

CONCEPTUAL BACKGROUND AND CASE STUDIES

Introduction to EVIPNet Europe

- Knowledge translation theory

- Resources

- Knowledge translation platforms

- Knowledge translation platform case studies

- Knowledge translation mechanisms

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CONCEPTUAL BACKGROUND AND CASE STUDIES

Introduction to EVIPNet Europe

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ABBREVIATIONS AND ACRONYMS

EVIPNet	Evidence-informed Policy Network
KTP	knowledge translation platform
M&E	monitoring and evaluation
NEv	Centre for Health Evidence
RAG	research-to-action group
WHA	World Health Assembly
WHO	World Health Organization

INTRODUCTION

ABOUT THIS DOCUMENT

In 2012, all Member States in the WHO European Region adopted the new European health policy framework, Health 2020. The use of the best available scientific evidence in policy-making has never been more relevant in discussions about how to maximize intended health outcomes and strengthen health systems in the Region (1). The Evidence-informed Policy Network (EVIPNet) Europe works to strengthen country capacity to develop evidence-informed policies on health system priorities that are in line with Health 2020, the European Health Information Initiative (2) and the "Action plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region 2016–2020". It functions as a network of platforms represented by multistakeholder partnership and multiple sectors.

The document has two main objectives. First, it provides an overview of evidence-informed policy-making, knowledge translation and EVIPNet. It presents lessons learned and experiences gained from the many groups around the world undertaking activities to support the use of research evidence in the policy process. Second, it assists countries in establishing EVIPNet country teams known as knowledge translation platforms (KTP).

The document is divided into five sections. Section 1 provides an overview of the major theoretical concepts in knowledge translation, including what it means. The section covers key related concepts such as the "knowledge" of knowledge translation, knowledge brokering, knowledge synthesis and networks. Finally, it discusses how both EVIPNet and EVIPNet Europe have operationalized knowledge translation processes through the work of KTPs around the world.

Section 2 introduces key knowledge translation mechanisms and approaches that have been implemented in various contexts around the world. In particular, this section introduces priority-setting approaches, evidence briefs for policy, deliberative policy dialogues (for which evidence briefs are a primary input), rapid response services and online clearinghouses (often called "one-stop shops").

Section 3 provides a description of KTPs, highlights their possible forms and functions, discusses the challenges in establishing and launching them, and illustrates possible strategies and workplans for operating a KTP.

Section 4 provides four brief case studies of KTPs that have been established in Brazil, Peru, Uganda and Zambia. This section presents an overview of experiences in which EVIPNet has been the most active. In particular, it discusses the successes, challenges and lessons learned across KTPs in sub-Saharan Africa. Finally, section 5 provides a short annotated list of knowledge translation resources and a glossary.

This document should give readers an understanding of the underlying concepts and the mechanisms and approaches available to support the use of research evidence in the policy-making process. This will allow them to respond more appropriately to specific needs in their own contexts. The document provides readers with short, targeted overviews and reference

lists. The resources and information in this kit provide concrete ideas on creating and launching a KTP that can bring together policy-makers, stakeholders and researchers at the country level to support evidence-informed policy-making and policy implementation and improve the health of populations.

For information on the process of joining EVIPNet Europe, please refer to “How to join EVIPNet Europe” (3).

BOX 1. KNOWLEDGE TRANSLATION

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 (4).

ABOUT EVIPNET

EVIPNet is a knowledge translation network established by WHO. EVIPNet envisions a world in which policy-makers and other stakeholders in low- and middle-income countries use the best available research evidence to inform policy-making. As a WHO initiative in knowledge translation, EVIPNet’s mission is to promote a network of partnerships at the national, regional and global levels among health system policy-makers, researchers and civil society. Taken together, this will strengthen health systems and improve health outcomes through regular access to, and assessment, adaptation and use of context-specific research evidence (5).

Since 2005, regional EVIPNet networks have been established in sub-Saharan Africa, the Americas, Asia and the Eastern Mediterranean. Over 40 individual country teams are interconnected within these regional networks. These country teams – often called KTPs (see Box 2) – are the core element of EVIPNet.

Discussing the ideas and concrete steps that countries take in creating a KTP is the primary focus of this document.

BOX 2. KTPs

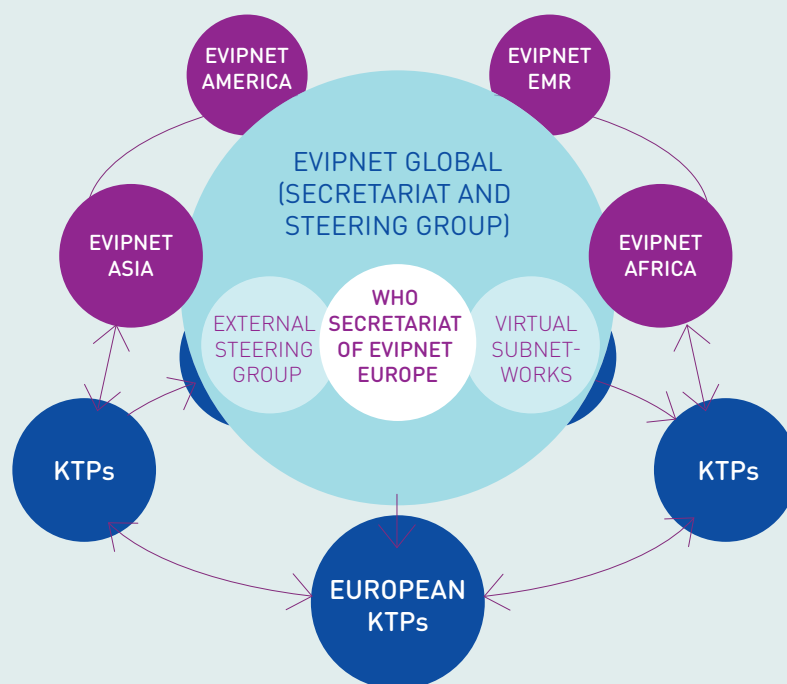
A KTP is an organization or network that brings together the worlds of research and policy. A KTP designs, leads and/or delegates strategies to: (i) understand the prevailing situation on a particular issue; (ii) harvest local evidence and experience and synthesize it with global knowledge to provide guidance in policy development and implementation; (iii) broker among stakeholders on key issues; (iv) package syntheses and other communications for specific audiences; (v) and strengthen the capacities of researchers, policy-makers and other stakeholders in accessing research evidence, in performing synthesis work, and in knowledge translation more generally (6).

ABOUT EVIPNET EUROPE

Launched in 2012, EVIPNet Europe is the most recent EVIPNet regional network. Like the global network, EVIPNet Europe seeks to improve public health and reduce inequities by increasing the systematic use of the best available scientific evidence to guide health systems policy development. EVIPNet Europe operates on three separate yet closely interconnected levels (Fig. 1):

- **Country level:** Country teams or KTPs comprising key national actors (including policy-makers, researchers and civil society representatives) lead the planning and implementation of knowledge translation activities and interventions.
- **Regional level:** Country teams or KTPs interact with each other to share experiences, lessons learned and innovative approaches. These interactions are supported by the WHO Secretariat of EVIPNet Europe based in the WHO Regional Office for Europe. The EVIPNet Europe Steering Group, comprising eight people with extensive experience in knowledge translation and evidence-informed policy-making, provides strategic advice and technical support to the WHO Secretariat of EVIPNet Europe.
- **Global level:** The global EVIPNet Secretariat within WHO headquarters in Geneva coordinates and supports the country and regional levels, and actively involves funders and other global stakeholders.

FIG. 1. THE NATIONAL, REGIONAL AND GLOBAL CONNECTIONS OF EVIPNET EUROPE'S NETWORKING STRUCTURE



Note. KTP = knowledge translation platform, EMR = Eastern Mediterranean Region.

Initial implementation period: multicountry- and country-specific tracks

Following its launch, EVIPNet Europe developed a five-year strategic plan for 2013–2017 (7) outlining its strategic directions and the roadmap for implementation, including both multicountry and country-specific tracks. The multicountry track focuses on capacity-building and strengthening of exchanges and networking among countries. The country-specific track refers to a formal pilot phase, launched in 2014, to test the feasibility of the EVIPNet methodology in the WHO European Region (5). Piloting comprises:

- undertaking situation analyses to better understand opportunities and barriers for evidence-informed policy-making in the country, specifically to create a KTP;
- formally establishing and operating a KTP; and
- planning and implementing one full EVIPNet action cycle (see section 3.1.3) and other knowledge translation interventions adapted to the local context.

Added value and benefits of EVIPNet Europe

EVIPNet Europe members are formally supported, in particular through KTPs, to achieve improved, evidence-informed national health policy-making, leading to stronger health systems and improved health outcomes.

Member countries become part of a peer-support and capacity-building network. At the regional level, the WHO Secretariat of EVIPNet Europe offers support to individual brokers and countries intending to institutionalize knowledge brokering in the form of a KTP, through:

- skills development training and capacity-building workshops;
- direct technical support in operational and strategic positioning and implementation;
- access to knowledge translation tools, technical guidelines and global, regional and national best practices;
- establishment of interactive exchanges and communication channels among peers; and
- fostering a culture, practice and the advancement of knowledge translation at national and regional levels.

Recent updates on EVIPNet Europe member countries and activities are available on the WHO Regional Office for Europe website (<http://www.euro.who.int/en/evipnet>).

1. KNOWLEDGE TRANSLATION THEORY

This section provides an overview of the theory on knowledge translation mechanisms and approaches.

At the end of section 1, readers should be able to describe:

- the history and scope of knowledge translation (section 1.1);
- the knowledge that informs knowledge translation activities (section 1.2);
- the role that knowledge brokering and synthesis play in knowledge translation (sections 1.3 and 1.4); and
- how networking in knowledge translation adds a crucial knowledge sharing dimension (section 1.5).

1.1 KNOWLEDGE TRANSLATION

KEY MESSAGES

- Knowledge translation is a process of increasing the systematic and transparent use of research evidence in policy- and decision-making to improve health outcomes.
- WHO has become a key player in knowledge translation as part of its mandate to improve public health.
- EVIPNet focuses on exchange, linkages and integrated models of knowledge translation frameworks.

1.1.1 Research–policy gap

Identifying the best approaches to supporting evidence-informed health policy-making is becoming increasingly important on the international agenda to strengthen national health systems. There is a commitment to establish new, or scale up existing, mechanisms to improve the linkages between the best available research evidence and policies adopted to strengthen health systems and improve population health (4,8–10). This is evident in the 2004 *World report on knowledge for better health* (4), the resolutions of the Fifty-eighth World Health Assembly (11) and knowledge translation initiatives such as EVIPNet.

Transferring research into policy is a complex and haphazard process. “Researchers [...] busy filling shelves of a shop front with a comprehensive set of all possible relevant studies that a decision-maker might some day drop by to purchase” (12) will rarely be sufficient to influence decision-making. Major barriers exist to the use of research evidence in health policy-making.

