition;
- the programmes, services or drugs currently being used to address a risk factor, disease or condition;
- the current health system arrangements within which programmes, services and drugs are provided;
- governance arrangements;
- financial arrangements;
- delivery arrangements;

- 
- the current degree of implementation of an agreed-upon course of action;
  - patients/citizens (e.g. lack of awareness of a free programme);
  - health workers (e.g. lack of adherence to guidelines).

## **2. *How did the problem come to attention?***

This could have happened through:

- a focusing event (e.g. a medical error case that led to amputation of limbs of a child);
- a change in an indicator (e.g. high suicide rate reported in the country);
- feedback from the operation of current policies and programmes (e.g. internal evaluation report identifies operational challenges in getting drug supplies to primary care practices).

## **3. *What indicators can be used, or collected, to establish the magnitude of the problem?***

These could include the following:

- national and community surveys and vital registries are examples of good sources of indicators about a risk factor, disease or condition;
- health-care administrative data (or what are sometimes called health management information systems), M&E data, community surveys, and health-care provider surveys can all be good sources of indicators about the programmes, services and drugs currently being used;
- legislation, regulation, policies, drug formularies and policy-maker surveys can be good sources of indicators about governance arrangements;
- health expenditure surveys and health-care provider surveys can be good sources of indicators about financial arrangements;
- health-care administrative data can be a good source of indicators about delivery arrangements;
- community surveys and health-care provider surveys, as well as health-care administrative data, can be good sources of indicators about the current degree of implementation of an agreed-upon course of action.

## **4. *What comparisons can be made to establish the magnitude of the problem and to measure progress in addressing it?***

These could include comparisons:

- over time within a country
- between countries and other appropriate comparators
- against plans
- against what policy-makers and/or stakeholders predicted or wanted.

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## 5. *How can a problem be framed (or described) in a way that will motivate the audience?*

- A problem can be framed positively or negatively based on the target audience.

### **Description of the consequences of the problem**

Highlighting the consequences of this problem/issue so far in the country, along with the consequence of inaction, can incentivize stakeholders to act upon the problem being described. As such, the next few paragraphs of the EBP should focus on the outcomes of this problem/issue.

Local evidence can be relied upon to highlight the local consequences. However, if local data are not available or comprehensive enough, regional and international evidence can be equally relied upon to show the problem's consequences. For example, if inadequate prescription patterns in community pharmacies have been shown to contribute to AMR in country X, it might be necessary to mention that fact among the consequences of inadequate prescribing practices, even if local data in the country in question (the country of focus in the EBP) are missing.

Consequences of a certain problem/issue can include (among others): a delay in achieving global targets; increased mortality, morbidity or disability; increased expenditure on health care; reduced efficiency or effectiveness of certain interventions/programmes; and a projected increase in the problem.

Certain questions can guide the description of the consequences of the problem.

1. What are the consequences of inaction, or inefficient action?
2. What is the current and projected impact on health and economic outcomes?

### **Description of the underlying factors of the problem**

How can a problem/issue be solved if its underlying factors/causes are not understood? Once the real underlying factors of the problem are identified, finding solutions is more achievable.

For this section of the EBP, the underlying factors documented by the local, regional and international evidence should be discussed. Nonetheless, underlying factors identified from the problem tree should also be mentioned, along with the tacit knowledge of the stakeholders involved, as their valuable input might not have been documented in any research paper. However, it is important to mention that this information was based on tacit knowledge.

Certain questions can be answered to guide the description of the factors underlying the problem (see Table 2.16 and Table 2.17).

#### **1. *What are the possible direct factors underlying the problem?***

These could include:

- 
- the current health system arrangements
  - governance arrangements
  - financial arrangements
  - delivery arrangements
  - cultural/societal underlying factors
  - individual underlying factors.

2. ***What are the possible indirect factors underlying the problem that are leading to the direct underlying factors?***

These could include the same factors as those listed in Question 1 (above), plus:

- social/structural determinants of health.

### **Description of the equity considerations related to the problem**

For an evidence-informed decision about the policy options, the decision-makers need to understand how a certain option might affect certain populations/settings differently. If this is the case, identifying and highlighting this equity-based shortcoming would allow measures to be identified that could help overcome the inequity (even ahead of time). This would ensure that the options selected have an equitable chance of improving the health of the population.

Equity considerations could be assessed in terms of different PROGRESS groups: **P**lace of residence, **R**ace/ethnicity/culture/language, **O**ccupation, **G**ender/sex, **R**eligion, **E**ducation, **S**ocioeconomic status, **S**ocial capital (O'Neill et al., 2014).

Certain questions can be answered to guide this assessment, adapted from the guidance provided in the SUPPORT tools (Oxman, Lavis, et al., 2009).

1. Which PROGRESS groups or settings are likely to be disadvantaged in relation to the option being considered?
2. Are there plausible reasons for anticipating differences in the relative effectiveness of the option being considered for disadvantaged PROGRESS groups or settings?
3. Are there likely to be different baseline conditions across PROGRESS groups or settings, such that the absolute effectiveness of the option being considered would be different; and is the problem more or less important for disadvantaged groups or settings?
4. Are there any important considerations when implementing the option being considered to ensure that inequities are reduced, if possible, and that they are not increased?

### **Example 1. Problem description**

**The problem statement:** the overall problem is the inappropriate prescribing of pharmaceutical drugs, which puts patients at risk of serious adverse effects, increases drug resistance, and leads to unnecessary increased costs for patients and the community at large. The current health system arrangements do not promote rational prescribing of drugs.

**The problem:** inappropriate prescribing quality and pattern of drugs.

**Risk factor, disease or condition:** rising rates of drug resistance, increased risk of adverse drug reactions and high expenditure on pharmaceuticals.

**TABLE 2.16. EXAMPLE 1: UNDERLYING FACTORS**

UNDERLYING FACTORS	
<b>Governance arrangement</b>	<ul style="list-style-type: none"> <li>▪ Absence of laws and legislations to regulate physician–industry interactions</li> <li>▪ Weak clinical governance (standardized clinical guidelines, clinical pharmacy services and systems for prescription audits and feedback)</li> <li>▪ Inadequate systems to monitor quality of drugs at national level</li> <li>▪ Physician interaction with pharmaceutical industry representatives in health-care organizations, along with industry-sponsored continuous medical education</li> <li>▪ Weak institutional policies on conflict of interest</li> <li>▪ Poor consumer involvement in shared decision-making related to medication use</li> </ul>
<b>Financial arrangement</b>	<ul style="list-style-type: none"> <li>▪ Payment of physicians on a fee-for-service basis</li> <li>▪ High out-of-pocket expenditure on pharmaceuticals</li> <li>▪ No proper incentive systems to encourage generic drug use</li> </ul>
<b>Delivery arrangement</b>	<ul style="list-style-type: none"> <li>▪ Absence of guidelines for pharmaceutical prescriptions</li> <li>▪ Poor consumer involvement in shared decision-making related to medication use</li> </ul>
<b>Degree of implementation of an agreed course of action (e.g. a policy)</b>	<ul style="list-style-type: none"> <li>▪ Lack of enforcement of the recently launched code of ethics legislation regulating the promotion of medical products</li> </ul>

**Example 2. Problem description developed for an EBP by the EVIPNet Estonia team**

**The problem statement:** the consumption of sugar-sweetened beverages is associated with increased energy intake, higher risks for poor oral health and weight gain, and therefore also with increased risks for various noncommunicable diseases (NCDs). The association between consumption of sugar-sweetened beverages and weight gain is stronger than that for any other food or beverage; 89.2% of Estonian schoolchildren drink sugar-sweetened beverages, the numbers of overweight and obese Estonians are growing rapidly and the numbers of newly diagnosed cases of diseases related to overweight and obesity have also increased, including other hyperalimentation diseases and type 2 diabetes.

**The problem:** increased intake of sugar-sweetened beverages.

**Risk factor, disease or condition:** rising prevalence of obesity, type 2 diabetes, NCDs and poor oral health.

*Source:* adapted from Köhler et al., 2016.

**TABLE 2.17. EXAMPLE 2: UNDERLYING FACTORS**

<b>UNDERLYING FACTORS</b>	
<b>Governance arrangement</b>	<ul style="list-style-type: none"> <li>▪ Absence of laws and legislation to regulate sugar-sweetened beverages in industry marketing, advertising and sponsorship</li> <li>▪ Absence of laws and legislations to regulate availability, affordability accessibility and content of sugar-sweetened beverages</li> </ul>
<b>Financial arrangement</b>	<ul style="list-style-type: none"> <li>▪ Funding of community-based initiatives by the sugar-sweetened beverages industry</li> <li>▪ Affordability of sugar-sweetened beverages</li> <li>▪ Funding of media outlets through income from advertisements of the sugar-sweetened beverages industry</li> </ul>
<b>Delivery arrangement</b>	<ul style="list-style-type: none"> <li>▪ Ready availability/accessibility of sugar-sweetened beverages to the population</li> <li>▪ Sale of sugar-sweetened beverages in school canteens and shops in proximity of schools</li> <li>▪ Incentives for shops provided from local distributors</li> <li>▪ Point-of-sale marketing strategies</li> <li>▪ Huge marketing campaigns targeting adolescents</li> <li>▪ Use of flavours and high sugar levels to make it more appealing</li> <li>▪ A sugar-sweetened beverages factory owned by a powerful policy-maker</li> </ul>
<b>Individual factors</b>	<ul style="list-style-type: none"> <li>▪ Lack of awareness among children and their families</li> </ul>

**TIPS**

- The starting point should be the EBP ToR, adding in the information gathered from the key informant interviews. The research evidence that answers the above questions and supports the suggestions of key informants should be identified. The evidence should then be appraised, starting with bullet points for an outline and then drafting the full section.
- Medical and research jargon should be avoided: remember that the audience of the EBP is policy-makers and decision-makers. In many cases, they might not be familiar with how to interpret research evidence → this should be done for them, giving them only the most relevant information to enable an informed decision.
- The focus should not be on the methodology of the research, but rather on the main results and conclusion from the study; and the quality of evidence.
- The results of different research papers should not be just listed; instead, all the research evidence should be synthesized in an engaging way.
- Figures, graphs, infographics and tables should be used to highlight the most important facts.
- Missing evidence should be discussed; not just the available evidence. Where necessary, the limitations of the evidence should be mentioned if they are critical for an informed decision-making process.
- This section is very important, but should not be more than 3–4 pages of the full EBP.
- The framing of the problem should be discussed with the EBP team and steering committee, and the framing updated after the key informant interviews.
- It should be borne in mind that during the policy dialogue, stakeholders usually discuss problem framing more than anything else, so some time should be invested in the framing aspect. Also, stakeholders might suggest changing the framing of the problem.

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## 2.2.8 How to frame the options to address a problem

After the problem and its underlying factors have been thoroughly described, policy options/elements to address it are the next step. An option to address a problem can be classified as appropriate if it is:

- evidence informed
- objective
- context specific
- feasible
- in keeping with the local values and framework
- acceptable in terms of the impact it will have on the budget.

An EBP describes the options identified by the literature as being effective in addressing the problem/issue in question and its underlying factors. The options could be comprehensive enough to cover all of the identified underlying factors; or they could cover only a few underlying factors, while acknowledging the need to work on the others. Policy options can be used for three main situations, depending on the context (Lavis, Wilson, et al., 2009a):

1. to maximize the benefit, reduce the risks, ensure cost-effectiveness and improve implementation of existing decisions;
2. to present an assessment of policy options for a policy-making process that is already under way;
3. to present policy options for a problem that has not yet entered the policy-making process.

On an average, an EBP presents around 3–4 policy options to address a problem/issue. These options can be mutually exclusive, whereby stakeholders can decide to choose one rather than the other. However, policy options can also be complementary, whereby implementing them all together can comprehensively address the problem. In such cases, the terminology would change from “option” to “element”.

Systematic reviews are the preferred source of evidence to identify the options/elements and identify the potential harms, benefits and implementation considerations. Systematic reviews of effectiveness are the most likely place to find information about the benefits and risks of policy options; cost-effectiveness studies will identify the cost and cost-effectiveness of a certain option; and systematic reviews of qualitative studies will help in the identification of barriers to and facilitators of implementation at multiple levels. In the event that systematic reviews are not available for an identified option, the matter should be reviewed with the EBP team and steering committee to either state that there is low-quality evidence on the option/element, or to drop the option/element.

The options (and the tables around the options) should not be considered as recommendations/suggestions, and policies/action should not be developed based on the interpretations of the authors and the EBP team. The policy options within the EBP inform the deliberations during the policy dialogue to promote evidence-informed decision-making. Stakeholders in the policy dialogue can then decide how to move forward with these policy options and draw up recommendations for the next steps.

Certain questions should be considered while developing the options and filling in the tables (based on the guidance provided in the SUPPORT tools) (Lavis, Wilson, et al., 2009a).



- 
1. Has an appropriate set of options been identified to address a problem?
  2. Which benefits are important to those who will be affected and which benefits are likely to be achieved with each option?

The term P(People)-O(Option)-C(Comparison)-O(Outcome) (POCO) should be used to identify research on the benefits of the option.

3. What harms are important to those who will be affected and what harms are likely to arise with each option?

The term POCO should be used to identify research on the harms of the option.

4. What are the local costs of each option and is there local evidence about their cost–effectiveness?
5. What adaptations might be made to any given option to contextualize it and could they alter its benefits, harms and costs?
6. What are the equity considerations for each of the options (in terms of financing, delivery and governance)? Do they address all populations in an equitable manner? Do they harm/benefit specific groups, without influencing the others?

### **Examples of options and their considerations**

- Option 1 has been proven to improve health outcomes among individuals with high socioeconomic status living in urban settings, more so than among individuals with lower socioeconomic status.
- Option 2 does not improve the outcomes among patients in intensive care units.
- Option 3 does not have any reported equity considerations.

Table 2.18 is included in the EBP template to provide an outline for the answers to the questions listed above.

**TABLE 2.18. EBP POLICY OPTIONS**

CATEGORY OF FINDING	KEY FINDINGS
Benefits	<ul style="list-style-type: none"> <li>▪ [Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that the findings are presented with reference to the whether it is recent, and the quality, local applicability, prioritized group applicability, and applicability to the issue]</li> </ul>
Potential harms	<ul style="list-style-type: none"> <li>▪ [Insert one or more bulleted key messages about the harms that have been found for each component of the option, ensuring that findings are presented with reference to whether it is recent, and the quality, local applicability, prioritized group applicability and applicability to the issue]</li> </ul>
Resource use, costs and/or cost-effectiveness	<ul style="list-style-type: none"> <li>▪ [Insert one or more bulleted key messages about the resource use, costs and/or cost-effectiveness level that have been found for each component of the option]</li> </ul>
Uncertainty regarding benefits and potential harms (so M&E could be warranted if the option was to be pursued)	<ul style="list-style-type: none"> <li>▪ Uncertainty because no systematic reviews were identified               <ul style="list-style-type: none"> <li>▫ [Insert a brief description of option components for which no reviews were identified]</li> </ul> </li> <li>▪ Uncertainty because no studies were identified despite an exhaustive search as part of a systematic review               <ul style="list-style-type: none"> <li>▫ [Insert a brief description of option components for which “empty” reviews were identified]</li> </ul> </li> <li>▪ No clear message from the studies included in a systematic review               <ul style="list-style-type: none"> <li>▫ [Insert a brief description of option components for which there is insufficient evidence]</li> </ul> </li> </ul>
Key elements of the policy option if it was tried elsewhere	<ul style="list-style-type: none"> <li>▪ [Insert one or more bulleted key messages about the key elements of the policy option, ensuring that the findings are presented with reference to whether it is recent, and the quality, local applicability, prioritized group applicability and applicability of the issue]</li> </ul>
Stakeholders’ views and experiences	<ul style="list-style-type: none"> <li>▪ [Insert one or more bulleted key messages about stakeholders’ views and experiences, ensuring that the findings are presented with reference to whether it is recent, and the quality, local applicability, prioritized group applicability and applicability of the issue]</li> </ul>

Source: EVIPNet Europe template for EBPs, adapted from approaches used by the McMaster Health Forum (McMaster Health Forum, 2017).

### Where to find the answers to the questions for developing the policy options

It might be necessary to develop a new search strategy that is specific for each policy option. Finding the answers to all those questions can be tricky and might require further searches for studies other than the ones originally retrieved. The answers to all the questions in Table 2.6 and Table 2.8 (see Subsection 2.2.4) might result in:

- the same systematic review suggesting a specific option, but in different sections within the review;
- another systematic review assessing the quality of previous systematic reviews;
- an overview of systematic reviews;
- the individual studies mentioned in the systematic reviews;
- tacit knowledge identified through key informant consultations.

### Example

This example draws on selected elements of the options addressing the problem of inappropriate antibiotic use in relation to AMR in human medicine in Hungary (Hajdu et al., 2018).

**Option 1.** Developing a national antibiotic stewardship programme (ASP), complemented by evidence-informed guidelines on the diagnosis and treatment of common infections (Table 2.19).