- Research is not valued by policy-makers as a helpful input to their work.
- It is viewed as irrelevant to the policy process, which is characterized by power and budget struggles.
- It is difficult to use because it lacks quality or relevance, or is not available when policy-makers need it (13,14).
- It is not effectively communicated, due to an absence of personal contact and interaction between researchers and policy-makers, and/or mutual mistrust.

1.1.2 The evolution of knowledge translation

Knowledge translation is a process of increasing the systematic and transparent use of research evidence in policy- and decision-making to improve health outcomes. 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. (4)

Knowledge translation is rooted in the evidence-based medicine movement of the 1990s, which highlighted the need for clinicians to integrate research evidence into practice (15,16). It also has its origins in the field of health technology assessment, which likewise emerged in the early 1990s as an approach to policy decision support based on evidence (17). The evidence-based medicine movement fundamentally changed how clinicians delivered health care, but revealed that despite the availability of research evidence, the implementation of evidence-based interventions was far from uniform. In some cases, interventions that were supported by evidence were not implemented (13,15,17). The Bellagio Child Survival Study (2003) brought the practical implications of this challenge to the fore. It revealed that many mothers and their children were not receiving care based on the best available research evidence. If evidence-based interventions were to become universally available to them, it was possible that 63% of the 10 million annual child deaths could be avoided (17).

Within the field of health, the paradigm of evidence-based medicine has inspired other areas to improve the quality of health systems and care, and has expanded to become evidence-based policy. The term “evidence-based policy” has since evolved into “evidence-informed policy” to emphasize the coexistence of other contextual and political factors that equally influence (and sometimes dominate) decision-making. These include institutional structures and policy legacies, interest group pressure, and dominant values and beliefs (18–21).

1.1.3 The WHO approach to knowledge translation

In the last 20–30 years, recognition of the importance of the “know–do gap” has gained political momentum. This describes the difference between what we “know” and what we “do” in terms of practice and policy development. This trend culminated in the World Health Assembly (WHA) of 2005, at which knowledge translation was one of the main agenda topics. That year, the WHA called on WHO Member States to “establish or strengthen mechanisms to transfer knowledge in support of evidence-based public health and health care delivery systems and evidence-based health-related policies” (11). Bridging the know–do gap has become a great challenge and opportunity for achieving the best care for all in global health (13,22–24).

WHO supported a meeting of the world’s health ministers in Mexico in 2004 and in Mali in 2008 (10,25). These summits both resulted in formal declarations and commitments for Member States to establish or strengthen mechanisms to support the use of research evidence and bring together research and policy communities.

WHO supports knowledge translation primarily through EVIPNet (see Introduction).

1.1.4 Knowledge translation models

Knowledge translation efforts can be grouped into four models (see Fig. 1.1) (13).

- **Push efforts** tailor and target the key messages arising from research evidence to policy-makers by making it more accessible and easier to use. Examples include the preparation and targeted distribution of user-friendly summaries of policy-relevant systematic reviews.
- **User-pull efforts** concentrate on how policy-makers are supported through processes and structures to demand evidence from the research community. These efforts are facilitated through the establishment of one-stop shops, which make it easier for policy-makers to efficiently access high-quality research evidence. An example of this is online repositories of high-quality, policy-relevant, systematic reviews.
- **Exchange efforts** encourage researchers and policy-makers to developing partnerships, collaborative research projects or shared understandings, which enable them to jointly ask and answer relevant policy questions. Examples include convening deliberative policy dialogues.
- **Integrated efforts** bring together various different components of push, user-pull and exchange, and are embodied in a knowledge translation platform. This approach acknowledges that activities that fall within each of the other categories are not mutually exclusive or meant to be considered in isolation.

FIG 1.1. MODELS FOR LINKING RESEARCH AND POLICY



Source: Adapted from Moat et al. (26).

While EVIPNet focuses on all four efforts, it concentrates in particular on institutionalizing exchange and integrated efforts, which have shown much promise in a number of settings (15, 26). There is an increased interest in understanding the factors that contribute to the successful development of knowledge translation activities in low-and middle-income countries (6,26–29), and in evaluating their effectiveness (26,30). Section 2 provides a more detailed description of activities within each of the models.

1.2 THE “KNOWLEDGE” OF KNOWLEDGE TRANSLATION

KEY MESSAGES

- Knowledge is a combination of explicit knowledge (e.g. research evidence, health information and data) and tacit knowledge (e.g. expertise, tradition and/or common sense).
- Explicit knowledge is structured, verifiable and replicable, while tacit knowledge is often unarticulated and context-specific, deriving from experience.
- The “best available evidence” typically refers to explicit knowledge from global and national research evidence combined with tacit knowledge at the local level.

Knowledge can be both scientific (31,32) and experience-based (32–36), in that it derives from scientific study and from experience that often contextualizes the issue (33,34) (Fig. 1.2). An awareness of these different dimensions of knowledge is central to knowledge translation.

1.2.1 Types of knowledge

Any knowledge translation strategy needs to take both explicit and tacit knowledge into account. Explicit knowledge is scientific, structured, verifiable and replicable. Several methods have been suggested to rank knowledge according to the strength of evidence and scientific rigor. One of the most widely accepted methods groups explicit knowledge into two tiers (Fig. 1.2) (37,38). The bottom tier includes individual studies including randomized

FIG. 1.2. THE HIERARCHY OF EXPLICIT KNOWLEDGE CONTRASTED (23)



Source: Campbell (23).

controlled trials, cohort studies and case-control studies. The quality of individual studies might vary as methods, assumptions, contexts and chance variation can result in contradictory findings. The top tier includes evidence synthesis products, such as systematic reviews, in which research evidence has been systematically and transparently searched, appraised and synthesized (see section 1.3). Evidence synthesis products package the most relevant and high-quality studies to provide a more comprehensive picture than any single study can.

Explicit knowledge also includes health information produced from data that has been analysed into meaningful and relevant information for decision-making (39). Knowledge derived from data, such as that routinely collected through monitoring and evaluation and epidemiological surveys, is required to clarify policy issues (40). Data may be used to describe the size and/or consequences of the issue in terms of risk factors, disease, coverage, quality of care, cost of services and implementation rates. These data can be compared to, for example, targets in a national plan, regional averages, international standards, and across different time periods (41).

Tacit knowledge, on the other hand, is drawn from experience, lessons learned, organizational tradition and best practice. It is a mixture of intuition, common sense, know-how and pragmatism (42).

Often the knowledge translation literature refers to a different kind of knowledge and/or evidence typology, as outlined in Box 1.1.

BOX 1.1. CONTEXT-FREE, CONTEXT-SENSITIVE AND COLLOQUIAL EVIDENCE

As another way of thinking about the “knowledge” of knowledge translation, Lomas et al. (43) describe three different types of evidence (context-free and context-sensitive evidence refer to explicit knowledge and colloquial evidence refers to tacit knowledge).

- The first is **context-free evidence**. This is typically medical effectiveness or biomedical research (e.g. male circumcision can be a strong preventative measure for HIV acquisition in men living in high incidence populations).
- The second is **context-sensitive evidence**, which puts evidence into a context that makes it operational or relevant to a particular setting (e.g. male circumcision in low- and middle-income countries may fail as an intervention due to health system weaknesses and underlying poverty issues). Both of these types of evidence are captured in systematic reviews, in other syntheses, in single studies and in pilot or case studies.
- The third category of evidence is **colloquial evidence** – evidence “that establishes a fact or gives reason for believing in something” (43) (e.g. most experts agree that implementing a universal male circumcision policy is impossible because of the current cultural, political and socioeconomic environment). This type of evidence can be very useful for addressing the weaknesses in the other types of evidence (e.g. implementation context).

Box 1.1: (43)

1.2.2 The best available evidence

The use of “the best available evidence” aims to address the lack of perceived relevance and unavailability of research evidence, which are identified as barriers to the use of research evidence in policy-making (see section 1.1.1). This involves combining strong and undisputed evidence from global databases (often systematic reviews) with local evidence and/or local

tacit knowledge to design context-specific solutions. In many low- and middle-income countries, locally created explicit evidence on a particular issue might be limited, while a raft of studies performed globally or in other countries exist. A knowledge translation practitioner can synthesize the best available evidence using different knowledge translation mechanisms (e.g. policy dialogue) to determine how this evidence might both inform and blend with local tacit evidence (see section 2).

1.2.3 Policy-makers and knowledge

When a knowledge translation practitioner understands how a particular type of knowledge fits into the larger puzzle, the knowledge translation strategy has a better chance to influence policy (23). In addition to methodological rigor, the following contextual factors need to be taken into consideration to increase the uptake of research evidence.

Alignment with policy-makers' beliefs and aims: Humans "believe in" the knowledge that best aligns with their own values or perceptions (22,44–47). "Users selectively interpret and use knowledge as it serves their own purposes, fits their unique situations and reflects their relations with their practicing community."(48). For example, policy-makers may use research evidence in an instrumental way if it directly aligns with and provides answers about how to address a pressing policy challenge. They may use it in a conceptual way if it helps them think about the issues they are dealing with differently, or in a symbolic or strategic way if it helps to justify a decision already taken (49–52). These opportunities include developing actionable messages for decision-makers (only 30 percent of research organizations frequently or always do this).

Perceived competence and integrity of researchers or knowledge brokers: Policy-makers prefer to work with researchers or knowledge brokers if they are deemed to be trustworthy, not whether they are the most objective and/or the best source of relevant evidence about a particular topic (53). Trustworthiness can be perceived as competence, integrity and support of a policy reform agenda. Researchers' personal traits, motivations and willingness to advocate appear to matter most for getting them into the policy fray, and not the quality or objectivity of their research (54).

Perceived quality of research: Policy-makers turn to knowledge that is available, easy to consume, uncontroversial and clear, and is the most relevant to their context and issue (22,24,43–45,55). Researchers who actively dispute the evidence base on a particular issue may weaken the role that research evidence as a whole might play. This could lead policy-makers to turn to other types of (largely tacit) knowledge – such as those created and advanced by lobbyists and paid consultants.