**TABLE 2.19. EXAMPLE OF EBP POLICY OPTION 1**

CATEGORY OF FINDING	KEY FINDINGS
<b>Benefits</b>	<ul style="list-style-type: none"> <li>▪ A high-quality meta-analysis shows a 19.1% decrease in antibiotic use after the implementation of hospital ASPs.</li> <li>▪ Two medium-quality systematic reviews present low-strength evidence of ASPs in hospitals resulting in better prescription and better outcomes.</li> </ul>
<b>Potential harms</b>	<ul style="list-style-type: none"> <li>▪ No systematic reviews dealing with patient outcomes reported any significant adverse effects of ASPs.</li> </ul>
<b>Resource use, costs and/or cost-effectiveness</b>	<ul style="list-style-type: none"> <li>▪ A high-quality meta-analysis showed a decrease in overall antimicrobial cost by –33.9%, and of length of stay by –8.9% in a hospital setting.</li> <li>▪ Hospital ASPs result in significant decreases in antibiotic consumption and cost. The rates of infection due to specific antibiotic-resistant bacteria decreased and the overall length of hospital stay improved.</li> </ul>
<b>Uncertainty regarding benefits and potential harms (so M&amp;E could be warranted if the option were pursued)</b>	<ul style="list-style-type: none"> <li>▪ Certain point-of-care tests lack convincing evidence on reliability in sinusitis and lower respiratory tract infections.</li> <li>▪ The significance of the positive effects of ASPs on patient outcomes is not established in all reviews.</li> </ul>
<b>Key elements of the policy option if it was tried elsewhere</b>	<ul style="list-style-type: none"> <li>▪ According to systematic reviews, the following interventions have been carried out successfully (with at least medium-quality evidence supporting their efficacy):               <ul style="list-style-type: none"> <li>▫ therapeutic drug monitoring in hospital settings (reduced length of stay);</li> <li>▫ pre-approval strategies in hospital</li> <li>▫ prospective audit and feedback in hospital settings</li> <li>▫ stewardship education in hospital settings</li> <li>▫ training on communication skills in outpatient settings.</li> </ul> </li> <li>▪ A systematic review found medium-quality evidence that restrictive interventions are more effective than persuasive ones in the short term (up to six months), but no significant difference across a longer time frame. Restrictive interventions included:               <ul style="list-style-type: none"> <li>▪ compulsory order form</li> <li>▪ expert approval prescription</li> <li>▪ removal of restricted antibiotics from the cupboard(s)</li> <li>▪ review of prescription and effective change.</li> </ul> </li> </ul>
<b>Stakeholders' views and experiences</b>	<ul style="list-style-type: none"> <li>▪ In Hungary, interviews with key informants led to the conclusion that a wide range of stakeholders support both national and local implementation of ASPs, but certain important barriers need to be tackled prior to establishing such a programme.</li> </ul>

Source: adapted from the EVIPNet Hungary EBP (Hajdu et al., 2018).

**TIPS**

In summary, each option/element would ideally have the following features.

- The totality of evidence around a certain option/element should be synthesized in a way that is both easily understood and captures the main areas that a policy-maker might be interested in.
- Example: 12 systematic reviews support that x can prevent y. However, if x were to be implemented, it would have to have a, b and c to be effective. Furthermore, two systematic reviews have shown that x might lead to d and e harms, unless f and g were to be implemented.
- In the text (2–3 paragraphs), the following elements should be included.
  - An overview should be given of the current context around the option (rather than the problem). This section should cover the local readiness for this option/element, such as the available programmes, interventions, resources and policies that can be leveraged. This section can be

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compiled based on the policy and political context-mapping exercise conducted in the pre-EBP phase.

- A general description of the option/element should be provided, along with its benefits and the number and quality of the systematic reviews supporting it.
- Details should be given about the established key issues needed for the implementation to reach positive outcomes, based on previous experiences, i.e. the key considerations to make the option effective.
- The EBP policy option table is available in the EBP template.
  - In bullet points, certain factors should be outlined, including:
    1. the main benefits and harms (outcome on health indicators, outcome at system level, and others);
    2. resource use, costs and/or cost–effectiveness;
    3. uncertainty regarding benefits and potential harms;
    4. key elements of the policy option if it was tried elsewhere;
    5. stakeholders' views and experiences around the option.
  - The type and quality of evidence should be mentioned, ensuring that each one of the above-mentioned factors is mentioned, so that they can be weighed appropriately. For example, two systematic reviews have shown that x might be harmful is different from stating one primary study identified that x might be harmful.
- It is important to be objective, concise and avoid using medical/research jargon or making recommendations/suggestions.

Following this approach can help to start the discussion moving along the right track. Strong evidence about the benefits of a certain option and the key details about its impactful implementation are an important place to start. Then, outlining the harms, cost–effectiveness and equity considerations can help in deciding whether to adopt the policy option as it stands, or to adapt it first to the context to minimize the harms and improve its cost–effectiveness.

### 2.2.9 How to identify implementation considerations for an option

If an option was shown to be effective in improving/solving a problem/issue, what barriers might arise in implementing that option in the local context? What are the facilitators that will help to overcome those barriers?

In the next section of the EBP, an answer to these questions is essential to ensure that once this option is implemented in the local context, it will be successful in yielding benefits. QES and systematic reviews of qualitative studies are usually the preferred source for identifying the implementation considerations.

As such, it is necessary to identify the level(s) at which there are potential barriers to (and facilitators for) the successful implementation of an option or element. For example, these might be at the level(s) of:

- patients/citizens (e.g. awareness of the availability of a free programme)
- health workers (e.g. adherence to guidelines);
- organizations (e.g. performance management to ensure the delivery of high-quality care);

- 
- the system (e.g. enforcement of regulations).

Certain questions should be considered, based on guidance provided by the SUPPORT tools (Fretheim et al., 2009).

1. What strategies should be considered to facilitate the necessary behavioural changes among patients/citizens?

These could include:

- providing information or education
- supporting behavioural change
- developing skills and competencies
- (personal) support
- facilitating communication and decision-making
- encouraging system participation.

2. What strategies should be considered to facilitate the necessary behavioural changes among health workers?

These could include:

- educational materials
- educational meetings
- audit and feedback
- reminders and prompts
- tailored interventions
- patient-mediated interventions
- multifaceted interventions.

3. What strategies should be considered to facilitate the necessary organizational changes?

One approach to delineating the strategies could be to answer the following questions.

- How can we understand complexity, interdependence and fragmentation?
  - Implement the content, context and process model.
  - Examine the five whys.
- Why do we need to change?
  - Implement a SWOT (strengths, weaknesses, opportunities and threats) analysis.
- Who and what can change?
  - Introduce a system of total quality management.
- How can we make change happen?
  - Become a learning organization.
  - Implement an action research approach.

4. What strategies should be considered to facilitate the necessary system changes?

- Governance arrangements
- Financial arrangements
- Delivery arrangements.

Table 2.20 provides an example of possible barriers and facilitators that might arise at multiple levels if three options (developing a national ASP; strengthening undergraduate and postgraduate education; raising public awareness) were to be implemented to address the problem of inappropriate antibiotic use in relation to AMR in human medicine in Hungary (Hajdu et al., 2018).

**TABLE 2.20. EXAMPLES OF BARRIERS AND FACILITATORS FOR THE IMPLEMENTATION OF ANTIBIOTIC STEWARDSHIP PROGRAMMES**

(Option 1, O1) of education development on the prudent use of antibiotics (Option 2, O2) and of awareness raising about prudent antibiotic use (Option 3, O3) (using Hungary as a case example). Barriers and facilitators have been defined separately, and are not directly corresponding to each other.

LEVEL	BARRIERS	COUNTERSTRATEGIES
<b>Patient</b>	None were identified	–
<b>Professional</b>	<p>Physicians are often primarily concerned with their individual patients’ direct clinical outcomes, and the risk of antibiotic resistance is a factor that is likely to only marginally influence their antibiotic choices. (O1)</p> <p>Time constraints may lead to general practitioners (GPs) not necessarily following and applying the latest professional guidance. (O1)</p> <p>Shortage of time during patient–doctor visits impedes detailed discussions and the communication of key messages. (O3)</p>	<p>In hospitals, incorporating antibiotic stewardship into the mandatory induction training for new medical staff, along with regular in-house training of clinical personnel would be easy ways to ensure that all staff members are aware of the requirements for prudent antibiotic prescribing. (O1)</p> <p>The future tasks of recently established lead GPs at the district level could include advocacy of directives and guidelines relating to ASPs and monitoring of compliance among GPs. (O1)</p> <p>The Primary Health Care Act, which entered into force in Hungary in August 2015, emphasizes the expansion of preventive services and definitive health care within primary care, which would further support opportunities for communication. (O3)</p>
<b>Organizational</b>	Introducing a new subject or educational course may necessitate a revision of and reductions in the training time dedicated to other disciplines, possibly leading to conflicts of interest among the stakeholders concerned. (O2)	Under the current legal framework, while respecting university autonomy, the Ministry of Human Capacities (which incorporates the state secretariats for health care and education) defines the subject matter of mandatory postgraduate core courses. (O2)

<b>System</b>	<p>Some narrow-spectrum antibiotics have been withdrawn from the national market. Applying individual import schemes is time-consuming, and thus inconvenient for securing the availability of essential antibiotics for the treatment of acute infections. (O1)</p> <p>Developing and periodically updating national guidelines to support prudent antibiotic prescribing is labour-intensive, requiring institutional and budgetary support. (O1)</p>	<p>Development of the existing primary care quality indicator framework is needed, so that it is based not only on quantitative, but also on qualitative measures. Data collection and database systems should be developed to achieve this. Linking antibiotic prescription to clinical diagnoses could be an important step forward. (O1)</p> <p>The recent launch of a number of national projects on patient safety has created the opportunity to invest in the development of professional guidelines and related training materials. (O1)</p>
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Source: adapted from Hajdu et al. (2018).

## TIPS

- Where can implementation considerations be found?  
They can be looked for in:
  - systematic reviews around the options;
  - QES and qualitative systematic reviews around implementation considerations;
  - the local context (derived from local data), as well as key informant interviews and structured brainstorming with stakeholders;
  - various other articles (in particular, for barriers and facilitators).
- How should the implementation considerations be written up?
  - The EBP template segregates the barriers at multiple levels in a table, and the facilitators are described in the text.
  - Another way is to add both barriers and facilitators/opportunities at multiple levels within the table.
  - The implementation considerations can be segregated by option/element, or all of them reported on together to address the problem.
  - It is essential to not forget to add the references (and the type of evidence for each).

## 2.2.10 How to develop the full EBP

### Development stages

- The preliminary draft of the EBP outline/ToR should be expanded upon, with changes made to it according to the key informant consultations.
- Two phases of literature search should be carried out, with a search strategy specific to each phase. Phase 1 includes a search strategy specific to the literature around the problem, consequences, underlying factors and the general policy options. Phase 2 involves a specific search strategy for each policy option/element and its implementation considerations to capture all the information needed for an evidence-informed decision.

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- The tables summarizing the available research evidence and its quality should be drawn up.
  - Regular meetings should be conducted among the authors of the EBP, the full EBP team and the steering committee, in order to discuss:
    - progress in developing the EBP, including the timeline and workplan
    - feedback from the key informant consultations, what to include and what other tacit knowledge might be missing that would be worth capturing;
    - the available research evidence and any missing evidence;
    - the quality and relevance of various research papers;
    - the challenges and issues that might arise at the financial, logistical and technical levels;
    - the coherence and flow of the draft.
  - Rough drafts should be sent to WHO, allowing around 10 working days as a response time from them.
  - The EBP draft should be updated based on the comments received, taking into consideration in the timeline and workplan the time needed to incorporate reviewers' comments into the EBP. This step should not be underestimated as it may necessitate several rounds of editing and rewriting. This, in turn, should also be accounted for in the budget.
  - The EBP should be finalized with the steering committee and the EBP team.
  - The merit-review should be carried out and the EBP updated accordingly.
  - The final stages include proofreading, finalizing the document template, translating into the local language(s) and printing.

### Graded entry format (1:3:25 pages)

- Key messages (1 page)
  - The key messages comprise one page of bullet points summarizing the most important take-home messages around the problem, its size, the main underlying factors and the headlines of the policy options/elements ➤ these are the simple and concise messages that could be shared with a decision-maker if you had only five minutes to discuss the matter with them.
- **Executive summary (3 pages)**
  - This is a synopsis of the problem, policy options and implementation considerations ➤ a detailed description of the problem and the policy options for decision-makers who have 20 minutes to read about the issue.
- **Full report (25 pages)**
  - The full report contains the full description of the problem, policy options and implementation considerations:
    - The problem, including:
      - how it came to attention
      - the problem statement
      - the size of the problem
      - the consequences of the problem
      - the underlying factors behind the problem
      - equity considerations related to the problem.
    - Policy options, in terms of:
      - the local readiness for the various options;
      - the likely impacts (benefits/harms);
      - equity, cost and cost–effectiveness considerations.



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- Implementation considerations, including:
    - barriers to implementing the options;
    - facilitators or implementation strategies.
  - **Next steps (1 page)**
    - This involves considering how the EBP will be moved forward to ensure its uptake and successful impact, including the policy dialogue, following up on the implementation and evaluation.
  - **References**
    - A uniform referencing style should be maintained, including between the citations in the text and their entries in the full bibliography.
  - **Appendices**
    - These comprise a summary of the studies included in the EBP and their quality, along with any other relevant information that could not be added to the full EBP.

Certain questions should be considered to guide the process of developing the EBP, based on the guidance provided in the SUPPORT tools (Lavis, Permanand, et al., 2009).

1. Does the EBP address a high-priority issue and describe the relevant context of the issue being addressed?
2. Does it describe the problem, costs and consequences of options to address the problem, and the key implementation considerations?
3. Does the EBP employ systematic and transparent methods to identify, select and assess synthesized research evidence?
4. Does the brief take quality, local applicability and equity considerations into account when discussing the research evidence?
5. Does it employ a graded-entry format (1:3:25 pages)?
6. Was the EBP reviewed for both scientific quality and system relevance?

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## TIPS FOR A SUCCESSFUL EBP:

- Always keep in mind the target audience for the EBP. For example, policy-makers are not interested/do not know how to interpret research evidence.
  - As such, the EBP should aim to simplify and state clearly what the evidence means, rather than simply setting out the evidence. It should focus on the results and the discussion of those results, rather than stating the figures or the methodology behind them. However, it is important to mention the study limitations that might be relevant to policy.
- EBPs are characterized by being written in a way that is relevant and easy for policy-makers to make the necessary decisions based on the evidence.
  - Policy-makers are interested in: (i) striking numbers; (ii) local data; (iii) what the data mean and why they should act fast upon it; (iv) a policy option to solve the problem that has its implementation details with benefits, risks, costs and cost-effectiveness.
- The key focus should be on the problem/issue from start to finish of the EBP.
- The EBP should be coherent and it should flow smoothly (and the options should address the underlying factors).
- The argument should be grounded in strong and reliable evidence.
- Objectivity should always be paramount; this means avoiding adding recommendations or suggestions.
- The options presented should be practical and feasible.
- Rough drafts should be started within the original EBP template, as this will ensure the focus remains on writing the key sections.
- Using short sentences and paragraphs is important to ensure that the EBP is concise.
- The EBP should be made interesting and attractive by using colours, flow charts, boxes and infographics.
- Scientific/medical jargon and too many acronyms should be avoided.
- It could be useful to add the methodology to the EBP.
- An overview should be provided of any and all cost implications for implementing the option(s).

### 2.2.11 Using the EBP template

Annex 2 contains an EBP template. This template also contains prompts using the AMR example as a guide. It is worth filling in the template directly after conducting the stakeholder interviews, as this can facilitate bringing together the final EBP later in the process (see Subsection 2.2.10). Furthermore, there are plenty of published EBPs, notwithstanding their slight differences in template structure, which could be used as examples to guide the writing process.

### 2.2.12 Identifying merit-/peer-reviewers

The steering committee and/or primary authors should identify 3–4 merit- and peer-reviewers for the EBP, among which there should be at least one policy-maker, one content expert and one methodological expert. These actors should be approached months ahead of starting the process to ensure that they will be available and are willing to be the merit- and peer-reviewers. The merit-reviewers can be chosen at the national level from among policy-makers, researchers and stakeholders, whereas the peer-reviewers should be chosen from among members of another EVIPNet country and/or should be international experts. The decision regarding the reviewers should be based on:

- their knowledge/expertise in (a) the content of the EBP and/or (b) its methodological process;
- the individuals being independent and external to the process of developing the EBP.

Options for who to choose include:

- policy-makers
- method specialists in EBP development (local and/or international) for the methodological review
- content experts in the relevant field of the EBP (local and/or international)
- the WHO Secretariat
- other EVIPNet Europe Member countries.

Peer-review is defined as: “a process of subjecting an author’s scholarly work, research or ideas to the scrutiny of others who are experts in the same field” (IJCA, 2014). Its purpose is to:

1. provide suggestions on ways of improving the quality of the work before publishing;
2. filter only the high-quality work that has validity, significance and originality.

The merit- and peer-reviewers are given approximately 1–2 weeks to provide their feedback. The draft EBP, in addition to merit-/peer-review guidelines, should be sent via email to the reviewer(s). They should also fill in a WHO declaration of interest form. The comments of the reviewers should be discussed among the EBP team members and changes made accordingly.

For more details and the template for the review process, see Annex 3.

## TIPS

- Some countries have experienced difficulties in obtaining a response from non-contracted reviewers. So reviewers should be contracted in advance, even if this might cause additional administrative burden for relatively little transfer of funds.
- The merit-/peer-reviewers should be acknowledged for their contribution in the acknowledgments section of the EBP.

### 2.2.13 Translation, proofreading and formatting

- Sufficient time should be allowed for editing after receiving the reviewers’ comments. This step can take time and effort, so accounting for it in the timeline/project plan is important.
- Once the final EBP has been approved by the team, the steering committee and WHO, it should be translated by an external translator and then the translation reviewed internally for editing and/or validation purposes.
- Technical editing and proofreading of the document (in English) should be carried out before publishing.
- All sections should have similar formatting.
- The final stage is to send the EBP to be printed.

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## 2.3 POST-EBP UPTAKE PHASE

EBPs are simply a way to package the evidence in an easy, objective and policy-relevant way. However, further efforts should be undertaken to ensure the proper uptake of the evidence-informed policy options and the use of the EBP as an input to influence the policy-making process. As such, the following subsections explain a few methods that can be used to ensure the uptake and use of the EBP policy options. These methods include a policy dialogue with the key policy-makers, influencers and researchers in the field to discuss the policy options and the way forward to address the public health challenge. Monitoring the uptake/impact can also include advocacy, a post-dialogue survey, policy tracing and media analysis. Monitoring can help to identify whether or not these options have been adopted and by whom.