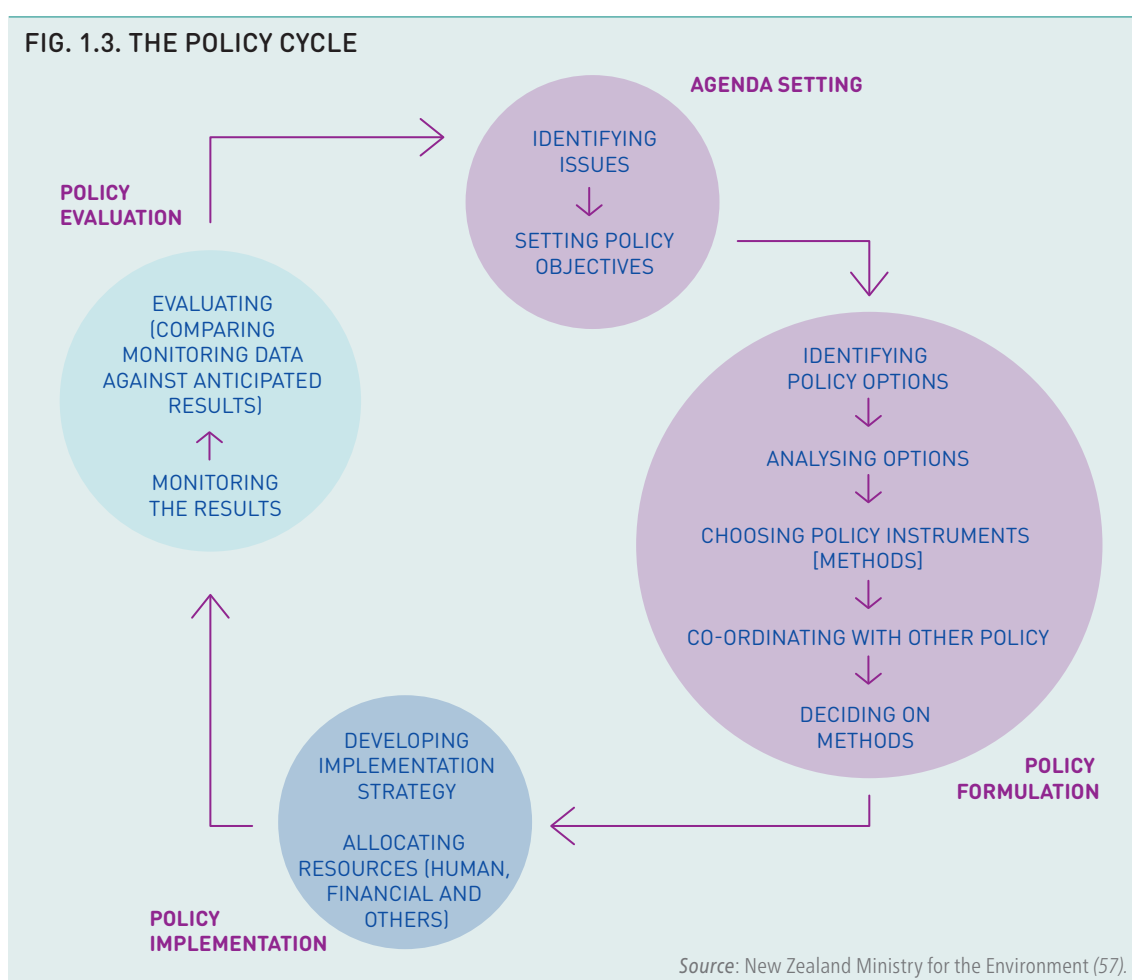
Timeliness of research: Policy-makers prefer that research is provided within a timeframe that aligns with the hours, days or weeks they work within, rather than the years it can take to complete a research project (24).

Perceptions of knowledge, motivations to use it, approaches to accessing it, and how it is used to inform decision-making are dynamic. Knowledge translation strategies need to be designed, tailored and implemented based on the prevailing conditions and opportunities for the uptake of evidence by policy-makers.

1.2.4 The use of research evidence in policy-making

Research evidence can play a critical role in clarifying the issues being addressed at each stage of the policy cycle (see Fig. 1.3). The uptake of research evidence can be grouped into the following:

- Direct use (i.e. instrumental or engineering) refers to the link between research findings and their applicability to solving specific problems, which policy-makers are seeking to address.
- Selective use (i.e. symbolic or legitimating) refers to research being applied in a political, strategic manner to persuade, and legitimize predetermined decisions.
- Enlightening use (i.e. conceptual) refers to research that has informed or influenced how policy-makers think about issues (56).



The importance of analysing the policy cycle is to identify the extent to which evidence is being used in the different phases (see Table 1.1).

- **Agenda setting:** This stage involves establishing the rationale for key policies including identification of health problems.
- **Formulation:** The appropriate use of evidence can support the formulation of clear and specific policy objectives and options.

- **Implementation:** This is the stage at which policy options identified in the previous stage are rolled out. Evidence can be of utmost importance in making well-designed choices. Implementation includes monitoring of results to understand the impact of interventions on health and enable policy or programme corrections.
- **Evaluation:** This phase may include research evidence and methods, or focus on the social response to policy. The issue will be the extent to which the original problem is being addressed and the efficiency of the programmes and actions implemented to this end. Evaluation findings inform the next actions in the policy cycle.

TABLE 1.1. COMPONENTS OF POLICY PROCESSES AND DIFFERENT EVIDENCE ISSUES

STAGE OF THE POLICY PROCESS	DESCRIPTION	DIFFERENT EVIDENCE ISSUES
Agenda setting	Awareness and priority given to an issue	The evidence needs here are in terms of identifying new problems or the build up of evidence regarding the magnitude of a problem so that relevant policy actors are aware that the problem is indeed important. A key factor here is the credibility of evidence but also the way evidence is communicated.
Formulation	There are two key stages to the policy formulation process: determining the policy options and then selecting the preferred option (58).	For both stages, policy-makers should ideally ensure that their understanding of the specific situation and the different options is as detailed and comprehensive as possible - only then can they make informed decisions about which policy to go ahead and implement. This includes the instrumental links between an activity and an outcome as well as the expected cost and impact of an intervention. The quantity and credibility of the evidence is important.
Implementation	Actual practical activities	Here the focus is on operational evidence to improve the effectiveness of initiatives. This can include analytic work as well as systematic learning around technical skills, expert knowledge and practical experience. Action research and pilot projects are often important. The key is that the evidence is practically relevant across different contexts.
Evaluation	Monitoring and assessing the process and impact of an intervention	The first goal here is to develop monitoring mechanisms. Thereafter, according to Young and Quinn (58), 'a comprehensive evaluation procedure is essential in determining the effectiveness of the implemented policy and in providing the basis for future decision-making'. In the processes of monitoring and evaluation, it is important to ensure not only that the evidence is objective, thorough and relevant, but also that it is then communicated successfully into the continuing policy process.

Source: Reproduced from Sutcliffe and Court (59).

1.3 EVIDENCE SYNTHESSES

A strong body of evidence shows that a single set of findings alone rarely influences policy, with research being more likely to influence policy in a synthesized form (22,60–64). For that reason, evidence synthesis is a core mechanism of knowledge translation.

Evidence synthesis is a process of “contextualizing and integrating research findings of individual research studies within the larger body of knowledge on the topic” (65). This can result in systematic reviews, summaries of systematic reviews, evidence briefs for policy, and press releases. Realist syntheses, narrative syntheses, meta-analyses, meta-syntheses and practice guidelines are all forms of synthesis (66). These syntheses summarize information from a wide range of sources including the non-peer-reviewed literature through rigorous, systematic and transparent processes. Evidence syntheses respond to policy concerns and questions from policy-makers. They are up-to-date summaries of evidence that highlight what is known and not known about the policy question in concern. They indicate gaps in evidence and information, underscore key areas of debate and trends, and provide practical policy options for action.

The approaches and products described above package evidence in specific formats that present key messages for different audiences. Because each synthesis is aimed at different target audiences (e.g. researchers, policy-makers, the general public) it is crucial to match the type of message package to the intended recipients.

Knowledge syntheses become a highly useful mechanism for influencing policy-makers when they move beyond purely scientific considerations and include a fuller appreciation of all relevant contextual factors. As Morestin et al. state, “decision-makers are influenced by considerations that go beyond effectiveness, and which must be taken into account in the information they are provided: syntheses that present evidence in a manner that is divorced from the realities of policy implementation are of little use to decision-makers” (67).

Systematic reviews combine findings from multiple research studies in a systematic, transparent and reproducible manner using quantitative and/or qualitative methods (68). High-quality systematic reviews provide a comprehensive and weighted overview of the evidence that responds to a certain question (55). Systematic reviews are often preferable to single studies as they:

- reduce the likelihood of biased selection and interpretation of evidence because of the methods used to identify, select, appraise and synthesize a range of single studies;
- increase confidence about what can be expected from a particular intervention, because the results are based on a larger number of study units and settings than any individual study; and
- allow policy-makers to invest more time considering the applicability of the findings in their own context, since the hard work of finding all relevant single studies is done for them and presented in a single place (63).

Building on systematic reviews, summaries of systematic reviews and evidence briefs for policy are tools which further synthesize knowledge that is generally targeted at policy-makers. Summaries of systematic reviews are structured summaries of relevant systematic reviews on a specific topic (69, 70). An evidence brief for policy (see section 2.2) summarizes the findings from a full range of systematic reviews that clarify policy problems, frame policy options and identify key implementation considerations. These are combined with local evidence related to a specific policy issue (26,71). A consideration of the quality of the evidence is generally provided so that users can determine how much confidence to place in the results of a review. Two tools are often used to achieve this: (i) the AMSTAR assessment system, which provides a quality rating of how well a review was conducted based on the methods used (72); and (ii) the GRADE system, which determines the strength of the evidence

(and thus, whether recommendations can be made based on the evidence) (73). This type of “value-added” information can be important for policy-makers who want to know whether a review or set of reviews are of high or low quality before making a decision (74).

The second major type of evidence synthesis is less scientific in nature, yet it is a more accessible, user-friendly approach to providing research evidence to a lay audience and/or policy-makers. This includes press releases, take-home messages and community events such as radio shows or dramas. As these approaches do not explicitly demonstrate the quality of the research being considered, some discretion should be advised to the potential users.

1.4 KNOWLEDGE BROKERING

KEY MESSAGES

- Knowledge brokers are often senior, well-connected and respected individuals, or an organization (such as a knowledge translation platform) whose core function is to connect people to exchange knowledge.
- Knowledge brokers bring stakeholders together, build relationships, cement coalitions and alliances, and build new skills and capacities.
- Effective knowledge brokering drives the change agenda, typically by convening the required stakeholders to exchange knowledge and discuss how change might unfold.

Knowledge brokering is another key mechanism of knowledge translation. This refers to the act of bringing together stakeholders – mainly researchers and policy-makers – through building relationships and alliances, sharing ideas and knowledge, and improving knowledge translation skills and capacities.

1.4.1 Knowledge brokers

Whether an individual, an institution or a network, a knowledge broker serves as “a catalyst for systems change, establishing and nurturing connections between researchers and end users, and facilitating learning and exchange of knowledge”(75). A knowledge broker is generally a respected opinion leader, who has experience in the worlds of research, policy and/or practice (23). Although an official mandate is useful in purveying more credibility and authority, knowledge brokers can function without a formalized role, utilizing their unique attributes and skills to facilitate the exchange of knowledge (76). Knowledge translation platforms are a specific type of a knowledge broker organization that institutionalizes these characteristics (see section 3).