### KEY MESSAGES

- Policy dialogues enable interactions between multidisciplinary and multisectoral stakeholders for the timely identification of the points of intersection between the research evidence, and the values and goals of the policy-makers and the stakeholders.
- A dialogue summary summarizes the key deliberation points in the policy dialogue around the problem, underlying factors and the policy options, along with their implementation considerations.
- Advocacy strategies might be essential in topics that require lobbying to influence policy-makers to take action to enhance public health.
- Communication strategies are developed to reach policy-makers, influencers and the public in order to raise awareness of the problem and the availability of evidence-informed policies to deal with it.
- Press tracing, media analysis and post dialogue survey can inform the next steps in the advocacy plan. They also serve as a monitoring and evaluation tool for the adoption of the policy options.
- Policy tracing identifies the factors that influenced the success or failure of a policy and trace the role and uptake of evidence (from the EBP and other sources) in the policy-making process.

### 2.3.1 Policy dialogue

Developing an EBP alone is not enough without also investing in its uptake. As such, policy dialogues are increasingly being used to influence the use of research evidence in health policy- and decision-making, because they:

- enable interactions between (among others) multidisciplinary and multisectoral stakeholders, including researchers, policy-makers, key decision-makers, members of the media;
- allow for the timely interpretation of the evidence-informed policy options to address a priority health issue;
- allow for the timely identification of the points of intersection between the research evidence, and the values and goals of the policy-makers and the stakeholders.

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Policy dialogues are a tool used to promote EIP and they can have short-, medium- and long-term benefits in terms of the participants' awareness, empowerment and ultimately influencing the policy agenda, leading to better health outcomes (Biermann & Kuchenmüller, 2016). These dialogues are characterized by being participatory and consultative, inclusive and transparent. They facilitate the integration of explicit knowledge with tacit knowledge to influence policy-making while relying on research evidence.

Certain questions should be considered while preparing for and conducting policy dialogues, based on the guidance provided in the SUPPORT tools (Lavis, Boyko, et al., 2009).

1. Does the policy dialogue address a high-priority issue?
2. Does it provide opportunities to discuss the problem, options to address the problem and key considerations for implementation?
3. Is the dialogue informed by a pre-circulated EBP and by a discussion about the full range of factors that can influence the policy-making process?
4. Does it ensure fair representation among those who will be involved in, or affected by, future decisions related to the issue?
5. Does the policy dialogue engage a facilitator, follow the Chatham House Rule (requiring comments to not be attributed to individuals) and not aim for consensus (The Royal Institute of International Affairs, 2019)?
6. Are outputs produced and follow-up activities undertaken to support action?

## Preparation

The process of preparing for the policy dialogue should start concurrently with the process of developing the EBP.

Readiness and acceptability for a policy dialogue should be identified by soliciting feedback from key stakeholders on the priority health issue/problem, before starting the process of developing the EBP. In countries in which stakeholders are less familiar with the EVIPNet methodology, the EBP team may want to raise awareness for and understanding of the policy dialogue in parallel with developing the EBP to create enabling conditions. Once readiness for the policy dialogue is secured, preparations for it can start alongside the development of the EBP. An extensive checklist is provided in Table 2.21 for use before, during and after the dialogue.

- Identification of the possible policy dialogue invitees should take place early on, while developing the stakeholder list (refer to Subsection 2.1.5). Nonetheless, this list should be updated as EBP development progresses, with better understanding of the context and the 18–24 key stakeholders. The choice of invitees is dependent upon (Lavis, Boyko, et al., 2009):
  - their degree of involvement in/knowledge about the problem and its relevant solutions;
  - their ability to constructively engage in the discussions and to articulate the problem and its possible solutions;
  - their ability to champion the actions recommended in the EBP.
- The must-have invitees, who are the 4–5 essential participants in the policy dialogue, should be identified and invited early on in the process to secure their attendance.

- 
- Multiple steering committee and EBP team meetings should be organized to set the goals of the dialogue and discuss the possible contribution of each invited stakeholder to finalize the list of those who will be invited.
  - Invitations should be sent as early as possible to secure the attendance of the participants. Depending on the context, this can range from four weeks to three months prior to the policy dialogue date, and invitations should be followed up.
  - Setting the dialogue date should be based on:
    - the availability of the must-have participants;
    - a possible window of opportunity/focusing event (international event dates, around elections, for example);
    - initial agreement in the MoU/ToR;
    - the budget and timeline of the project and the availability of the EBP team and steering committee.
  - Concurrently, the policy dialogue budget and logistics plan should be developed, including
    - setting out the budget required for the policy dialogue;
    - booking the venue, catering and photography;
    - if applicable, preparing travel/transportation for the participants/EBP team;
    - printing material (including the agenda, the EBP and the evaluation forms [see Section 3]);
    - identifying the note-takers for the policy dialogue.
  - The facilitator should be identified and prepared (which includes discussing the objectives, materials, specific dynamics among and between the participants). More details are given in the subsection that follows on dialogue facilitation.

**TABLE 2.21. CHECKLIST FOR PREPARING THE POLICY DIALOGUE**

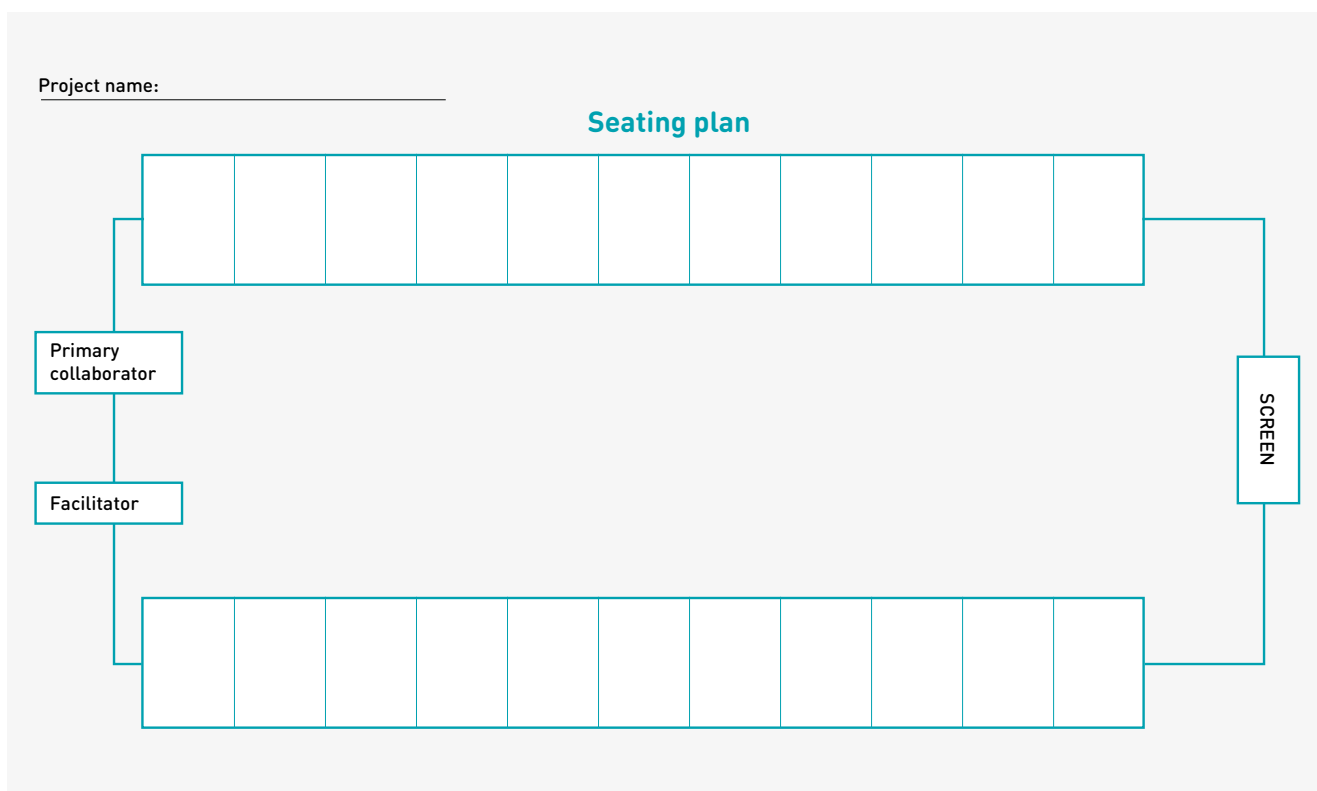
TASK	RESPONSIBILITY	TIMELINE	CHECK
<p><b>Before the policy dialogue</b>            Preparing the pre-circulated documents includes:</p> <ol style="list-style-type: none"> <li>1. finalizing the pre-circulated EBP documentation;</li> <li>2. proofreading for spelling, grammar and formatting by someone external to the author team;</li> <li>3. ensuring there is only one pre-circulated document to avoid confusing the dialogue participants with too many documents;</li> <li>4. translating the EBP as necessary;</li> <li>5. back-translating to validate the translation;</li> <li>6. sending the document for final formatting;</li> <li>7. assigning tasks for EBP team members during the policy dialogue (reception, registration, note-taking, social media and communication, dialogue facilitator, etc.).</li> </ol> <p><b>Preparing the list of possible policy dialogue participants includes:</b></p> <ol style="list-style-type: none"> <li>8. setting up a list of possible participants based on a stakeholder mapping (see Subsection 2.1.5);</li> <li>9. peer-reviewing the list of possible participants among the EBP team and steering committee to ensure the suitability of the proposed participants and the completion of contact information;</li> <li>10. clarifying the policy dialogue date with the few must-have stakeholders a few months in advance;</li> <li>11. inviting more than one person from key organizations to ensure proper representation if one of them fails to attend;</li> <li>12. booking the venue, date/time and catering;</li> <li>13. developing an agenda for the policy dialogue;</li> <li>14. developing personalized invitation letters and email text for each of the invitees;</li> <li>15. sending invitation letters and the provisional agenda via email (sent by the EBP team lead);</li> <li>16. keeping track of confirmations by the list of invitees using a tracking sheet;</li> <li>17. sending a reminder email to participants who have not yet confirmed and following up with a call a week after the first email (if sending again, it is important to ensure that the provisional agenda is attached);</li> <li>18. if relevant, preparing travel logistics for participants;</li> <li>19. ten days before the dialogue, sending a second email (sent by the policy dialogue coordinator) to only the confirmed participants, attaching the agenda and relevant documents .pdf file of the agenda, and the EBP in English and the native language as necessary);</li> <li>20. developing tent cards for the dialogue participants;</li> <li>21. developing name tags for the EBP team;</li> <li>22. printing the pre-circulated material (one copy to proofread and check the colours and formatting);</li> </ol>			

TASK	RESPONSIBILITY	TIMELINE	CHECK
<p>23. arranging for a photographer/videographer to take photos and carry out dialogue interviews;</p> <p>24. preparing the policy dialogue communication plan (the press release, along with a list of media outlets to share it with, and the social media posts);</p> <p>25. developing a PowerPoint presentation for the policy dialogue and sending it for final formatting (work should be started on this at least two weeks ahead of the dialogue and the presentation discussed with the EBP team and steering committee);</p> <p>26. developing a seating plan for the participants that ensures maximum interaction between them (see Fig. 2.8);</p> <p>27. sending a reminder email with the agenda attached a few days before the event;</p> <p>28. making a list of 5–6 participants to interview during the break for the communication plan;</p> <p>29. preparing the documents and the PowerPoint presentation on (two) USBs, along with the fonts to be used;</p> <p>30. if the room is available one day before the event, visiting the venue to check the setting, arrange the banners and put the folders on the table;</p> <p>31. ensuring that the folders contain the policy dialogue evaluation form, the EBP, the agenda, a notebook, a pen and any other relevant material.</p> <p><b>Printing</b> The following items should be printed:</p> <p>32. evaluation forms for the pre-circulated documents in English and the native language (Section 3);</p> <p>33. evaluation forms for the policy dialogue event (in English and the native language);</p> <p>34. the seating plan, with large tent cards in front of each participant (additional tent cards and folders should be brought along to the dialogue);</p> <p>35. the agenda;</p> <p>36. consent forms for video interviews;</p> <p>37. registration sheets.</p> <p><b>Day of the event</b> The important steps to follow include:</p> <p>38. arriving at the conference room 1.5–2 hours before the start of the policy dialogue;</p> <p>39. arranging the banners at the entrance and inside the conference room (ensuring that at least one banner is situated behind where the facilitator will be positioned);</p> <p>40. installing the required fonts on the laptop and setting up the PowerPoint presentation;</p>			

TASK	RESPONSIBILITY	TIMELINE	CHECK
<p>41. ensuring that the microphones are working properly (the room should preferably be equipped with microphones on the tables; if not possible, around 10 individual microphones are needed);</p> <p>42. arranging the pre-circulated documents, agenda and other materials (notebooks/pens) on the tables;</p> <p>43. placing the tent cards on the tables, based on the seating plan;</p> <p>44. arranging the registration desk to have: registration sheets (with pens), evaluations forms for the pre-circulated documents (the participants are to sign in, be shown to their seats and given the evaluation forms, which are to be collected before the dialogue starts);</p> <p>45. once the event starts, taking detailed notes at all times (to be taken by two designated authors of the EBP [see Subsection 2.3.2]);</p> <p>46. facilitating the photographer’s role;</p> <p>47. live tweeting and uploading Facebook posts with high-resolution photos, while ensuring that the Chatham House Rule is respected;</p> <p>48. during the break, approaching 4–5 participants and asking them if they would be willing to give a 2-minute interview about the event directly after the policy dialogue ends;</p> <p>49. collecting evaluation forms for the dialogue before the event ends;</p> <p>50. recording the interviews with the camera crew and participants, and ensuring that they sign consent forms;</p> <p>51. editing the press release if needed and sending it to the communications team in the relevant languages, along with some high-resolution photos.</p> <p><b>After the event</b> The actions to be taken after the EBP include:</p> <p>52. collecting all materials (banners, consent forms, evaluation forms, tent cards, folders, USBs, laptops, extra products, etc.) and returning them to the office;</p> <p>53. calling some journalists/media contacts to ensure that news of the press release is disseminated;</p> <p>54. sending a thank-you note to all the participants, with a photo;</p> <p>55. revising the pre-circulated documents, as necessary;</p> <p>56. developing a policy dialogue summary (see Subsection 2.3.2) based on the notes taken, and sending it for final formatting;</p> <p>57. sending the dialogue summary to participants who attended via email within 2–3 weeks after the dialogue;</p> <p>58. disseminating the dialogue summary through all relevant channels (see Subsection 2.3.2).</p>			

Source: adapted from the K2P Center’s standard operating procedures for policy dialogues.

FIG. 2.8. SEATING PLAN FOR THE POLICY DIALOGUE



*Note.* The seating plan is prepared by the dialogue coordinator to ensure maximum interaction between stakeholders.

### Dialogue facilitation

The dialogue facilitator is of utmost importance in a policy dialogue, ensuring its success (or not). As such, the policy dialogue facilitator should be chosen wisely.

The facilitator should have a certain set of skills (Biermann & Kuchenmüller (2016), including:

- experience in facilitating
- knowledge about the content of the EBP
- knowledge of health systems, social policies and health policies in general
- neutrality
- understanding of the underlying politics between and among the stakeholders
- being confident, transparent, trustworthy, respectful, professional and assertive.

Therefore, the facilitator should be well informed and prepared prior to the policy dialogue. As such, the potential facilitator should be approached a few months before the dialogue and agreement reached on the dialogue date, the goals of the policy dialogue and the monetary terms. They should be kept in the loop of all the updates, challenges and changes in the process of developing the EBP.

During the policy dialogue, the facilitator should (adapted from Biermann & Kuchenmüller (2016)):

- be well prepared (e.g. on the goals of the policy dialogue, the background to the issue) and have the necessary materials and the PowerPoint presentation at hand;
- clarify the objectives, expectations and outcomes of the policy dialogue for the participants;
- clarify the rules to be observed (e.g. Chatham House Rule);
- avoid aiming for consensus;
- create a friendly atmosphere, but be prepared for disruptive participants;
- listen well and intervene when needed;
- demonstrate neutrality;
- be motivated and encourage participation and active engagement;
- ensure that people feel valued/have a sense of importance;
- clarify differences of opinion;
- ask for clarification or examples where necessary;
- encourage participants to use jargon-free, clear and person-first vocabulary;
- focus on ideas, not people;
- push towards tangible formulation of next steps (i.e. action-oriented outcomes).

Chatham House Rule refers to a situation whereby you agree to freely use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed. This rule ensures meeting confidentiality and, as such, facilitates free speech in important meetings.

For more details on facilitating and troubleshooting, the EVIPNet Policy dialogue preparation and facilitation checklist is available from the WHO Regional Office for Europe (Biermann & Kuchenmüller, 2016).

### 2.3.2 Dialogue summary

The dialogue summary is a tool used to outline the results of the discussions during the policy dialogue. It forms the road map for how to move forward with tackling this priority health issue/problem, based on the deliberations around the EBP. The dialogue summary is then shared with the participants of the policy dialogue and widely disseminated.

#### Who are the people in charge?

- During the policy dialogue, two independent note-takers are to be in charge of taking notes. This dual note-taking process reduces the possibility of missing important points made during the dialogue. It also ensures neutrality in the way the notes are being taken.
- The two independent note-takers should be from the EBP team, preferably from among the authors. They are responsible for writing the minutes of the policy dialogue, and for working on developing the dialogue summary.

#### What is the process of note-taking during the policy dialogue?

- The note-takers should be seated so that they can see all the dialogue participants.
- If one of the note-takers missed a point during the discussion, they are responsible for making sure that the other note-taker recorded it.