1.4.2 Knowledge brokering activities

An effective knowledge broker is a catalyser of change (77–79), through:

- accessing, critically appraising and synthesizing research information for specific audiences;
- establishing online databases that serve as one-stop shops for the best available research evidence (see section 2.5);

- convening deliberative, multistakeholder meetings to discuss the research agenda and knowledge gaps; discuss partnerships among researchers, or between researchers and research-users; consider new or pressing issues that require collective action; and to conduct situation analyses identifying major stakeholders and the dynamics among them;
- facilitating off-the-record meetings (potentially using the Chatham House Rule) to discuss sensitive policy concerns, given that stakeholders are sometimes unwilling to speak on behalf of their organization for fear of stating the wrong thing or making a difficult commitment; and
- encouraging the secondment of brokers to specific organizations (e.g. a government ministry) working as “boundary spanners, identifying, selecting, and obtaining information from the environment and efficiently transmitting it within the organization according to needs” (32).

1.4.3 Qualifications of knowledge brokers

As either an individual or an institution, knowledge brokers perform core knowledge translation tasks (23,75,77). They possess:

- an in-depth understanding of the research and policy communities, allowing them to develop relationships and trust across these communities, including by supporting the development of multidisciplinary research projects;
- the ability to access and critically appraise research information, and then to synthesize it for specific audiences;
- expertise in knowledge utilization, including a sound awareness of conduits into particular policy-making organizations and processes; and
- experience in knowledge translation, which allows them to build the capacities of both researchers and research-users to foster knowledge translation.

1.5 NETWORKING AND KNOWLEDGE TRANSLATION

KEY MESSAGES

- Networks are a critical part of knowledge translation and offer the space to combine explicit and tacit knowledge to create products for addressing health priority issues.
- Networking opens space for dialogue and joint value creation among researchers, policy-makers and civil society.
- EVIPNet is a prime example of a knowledge translation network, bringing together interdisciplinary stakeholders to advance knowledge translation mechanisms and methodologies that ultimately improve health outcomes.

“No one knows everything, everybody knows something” – Pierre Lévy (80)

A network comprises groups of individuals, organizations and/or existing networks, which interact based on shared interests and goals (81). The creation and use of a network structure may be decided at operational, personal and strategic levels.

1.5.1 Comparative advantages of networks

While an individual or a single organization is limited by its own resources and expertise, networks create a multiorganizational structure to expand mutually supportive actions to achieve individual and collective goals. Network coordination has many advantages.

- **Enhanced learning:** Shared learning is often a network-level outcome and a rationale for collaboration. Capacity building, mentoring and sharing best practices can be a network-level activity.
- **Strategic advantages:** A network structure can facilitate effective communication and sharing of priorities, organizational changes, and resource mobilization that are otherwise not possible without vertical and horizontal linkages in a network.
- **Increased and diversified authority, resources and expertise:** These advantages are particularly manifest in horizontal networks with multidisciplinary, cross-organizational environments.
- **Mutual accountability and healthy competition:** These allow network-level outcomes to be achieved collectively.
- **Shared risks:** A new or untested endeavour or cost intensive project, for example, may be a strategic reason for a network structure.

1.5.2 Knowledge translation networks

A knowledge translation network may assume similar functions to a knowledge broker (see section 1.4), but it exceeds the knowledge brokers' role as an intermediary or a catalyst of knowledge translation. The key activities of a knowledge translation network are outlined below.

- **Space for regular multistakeholder engagement, institutionalized interaction and partnership creation:** Beyond the typical knowledge broker functions of facilitating push, pull and exchange efforts (see section 1.1), EVIPNet operates through multidisciplinary knowledge translation platforms. It brings together researchers, policy-makers and other stakeholders in an institutionalized manner to achieve policy influence. This includes the joint creation, synthesis, dissemination and promotion of the use of knowledge to shape policy and research agendas. Knowledge translation networks provide the opportunity for stakeholders to collaborate in partnership, develop and maintain trusting relationships and overcome barriers.
- **Routine exchanges, learning and communication with multiple stakeholders:** This can include sharing lessons learned and peer-support among its members no matter their location. A network may identify and invite stakeholders essential to its own operation, or stakeholders outside the network who, for instance, are in a position to act upon the network's knowledge products.
- **Joint identification of policy priorities:** Based on internal relationships between researchers, policy-makers and other stakeholders, knowledge translation networks are well suited to identify policy-relevant knowledge gaps and policy priorities. They are able to mobilize resources to generate knowledge addressing these gaps.
- **Collaborative research:** Knowledge networks support context-specific collaborative research on the real-world implementation of policies based on the best available evidence (82). This ensures that all stakeholders necessary for the successful roll-out

or scale-up of a promising intervention are working together to identify and overcome policy implementation challenges.

1.5.3 EVIPNet and knowledge translation networks

EVIPNet is a prime example of a knowledge translation network, bringing together interdisciplinary stakeholders to advance knowledge translation mechanisms and methodologies that ultimately improve health outcomes. National and regional networks of researchers, policy-makers and civil society that support evidence-informed policy-making are the core form and function of EVIPNet Europe (see Introduction).

EVIPNet operates on three closely interconnected levels.

- **The country level:** Formalized networks of key national actors (including policy-makers, researchers and civil society representatives) known as a knowledge translation platform (KTP) are charged with planning and implementing knowledge translation activities and interventions (see section 2).
- **The regional level:** KTPs share experiences, lessons learned and innovative approaches, supported and coordinated by the regional EVIPNet secretariats in the WHO regional offices.
- **The global level:** The global EVIPNet Secretariat within WHO headquarters supports national and regional networks of KTPs and actively involves funders and other global stakeholders to create another layer of networking.

1.5.4 Network structures and forms related to EVIPNet at country level

Table 1.2 outlines key features and forms of a network, and highlights the links with EVIPNet. Any network can assume one or a combination of these forms. In order to decipher which form(s) of networks are most relevant, influential and appropriate in a given context, an analysis of existing and potential stakeholders and their power dynamics and structures is crucial. EVIPNet Europe conducts national situation analyses to understand interactions among a country's research and policy-making communities and identify opportunities and barriers in organizing and establishing a KTP (see section 3).

A national EVIPNet Europe KTP may be initiated by its own members or convened or mandated by an external stakeholder. A network may have a combination of vertical and horizontal linkages depending on varying mandates, degrees of authority, resources and discipline. Some of these forms might be open (anyone can join) or closed (one must apply or be invited to join). They may be time limited or functioning for an indeterminate amount of time, or transitional and multidisciplinary.

In summary, networks matter in knowledge translation processes. The dynamics of relationships among policy actors can have a significant effect on knowledge translation outcomes, as the literature often highlights (83–85).

TABLE 1.2. NETWORK FORMS

NETWORK FORM	DESCRIPTION	EVIPNET
Formal	Has a governance structure with budget, staff, etc.	EVIPNet institutionalizes a formal network at national, regional and global levels, comprising policy-makers, researchers and civil society. This is called a knowledge translation platform (KTP) at a national level (see section 3).
Informal	Arising periodically to share ideas and expertise to advance work on a particular issue.	In an early stage of implementation, an informal network made up of committed leaders and individuals (e.g. from a ministry of health and a research institute) may be formed while resources are mobilized, and capacity and awareness are built.
Event specific	Created for a specific event (e.g. delegates to an upcoming conference all share information and collectively prepare for the event).	For EVIPNet's stakeholder consultation meetings and policy dialogues, an ad-hoc network may be formed to plan, organize and implement events.
Thematic	Stakeholders are connected through their interest in a core issue (e.g. tobacco control). The network might determine a formal agenda (e.g. to lobby the government to raise taxes on tobacco products), and the types of knowledge products needed to effectively influence the government (e.g. an evidence brief for policy analysing local and regional evidence on the issue and suggesting concrete policy options). Resulting action from this thematic network could see researchers studying particular knowledge gaps, civil society groups highlighting critical implementation issues, and policy-makers contributing their experience and know-how in terms of how policy could be created, amended or shifted.	In Zambia's KTP, these thematic networks have taken the form of research-to-action groups, serving to crystallize the country's expertise and interests in three broad groups. There is a group on mental health, another on human resources for health and a third on reproductive health. For more on Zambia's KTP, see section 4.5.

2. KNOWLEDGE TRANSLATION MECHANISMS

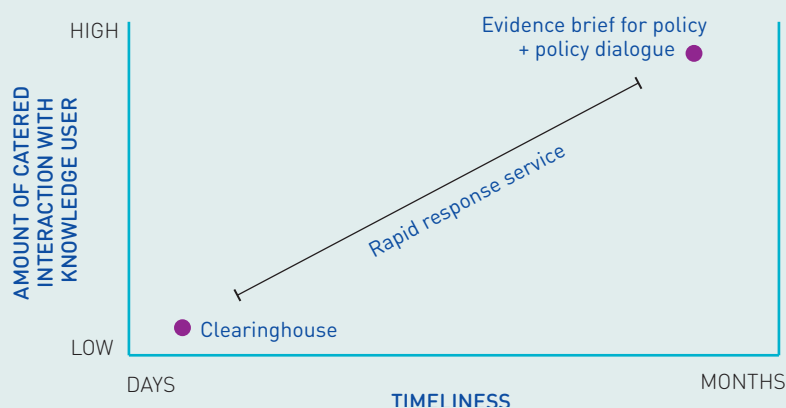
This section introduces the core knowledge translation mechanisms of EVIPNet: priority-setting processes, evidence briefs for policy, policy dialogues, rapid response services and clearinghouses. A description of these mechanisms can be found in Table 2.1.

TABLE 2.1. KNOWLEDGE TRANSLATION MECHANISMS

KNOWLEDGE TRANSLATION MECHANISMS	KEY CHARACTERISTICS
<p>Priority setting</p>	<ul style="list-style-type: none"> • shapes a policy and/or research agenda and determines which health topics should be addressed by knowledge translation platforms through an evidence brief and dialogue processes • includes priority setting for policy issues and priority setting for research • based on clear, objective and fair criteria
<p>Evidence brief for policy</p> <p>Synthesis of the best available global and locally produced evidence (explicit knowledge)</p>	<ul style="list-style-type: none"> • starts with a priority policy issue and then draws on the best available global research evidence (usually systematic reviews) alongside local data and studies that address the local context and realities
<p>Policy dialogue</p> <p>Deliberations among policy-makers, researchers and stakeholders that integrate explicit knowledge and tacit knowledge to guide policy development</p>	<ul style="list-style-type: none"> • informed by a pre-circulated evidence brief • stakeholder mapping helps to identify participants • a neutral facilitator ensures a fair and inclusive process • includes deliberations about the problem, options for addressing it and key implementation considerations (and in some cases next steps) • following the dialogue a summary of major points is disseminated to participants and other stakeholders
<p>Rapid response service</p> <p>User-friendly synthesis of high-quality research in a short timeframe</p>	<ul style="list-style-type: none"> • starts with a request from policy-makers about a specific high-priority policy issue or question • concisely summarizes research evidence for policy-makers in a short timeframe, typically within days, and at most a few weeks • does not typically include implementation guidelines • does not deliberately include both tacit and explicit knowledge • undergoes peer and/or expert review process to verify technical details
<p>Clearinghouse</p> <p>Repository of documents that allows users to easily access research evidence</p>	<ul style="list-style-type: none"> • includes a comprehensive and continually updated inventory of the best available and pre-appraised research evidence (usually systematic reviews) • presents research evidence in formats that highlight policy-relevant information and add value by providing other information (e.g. quality ratings, links to free full-text, links to related documents) • most often accessed online and usually free, removing barriers related to payment for access to full-text journal articles • packaged specifically for policy-makers and stakeholders • identification of documents to be included is a transparent and methodologically rigorous process

The knowledge translation mechanisms best suited to a policy-maker's needs depend on the timeliness and interaction with users that are required, as shown in Fig. 2.1. Further information about each of these knowledge translation mechanisms, including real-world applications, are included as part of the case studies in section 4.

FIG. 2.1. OVERVIEW OF KNOWLEDGE TRANSLATION MECHANISM USE



Source: Michael Wilson, McMaster, unpublished observations, 2013.

At the end of this section, readers should be able to:

- explain the role priority setting plays in knowledge translation (section 2.1); and
- describe the key characteristics of evidence briefs for policy (section 2.2), policy dialogues (section 2.3), rapid response services (section 2.4) and clearinghouses (section 2.5).

2.1 PRIORITY SETTING

KEY MESSAGES

- Priority setting is a knowledge translation mechanism that identifies and ranks urgent issues, topics and/or research questions based on explicit, pre-defined criteria.
- Priority-setting processes bring together policy-makers and a range of other stakeholders (e.g. professional associations and civil society representatives) to discuss their policy needs, and researchers to discuss the existing evidence base or knowledge gaps.
- The dialogue inherent to priority setting builds relationships, trust and interactions among policy-makers, researchers and civil society.

Priority-setting processes can be used in shaping a policy and/or research agenda. Priority setting has particular importance for an EVIPNet knowledge translation platform (KTP) in determining which health issues should be addressed through evidence briefs and dialogue processes. Given that every country has critically unresolved issues and stakeholders perceive these in different ways, KTPs use priority setting to select a health topic in a fair, transparent and legitimate way. Priority setting, in addition, may be useful for identifying gaps in the evidence base.

BOX 2.1. THE CONVERGENCE OF PRIORITY SETTING

Priority setting is a formal process where policy-makers can discuss their policy needs. Researchers can discuss the types of knowledge or methods that might answer those needs, or existing knowledge gaps. Other stakeholders can provide their own perspective on the knowledge needed to help solve pressing problems. As a knowledge translation mechanism, priority setting is a unique and powerful intervention that connects research and policy processes.

2.1.1 Major types of priority-setting processes

The two major types of priority setting are for policy issues and for research.

Priority setting for policy issues is closely linked to the agenda-setting stage in the policy development process (see section 1.2.4). When knowledge translation practitioners try to determine which priority issues are most likely to gain traction and where to focus their knowledge translation efforts, the following model could be considered. Kingdon's "three streams" model explains why some policy issues rise to become priorities, while others do not (86). Overall, the model suggests that issues become priorities for decision-making (i.e. they make it on to a government's decision agenda) when a policy entrepreneur combines compelling problems (stream I) with viable solutions (stream II) within a conducive political environment (stream III) (86).

Priority setting for research, on the other hand, involves deliberative techniques to create consensus on the priorities for a research agenda. Three questions are being addressed.

- What are the (general or specific) research needs of policy-makers?
- What are the present gaps in the research evidence?
- What types of research could best fill those gaps?

Both priority-setting types:

- require clear, objective and fair criteria to determine the knowledge needs (see section 2.1.2);
- rely on the participation of a range of stakeholders (researchers, policy-makers and other stakeholders), which have been purposefully selected based on stakeholder mapping and analysis;
- usually result in a ranked list of priority topics or priority research questions.

Achieving consensus, however, is not a necessary requirement of any priority-setting exercise (87,88). The process of dialogue and building social relationships, trust and interactions that are essential to a strong health system is just as important as the product itself for knowledge translation. KTPs should use a stakeholder mapping exercise to determine who should be involved in any priority-setting process.

2.1.2 Criteria for priority setting

Determining explicit criteria for a specific priority-setting exercise is crucial to allow a group to objectively weigh, analyse and determine what is a priority and what is not, and how

seemingly equal priorities measure against each other (89). This is particularly important, as priority setting involves value decisions (e.g. Why does stakeholder X consider topic A more important than topic B?). Although not an inclusive list, the criteria listed below are often used in priority setting for research, and should be adapted to priority setting for policy issues (86).

- **Magnitude, relevance and urgency:** Will the research be needed within the next 3–5 years? Will the issue at hand still be a priority in five years' time? (91,92)
- **Applicability, deliverability, affordability and sustainability:** Is the research highly applicable to its context? Will the research study or inform the development of interventions that are deliverable, affordable and sustainable? (93)
- **Maximum potential to reduce disease burden equitably:** Will the research address issues designed to reduce poor health outcomes across all dimensions of a society? (93,94)
- **Originality:** Is the issue under researched or is there an existing knowledge base? (91,92)
- **Research capacity and feasibility:** Do the skills exist to do the research? Is it feasible financially, technically, socioculturally and ethically? (92,93,95)
- **Policy relevance:** Will the research influence health policy decision-making? (91)
- **Expected impact of the research:** Will the impact of the research be greater than its relative cost? (95)

Table 2.2 describes some of the steps involved in conducting a priority-setting process. See Campbell (23) and El-Jardali (90) for more information.

2.2 EVIDENCE BRIEFS FOR POLICY

2.2.1 Research evidence and policy-making

KEY MESSAGES

- Evidence briefs for policy are a core knowledge translation mechanism. They package the synthesis of the best available research evidence in a way that is accessible, relevant, easy to use and applicable for policy-making.
- Evidence briefs for policy begin with the identification of a high-priority issue within a specific policy context and include descriptions of a problem, policy options and implementation considerations.
- Evidence briefs for policy are deliberated, validated and further complimented with tacit knowledge at policy dialogues.

A central challenge in the use of research evidence is that policy-makers often do not consider evidence relevant to their decision-making (96). Existing evidence syntheses, such as systematic reviews, are of limited use for policy-makers as they are typically not adapted to the local context and are not written with policy-makers in mind. This causes policy-makers to “hear noise, not music” (97). Above all, policy-makers require high-quality research evidence that is accessible, understandable and contextualized, factoring in implementation and financial considerations (24,97).

TABLE 2.2. A PRIORITY-SETTING CHECKLIST

BEFORE THE PRIORITY-SETTING PROCESS

1. Context: Which contextual factors underpin the process? What are the underlying values and/or principles? What is the reason for the process? What resources are available?

2. Approach: Is it comprehensive, appropriate and suited to context? Is guidance for the process structured, detailed and step-by-step?

3. Inclusivity: Who will be involved in the process? Is representation of expertise, disciplines, gender, regions, etc. sufficient? Have other sectors or constituencies been consulted and/or included?

4. Information: What information will inform the process? This could be literature reviews, technical data, stakeholder survey reviews or evaluations of previous priority-setting exercises, etc.

5. Planning for implementation: Are plans in place to either implement or enforce the priorities? Who will implement the identified research priorities?

DURING THE PRIORITY-SETTING PROCESS

6. Criteria: How will criteria for the process be determined?

7. Methods for determining priorities: How will the stakeholders ultimately decide among priorities? Will they use a consensus-based approach or a metrics-based approach (pooling individual rankings) or a combination?

AFTER THE PRIORITY-SETTING PROCESS

8. Evaluation: When and how will evaluation of the priorities and of the process take place?

9. Transparency: Write and disseminate widely a report documenting who set the priorities and how.

Source: Adapted from Viergever (95).

2.2.2 Key features of evidence briefs for policy

Evidence briefs for policy address this challenge by synthesizing the best available global research evidence (generally in the form of systematic reviews) with locally produced evidence and other studies to cater to what is most relevant to the policy process. In the knowledge translation literature, the term “local evidence” is often used to describe locally generated evidence that studies domestic issues. In many cases, this local evidence is not formally databased and is thus not accessible beyond the country, city or institution in which it was produced.

Evidence briefs maximize user-friendliness and quality by packaging research evidence in a way that is accessible, relevant, easy to use and applicable in a given national context (98).

Evidence briefs begin with a priority-setting process – the identification of a high-priority issue within a specific policy context (98). The brief includes a description of the problem and its context and an exploration of three policy options that address the problem. For each policy option, the briefs include cost effectiveness, benefits and harms. In addition, they explore policy-relevant information such as each policy option’s costs, barriers to implementation, stakeholder views, lessons learned from past implementation of these options and any associated uncertainties (26,98). Knowing how another jurisdiction

addressed a problem and implemented a solution is, for instance, often extremely valuable at the policy level (55).

2.2.3 Graded entry

In order to improve the accessibility, timeliness and ease of use, evidence briefs are written using a graded-entry format, known as the 1:3:25 format, to reflect page length. This format allows the reader to quickly assess the brief's relevance and whether it warrants a fuller read-through. Graded entry keeps research language and jargon to a minimum while maintaining transparency and thoroughness in its methodology (98). The graded entry format provides three different summaries:

- a one-page sheet of take-home messages that summarizes the brief's major contributions (intended for high-level policy-makers with limited time and/or evidence-comprehension abilities);
- a three-page executive summary that provides more detail and context around the brief's major contributions (intended for a more general policy-maker audience); and
- a 25-page report that presents the research evidence and contextual factors much more comprehensively (intended for scientific advisors or researchers connected to the policy-making process).

Additional resources on developing an evidence brief for policy can be found in the *SUPPORT Tools for evidence-informed Policy-making (STP)* (99) and *The SURE Guides for preparing and using evidence-based policy briefs* (41) described in section 5.1.1.

2.2.4 Evidence briefs for policy and policy dialogues

Once an evidence brief is drafted and peer- and merit-reviewed, it is further deliberated and validated at a policy dialogue with researchers, policy-makers and other key stakeholders (see section 2.3). While research evidence is central, a policy dialogue provides an opportunity to compliment the evidence brief with tacit knowledge and political considerations. An effective policy development process depends on the active participation of policy-makers at several different points. These include identifying a topic for the brief, participating in deliberative dialogue and pushing forward next steps that may lead to the formulation of a policy.

Given that the policy development process does not always lead to the development of a new policy, per se, the evidence brief and deliberative dialogue process can also result in:

- a shift in how key policy-makers and stakeholders conceive of policy problems and/or appropriate options;
- a decision to develop another evidence brief and convene another dialogue in order to fully understand a new conceptualization of problems and/or options; and
- a decision on how to improve the implementation of existing policies, or that nothing should be done (i.e. a "no go" decision).