- 
- The note-takers should record proceedings in such a way that makes no direct reference to the participants. The Chatham House Rule should be respected even during the note-taking (not only in the write-up).
  - In some cases, where the dialogue ends with direct recommendations and next steps, and with a clear agreement from the participants to disclose, the next steps can be recorded along with the affiliations of the participants (but not their names). For example, if participant **x** states that they officially agree that their NGO **y** will be responsible for a certain policy element, then both the notes and the dialogue summary shall reflect that NGO **y** will be responsible for that certain policy element, but they must not mention that participant **x** stated this.
  - The notes should remain confidential, shared among the note-takers only.
  - The notes should be typed up in a Word document, no later than three days after the policy dialogue. The sooner they are written up, the less likely that anything will be forgotten.

### How to write the dialogue summary

- One or both note-takers should be responsible for writing the dialogue summary. In all cases, the author of the summary should be from the EBP team (one of the authors), and familiar with the EBP.
- The author shall read both sets of notes written up from the dialogue, synthesize the notes so as to not disclose the names and affiliations of the participants (unless clearly asked to do so by individual participants themselves).
- The dialogue summary should state the points of convergence and divergence with the EBP.
- The summary is to be divided up into the same sections as the EBP (i.e. deliberations about the problem and its size, the underlying factors, and about the elements/options and their implementation considerations).

### *Authors and acknowledgments*

A separate introductory page to the dialogue summary should include the following:

- authors
- funding information
- acknowledgments
- dialogue description (time, date, place, facilitator)
- suggested citation.

### *Section 1: preamble*

This section comprises an introduction to the policy dialogue, including:

- time
- date
- place
- number of stakeholders attending

- 
- participants' general (unidentifiable) affiliation (e.g. “the dialogue was attended by two representatives from the Ministry of Health and one from the Ministry of Education”, without names or positions that could make them identifiable). This is the only section in which affiliations can be mentioned.

### ***Section 2: deliberations about the problem***

This section should cover the deliberations about the problem discussed during the policy dialogue, along with its size and scope. The writing should reflect the points of agreement and disagreement with the EBP, as well as those among the dialogue participants, including any suggestions to improve the phrasing of the problem.

### ***Section 3: deliberations about the underlying factors***

Similarly, this section should reveal the points of agreement and disagreement about the factors underlying a certain problem, along with any recommendations to improve the underlying factors section of the EBP.

### ***Section 4: deliberations about the elements/options involved in an approach to addressing the problem***

This section should be split up into the different elements/options presented in the EBP. The opinions of the participants on each of those elements/options should be described in a way that shows their recommendations for steps to be taken on the issue (without disclosing the names or affiliations of the participants). A section should be added at the end of each element/option, listing key implementation considerations discussed and suggestions on how to overcome any barriers to implementation.

### ***Section 5: recommendations and next steps***

This section should reflect the action-oriented discussions in the policy dialogue about the recommendations and next steps. The key recommendations and next steps should be listed. Sometimes these recommendations and next steps will need to be divided into sections according to the party involved, but this will depend on the process of the particular policy dialogue and agreement among the EBP team and steering committee.

## **Reviewing the dialogue summary**

The dialogue summary is to be approved by the EBP team and the steering committee before it is sent for formatting.

## **Disseminating the dialogue summary**

The summary is to be completed within a maximum of two weeks after the policy dialogue date. It will then be disseminated to:

- all the dialogue participants via email;
- websites of relevant institutions;

- 
- media and social media sites (e.g. Facebook and Twitter) and other outlets;
  - other key stakeholders, partners, policy-makers and relevant organizations, as well as advocacy groups.

In some instances, some key stakeholders might not have been able to attend the policy dialogue; in which case, a separate meeting should be organized with them individually to discuss the EBP and the dialogue summary.

### **Following up on the adoption/implementation of the policy**

After the policy dialogue and the dissemination of the dialogue summary, it is necessary to actively work on the uptake/adoption of the policy options as well as monitor their adoption to reach the desired health outcomes. Dissemination methods should be identified and implemented along with advocacy activities to ensure adoption of the policies. Monitoring the uptake/impact can also include advocacy, post-dialogue survey, policy tracing and media analysis. Monitoring can help to identify whether or not these options have been adopted and by whom. Although this step is carried out after the policy dialogue, the preparation phase should be conducted in parallel with the development of the EBP itself. The political and policy context mapping exercise, along with the stakeholder mapping, can also provide general guidance on who, when and how the communication plan should be made.

### **2.3.3 Advocacy plan**

Advocacy can facilitate both the adoption of the policy options and the monitoring. Depending on the specific goal(s) and approach of the advocacy strategies being used, the desired outcomes can be achieved in a variety of ways. If the policy options have not yet been adopted, or are being implemented in suboptimal way, advocacy strategies should be employed to encourage the stakeholders to carry out proper adoption or implementation.

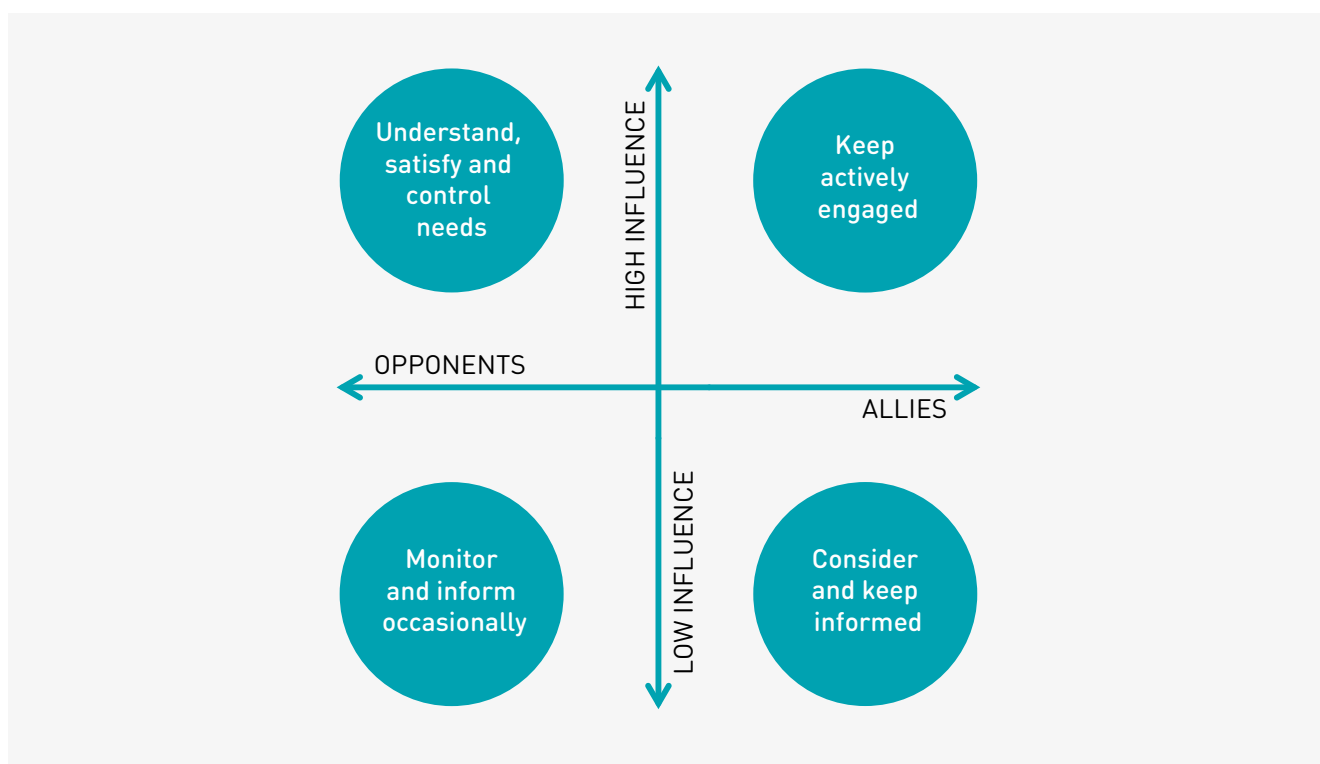
#### **Steps to be followed to facilitate the advocacy plan**

Four key steps should be taken to facilitate and ensure the success of the advocacy plan.

1. A study should be carried out of each stakeholder's role, power and position on the issue in question (by the EBP team and the steering committee). This is a continuous process to be revisited from the starting point of working on the EBP through to adoption and implementation of policies. The earlier steps of political and policy context mapping and stakeholder mapping can further inform this analysis. In addition, assessments of stakeholders' positions might be warranted throughout the key informant consultations, for example, by means of:
  - a visit/phone call/email
  - sending a fact sheet, policy brief, presentation, infographics or video
  - engaging in focus group discussions with stakeholders
  - closely following their work.

Once the stakeholder positions have been identified through all the earlier steps during the development of the EBP, they should be mapped out according to the power analysis matrix shown in Fig. 2.9 to inform the next steps. This step can be conducted several times throughout the project, as

FIG. 2.9. STAKEHOLDER POWER ANALYSIS MATRIX



the positions of stakeholders might change or become clearer (see Fig. 2.10). It should always be borne in mind that the public is an important stakeholder and should not be forgotten in the process.

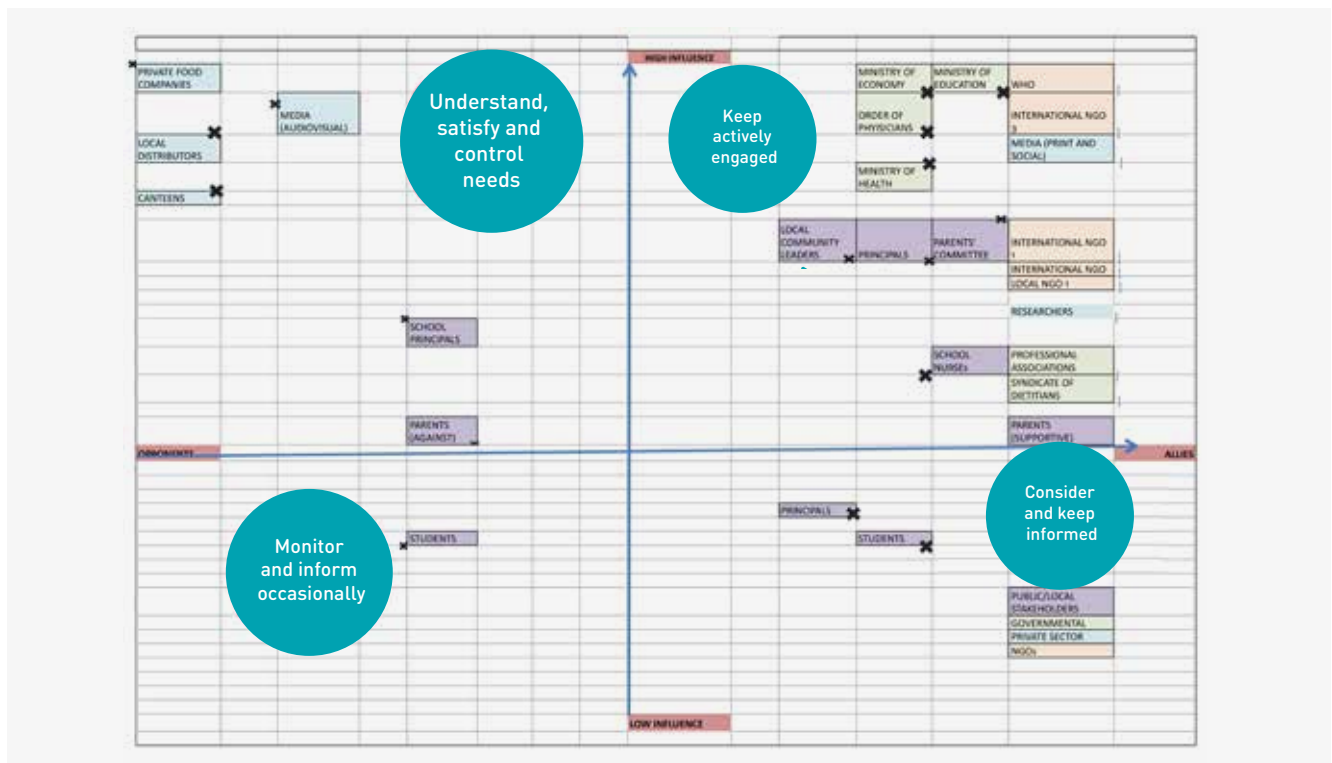
### **Example**

**Problem:** controlling the availability, accessibility and marketing of sugar-sweetened beverages for children in schools.

**Stakeholders include:** relevant ministries (of education, health, economy, etc.), researchers, national NGOs, international NGOs, WHO, UNICEF, the media, heads of schools, parents, teachers, students, school nurses, the private industry sector, distributors of sugar-sweetened beverages and canteen suppliers (among others).

After figuring out their positions, the stakeholders' power and positions should be distributed on the power analysis grid (see Fig. 2.10). This step should be conducted through multiple meetings with the EBP team and steering committee.

FIG. 2.10. EXAMPLE OF A STAKEHOLDER POWER ANALYSIS OF SUGAR-SWEETENED BEVERAGES IN SCHOOLS



2. Advocacy goals/objectives should be set for each one of the stakeholders, based on their position on the matrix.

After identifying the power and position of each stakeholder, discussions should be held with the team/steering committee and an advocacy goal/objective set for each of them to either: keep engaged, keep informed, monitor or satisfy/control needs.

The goals/objectives can be divided up based on:

- the stakeholder group: policy-makers, influencers and the public;
- their position and power within the power analysis grid, e.g. allies of high influence, allies of low influence, opponents of high influence, or opponents of low influence;
- a goal/objective for each stakeholder.

### Examples of goals

A few of the advocacy goals for the example above would be:

- to create a coalition of powerful allies to develop, implement and evaluate activities to control sugar-sweetened beverages inside schools;
- to develop and implement participatory advocacy activities with the public, local/international NGOs, and relevant professional organizations;
- to consult with the public to understand their needs and values on the issue;

- 
- to monitor the activities of the private sector/industry;
  - to reach out to various media outlets.
3. Communication/advocacy tools should be identified to address each one of the goals, and to implement and evaluate them.

After identifying the goal/objectives of the advocacy campaign, a full plan should be drawn up, with clearly identified activities, communication methods, target audience, timelines, resources needed and a budget.

### **Example**

For the goal of consulting with the public as a target audience to identify their needs, three activities can be carried out:

- i. establish a citizen panel or a focus group with citizens
- ii. set up a hotline where citizens can call and share their concerns/recommendations
- iii. create a Facebook/Twitter account with a hashtag that can be used to contribute to the discussions.

For activity iii above (setting up and running the social media accounts), the following considerations will be necessary.

- one full-/part-time position will be required. The person should have expertise in social marketing/communication. The appropriate salary will need to be allocated for the timeline required.
  - Stickers/posters will need to be designed and printed, adorned with the relevant hashtag, for distribution among local communities.
  - A budget will be needed for paid reach through a few Facebook posts to increase the coverage and visibility of the issue.
4. Monitoring for change is important, as well as being as creative as possible.

For each of the advocacy goals and activities, indicators should be defined to monitor their success in terms of process and outcome. Monitoring and evaluating the progress of advocacy activities is essential for understanding the level of success in influencing the target group, and whether it is necessary to change strategies. It might be necessary to revise the strategy, alter some activities, or add new stakeholders. Creativity in the activities chosen, as well as how they are evaluated, is key to success going forward.

### **Example of indicators for activity iii (running social media account(s))**

- number of posts per week
- number of “likes”, comments, shares, tags (compare across time)
- number of new “likes” to the page
- qualitative analysis of the comments and direct messages received.

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## TIPS

- There is no one-size-fits-all rule in advocacy. Maximum flexibility and creativity are important in designing, implementing and evaluating the activities. It is important to be:
  - responsive and flexible to allow for constant changes;
  - ready for some major opposition;
  - reasonable in setting the timeline – advocacy requires a very long time;
  - reasonable in terms of expectations.

### 2.3.4 Communication plan

The first step in communicating with the right stakeholders is to inform them about the topic starting from scratch. A good starting point is the 5Ws rule: what, when, where, why and who. In answering these questions for the stakeholder or the relevant partner, they will have a good general overview of the problem.

Putting the issue into context aims to ensure that the prospective participant can identify with the problem, and from this point, communicating about the details should become easier. It is important to point out that the stakeholders to be approached will be from different backgrounds (e.g. researchers, media representatives, ministers, etc.), therefore, the approach will be slightly different for each, but should have the same basis of presenting the problem in the right context.

The communication plan should include:

1. the aims of the plan (e.g. to set the health problem that is the focus of the EBP on the agenda; disseminate the EBP and policy dialogue summary; advocate for the adoption of the policies; raise the awareness of the public, etc.) and the expected outcomes;
2. the target audience, with an answer for each of the 5Ws: what, when, where, why and who to engage;
3. the tools needed to achieve the goals;
4. the resources required (human and financial);
5. a timeline (consider key windows of opportunity for a launch or similar activities);
6. the message content and the frequency of its dissemination;
7. the evaluation plan for the tools, with indicators for the process of implementing the tools and assessing the outcomes of the implementations.

It should be noted that if a comprehensive advocacy plan is in place, the communication plan becomes a subset of the advocacy plan. It should be used to specifically implement the communication/advocacy tools.

Depending on the scope and scale of the advocacy and communication plans, a team will be needed to support their implementation. The minimum needed is one full-time officer for advocacy and communication, with relevant expertise in the field. As activities are scaled up, it could be worth expanding the team or attracting some volunteers.

Various products/activities used for communication and advocacy, according to the target audience, are detailed in Table 2.22.

**TABLE 2.22. DIFFERENT ADVOCACY AND COMMUNICATION TOOLS FOR VARIOUS STAKEHOLDERS**

<b>RESEARCHERS</b>	<b>STAKEHOLDERS (POLICY-MAKERS AND INFLUENCERS)</b>	<b>THE GENERAL PUBLIC</b>
<ul style="list-style-type: none"> <li>▪ Policy studies</li> <li>▪ Research papers</li> <li>▪ Working papers</li> <li>▪ Policy reports</li> <li>▪ Policy-oriented journal articles</li> <li>▪ Conference/seminar presentations</li> <li>▪ Less formal presentations in meetings or lobbying activities</li> <li>▪ Presentations to working groups and public hearings</li> </ul>	<ul style="list-style-type: none"> <li>▪ Policy briefs, memos and fact sheets</li> <li>▪ Media (sound)bites</li> <li>▪ Newsletters</li> <li>▪ Policy reports</li> <li>▪ Infographics</li> <li>▪ Less formal presentations in meetings or lobbying activities</li> <li>▪ Presentations to working groups and public hearings</li> <li>▪ Documentary videos</li> <li>▪ Advocacy-based advertising</li> <li>▪ Email campaigns</li> <li>▪ Dedicated advocacy websites or pages</li> <li>▪ Social networking: Facebook, Twitter</li> <li>▪ SMS/WhatsApp messaging campaigns</li> </ul>	<ul style="list-style-type: none"> <li>▪ Articles in newspapers</li> <li>▪ Adverts, banners, posters, T-shirts, stickers</li> <li>▪ Radio and TV programmes</li> <li>▪ Public meetings and hearings</li> <li>▪ Speeches to the public</li> <li>▪ Infographics</li> <li>▪ Documentary videos</li> <li>▪ Advocacy-based advertising</li> <li>▪ Email campaigns</li> <li>▪ Dedicated advocacy websites or pages</li> <li>▪ Social networking: Facebook, Twitter</li> <li>▪ SMS/WhatsApp messaging campaigns</li> </ul>



There is no conclusive evidence on which communication method is more effective. The choice of each method will depend on the target audience, the advocacy/communication goal, the problem being studied and the stakeholder's current position. A recent systematic review showed that media interventions (including the use of print media, news coverage, TV talk shows, press releases, adverts, videos and interviews) may have a positive impact when used as accountability tools, as tools to increase policy-makers' awareness and influence policy formulation, and as awareness tools leading to policy adoption and improve compliance with laws and regulations (Bou-Karroum et al., 2017).

### **Example of a communication plan**

The communication plan for activity iii in the example presented in the previous subsection (setting up and running social media accounts) is outlined in Table 2.23.

**TABLE 2.23. COMMUNICATION PLAN EXAMPLE**

<p><b>GOAL</b> Increase public awareness of and willingness to pressure local communities</p>
<p><b>AUDIENCE</b> The public: parents of schoolchildren</p>
<p><b>COMMUNICATION TOOL</b> Social media: Facebook page</p> <ul style="list-style-type: none"> <li>• Title: "Our children's health matters"</li> <li>• With logo, specific colours and templates for the post</li> <li>• Pictures, texts, videos, polls</li> </ul>
<p><b>MESSAGE CONTENT</b></p> <ul style="list-style-type: none"> <li>• Post 1: picture of a school canteen with sugar-sweetened beverages</li> <li>• Post 2: link to the legislation banning sugar-sweetened beverages in schools</li> </ul>
<p><b>FREQUENCY</b> 3 posts per week (Monday, Wednesday and Friday at 1:30 pm)</p>
<p><b>INDICATORS</b> The number of "likes", comments, "shares" and tags</p>
<p><b>RESPONSIBLE PERSON</b></p> <ul style="list-style-type: none"> <li>• Person A develops the posts</li> <li>• Person B posts and monitors them</li> </ul>
<p><b>RESOURCES NEEDED</b></p> <ul style="list-style-type: none"> <li>• Internet</li> <li>• Computers</li> <li>• Graphic designer</li> <li>• Approx-imately \$20 per week for paid reach for Facebook posts</li> <li>• Personnel</li> </ul>
<p><b>TIMELINE</b> February to June 2018 [5 months]</p>

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## TIPS

- The EBP and the policy dialogue summary should be disseminated to all the relevant stakeholders.
- Words should be chosen and ideas should be framed in such a way as to be clear, understandable and visually appealing.
- Brief sentences, clear terms and infographics are strongly advised to catch stakeholders' attention from the first to the last words.
- The strongest part of the document should be highlighted.
- Policy-makers respond well to infographics paired with some text/description.
- Media representatives search for content that is easy, brief and interesting. As such, they should be given the answers to the 5Ws: what, who, when, where and why. It could also be good to add the "how to". Media representatives tend to cover what they can understand and what is important to them, staying away from anything too technical or that might not interest people.
- Another key element to successful media-research cooperation is achieving the balance between the right dose of rational/scientific information and the emotional touch that lends spirit to the whole EBP and a story that people can identify with, allowing them to believe in the purpose of the EBP.
- As for social media, understanding the audience is the first and most important step to reaching communication and advocacy goals. Researchers should adapt their messages based on their audience, not the other way around.

### 2.3.5 Press tracing and media analysis

Monitoring the media and analysing their coverage can inform the next steps in an advocacy plan. Furthermore, press tracing and media analysis can serve as M&E tools for the adoption of the policy options, and even to establish whether the priority health issue/problem has been put on the policy/political agenda as a result of the work carried out.

- Media analysis aims to capture reports about the development and implementation of the policy over time and to analyse how the intended policy or policy options are perceived. It also aims to obtain an overview of the social, political and economic conditions and events that might have influenced policy implementation, as well as to identify the actors in this policy.
- Media analysis is carried out through a chronological examination of the published media (print, audiovisual and social media) to identify policy actions and trace progress. Data collection can be performed using an Excel sheet (Table 2.24).
- The data collected can include the following items: author, title, source and date of publication, stakeholders and their position (supporting or resisting the policy), key topics, implementation barriers, the use of evidence and a summary of the news item.
- The items chosen will depend on each policy and the purpose of the media analysis.
- The results should be analysed both qualitatively and quantitatively.

**TABLE 2.24. EXAMPLE OF DATA COLLECTION RECORDED FOR PRESS TRACING**

ARTICLE INFORMATION	NAME OF AUTHOR	MARWAN ISKANDAR	ANONYMOUS	ANONYMOUS
	Title of publication	The issue of social security as a system in Lebanon	The draft decree of the voluntary social security system for all uninsured Lebanese	The law of the voluntary social security for elderly
	Source of publication	Al Ra'id Al Arabic magazine	Al Anwar	Al Anwar
	Language	Arabic	Arabic	Arabic
	Date of publication	June 1961	13 August 2001	13 August 2001
	How was the article found?	Google search engine	Syndicate documents	Syndicate documents
	Link to article	<a href="http://www.al-hakawati.net/arabic.asp">http://www.al-hakawati.net/arabic.asp</a>	Syndicate documents	Syndicate documents
CONTENT ANALYSIS	Key topics	Legislation Socioeconomic benefits Social security Equity	Establishing a special section for voluntarily insured people within the maternity and sickness branch of the National Social Security Fund (NSSF)	Stopping the implementation of the law relating to voluntary social security for elderly people because of an imbalance in incomes and outcomes
	Stakeholders (for or against the NSSF policy)	The State? Lebanese workers? Lebanese farmers?	NSSF The Ministry of Labor Lebanese workers and their families	NSSF People aged over 64 years
	Spokesperson			
USE OF EVIDENCE	Was evidence used? Research (What type of study?) Researcher name/policy meetings (location, date, purpose, recommendations)?	Yes	Yes Decree number 13955 26 September 1963	Yes Law number 284 9 August 2000

**TIPS**

- Monitoring media coverage can inform the next steps in the advocacy plan.
- Press tracing and media analysis can serve as M&E tools for the adoption of the policy options and for establishing whether the priority health issue/problem in question has been moved onto the policy/political agenda as a result of the work carried out.

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### 2.3.6 Post-dialogue survey

Six months after the policy dialogue, a short survey can be circulated to key policy dialogue participants from different agencies that championed the issue targeted in the EBP in the country, each in their own capacity. The selection of the participants will be decided by the EBP team and steering committee, as they are positioned as the most knowledgeable about the latest developments. The survey will follow up on the deliberations that took place, track progress, identify actions taken by stakeholders and implementation issues and challenges that be encountered in translating into action the elements that were discussed at the dialogue.

The 6-month period between the policy dialogue and the post-dialogue survey is appropriate for examining short-term developments arising from the activities; however, a longer period might be needed to capture further changes that might materialize in due course.

#### *Example*

Box 2.4 outlines the post-dialogue survey that was carried out by the K2P Center after developing an EBP and conducting a policy dialogue on mental health services in the primary care setting in Lebanon.

#### **BOX 2.4. POST-DIALOGUE SURVEY EXAMPLE**

As a follow up to the deliberations that took place at the policy dialogue, and to track progress and identify any implementation issues, the K2P Center is conducting a short post-dialogue survey of stakeholders' views. We would appreciate taking 15 minutes of your time for a brief telephone interview to answer the questions below.

1. Please list at least 1–3 important actions that you personally have undertaken over the past 5 months in relation to the issue of securing mental health in primary care.
2. Please list at least 1–3 important actions (of which you are aware) that have been undertaken by policy-makers, stakeholders and/or researchers over the past 5 months in relation to the issue of securing mental health in primary care.
3. Please highlight any challenges you encountered in translating into action the options/recommendations that were discussed at the policy dialogue.
4. Aside from the EBP and policy dialogue, what other strategies do you think should be implemented to promote the integration of mental health in primary care in Lebanon?

#### **TIPS**

- Key policy dialogue participants should be surveyed, chosen from among the various agencies that championed the issue targeted in the EBP in the country.
- Participants selected should be the most knowledgeable about the latest developments.
- The 6-month period between the policy dialogue and the post-dialogue survey is appropriate for examining short-term changes.

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### 2.3.7 Policy tracing

Policy tracing can be conducted to assess whether the desired policy objectives have been achieved. It also aims to understand the factors that influenced the success or failure of a policy and to trace the role of the evidence and its uptake (from the EBP and other sources) in the policy-making process. Policy tracing is based on a thorough protocol, along with information from multiple sources, as detailed here.

1. Media analysis should be carried out (see details in Subsection 2.3.5).
2. Key informants' interviews are required.
  - A sampling framework should be developed to identify the selection criteria for the key informants.
  - Key informants will also be selected according to which stakeholders were first selected, to be part of litmus testing and the policy dialogue.
  - Additional stakeholders are to be selected based on the findings of the media analysis and using the snowballing sampling technique.
  - Face-to-face, semi-structured interviews are to be conducted, and recorded and transcribed.
  - The interview tool should include questions addressing the following themes: the role of the policy-maker/stakeholder in the policy-making process; their position on the policy; the use of evidence; the factors that influenced the development and implementation of the policy; the implementation barriers; and the key lessons learnt. The questions can be customized based on the policy being analysed and the specific purposes of the policy tracing. Interviews will be analysed qualitatively.
3. A documentation review should be conducted.
  - The documents are to be identified from the interviews and the media analysis, and used to further validate the findings of the media analysis and interviews in addressing the initial objectives.
  - Documents reviewed will include (among others) legislation, decrees, regulations, meeting minutes and official correspondence.
  - Data are to be collected using a data-collection sheet that includes the title of the document, the type, the date, the actors, whether evidence from the EBP (or other evidence) was used or not and a summary (see Table 2.25). Data will be analysed qualitatively.

It should be noted that this policy tracing method is a costly and lengthy process. The choice to conduct policy tracing depends on the availability of financial and human resources and the added value that the policy tracing could bring to the process.

In addition to the policy tracing technique, the long-term impact of a policy can be evaluated by collecting data on selected indicators and comparing them against baseline indicators.

However, it is hard to attribute the observed change to the policy, the options provided by the EBP or the related activities specifically, as many factors might interfere.

**TABLE 2.25. EXAMPLE OF A DATA COLLECTION TABLE FOR THE DOCUMENTATION REVIEW**

<b>TITLE</b>	NSSF law article no. 11	Minutes of the NSSF Board of Directors meetings	Letter from the Minister of Finance to Council of Ministers regarding the establishment of the voluntary insurance fund in the NSSF
<b>DATE</b>	1963	4 July 2001	31 August 2001
<b>TYPE</b>		Meeting minutes	Official letter
<b>ACTORS</b>		Head of the NSSF Board of Directors, members of NSSF Board of Directors, NSSF Director-General	Fouad Saniora, Minister of Finance, Council of Ministers
<b>EVIDENCE USED OR NOT</b>		No	No
<b>SUMMARY</b>		The subject of discussions of meeting no. 121 of the NSSF Board was the draft decree that sets out the establishment of the voluntary insurance system in the maternity and sickness branch of the NSSF. The discussions between the different members of the NSSF Board revealed many important points. The Board agreed on the decree during this meeting session.	The Minister of Finance made many notes and comments regarding the voluntary insurance system decree, concerning the financial balance of the branch, the financial burden on the State's treasury and various administrative issues.
<b>REFERENCE</b>		Minutes of the NSSF Board of Directors meeting (4 July 2001)	Fouad Saniora, Ministry of Finance Letter from the Minister of Finance to the Council of Ministers regarding the establishment of the voluntary insurance fund in the NSSF (31 August 2001).

### TIPS

- It is worth ensuring that policy tracing is actually needed, as it is a costly and lengthy process that requires the availability of significant financial and human resources.
- Data should be collected on baseline indicators to allow comparison and observe changes.
- It is important to keep in mind that it is hard to attribute any observed changes to the policy and the options provided by the EBP, or the related activities, as many factors might interfere.

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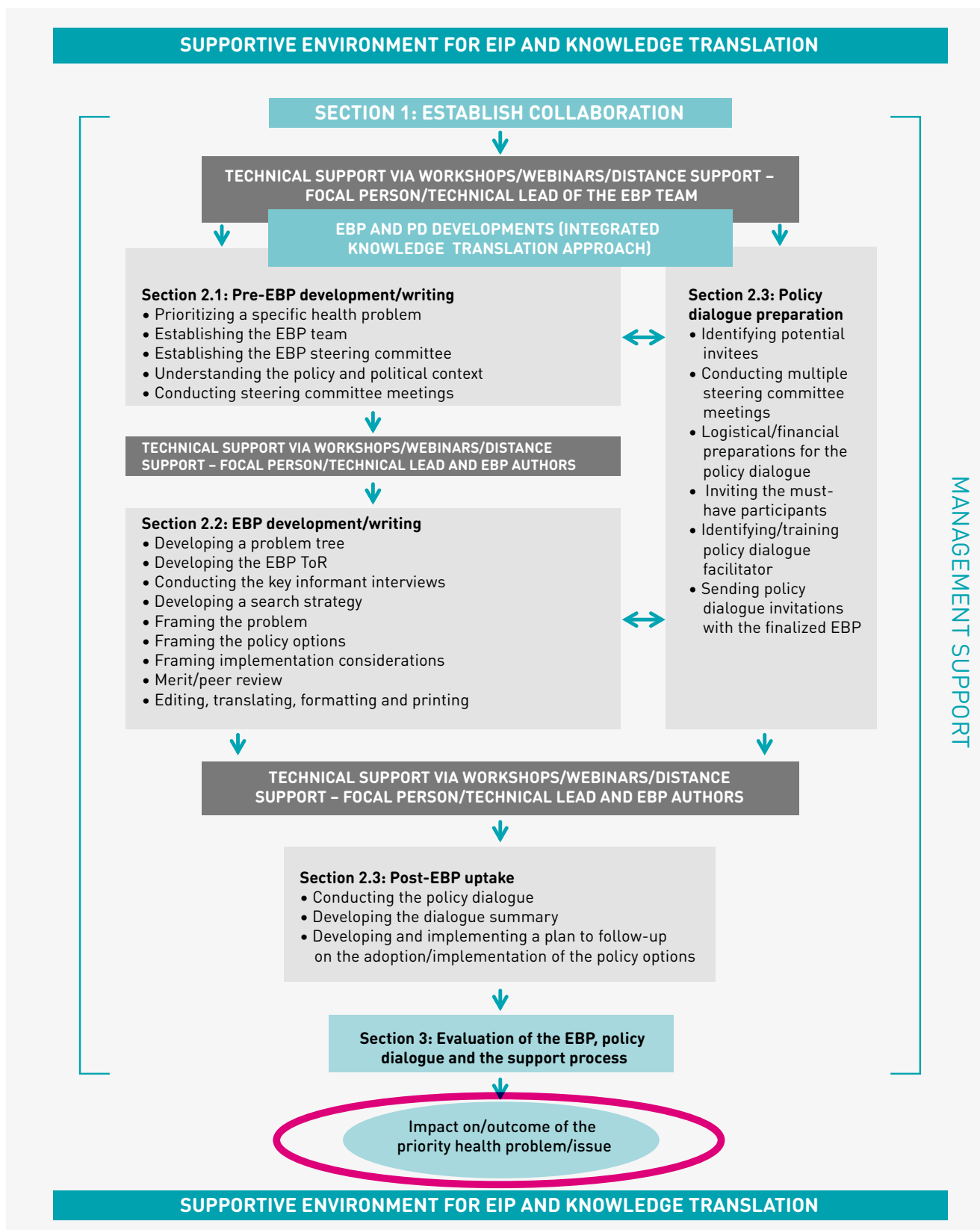
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FIG. A. FRAMEWORK FOR SUPPORTING COUNTRIES TO DEVELOP AND IMPLEMENT AN INTEGRATED KNOWLEDGE TRANSLATION APPROACH



Note. M&E: monitoring and evaluation

Source: adapted from the integrated knowledge translation framework presented by El-Jardali & Fadlallah (2015).

## SECTION 3

# EVALUATION

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Evaluation is an essential but often missed step in knowledge translation. It enables an understanding of whether the EBP and policy dialogue were effective and efficient in reaching their goals. It also identifies which processes were effective and whether any other processes need to be improved.