Regardless of what the evidence brief and dialogue process result in, the important point is that the process systematically and transparently integrates what is known from the best available research evidence with all of the other factors (e.g. stakeholders' views and experiences, contextual factors) that influence policy development.

2.2.5 Evidence briefs for policy and EVIPNet KTPs

Evidence briefs for policy are used as a core mechanism by almost every knowledge translation platform (KTP). These briefs have focused on many issues, including task shifting, improving the delivery of maternal and child health care and increasing adherence to tuberculosis treatments. The case studies in section 4 provide further examples of evidence briefs, and a list of published EVIPNet evidence briefs is available on the WHO website (100).

KEY MESSAGES

- Policy dialogues allow policy-makers to consider research evidence alongside the views, experiences and lessons learned (tacit knowledge) from major stakeholders (e.g. civil society groups) affected by decisions on the issue.
- The policy dialogue is informed by a pre-circulated evidence brief for policy.
- The end goal of the policy dialogue is often not consensus, rather it is a means for considering all inputs – including research evidence – to the policy-making process.

2.3 POLICY DIALOGUES

Policy dialogues are a knowledge sharing mechanism that convenes researchers, policy-makers and other stakeholders – typically in a meeting or workshop format – for facilitated discussions on a high-priority issue. Policy dialogues allow stakeholders to consider the best available research evidence alongside real-world factors, facilitating decision-making processes that are strongly evidence-informed (71). When local research evidence is not available, a policy dialogue is a good mechanism for utilizing local tacit knowledge.

2.3.1 Policy dialogues and evidence briefs

EVIPNet policy dialogues use evidence briefs as a pre-circulated input to ensure all dialogue participants have the same knowledge baseline (26). While the evidence brief presents the best available evidence, the dialogue takes into account context, experience, needs and politics. This kind of structured discussion can “help to clarify the problem and solutions and to develop a shared understanding among stakeholders; contribute to the development and implementation of effective policies; and contribute to good governance and democracy” (41). In addition to evidence briefs, other documents and information may be relevant and useful to the policy dialogue process.

2.3.2 Guidance for conducting policy dialogues

Table 2.3 lists the characteristics that differentiate a policy dialogue from a debate. The policy dialogue may also follow rules that create a safe space, such as the Chatham House Rules, where participants may speak confidentially, without fear of formal attribution (71).

As the activity is a dialogue and not a debate, the end goal is typically not to reach consensus for policy action (71). The policy dialogue is considered one input into the policy development process, and thus not an end-point for policy-makers (in some examples in Africa, however, dialogue participants decided to pursue consensus in order to have firm policy guidance). Policy-makers may require additional consultation with other stakeholders relating to institutional constraints and interest groups before finalizing a policy decision (101).

TABLE 2.3. DIFFERENCES BETWEEN DIALOGUE AND DEBATE

DIALOGUE	DEBATE
Collaborative	Oppositional
Common ground	Winning
Enlarges perspectives	Affirms perspectives
Searches for agreement	Searches for differences
Causes inuosppection	Causes critique
Looks for strengths	Looks for weaknesses
Re-evaluates assumptions	Defends assumptions
Listening for meaning	Listening for countering
Remains open-ended	Implies a conclusion

2.3.3 Policy dialogue participants

Policy dialogue participants are those involved in or likely to be affected by decisions on the issue at hand, including researchers, policy-makers and civil society groups. Stakeholder mapping exercises can help organizers determine the final composition of attendees. Organizers complete an inventory of relevant stakeholders with role categories (e.g. policy-makers, researchers, youth group, etc.). They then select participants based on their ability to (i) articulate the views and experiences of their affiliation, and effectively engage and learn from other participants; and (ii) support and advocate for the actions that will address the needs and perspectives of their affiliations (71).

2.3.4 Policy dialogue facilitators

A skilled and neutral facilitator is instrumental to ensuring inclusivity, fairness and the principles of the policy dialogue (71). The specific roles of a facilitator include:

- clarifying the goal, objectives and expectations of a dialogue;
- drawing out different opinions, values and beliefs, while maximizing the participants' contributions to the group in a fair, inclusive and respectful manner; and
- intervening and stewarding as necessary in order to keep the participants to the agenda and objectives.

Convening a policy dialogue is one of the core tasks of a knowledge broker, thus policy dialogue facilitators need to have similar attributes and qualifications, such as credibility and neutrality (see sections 1.4.1–1.4.3).

2.3.5 Post-dialogue events

Following the policy dialogue, a summary of its major points is disseminated to participants and to other concerned stakeholders, including the media. Video interviews of participants describing the insights from the policy dialogue and critical actions for addressing the issue can also be used to disseminate the results. When new evidence emerges about the priority issue, it should be shared to add momentum to proposed actions from the policy dialogue (71).

More information about how policy dialogues have been used in the policy-making process can be found in the case studies in section 4.

2.4 RAPID RESPONSE SERVICES

KEY MESSAGES

- A rapid response service starts with a request from a policy-maker about a specific, high-priority issue he/she is facing.
- It provides policy-makers with a user-friendly synthesis of the best available research evidence.
- It is tailored to the timelines of policy-makers, which range from days to weeks, rather than months to years.

Policy-makers often work within timelines of days and weeks, rather than months and years (102,103). When political factors come into alignment on a particular issue, a window to influence policy opens for a limited amount of time, and policy-makers must act quickly (86). For research evidence to become a timely input into the policy decision-making process, it must be readily available and accessible to policy-makers, sometimes in a matter of only hours (86).

Similarly to evidence briefs and policy dialogues, a rapid response service can provide high-quality research syntheses on a priority issue, but in a much shorter time. In a timeframe of hours to days to weeks, a team of researchers can provide policy-makers or other demanders with a synthesis of research evidence. This is in contrast to the months and years required for completing a systematic review or primary study, or to the months needed to systematically and transparently prepare an evidence brief and convene a policy dialogue (98,104). A rapid response service often specifies deliverables and timelines, although some services respond exactly as the requestor requires (104,105). For very short timelines (e.g. 1–2 days), a rapid response service may only provide a list of relevant references; for longer timelines (e.g. 1–3 weeks), such a service can generate a much more thorough synthesis of the key findings (104,105).

Aside from the quick turnaround, a rapid response has several key limitations when compared to an evidence brief. First, a rapid response is not necessarily oriented to a policy

decision, and often does not feature governance, delivery, financial and/or implementation considerations. Second, it does not go through the same deliberative steps to combine tacit and explicit knowledge – it is almost entirely a synthesis of explicit knowledge. Third, while a rapid response is peer-reviewed, it is not subject to revision and commentary through a policy dialogue process.

2.4.1 Steps in a rapid response

Once the rapid response team has refined the topic or problem, it searches of the scientific literature to locate key information sources, and contacts experts in the field for additional counsel (104,105). The team creates a synthesis of the key findings, which typically aims to concisely summarize the research evidence in a way policy-makers find useful (104,105).

BOX 2.2. PROBLEM CLARIFICATION

As shown in the Ugandan experience in piloting a rapid response service (see section 4.3), policy-makers have difficulty formulating their concerns into answerable research questions. A rapid response begins with a problem clarification process where the requestor and researcher discuss the specific policy issue and the kind of interventions that may be considered. Since staff workload varies with requests from policy-makers, organizations hosting a rapid response service often have difficulty balancing and prioritizing staff time. Organizations mitigate this challenge by diversifying the tasks for staff to work on.

On completion, the synthesis undergoes a formal peer-review or verification process. Some rapid response services utilize a panel of researchers and policy-makers, while others invite recognized experts to verify technical details. If the policy-maker or demander requires the synthesis before this peer-review or verification process is complete, a draft copy is provided and if discrepancies later arise, they are promptly notified.

2.4.2 Rapid response service pilot phases

The sustainability of the rapid response service model depends on the demand. In Canada, a rapid response team was progressively created within the Ontario HIV Treatment Network as the number of requests originating from partner organizations and agencies seeking timely access to research evidence increased. In other instances, pilot phases have been so successful that “once we turned on the tap, we could not turn it off” (Mijumbi R, REACH Uganda Rapid Response Service, personal communication, 2013). In this sense, the development and sustainability of a rapid response service is demand driven. In turn, the service helps deepen the culture of research evidence use. Without a rapid response service, many organizations and stakeholders would not use research evidence in their work since organizations rarely possess the capacity to synthesize research quickly.

Rapid response services have become successful in many countries. Several EVIPNet countries including Cameroon, Kenya, Uganda and Zambia, have launched such services with great success, while other countries are establishing their own services. More information on how rapid response services are being implemented can be found in the case study on Uganda in section 4.3.

2.5 CLEARINGHOUSES

KEY MESSAGES

- Clearinghouses are “one-stop shops” that include a comprehensive inventory of best available and pre-appraised research evidence for policy-makers and other stakeholders to quickly access in user-friendly formats.
- Documents are identified through a transparent and methodologically rigorous search strategy and then categorized with a topic-specific taxonomy.
- Clearinghouses are the most “self-serve” option for accessing research evidence (see Figure 2.1).

One challenge for the uptake of evidence is that research is not easy to use, and is rarely available when policy-makers need it and in a form that they can use (24,35,74). Clearinghouses allow lay audiences such as policy-makers and stakeholders to quickly access high-quality research evidence.

Clearinghouses are repositories of documents that act as a “one-stop shop” for users seeking research evidence, relevant to and packaged for policy-makers and other research-users (74,106). Documents included in clearinghouses are identified through a transparent and methodologically rigorous search strategy and appraisal. Table 2.4 lists examples of clearinghouses.

Through clearinghouses, users can be confident that the research evidence they access is up to date, relevant and rated for quality. Once identified for inclusion in a clearinghouse, the research evidence is categorized with a topic-specific taxonomy to allow for easy retrieval.

TABLE 2.4. EXISTING CLEARINGHOUSES FOR SYNTHESIZED EVIDENCE RELATED TO HEALTH

	SUBJECT(S) ADDRESSED	LINK
Cochrane Review	Programmes, services and drugs	http://www.cochrane.org/cochrane-reviews
Health Evidence	Public health interventions	http://www.healthevidence.org
Health Systems Evidence	Health systems governance, financial and delivery arrangements, and implementation strategies	http://www.healthsystemsevidence.org
EVIPNet	A resource that draws on many sources that address programmes, services and drugs, public health, and health systems, to support evidence-informed policy	http://global.evipnet.org/

2.5.1 Online clearinghouses

Clearinghouses are most often available online and are usually free of charge. Health Systems Evidence (see Table 2.4), for instance, provides links to free full-text articles whenever available, with a one-page summary of the content (74,107). Clearinghouses recognize that researchers need to stay up to date with evidence on specific topics. Thus, they provide a customizable evidence service, allowing users to identify areas of interest and receive periodic digest updates whenever relevant documents are added to the clearinghouse (74).