## KEY MESSAGES

- Evaluating the EBP, the policy dialogue and all other activities to monitor uptake is essential for tracking the outcomes and impact of the work carried out and to assess what processes were effective and whether any other processes need to be improved.
- The evaluation activities should be planned ahead of time and evaluation plans prepared for every step conducted.
- The evaluation criteria should be aligned with the project goals. Each item to be evaluated must match the goals and objectives set out for the process, and the outcomes.

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## 3.1 EBP EVALUATION FORM

The EBP evaluation questionnaire to evaluate the process and outcomes of the EBP should be short and precise. The questionnaire shown in Table 3.1 is only an example of the type of questionnaire to be used. The items chosen should reflect the goals and objectives of the knowledge translation work.

The questionnaire and the form accompanying it can be distributed to the participants when they register at the start of the policy dialogue (and it should be collected before the dialogue starts). It can also be sent via email after the stakeholders have read the EBP. The questionnaire rates multiple process and outcome objectives on a seven-item scale ranging from “very unhelpful” to “very helpful”. It covers the main areas and sections within the EBP, the general goal of the EBP and some background information about the participants. The questionnaire should of course remain anonymous.

TABLE 3.1. EBP EVALUATION QUESTIONNAIRE AND ANONYMOUS BACKGROUND FORM

[Title of the EBP]

How helpful did you find each of the approaches described below? Please circle the number that corresponds to your answer.

	VERY UNHELPFUL	MODERATELY UNHELPFUL	SLIGHTLY UNHELPFUL	NEUTRAL	SLIGHTLY HELPFUL	MODERATELY HELPFUL	VERY HELPFUL
1. The EBP described the context for the issue being addressed.	1	2	3	4	5	6	7
2. The EBP described different features of the problem, including (where possible) how it affects particular groups.	1	2	3	4	5	6	7
3. The EBP described the elements of an approach for addressing the problem.	1	2	3	4	5	6	7
4. The EBP described what is known, based on synthesized research evidence, about each of the elements/options and where there are gaps in what is known.	1	2	3	4	5	6	7
5. The EBP described key implementation considerations.	1	2	3	4	5	6	7
6. The EBP took quality considerations into account when discussing the research evidence.	1	2	3	4	5	6	7
7. The EBP took local applicability considerations into account when discussing the research evidence.	1	2	3	4	5	6	7
8. The EBP did not conclude with any particular recommendations.	1	2	3	4	5	6	7
9. The EBP employed a graded-entry format (e.g. a list of key messages and a full report).	1	2	3	4	5	6	7

## Overall assessment of the EBP

10. The purpose of the EBP was to present the available research evidence on a high-priority policy issue to inform a policy dialogue during which research evidence would be just one input into the discussion. How well did the EBP achieve its purpose?

FAILED	MODERATELY FAILED	SLIGHTLY FAILED	NEUTRAL	SLIGHTLY ACHIEVED	MODERATELY ACHIEVED	ACHIEVED
1	2	3	4	5	6	7

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Your role and background

I am a (please tick (✓) the single most appropriate role category):

BROAD ROLE CATEGORY	SPECIFIC ROLE CATEGORY	TICK (✓)
Policy-maker	Public policy-maker (e.g. elected official, political staff or civil servant) in the national government	
	Manager in a district/region (if it does not have independent policy-making authority)	
	Manager in a health-care institution (e.g. hospital, primary health care setting)	
	Manager in a nongovernmental organization (NGO)	
Stakeholder	Staff/member of a civil society group/community-based NGO	
	Staff/member of a health professional association or group	
	Staff of a donor agency	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

I have been working in my current position for \_\_\_\_ years.

Thank you

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## 3.2 POLICY DIALOGUE EVALUATION FORM

The policy dialogue evaluation questionnaire to evaluate the process and outcomes of the dialogue should also be short and precise. In terms of evaluating the impact, Subsection 2.3.7 provides further details. The questionnaire shown in Table 3.2 is only an example of the type of questionnaire to be used. The items chosen should reflect the goals and objectives of the knowledge translation work.

The questionnaire and the form accompanying it can be distributed to the participants after finishing the policy dialogue. It can also be sent via email after the dialogue. The questionnaire rates multiple process and outcome objectives on a 7-item scale ranging from “very unhelpful” to “very helpful”. It covers the main parts of the policy dialogue, the general goal of the dialogue and some background information about the participants. The questionnaire should of course remain anonymous.

TABLE 3.2. POLICY DIALOGUE EVALUATION QUESTIONNAIRE AND ANONYMOUS BACKGROUND FORM

**Policy dialogue evaluation questionnaire: [TITLE]**

How helpful did you find each of the approaches given below? Please circle the number that corresponds to your answer:

	VERY UNHELPFUL	MODERATELY UNHELPFUL	SLIGHTLY UNHELPFUL	NEUTRAL	SLIGHTLY HELPFUL	MODERATELY HELPFUL	VERY HELPFUL
1. The policy dialogue was informed by a pre-circulated EBP.	1	2	3	4	5	6	7
2. The dialogue was informed by a discussion about the full range of factors that can suggest how to approach a problem, possible elements of an approach to address it and key recommendations.	1	2	3	4	5	6	7
3. The policy dialogue brought together many parties who could be involved in or affected by future decisions related to the issue.	1	2	3	4	5	6	7
4. The dialogue aimed for fair representation among policy-makers, stakeholders and researchers.	1	2	3	4	5	6	7
5. The policy dialogue engaged a facilitator to assist with the deliberations.	1	2	3	4	5	6	7
6. The dialogue allowed for frank, off-the-record deliberations by following the Chatham House Rule ("Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed").	1	2	3	4	5	6	7
7. The policy dialogue did not aim for consensus.	1	2	3	4	5	6	7

## Overall assessment of the policy dialogue

The purpose of the policy dialogue was to support full discussion of relevant considerations (including research evidence) about a high-priority policy issue to inform action. How well did the policy dialogue achieve its purpose?

FAILED	MODERATELY FAILED	SLIGHTLY FAILED	NEUTRAL	SLIGHTLY ACHIEVED	MODERATELY ACHIEVED	ACHIEVED
1	2	3	4	5	6	7

Comments: \_\_\_\_\_  
 \_\_\_\_\_  
 \_\_\_\_\_

## Your role and background

I am a (please tick ( ✓ ) the single most appropriate role category):

BROAD ROLE CATEGORY	SPECIFIC ROLE CATEGORY	TICK ( ✓ )
Policy-maker	Public policy-maker (e.g. elected official, political staff or civil servant) in the national government	
	Manager in a district/region (if it does not have independent policy-making authority)	
	Manager in a health-care institution (e.g. hospital, primary health care setting)	
	Manager in a nongovernmental organization (NGO)	
Stakeholder	Staff/member of a civil society group/community-based NGO	
	Staff/member of a health professional association or group	
	Staff of a donor agency	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

I have been working in my current position for \_\_\_\_\_ years.

Thank you

Source: adapted from the K2P Center's standard operating procedures, based on templates developed by the McMaster Health Forum.



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## 3.3 EVALUATION FROM BOTH SIDES

Beyond the evaluation of EPBs and policy dialogues, EVIPNet Europe is focusing on M&E of its overall activities. The objectives of the Network's M&E work are:

- to ensure transparency and accountability for all stakeholders;
- to measure the progress and effectiveness of its strategy and activity implementation;
- to facilitate real-time identification and management of implementation challenges; and
- to contribute to knowledge translation research in creating evidence about which strategies are effective to inform and scale up future work.

The overall M&E approach has been summarized and elaborated in a comprehensive framework that provides a conceptual and practical basis for conducting M&E<sup>6</sup>. The framework focuses on the relationship between the inputs, activities, outputs and outcomes at three major levels of EVIPNet Europe's structure: (i) the EVIPNet Europe Secretariat; (ii) KTPs at the national or subnational levels; and (iii) the network of KTPs in the WHO European Region.

### **Monitoring**

On an ongoing basis, all stakeholders at these three levels are to document and generate evidence on the outputs produced. On an annual basis, a report is to be produced by the WHO Secretariat and shared with the EVIPNet Europe regional and global steering groups, as well as the wider KTP network. The findings are to inform the EVIPNet Europe Secretariat to allow the allocation of necessary resources and technical assistance to the KTPs, and resolve any problems that may have arisen during the reporting period.

### **Evaluation**

Work at all three levels is to be evaluated systematically and comprehensively every five years. The evaluation should focus on the processes, outputs and outcomes at the three levels by assessing EVIPNet Europe's KTPs in terms of structural and contextual factors in the countries' EIP culture, and behavioural change leading to increased sustainable interaction between researchers, policy-makers and civil society.

### **Wrapping Up**

Evidence plays an important role in strengthening health systems, improving population health and accelerating attainment of the SDGs. EIP is an important means of ensuring that policy-making is well informed by the best available evidence. It involves the use of systematic and transparent processes for articulating evidence as a valuable resource for decision-making.

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<sup>6</sup> The framework can be requested from the WHO Secretariat of EVIPNet Europe by contacting [euevipnet@who.int](mailto:euevipnet@who.int).

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EBPs are a relatively new, innovative approach to packaging research evidence for policy-makers, synthesizing and contextualizing the best available evidence about a problem, finding viable solutions to address it, and considering key implementation issues through the involvement of content experts, policy-makers and stakeholders. It is also one of the main knowledge translation mechanisms used to promote EIP, as well as to close the gap between researchers and decision-makers.

This manual provides practical guidance for EVIPNet Europe Member countries to develop EBPs, and to organize related policy dialogues to promote EIP in this Region. Use of this manual ensures that the development of EBPs will be rigorous, evidence-informed and responsive to local needs.

It is hoped that WHO Member States, national stakeholder organizations, civil society, think tanks and other relevant actors seeking to contribute to effective knowledge translation will find this manual useful and benefit from its guidance. This manual aims to guide these actors to effectively plan the development, implementation and evaluation of EBPs on high-priority health topics. Feedback on the use of the manual would be welcome and can be sent to [euevipnet@who.int](mailto:euevipnet@who.int).

# ANNEXES

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## ANNEX 1. SYNTHESIZING EVIDENCE FROM SYSTEMATIC REVIEWS

The tables in this Annex provide detailed information about the systematic reviews identified for each policy option. Each row in a table corresponds to a particular systematic review. The focus of the review is described in the second column. Key findings from the review that relate to the option are listed in the third column, and the fourth column presents a rating of the overall quality of the review.

The quality of each review has been assessed using A Measurement Tool to Assess Reviews (AMSTAR). It is important to note that the AMSTAR tool was developed to assess reviews focused on clinical interventions, so not all criteria apply to systematic reviews pertaining to delivery, financial or governance arrangements within health systems.

A high score signals that readers of the review can have a high level of confidence in its findings. A low score, on the other hand, does not mean that the review should be discarded; merely that less confidence can be placed in its findings and that the review needs to be examined closely to identify its limitations (Lewin, Oxman, et al., 2009a). The fifth column notes the proportion of studies that were conducted in [insert name of country].

All of the information provided in the appendix tables was taken into account by the evidence brief for policy (EBP)'s authors in compiling Tables A1.1, A1.2 and A1.3 (which represent Tables 1–3 in the main text of the EBP).

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**TABLE A1.1. SUMMARY OF SYSTEMATIC REVIEWS RELEVANT TO OPTION 1**  
**[INSERT BRIEF DESCRIPTION OF OPTION 1]**

<b>OPTION/ELEMENT</b>	<b>FOCUS OF SYSTEMATIC REVIEW</b>	<b>KEY FINDINGS</b>	<b>AMSTAR OR SURE CHECKLIST (QUALITY) RATING</b>	<b>PROPORTION OF STUDIES THAT WERE CONDUCTED IN [INSERT COUNTRY NAME]</b>
[Insert phrase denoting option component]	[Insert the focus of the review]	[Insert the review authors' summary of the key findings]	[Insert AMSTAR or SURE rating]	[Insert proportion]

**TABLE A1.2. SUMMARY OF SYSTEMATIC REVIEWS RELEVANT TO OPTION 2  
[INSERT BRIEF DESCRIPTION OF OPTION 2]**

<b>OPTION/ELEMENT</b>	<b>FOCUS OF SYSTEMATIC REVIEW</b>	<b>KEY FINDINGS</b>	<b>AMSTAR OR SURE CHECKLIST (QUALITY) RATING</b>	<b>PROPORTION OF STUDIES THAT WERE CONDUCTED IN [INSERT COUNTRY NAME]</b>
[Insert phrase denoting option component]	[Insert the focus of the review]	[Insert the review authors' summary of the key findings]	[Insert AMSTAR or SURE rating]	[Insert proportion]

**TABLE A1.3. SUMMARY OF SYSTEMATIC REVIEWS RELEVANT TO OPTION 3 [INSERT BRIEF DESCRIPTION OF OPTION 3]**

<b>OPTION/ELEMENT</b>	<b>FOCUS OF SYSTEMATIC REVIEW</b>	<b>KEY FINDINGS</b>	<b>AMSTAR OR SURE CHECKLIST (QUALITY) RATING</b>	<b>PROPORTION OF STUDIES THAT WERE CONDUCTED IN [INSERT COUNTRY NAME]</b>
[Insert phrase denoting option component]	[Insert the focus of the review]	[Insert the review authors' summary of the key findings]	[Insert AMSTAR or SURE rating]	[Insert proportion]

Table A1.4 shows approaches to triangulation: mixed methods of synthesizing diverse forms of evidence (see also Subsection 2.2.6 on synthesizing critically appraised literature).

**TABLE A1.4. SYNTHESIZING DIVERSE QUALITATIVE AND QUANTITATIVE EVIDENCE TOGETHER**

<b>SYNTHESIZING DIVERSE QUALITATIVE AND QUANTITATIVE EVIDENCE</b>
<ul style="list-style-type: none"> <li>▪ <b>Interpretive synthesis</b>, whereby evidence is synthesized by subsuming the concepts into a higher-order theoretical structure – methods are qualitative in nature:               <ul style="list-style-type: none"> <li>i. <b>narrative</b>: this approach summarizes all available evidence together using methods including literature reviews, thematic analysis, narrative synthesis, realist synthesis or meta-narrative mapping; and</li> <li>ii. <b>qualitative</b>: this approach converts all available evidence into qualitative form, using techniques such as meta-ethnography, grounded theory and qualitative cross-case analysis (including developing meta-matrices).</li> </ul> </li> <li>▪ <b>Integrative synthesis</b>, whereby evidence is combined or amalgamated together – methods are quantitative in nature:               <ul style="list-style-type: none"> <li>i. <b>quantitative</b>: this approach converts all evidence into quantitative form, using techniques such as quantitative case survey or quantitative content analysis; and</li> <li>ii. <b>Bayesian meta-analysis and decision analysis</b>: this approach allows the conversion of qualitative evidence such as preferences on outcomes into quantitative form, by the use of weighting different elements such that it can be used in a quantitative manner through modelling.</li> </ul> </li> </ul>

Source: Mays, Pope & Popay, 2005.

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## ANNEX 2. EBP TEMPLATE<sup>7</sup>

### Evidence brief for policy (EBP)

*[Insert title]*

**Template with recommendations for an EBP (example subject used is antimicrobial resistance [AMR])**

[Insert date]

[Insert name of organization/initiative producing/publishing the EBP – e.g. EVIPNet Malaysia]

[Insert brief description of organization/initiative]

Authors

[Insert names and affiliations of authors]

Funding

[Insert details about funding, both for the production of the EBP and for the training workshops that supported it]

Conflict of interest

[Insert details about any professional or commercial interests relevant to the EBP and clarify whether the funder(s) played a role in the identification, selection, assessment, synthesis or presentation of the research evidence profiled in the EBP]

Merit-review

[Insert details of any review by researchers, policy-makers and stakeholders in order to ensure the EBP's scientific rigour and system relevance]

Acknowledgements

[Insert any appropriate acknowledgements of individuals who supported the production of the EBP but who are not named authors]

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<sup>7</sup> This template was developed based on (i) The SURE guides ([https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/SURE-Guides-v2.1/Collectedfiles/sure\\_guides.html](https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/SURE-Guides-v2.1/Collectedfiles/sure_guides.html)); and (ii) The McMaster Health Forum EBP template (unpublished).

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## Citation

[Insert a suggested citation, as you would like it to appear, which should include author(s) of the EBP, its title, the location and name of the organization/initiative producing/publishing it, and the date (year) of its publication]

## Table of Contents

### **KEY MESSAGES**

#### **THE PROBLEM**

[Insert a subheading for level 1]

[Insert a subheading for level 2]

[Insert a subheading for level 3]

[Insert a subheading for level 4]

Equity-related observations about the problem

#### THREE OPTIONS FOR ADDRESSING THE PROBLEM

Option 1 [Insert brief description of the option]

Option 2 [Insert brief description of the option]

Option 3 [Insert brief description of the option]

Equity-related observations about the problem

#### IMPLEMENTATION CONSIDERATIONS

#### REFERENCES

#### APPENDICES



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**KEY MESSAGES** – 1 = a one-pager of clear and concise take-home messages for decision-makers who are likely to skim-read or are pressed for time.

***What is the problem?***

[Insert a brief description of the problem/  
purpose that the EBP addresses]

***What do we know (from systematic reviews) about three viable options to address the problem?***

Option 1 [Insert brief description of the option]

[Insert brief description about what is known about the option]

Option 2 [Insert brief description of the option]

[Insert brief description about what is known about the option]

Option 3 [Insert brief description of the option]

[Insert brief description about what is known about the option]

***What implementation considerations need to be borne in mind?***

[Insert a brief description of implementation barriers and what is known about implementation strategies to address the barriers]

**Executive summary** – 3 = a 3-page executive summary with more details and resources for interested decision-makers and practitioners

[Insert a 3-page executive summary of the EBP based on the same structure as outlined in the key messages]

**Full report** – 25 = a 25-page scientific paper or synthesis for administrators or implementers

**Background to the policy brief**

This EBP mobilizes both global and local research evidence about a problem, three options for addressing the problem and key implementation considerations. Whenever possible, it summarizes research evidence drawn from systematic reviews of the research literature and occasionally from individual research studies. A systematic review is a summary of studies addressing a clearly formulated question and uses systematic and explicit methods to identify, select and appraise research studies and to synthesize data from the included studies. The EBP does not contain recommendations.

The preparation of the EBP entailed five steps:

- 1) convening a steering committee comprising representatives from [insert details];
- 2) developing and refining the ToR for the EBP, particularly the framing of the problem and three viable options for addressing it, in consultation with the steering committee and a number of key informants, and with the aid of several conceptual frameworks that organize thinking about ways to approach the issue;
- 3) identifying, selecting, appraising and synthesizing relevant research evidence about the problem, options, and implementation considerations;
- 4) drafting the EBP in such a way as to present concisely and in accessible language the global and local research evidence; and
- 5) finalizing the EBP based on the input of several merit-reviewers.

The three options for addressing the problem were not designed to be mutually exclusive. They could be pursued simultaneously or elements could be drawn from each option to create a new (fourth) option.

The brief was prepared to inform a policy dialogue at which research evidence was one of many considerations. Participants' views and experiences and the tacit knowledge they bring to the issues at hand are also important inputs to such a policy dialogue. One goal of the dialogue is to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. A second goal of the policy dialogue is to generate action by those who participate in the policy dialogue and by those who review the dialogue summary.

[Insert a brief description of the motivation for the EBP, including key concepts, a helpful organizing framework (if applicable), issues that are NOT covered in the EBP, and the key features of the policy and system context for it]

*You may start this section by emphasizing the global importance of AMR and the efforts engaged to counter its spread. References to WHO, the European Union (EU) or national strategies and goals may be particularly helpful.*

*You can also reflect on the specific mission of the EBP team in your country (organizations involved, role of the KTP, if it is in place, etc.). A key point may be to discuss how the topic of AMR was chosen for the EBP (e.g. who made the decision and, if known, on which grounds). If the topic is selected or approved by a high-level political decision-making entity – e.g. minister responsible for health – this may be an important source of legitimacy.*

*Here is a non-exhaustive list of possible subheadings.*

- *Purpose of the brief (e.g. to identify evidence-based options and support a deliberative dialogue)*
- *Stakeholders and preparation*
- *Limitations (eventual methodological limitations, but also including any issues not covered (e.g. animal health))*

### **Equity considerations**

A problem may disproportionately affect some groups in society. The benefits, harms and costs of options to address the problem may vary across groups. Implementation considerations may also vary across groups.

One way to identify groups warranting particular attention is to use PROGRESS, which is an acronym formed by the first letters of the following eight ways that can be used to describe groups\*:

- place of residence (e.g. rural and remote populations);
- race/ethnicity/culture (e.g. First Nations and Inuit populations, immigrant populations and linguistic minority populations);
- occupation or labour-market experiences more generally (e.g. those in precarious work arrangements);
- gender;
- religion;
- educational level (e.g. health literacy); and
- socioeconomic status (e.g. economically disadvantaged populations); and
- social capital/social exclusion.

The EBP strives to address all citizens, but (where possible) it also gives particular attention to two groups:

- [insert group 1]
- [insert group 2]

\*Many other groups warrant serious consideration as well, and a similar approach

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## **THE PROBLEM**

[Insert a description of the problem (or purpose) at all relevant levels of the health-care system, which includes: (1) the nature and burden of [insert disease or risk factor, if applicable] that the health-care system must manage; (2) the cost-effective programmes, services and drugs that the health-care system must provide to meet the needs of patients and citizens; (3) the health system arrangements that determine access to and use of cost-effective programmes, services and drugs; and (4) the current degree of implementation of existing policies and clinical practice guidelines]

*It is important to first clearly define the problem. Reference to the problem tree, usually developed at the beginning of the EBP process, may be useful.*

*AMR is a very complex issue, and the problem to be discussed in the EBP might be a contributing factor, e.g. antimicrobial misuse or infection prevention and control deficiencies. The causes and consequences of the problem must be defined accordingly.*

*It is recommended to employ non-expert language to the greatest extent possible. However, the subject matter may require the use of specific medical or pharmaceutical terms and concepts. A practical way of explaining these could be to put them in boxes.*

*The comparative statistics of the European Centre for Disease Prevention and Control (ECDC) are useful in assessing the AMR problem's relative importance in your country.*

*Systematic reviews, reports and other pieces of research, on the other hand, help explain the connections between different health system deficiencies and AMR.*

*Here is a non-exhaustive list of possible subheadings.*

- *Definition and framing of the problem*
- *Size of the problem*
- *Factors underlying the problem (causes)*
- *Consequences of the problem.*

*Handling the different subjects by sector (i.e. hospital or ambulatory) and health system level (i.e. patient, prescriber, health-care provider, industry, government, etc.) might be useful.*

*[Insert a subheading for level 1]*

*[Insert text]*

*[Insert a subheading for level 2]*

*[Insert text]*

*[Insert a subheading for level 3]*

*[Insert text]*

*[Insert a subheading for level 4]*

*[Insert text]*

## **Background to the policy brief**

This EBP mobilizes both global and local research evidence about a problem, three options for addressing the problem and key implementation considerations. Whenever possible, it summarizes research evidence drawn from systematic reviews of the research literature and occasionally from individual research studies. A systematic review is a summary of studies addressing a clearly formulated question and uses systematic and explicit methods to identify, select and appraise research studies and to synthesize data from the included studies. The EBP does not contain recommendations.

The preparation of the EBP entailed five steps:

- 1) convening a steering committee comprising representatives from [insert details];
- 2) developing and refining the ToR for the EBP, particularly the framing of the problem and three viable options for addressing it, in consultation with the steering committee and a number of key informants, and with the aid of several conceptual frameworks that organize thinking about ways to approach the issue;
- 3) identifying, selecting, appraising and synthesizing relevant research evidence about the problem, options, and implementation considerations;
- 4) drafting the EBP in such a way as to present concisely and in accessible language the global and local research evidence; and
- 5) finalizing the EBP based on the input of several merit-reviewers.

The three options for addressing the problem were not designed to be mutually exclusive. They could be pursued simultaneously or elements could be drawn from each option to create a new (fourth) option.

The brief was prepared to inform a policy dialogue at which research evidence was one of many considerations. Participants' views and experiences and the tacit knowledge they bring to the issues at hand are also important inputs to such a policy dialogue. One goal of the dialogue is to spark insights – insights that can only come about when all of those who will be involved in or affected by future decisions about the issue can work through it together. A second goal of the policy dialogue is to generate action by those who participate in the policy dialogue and by those who review the dialogue summary.

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## THREE OPTIONS FOR ADDRESSING THE PROBLEM

Many options could be selected to address the problem of [insert problem]. To promote discussion about the pros and cons of potentially viable options, three have been selected for more in-depth review. They include: [insert brief descriptions of options 1–3].

The focus in this section is on what is known about these options. In the next section, the focus turns to the barriers to adopting and implementing the options and to possible implementation strategies to address the barriers.

*The definition of options ought to be very concrete, so that decision-makers understand at first sight what is being proposed.*

*A possible organization of content would be as follows: for each option, the elements of the problem addressed by the option may be highlighted first, followed by a description of evidence on the given option's efficacy. To conclude, a list of suggested policy actions in the specific national context could be given.*

*Presenting the evidence in tables (see below) helps to quickly and easily measure the main messages extracted from the literature, as well as the methodological strength behind them. Although the EBP is not exclusively based on evidence from the literature, it is important that key points are supported by the findings of high-quality systematic reviews. Evidence tables help present the AMSTAR ratings of the most important pieces of evidence.*

Option 1 [Insert brief description of the option]

[Insert description of the option and, if applicable, its components]

Give a short description of the current status of implementing the proposed action in the specific health system context. This may be completely new or may have been implemented only partially. So that it is clear, outline the new dimension of the proposed option.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in Table A2.1. For those who want to know more about the systematic reviews contained in Table A2.1 (or obtain citations for the reviews), a more detailed description of the systematic reviews is provided in Annex 1.

**TABLE A2.1. SUMMARY OF KEY FINDINGS FROM SYSTEMATIC REVIEWS RELEVANT TO OPTION 1 [INSERT DESCRIPTION OF OPTION]**

<b>CATEGORY OF FINDING</b>	<b>KEY FINDINGS</b>
Benefits	[Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Potential harms	[Insert one or more bulleted key messages about the harms that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Resource use, costs and/or cost-effectiveness	[Insert one or more bulleted key messages about the resource use, costs and/or cost-effectiveness that have been found for each component of the option]
Uncertainty regarding benefits and potential harms (so M&E could be warranted if the option was to be pursued)	Uncertainty because no systematic reviews were identified [Insert a brief description of option components for which no reviews were identified] Uncertainty because no studies were identified despite an exhaustive search as part of a systematic review [Insert a brief description of option components for which “empty” reviews were identified] No clear message from studies included in a systematic review [Insert a brief description of option components for which there is insufficient evidence]
Key elements of the policy option if it was tried elsewhere	[Insert one or more bulleted key messages about the key elements of the policy option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Stakeholders’ views and experiences	[Insert one or more bulleted key messages about stakeholders’ views and experiences, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]

**Option 2 [Insert brief description of the option]**

[Insert description of the option and, if applicable, its components]

Give a short description of the current status of implementing the proposed action in the specific health system context. This may be completely new or may have been implemented only partially. So that it is clear, outline the new dimension of the proposed option.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in Table A2.2. For those who want to know more about the systematic reviews contained in Table A2.2 (or obtain citations for the reviews), a more detailed description of the systematic reviews is provided in Annex 1

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Option 2 [Insert brief description of the option]

[Insert description of the option and, if applicable, its components]

Give a short description of the current status of implementing the proposed action in the specific health system context. This may be completely new or may have been implemented only partially. So that it is clear, outline the new dimension of the proposed option.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in Table A2.2. For those who want to know more about the systematic reviews contained in Table A2.2 (or obtain citations for the reviews), a more detailed description of the systematic reviews is provided in Annex 1.

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**TABLE A2.2. SUMMARY OF KEY FINDINGS FROM SYSTEMATIC REVIEWS RELEVANT TO OPTION 2 [INSERT DESCRIPTION OF OPTION]**

<b>CATEGORY OF FINDING</b>	<b>KEY FINDINGS</b>
Benefits	[Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Potential harms	[Insert one or more bulleted key messages about the harms that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Resource use, costs and/or cost-effectiveness	[Insert one or more bulleted key messages about the resource use, costs and/or cost-effectiveness that have been found for each component of the option]
Uncertainty regarding benefits and potential harms (so M&E could be warranted if the option was to be pursued)	Uncertainty because no systematic reviews were identified [Insert a brief description of option components for which no reviews were identified] Uncertainty because no studies were identified despite an exhaustive search as part of a systematic review [Insert a brief description of option components for which “empty” reviews were identified] No clear message from studies included in a systematic review [Insert a brief description of option components for which there is insufficient evidence]
Key elements of the policy option if it was tried elsewhere	[Insert one or more bulleted key messages about the key elements of the policy option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Stakeholders’ views and experiences	[Insert one or more bulleted key messages about stakeholders’ views and experiences, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]

### **Option 3 [Insert brief description of the option]**

[Insert description of the option and, if applicable, its components]

Give a short description of the current status on implementing the proposed action in the specific health system context. This may be completely new or may have been implemented only partially. So that it is clear, outline the new dimension of the proposed option.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in Table A2.3. For those who want to know more about the systematic reviews contained in Table A2.3 (or obtain citations for the reviews), a more detailed description of the systematic reviews is provided in Annex 1.

**TABLE A2.3. SUMMARY OF KEY FINDINGS FROM SYSTEMATIC REVIEWS RELEVANT TO OPTION 3 [INSERT DESCRIPTION OF OPTION]**

CATEGORY OF FINDING	KEY FINDINGS
Benefits	[Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]
Potential harms	[Insert one or more bulleted key messages about the harms that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]
Resource use, costs and/or cost-effectiveness	[Insert one or more bulleted key messages about the resource use, costs and/or cost-effectiveness that have been found for each component of the option]
Uncertainty regarding benefits and potential harms (so M&E could be warranted if the option was to be pursued)	Uncertainty because no systematic reviews were identified [Insert a brief description of option components for which no reviews were identified] Uncertainty because no studies were identified despite an exhaustive search as part of a systematic review [Insert a brief description of option components for which “empty” reviews were identified] No clear message from studies included in a systematic review [Insert a brief description of option components for which there is insufficient evidence]
Key elements of the policy option if it was tried elsewhere	[Insert one or more bulleted key messages about the key elements of the policy option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]
Stakeholders’ views and experiences	[Insert one or more bulleted key messages about stakeholders’ views and experiences, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability and issue applicability]

### Equity-related observations about the three options

[Insert brief description of whether and how these key findings pertain to prioritized groups]

**Following discussion of the proposed policy options, a short section could be included (if necessary) on other potential policy interventions that are not discussed under the headings “policy options” or “implementation considerations”. Reasons should be provided as to why these were not considered, for example; insufficient data, culturally/socially inappropriate, political issues, etc.**

### IMPLEMENTATION CONSIDERATIONS

[Insert description of potential barriers to implementing the options]

Give a short description of pre-existing enablers in the national context, which provide a conducive environment for scaling up the proposed policy interventions.



The implementation of most AMR-related options is a fairly complicated exercise, because they each contain several interdependent tracks within them. For this reason, it may be useful to define the potential forms of action at this point (modification of certain pieces of legislature, a change of organization, the designation of new leaders, etc.).

(If this is already absolutely clear from the Options section above, then it is not necessary.)

In a second part, pre-existing and potential barriers should be summarized (using Table A2.4 as a template). Then, the pre-existing conditions that could enable the implementation of the proposed actions may follow, before finally presenting those factors that could help if they were to be put in place (e.g. the existence of therapeutic guidelines or a guideline development organization is a pre-existing enabler, while the wide involvement of health professionals in the development of an antibiotic stewardship programme [ASP] is a conditional enabler, which works only if it is put in place during the implementation).

Finally, cost evaluation should be an important part of the section on implementation, because it can allow decision-makers to measure the relative benefit of the proposed options in a context of scarce resources.

**TABLE A2.4. POTENTIAL BARRIERS TO IMPLEMENTING THE OPTIONS**

[Insert in the cells a brief description of any barriers to implementing each option that have been identified in the research literature, ensuring that the barriers are appropriately situated at the patient/individual, health-care provider, organization and system levels]

<b>LEVELS</b>	<b>OPTION 1 [INSERT BRIEF DESCRIPTION OF THE OPTION]</b>	<b>OPTION 2 [INSERT BRIEF DESCRIPTION OF THE OPTION]</b>	<b>OPTION 3 [INSERT BRIEF DESCRIPTION OF THE OPTION]</b>
<b>Recipients of care</b>			
Knowledge and skills			
Attitudes regarding programme acceptability, appropriateness and credibility			
Motivation to change or adopt new behaviour			
<b>Providers of care</b>			
Knowledge and skills			



Attitudes regarding programme acceptability, appropriateness and credibility			
Motivation to change or adopt new behaviour			
<b>Other stakeholders (including other health-care providers, community health committees, community leaders, programme managers, donors, policy-makers and opinion leaders)</b>			
Knowledge and skills			
Attitudes regarding programme acceptability, appropriateness and credibility			
Motivation to change or adopt new behaviour			
<b>Health system constraints</b>			
Accessibility of care, financial resources, human resources, educational system, clinical supervision, internal communication, external communication, allocation of authority, accountability, management and/or leadership, information systems, facilities, patient flow processes, procurement and distribution systems, incentives, bureaucracy, relationship with norms and standards			
<b>Social and political constraints</b>			
Ideology, short-term thinking, contracts, legislation or regulations, donor policies, influential people, corruption, political stability			

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[Insert in the cells a brief description of any barriers to implementing each option that have been identified in the research literature, ensuring that the barriers are appropriately situated at the patient/individual, health-care provider, organization and system levels]

[Insert description of possible implementation strategies and what is known about their benefits, harms, costs, etc.]

## REFERENCES

[Insert references]

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## ANNEX 3. EBP REVIEW FEEDBACK TEMPLATE

### Overview EVIPNet Europe: EBP review feedback form Technical review/Peer-review/Merit-review (WHO Regional Office for Europe) About Evidence Briefs for Policy (EBPs)

An EBP is a document that brings together global research evidence and local evidence on a high-priority issue to inform health policies and programmes. EBPs address three key factors impacting positively on the research use: (1) timeliness; (2) accordance between the research evidence and the beliefs, values and interests or political goals and strategies of policy-makers and stakeholders; and (3) interactions between researchers and policy-makers (Lavis, Permanand, et al., 2009). For more resources on EBPs, see the SURE guides (The SURE Collaboration, 2011a) and SUPPORT tools (Lavis, Oxman, et al., 2009a).

EBPs begin with a description of the policy problem, summarize the best available evidence to quantify the size and nature of the problem, describe the likely impacts of key options for addressing the problem, and inform considerations about potential barriers and facilitators to implementation of these options and how these could be addressed (Lavis, Permanand, et al., 2009). The target audience for EBPs are policy-makers and stakeholders who are interested in the policy-making process. EBPs are used to inform and involve stakeholders, and may serve as a foundation for future policy dialogues.

#### *EBP review process*

In order to ensure that the EBPs produced are consistent and of high quality, rigorous reviews are performed. The review process has three key aspects.