Clearinghouses enable users to rapidly identify key documents whenever and wherever they need them (108). Policy-makers can also be sure they are making their best effort to gather evidence given the time invested. Users, however, need skills in accessing the most appropriate databases and interpreting the evidence. In response, EVIPNet is developing capacity-building initiatives for policy-makers (109).

More information about how clearinghouses have been created and successfully implemented can be found in the case study on Uganda in section 4.3.

3. KNOWLEDGE TRANSLATION PLATFORMS

A knowledge translation platform (KTP) brings together the worlds of research and policy. KTPs are a core element of EVIPNet Europe as it launches and leads knowledge translation interventions. These platforms convene dialogues, synthesize explicit and tacit knowledge and lead networking. KTPs implement or delegate many key mechanisms including evidence brief and policy dialogue exercises, rapid response services, clearinghouses, and priority-setting exercises (see section 2).

Now established in over 40 countries around the world, KTPs undertake some or all of the following activities:

- organizing and facilitating joint meetings (e.g. priority-setting exercises, policy dialogues) among multiple actors to identify how research and policy processes might connect;
- inviting policy-makers to participate in research processes;
- compiling an inventory of local researchers, institutions, agencies and funders to describe the local evidence base, and illustrate who is doing and funding what;
- synthesizing and packaging research (e.g. preparing evidence briefs for policy);
- strengthening the capacity of researchers (e.g. in writing syntheses), research-users (e.g. helping the media to interact with research and researchers), and policy-makers (e.g. in research methodologies or in the role research might play in the policy process); and
- leading advocacy efforts to disseminate and support the use of research evidence, along with other core knowledge products.

This section will provide an overview of KTPs, including organizational structures, functions, guidelines for setting up a KTP and challenges that may be encountered when establishing one.

At the end of this section, readers should be able to describe:

- the different organizational forms a KTP might take (section 3.1)
- steps to consider in developing a KTP (section 3.2.1–3.2.2)
- challenges in establishing a KTP (section 3.2.3).

3.1 KTP FORM AND FUNCTION

KEY MESSAGES

- A knowledge translation platform (KTP) can take one of three established organizational forms.
- Fundamental to establishing a KTP is determining the values it will maintain.
- The EVIPNet action cycle represents a possible sequence of KTP activities.

Planning to create and launch a KTP should include consideration of possible organizational forms (including options for its location, funding, staffing and governance) as well as the functions or activities the KTP may carry out (see Box 3.1).

BOX 3.1. DESIGNING ORGANIZATIONAL MODELS TO SUPPORT KNOWLEDGE BROKERING IN EUROPEAN HEALTH SYSTEMS – THE BRIDGE PROJECT

If the goal of knowledge-brokering organizations [such as a KTP] is to serve as credible, competent and catalytic bridges between researchers and policy-makers, they need to organize themselves so as to:

- inform policy-making in an objective manner using the best health-systems information that can be prepared and packaged given time and resource constraints;
- inform the production, packaging and sharing of health-systems information in an objective manner and based on current and emerging policy-making priorities; and
- employ and continuously improve information-packaging and interactive knowledge-sharing mechanisms that are based on a solid understanding of all aspects of the national policy-making context, operate in an objective manner, and complement other national, European and global mechanisms.

Source: Lavis et al. (110)

3.1.1 Organizational form

There are six commonly established organizational forms for a KTP (110). Table 3.1 groups these forms into three distinct categories, with defining characteristics listed for each, along with a consideration of potential strengths and weaknesses.

In some instances, a KTP might initially operate best as a partnership of individuals in a ministry of health and a research institute. This kind of piloting can allow both parties to understand the potential value of a KTP before proceeding to the creation of a formalized organization.

Part of establishing a KTP is to demonstrate its values including credibility, innovation, continuous learning and networking. A KTP draws on innovative approaches to fairly balance explicit and tacit knowledge, arriving at policy options to support the decision-making process.

As KTPs are a new organizational form, it is key for them to document and communicate achievements and best practices, and share these with stakeholders and other KTPs.

3.1.2 KTP activities

Newly formed KTPs may initially embark on activities that are simple and have a great probability of success. They may engage in multiple activities to demonstrate their value to the target audience, and expand their work areas as the momentum builds. Table 3.2 outlines some of the possible activities and functions that could be adopted by a KTP as well as suggested resources.

3.1.3 The EVIPNet action cycle

An EVIPNet KTP often incorporates into the action cycle several of the functions detailed in section 3.1.2. The six steps of the EVIPNet action cycle are illustrated in Fig. 3.1., and described in more detail below.

TABLE 3.1. KTP ORGANIZATIONAL FORMS
KTP as a stand-alone, independent organization (e.g. forum, think tank)

General characteristics	Potential strengths	Potential weaknesses
<ul style="list-style-type: none"> • often located in civil society • has new, formal, physical office premises • requires dedicated funding • governed by a board of directors 	<ul style="list-style-type: none"> • can advocate for policy reform/adoption • can leverage its autonomy into neutrality/credibility in policy debates • potential to be a strong/neutral broker among key health system actors • freedom to hire most-capable staff 	<ul style="list-style-type: none"> • high start-up costs (e.g. in creating new office premises) • potential financial/institutional instability • potential conflict of interest via donor support • may, through its advocacy efforts, alienate political stakeholders

KTP hosted at another organization (e.g. at a policy-making entity, university, national research organization, parastatal organization, etc.)

General characteristics	Potential strengths	Potential weaknesses
<ul style="list-style-type: none"> • office premises at existing organization, to which it has formal ties (e.g. through a memorandum of understanding or partnership agreement) • governed by a supervising unit 	<ul style="list-style-type: none"> • can capitalize on existing organizational strengths, networks, employees, etc. • no need to create new operational systems (e.g. human resource, payroll etc.) • already part of an established actor, which may serve to attract highly qualified staff and provide a recognizable or esteemed brand identity etc. • connected to policy-making processes, giving its work a higher probability of influence • can quickly identify policy needs • can broker the development of research–policy partnerships 	<ul style="list-style-type: none"> • may have to align interests with existing organizational positions, bureaucracy or culture of host organization, which may negatively affect its abilities to advocate or broker • operations may be slowed or impeded by the organizational bureaucracy of the host organization • staff/finances may be drawn into other organization business

KTP as a network

General characteristics	Potential strengths	Potential weaknesses
<ul style="list-style-type: none"> • without office premises: could be a virtual organization • operates through key individuals and/or organizations • run via consultancy contracts, in-kind and volunteer contributions with staff widely dispersed 	<ul style="list-style-type: none"> • light organizational structure • can employ best-suited staff without regard for geography • few organizational constraints to advocacy • can swiftly broker among actors (e.g. no bureaucracy to navigate) 	<ul style="list-style-type: none"> • key individuals leading or working for network may only work on a time-limited basis • virtual operations: dependent on internet connection; may not be taken as seriously as a physical organization; may have credibility issues • may have financial constraints

Note. KTP = knowledge translation platform.

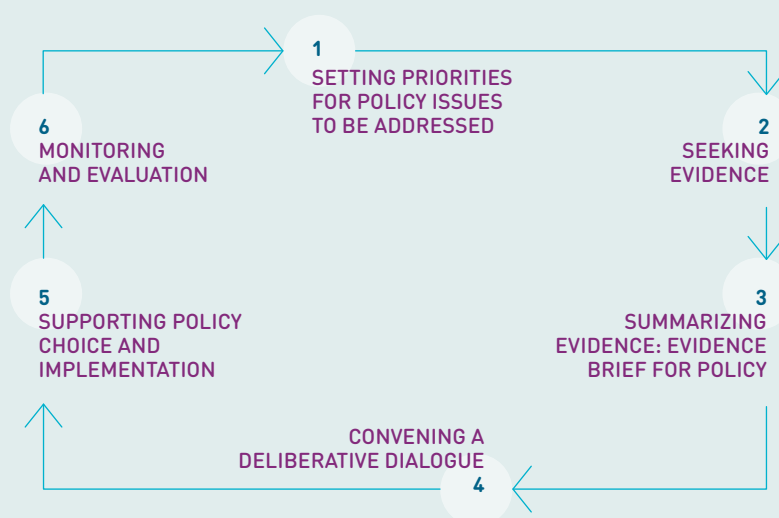
TABLE 3.2. OVERVIEW OF KTPS' KEY KNOWLEDGE TRANSLATION FUNCTIONS

KEY KNOWLEDGE TRANSLATION FUNCTIONS	DESCRIPTION OF HOW THE KTP MAY WISH PURSUE THE ACTIVITY OR FUNCTION	ILLUSTRATIVE EXAMPLES AND RESOURCES
Organization of a knowledge translation platform or team	Those interested in establishing a new KTP, or strengthening an existing one, may work through: <ul style="list-style-type: none"> • decisions about the optimal organizational model; and • determining how best to pursue individual and institutional capacity-building to support the full range of knowledge translation activities they wish to pursue. 	Lavis et al. (2013) (110) Uneke et al. (2015) (111)
Priority setting	As an initial step, the KTP may wish to convene one or more deliberative priority-setting exercises that could determine the most important areas and activities the KTP should work on or help determine various research agendas.	Section 2.1 Campbell (2012) (23) Campbell (2010) (89) El-Jardali et al. (2010) (90)
Evidence brief and policy dialogue	A newly formed KTP may wish to consider how to ensure the following key roles: <ul style="list-style-type: none"> • synthesizing and packaging research (when developing an evidence brief for policy); • creating linkages and exchange between research and policy; • facilitating meetings among multiple actors (e.g. priority setting or policy dialogue). 	Sections 2.2 and 2.3 Moat et al. (2014) (26) SURE Collaboration (2011) (41) Lavis et al. (2009) (71,98)
Clearinghouse	While several sources provide “one-stop shopping” for the best available global evidence (i.e. systematic reviews), in many countries, a single common resource (either physical or online) housing all local research evidence does not exist. As such, some KTPs have focused on developing clearinghouses featuring both primary local research evidence and synthesis work that often brings together the best available global evidence with local evidence.	Section 2.5 Uganda Clearinghouse for Health Policy and Systems Research (112)
Rapid response service	Rapid response services are one of the most common activities that KTPs pursue, although they often require significant investments of resources (both human and financial) and time to ensure that they can effectively respond to policy-makers’ requests. A KTP may perform or delegate this service.	Section 2.4 EVIPNet REACH (113) Mijumbi et al. (2014) (29)
Capacity-building	Many KTPs have focused on strengthening the capacity of core knowledge translation actors, including: <ul style="list-style-type: none"> • policy-makers – to improve their abilities to access, assess, adapt and apply research evidence; • researchers – to perform knowledge translation techniques or design knowledge translation strategies; • the media – to demand and use research evidence; and • civil society – to better contribute to the production and utilization of research evidence. 	Kasonde and Campbell (2012)(6)

KEY KNOWLEDGE TRANSLATION FUNCTIONS	DESCRIPTION OF HOW THE KTP MAY WISH PURSUE THE ACTIVITY OR FUNCTION	ILLUSTRATIVE EXAMPLES AND RESOURCES
Development of research-to-action groups (RAGs)	<p>RAGs are a decentralized, networked component of the KTP, focusing knowledge translation activities on a specific issue (e.g. mental health), on identified policy priorities, and/or in developing an evidence brief for policy.</p> <p>RAGs have a decentralized leadership (i.e. they are led by someone other than the KTP’s leader) and work to identify all the relevant stakeholders and dynamics within that issue. Critically, they serve to identify the individuals within the issue domain, be they policy-makers or researchers, with KTP leadership serving to mentor them as need be.</p> <p>RAGs may also lead evidence briefs, policy dialogues, training and the development of other RAGs, and identify young researchers for mentoring.</p>	Kasonde and Campbell (2012) (6)
Communications and advocacy	<p>Communications and advocacy are routine activities for KTPs. This can be as simple as issuing a press release to signify that a policy dialogue will be convened. A KTP should work to be visible and relevant; having strong communications and advocacy skills and good programming are a key part of this.</p> <p>A KTP typically advocates for a particular policy issue (as in the evidence brief/policy dialogue model), for behaviour change (e.g. through media dissemination of the implications of health research) and for a climate more favourable for knowledge translation. This includes advocating for increased funding for health research in general and for knowledge translation activities in particular.</p>	Campbell (2012) (23)

Note. KTP = knowledge translation platform.