- **A technical review** is carried out by the appropriate unit of the WHO Regional Office for Europe. This review looks at the technical and methodological elements of the EBP to ensure accuracy, clarity and consistency of its content.
- **A peer-review** is performed by members of another EVIPNet country. This review ensures that the processes followed are transparent, systematic and replicable, and acts as a checklist to ensure that all relevant aspects are included.
- **A merit-review** is carried out at the national level by policy-makers, researchers and stakeholders. This aspect deals with the context of the EBP, examining to what extent the EBP is realistic, pragmatic, feasible, acceptable and sound in terms of the sociocultural and political country context (Ako-Arrey et al., 2006).

This document provides:

1. instructions on how to undertake the review process
2. detailed criteria for each stage of the review process.

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## 1. Instructions

### *Before the review*

- i. Please treat the draft as confidential; do not circulate or quote it before it has been published.
- ii. The EBP should follow the structure of the WHO Regional Office for Europe EVIPNet template.
- iii. The EBP will be copy-edited; therefore, we ask you to review and comment only on clarity, consistency and technical accuracy.

### *During the review*

This review is structured in three stages.

Stage 1 is a general evaluation of the EBP, and provides an overview of the content and form of the document.

Stage 2 involves breaking down the document into section-specific questions.

Stage 3 deals with the feedback to be provided on the EBP when reviewing the document (while making use of the comments and/or track-changes functions).

### *After the review*

The technical review, and peer- and merit-reviews will be shared with the authors of the EBP and will be used in the final revision process. Reviewers may be contacted for clarification, as necessary, and their details will be kept confidential.

## 2. Detailed criteria

EBP TITLE	REVIEW TYPE (technical, peer or merit)
Reviewer affiliation	
Conflict of interest declaration	

## Stage 1. Overall assessment

Please complete the table below. It is intended to give an overview of the EBP, looking at the value, scope, presentation and style of the brief. For further clarification, see the SURE guides (The SURE Collaboration, 2011) and SUPPORT tools (Lavis, Oxman, et al., 2009a). Additional references will also be given where applicable.

CHARACTERISTICS	COMMENTS
<p><b>Value and relevance</b></p> <ul style="list-style-type: none"> <li>▪ What is the expected value of this EBP for the target audience, audience?</li> <li>▪ Does the EBP address a high-priority issue and has the process of how it was identified been described?</li> <li>▪ Is the EBP relevant, appropriate, and valid to the issue being addressed? (Ako-Arrey et al., 2006)</li> <li>▪ Does the EBP succeed in not making particular recommendations or biasing the presentation of evidence toward a particular option?<sup>8</sup></li> </ul>	
<p><b>Scope</b></p> <ul style="list-style-type: none"> <li>▪ Does the EBP describe the context of the issue being addressed in a fair and balanced way?</li> <li>▪ Does it concisely, yet adequately, describe different features of the problem, including (where possible) how it affects particular groups?</li> <li>▪ Does the description of the three options for addressing the problem adequately convey what they entail?</li> <li>▪ Does the EBP describe the costs and consequences of options to address the problem, and the key implementation considerations? (Lavis, Permanand, et al., 2009)</li> </ul>	
<p><b>Style</b></p> <ul style="list-style-type: none"> <li>▪ Is the EBP clear, succinct and unambiguous?</li> <li>▪ Is it written in a language appropriate for the target audience, e.g. policy-makers or decision-makers with a research background?</li> </ul>	
<p><b>Format</b></p> <ul style="list-style-type: none"> <li>▪ Does the report follow the structure and order (graded entry format) of the EVIPNet EBP (1 page of key messages, a 3-page executive summary, and a 25-page report)?</li> <li>▪ Are all tables and figures labelled with meaningful captions?</li> <li>▪ Do text boxes provide relevant, new information?</li> </ul>	
<p><b>Consistency</b></p> <ul style="list-style-type: none"> <li>▪ Are there any inconsistencies in the messages of the EBP?</li> <li>▪ Is the line of argumentation clear, and are the links between the problem, options and implementation considerations clear and consistent?</li> <li>▪ In particular, do the suggested options address the problem clearly?</li> </ul>	
<p><b>Level of detail</b></p> <ul style="list-style-type: none"> <li>▪ Are the problem, options and implementation considerations presented in sufficient detail?</li> </ul>	

<sup>8</sup> Presented in a handout by K. Moat on EBP review questions at the EVIPNet Europe Fifth multicountry meeting (Bratislava, 14–16 June 2017).

<p><b>Evidence</b></p> <ul style="list-style-type: none"> <li>▪ Does the EBP describe what is known, based on synthesized research evidence, about each of the three options and where there are gaps in what is known?<sup>9</sup></li> <li>▪ Does it take the quality of the research evidence into account? (Lavis, Permanand, et al., 2009)</li> <li>▪ Is the evidence considered in terms of local applicability? (Lewin, Oxman, et al., 2009b)</li> <li>▪ Is equity considered when discussing the research evidence? (Oxman et al., 2009)</li> <li>▪ Has the research evidence used been properly contextualized?</li> </ul>	
<p><b>Methods</b></p> <ul style="list-style-type: none"> <li>▪ Does the EBP employ systematic and transparent methods to identify, select and assess synthesized research evidence?</li> <li>▪ Are the methods described in a language that is appropriate for the target audience?</li> </ul>	
<p><b>Key definitions and terminology</b></p> <ul style="list-style-type: none"> <li>▪ Are they clear and accurate?</li> <li>▪ Are technical terms defined and explained?</li> <li>▪ Are the terms used consistently in the document?</li> </ul>	
<p><b>Gaps</b></p> <ul style="list-style-type: none"> <li>▪ Is there any other research evidence on the topic that would be particularly useful in framing the problem and proposing the options?</li> <li>▪ Are there any gaps in the argumentation used to connect the problem definition, options, costs and consequences in a logical and relevant way in this EBP?</li> </ul>	
<p><b>Limitations</b></p> <ul style="list-style-type: none"> <li>▪ Are any limitations in evidence, information and methods acknowledged?</li> <li>▪ Have deficiencies in evidence been adequately addressed?</li> </ul>	
<p><b>Other comments</b></p>	

<sup>9</sup> Presented in a handout by K. Moat on EBP review questions at the EVIPNet Europe Fifth multicountry meeting (Bratislava, 14–16 June 2017).

Stage 2a: Section-specific questions for technical reviewers

The purpose of this review is to assess the technical accuracy and consistency of the EBP. The framing of the problem, the range of options considered and the congruence between these two are to be addressed. The methodological and scientific process will also be examined, looking at the literature considered, the appraisal of this literature and its application to the issue. Please insert your comments in the table below, as well as directly into the EBP using comment bubbles; please do not use the track-changes function.

SECTION		QUESTIONS TO CONSIDER
<b>Key messages (1 page)</b>		Do these key messages summarize the most important sections, including: problem definition, policy options and implementation considerations?
<b>Executive summary (≤3 pages)</b>		Does this executive summary include relevant details to allow the reader to quickly capture the essential information, including: problem definition, policy options, available evidence and implementation considerations, as well as to assess quickly whether the policy options closely correspond to the problem in the given context?
FULL REPORT (25 PAGES)	<b>The problem</b>	<b>1) Identifying the problem</b> <ul style="list-style-type: none"> <li>□ Is the problem identification process transparent and systematic?</li> </ul> <b>2) Clarifying the problem</b> <ul style="list-style-type: none"> <li>a. Is the problem reported technically accurate and clear, and the country context provided?</li> <li>b. Are the nature, causes, magnitude, frequency and intensity of the problem clearly identified? (Ako-Arrey et al., 2006)                             <ul style="list-style-type: none"> <li>- Is the theory of change (i.e. a detailed description of logically related steps used to link causes to outcome) supported by the literature?</li> </ul> </li> </ul>
	<b>Policy options</b>	<b>1) Identifying and clarifying policy options</b> <ul style="list-style-type: none"> <li>a. Do the policy options identified address the problem?</li> <li>b. Do the authors present the policy options in a clear, succinct, unambiguous and consistent manner?</li> <li>c. Are the policy options provided shown to be effective in the current literature?</li> <li>d. Are all important policy options considered? (Are there others in the literature which have strong support/which should be included?)</li> <li>e. Have the views and experiences of national stakeholders been included?</li> </ul> <b>2) Trade-off judgement</b> <ul style="list-style-type: none"> <li>a. Are all important costs and consequences (benefits/harms) of the policy options considered?</li> <li>b. Do these costs/benefits include unintended consequences? (Ako-Arrey et al., 2006)</li> </ul> <b>3) Use of evidence</b> <ul style="list-style-type: none"> <li>a. Does the evidence used include the most important/influential literature on the issue?</li> <li>b. (<i>Quality of the evidence</i>) Do the methods describe a systematic way to appraise and report the evidence? Is the evidence found in the tables in the annex appraised in this manner? (Lewin, Oxman, et al., 2009a; Lavis, Oxman, et al., 2009b)</li> <li>c. (<i>Local applicability</i>) Is local evidence used to ensure contextualization of results? (Lewin, Oxman, et al., 2009b)                             <ul style="list-style-type: none"> <li>i. Is this local evidence appropriately appraised?</li> <li>ii. Is this evidence representative and accurate to the context in which it is used?</li> </ul> </li> <li>d. (<i>Equity</i>) Does the evidence consider which groups or settings could be disadvantaged by the options considered? Are these based on plausible assumptions? (Oxman et al., 2009)</li> <li>e. (<i>Gaps in research evidence</i>) Are the gaps addressed by M&amp;E considerations to ensure that missing evidence will be available at a defined point in the future?</li> </ul>
	<b>Implementation considerations</b>	<b>Facilitators and barriers</b> <ul style="list-style-type: none"> <li>a. Are the policy options operationalized clearly in terms of conceptualization, operational guidance and modes of delivery? (Ako-Arrey et al., 2006)</li> <li>b. Are the barriers and facilitators to implementation considered in a systematic and transparent manner for each option? (Fretheim et al., 2009)</li> <li>c. Are the identified facilitating factors feasible?</li> <li>d. Are implementation strategies considered that could overcome these barriers?</li> <li>e. (<i>Equity in implementation</i>) Are important considerations in implementation made to ensure that inequities are reduced? (Oxman et al., 2009)</li> <li>f. Is the evidence for these implementation strategies explicitly mentioned? Has the quality of this evidence been assessed?</li> </ul>
	<b>Methods</b>	« Are the methods used comprehensively described, including: <ul style="list-style-type: none"> <li>i. details of databases searched; and</li> <li>ii. reference to quality, local applicability and other “checklists” used to assess systematic reviews and local data?</li> </ul>
<b>Comments</b>		

## Stage 2b. Section-specific questions for peer-reviewers

The purpose of this review is to assess the process of creating the EBP and the content of the produced document with regard to the process and objectives of an EVIPNet EBP. This review should be used as a type of checklist to ensure that all relevant considerations have been examined and included. Please insert your comments into the table below as well as directly into the EBP, using comment bubbles; please do not use the track-changes function.

SECTION		QUESTIONS TO CONSIDER
<b>Key messages</b> (1 page)		Do these key messages summarize the most important sections, including: problem definition, policy options, implementation considerations and next steps?
<b>Executive summary</b> (≤3 pages)		Does this executive summary include relevant details to allow the reader to quickly capture the essential information, including: problem definition, policy options, available evidence, implementation considerations and actionable next steps?
FULL REPORT (25 PAGES)	<b>The problem</b>	<p><b>1) Identifying the problem</b></p> <ol style="list-style-type: none"> <li>Do the authors describe how the problem came to their attention?</li> <li>Are the types of actors involved in the problem identification listed (e.g. NGOs, project managers, university researchers, policy-makers)?</li> <li>Do the authors explore the causes of the problem?</li> <li>Is justification given for prioritizing this issue?</li> <li>Is there a justification for the timing of this EBP?</li> </ol> <p><b>2) Clarifying the problem</b></p> <ol style="list-style-type: none"> <li>Do the authors clearly state the size/scope of the problem?               <ol style="list-style-type: none"> <li>Do the authors support this with appropriate evidence?</li> <li>Is the baseline/target to which this is compared noted?</li> <li>Is this baseline/target appropriate?</li> </ol> </li> <li>Is the framing of the issue made clear?               <ol style="list-style-type: none"> <li>Is it linked to the actors involved?</li> </ol> </li> <li>Where uncertainty exists, has it been identified in the problem clarification?</li> </ol>
	<b>Policy options</b>	<p><b>1) Identifying and clarifying policy options</b></p> <ol style="list-style-type: none"> <li>Do the authors present the policy options in a clear, succinct, unambiguous and consistent manner?</li> <li>Are the policy options considered technically feasible, affordable and within the norms/values of the context?</li> <li>Have the policy options considered been shown to be effective in the evidence?</li> <li>Are the policy options that have been identified operationalized with regard to conceptualization, operational guidance and mode of delivery?</li> <li>Are these policy options only presented independently, or is a mixture of options also considered?</li> </ol> <p><b>2) Trade-off judgement</b></p> <ol style="list-style-type: none"> <li>Do the authors discuss the costs and benefits of the policy options due to:               <ol style="list-style-type: none"> <li>resources input for implementation;</li> <li>direct outcomes;</li> <li>impact?</li> </ol> </li> <li>Are the criteria used to select costs and benefits made explicit?</li> <li>Is a cost-effectiveness analysis included?</li> <li>Are uncertainties acknowledged?</li> </ol> <p><b>3) Use of evidence</b></p> <ol style="list-style-type: none"> <li>Is there a record of the type of evidence considered for each option?               <ol style="list-style-type: none"> <li>Does this include global and local evidence?</li> </ol> </li> <li>Do the authors reflect on the quality of the evidence used?               <ol style="list-style-type: none"> <li>Is the GRADE system used?</li> <li>If systematic reviews are used, were any of the following tools utilized: AMSTAR, Critical Appraisal Skills Programme (CASP) tools, the Oxman and Guyatt index?</li> <li>Consider a sample of the literature used: has it been appraised appropriately?</li> </ol> </li> <li>Are ethical issues relating to the policy options identified and addressed?</li> <li>Do the policy options make allowances for equity questions?</li> <li>Is M&amp;E considered?</li> <li>Have relevant economic evaluation criteria been used?</li> </ol>
	<b>Implementation considerations</b>	<p><b>Facilitators and barriers</b></p> <ol style="list-style-type: none"> <li>Do the authors identify potential facilitators and barriers to implementing the policy options identified?</li> <li>Do the authors reflect on implementation strategies that could overcome these barriers?</li> <li>Is the evidence for these implementation strategies explicitly mentioned? Is the quality of this evidence assessed [see above]?</li> <li>Is any uncertainty observed in the evidence noted where necessary?</li> </ol>
	<b>Next steps</b>	Is there a discussion of the application of this EBP to policy dialogues?
<b>Comments</b>		



## Stage 2c: Section-specific questions for merit-reviewers

The merit-review is intended to look at the applicability and suitability of the EBP to the local, national and international context in which it is intended. The focus will be on the usability, applicability and appropriateness of the problem identified, options considered, implementation barriers and facilitators given, and the use of evidence. Please insert your comments into the table below as well as directly into the EBP, using comment bubbles; please do not use the track-changes function.

SECTION		QUESTIONS TO CONSIDER
Key messages (1 page)		Do these key messages summarize the most important sections, including: problem definition, policy options, implementation considerations and next steps?
Executive summary (≤3 pages)		Does this executive summary include relevant details that allow the reader to quickly capture the essential information, including: problem definition, policy options, available evidence, implementation considerations and actionable next steps?
FULL REPORT (25 PAGES)	<b>The problem</b>	<p><b>1) Identifying the problem</b></p> <ol style="list-style-type: none"> <li>Does the identification of the problem reflect the context in which the issue is identified? (Ako-Arrey et al., 2006)               <ol style="list-style-type: none"> <li>Does this problem consider the local health system structures and health strategy (government agenda and links with other policy issues) relevant to the problem?</li> <li>Have the authors considered the political, institutional and sociocultural components of the local and national environment?</li> </ol> </li> <li>Are the most important actors involved in the process of identifying the problem?</li> <li>Did the process of engaging stakeholders:               <ul style="list-style-type: none"> <li>link with other relevant activities;</li> <li>build on previous experience in the country? (The SURE Collaboration, 2011)</li> </ul> </li> </ol> <p><b>2) Clarifying the problem</b></p> <p>Is the prioritization of this problem consistent with the agenda of the major stakeholders involved in decision-making?</p>
	<b>Policy options</b>	<p><b>1) Identifying and clarifying policy options</b></p> <p>Are the policy options provided:</p> <ol style="list-style-type: none"> <li>feasible in the given implementation environment;</li> <li>affordable within the financial structures and budgetary allocations of the health system;</li> <li>adaptable to the expertise and professional judgement of the local conditions;</li> <li>fitting within the societal and cultural perspective of the environment in which they will be implemented;</li> <li>in alignment with the political interests/commitments of the system;</li> <li>sustainably able to provide long-term outcomes? (Ako-Arrey et al., 2006)</li> </ol> <p><b>2) Trade-off judgement</b></p> <p>Do the considerations for costs and benefits of the policy options:</p> <ol style="list-style-type: none"> <li>include the most important costs and benefits for the local context;</li> <li>account for equity and ethical issues in the implementation environment? (Lewin, Oxman, et al., 2009b)</li> </ol> <p><b>3) Use of evidence</b></p> <p>Does the evidence used:</p> <ol style="list-style-type: none"> <li>include local evidence (Lewin, Oxman, et al., 2009b);</li> <li>adjust international evidence to the local context? (Lavis, Oxman, et al., 2009b)</li> </ol>
	<b>Implementation considerations</b>	<p><b>Facilitators and barriers</b></p> <ol style="list-style-type: none"> <li>Are local implementation considerations adequate?</li> <li>Are context-appropriate barriers to implementation considered?</li> <li>Are the strategies for overcoming these barriers locally applicable?</li> <li>Is the evidence for these implementation strategies locally appropriate?</li> </ol>
	<b>Next steps</b>	Do the next steps accurately reflect the national procedures for policy dialogues?
	<b>Comments</b>	

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## Annex references

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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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