FIG. 3.1. EVIPNET ACTION CYCLE



Step 1. Setting priorities for policy issues to be addressed: The KTP periodically organizes priority-setting processes to identify and frame public health policy and/or health system priority issues that they anticipate facing in the next 6–18 months and over longer time scales. These issues will be converted into topics for evidence briefs for policy, systematic reviews and/or new primary research.

Step 2. Seeking evidence: Once a health priority issue is identified, the KTP develops a searchable research question and a search strategy. Next, it finds, retrieves and maps relevant evidence, and appraises its quality. Finally, it examines the findings in terms of local applicability (assesses stakeholders' values and beliefs, power dynamics among actors, institutional constraints and donor funding flows) while taking related benefits, damage, costs and equity into consideration.

Step 3. Summarizing evidence: In this step, the KTP summarizes and packages the relevant information in a user-friendly format (e.g. an evidence brief) to frame the priority policy issue; outline the governance, delivery and financial considerations for viable policy options; and set out potential implementation issues.

Step 4. Convening a deliberative dialogue: A deliberative dialogue convenes key national stakeholders concerned with the priority policy issue addressed in the evidence brief to: discuss factors that influence decision-making about the issue; capture the tacit knowledge, views and experiences of stakeholders; and identify key next steps for different constituencies.

Step 5. Supporting policy choice and implementation: In this step, the KTP fosters the integration of the findings into policy formulation and the implementation of actions.

Step 6. Monitoring and evaluation (M&E): KTPs regularly monitor and evaluate their processes and results, and assess whether observed changes can be attributed to their interventions. The M&E findings should inform KTPs whether to continue, change or cancel activities.

It is worth noting that not all potential KTP activities are represented in the action cycle above. Only the three most innovative EVIPNet KTP activities – priority setting, evidence briefs and policy dialogue – are included. A KTP may opt to integrate any of the other knowledge translation mechanisms described in section 2.

3.2 KTP ESTABLISHMENT, OPERATIONALIZATION AND LAUNCH

This section outlines some of the key steps in establishing, operationalizing and launching a KTP, including the development of strategies, work plans and terms of references for KTP members. These steps are relevant to country teams who support EVIPNet activities prior to a formal launch of a KTP. A country team may comprise members of the WHO Country Office and key stakeholders from policy and research communities as well as civil society.

3.2.1 Steps in the KTP development process

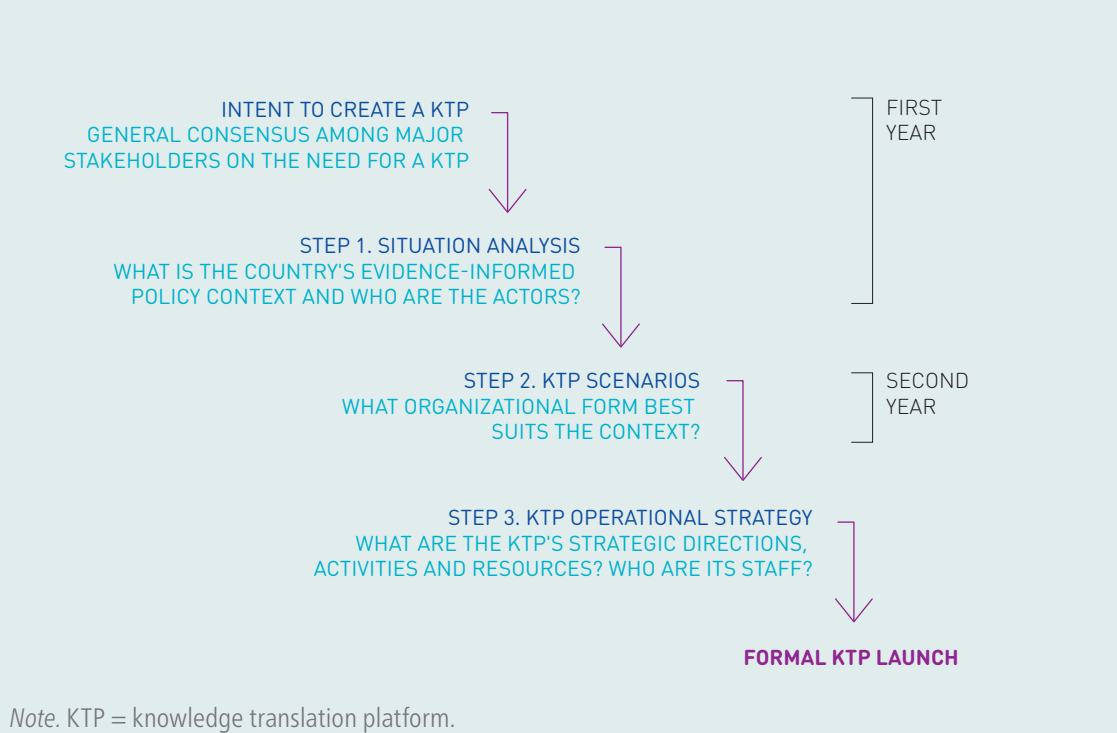
EVIPNet Europe assists country teams in selecting an optimal KTP form through direct technical support and a series of guidance documents that explain important steps in the

KEY MESSAGES

- A knowledge translation platform (KTP) is led by an individual or organizational champion ensuring that it fulfils its mission and mandate.
- A KTP must find “early wins” to immediately demonstrate its value.
- A KTP should regularly evaluate its activities along with its overall achievements to make the necessary adjustments, and to determine a second phase of activities.
- Engagement of multiple stakeholders is crucial in establishing and determining the programming for a KTP.

process. EVIPNet Europe suggests three broad steps for countries to complete in taking a KTP from idea to organization, as shown in Fig. 3.2.

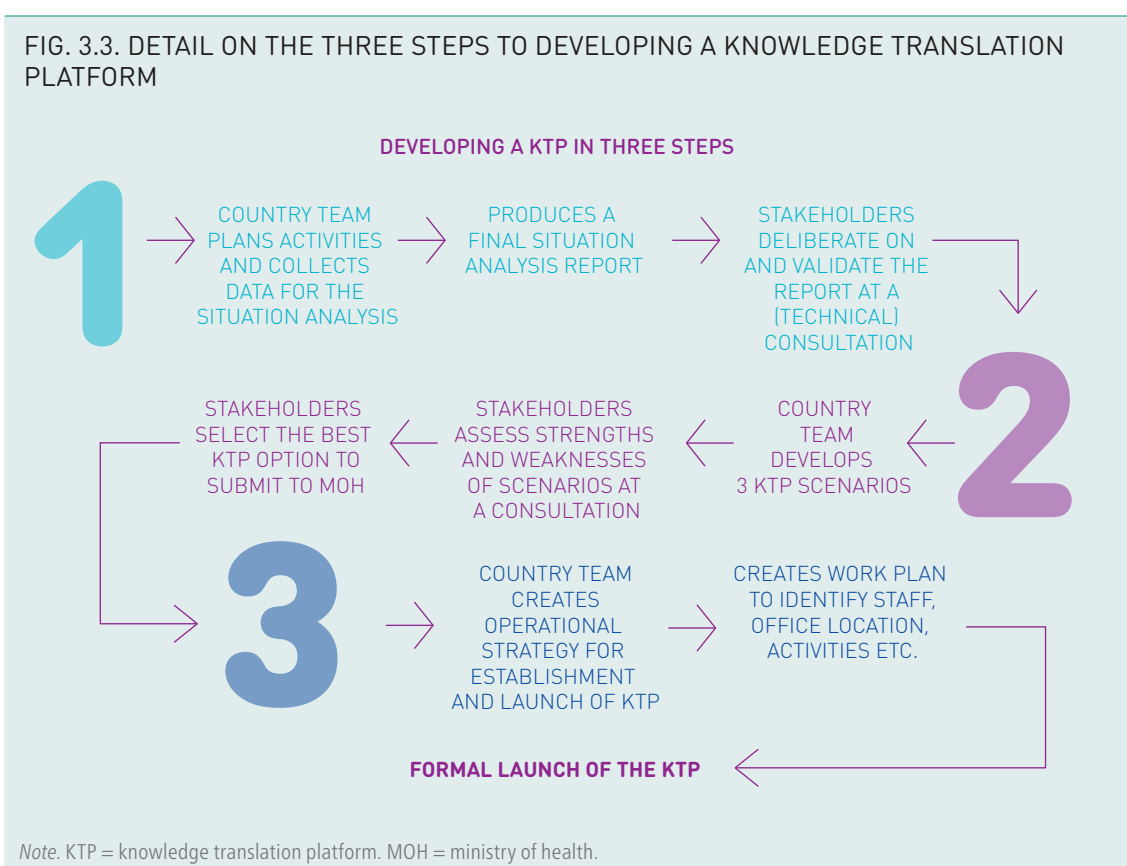
FIG. 3.2. THE THREE STEPS IN DEVELOPING A KNOWLEDGE TRANSLATION PLATFORM



These development steps are sequential and are illustrated in more detail in Fig. 3.3. In the first step, situation analysis, the country team collects information on existing barriers and opportunities to strengthen evidence-informed policy-making. This includes an assessment of the national context and the major political, public health, socioeconomic and cultural factors influencing evidence-informed policy-making. It looks at the health system and health research system – its structures, capacities, activities and actors related to evidence-informed policy-making – and reviews already existing policy processes in the country. This analysis provides essential background information required to inform decisions on the establishment and operationalization of a KTP. The *EVIPNet Europe situation analysis manual* (114) provides approaches and tools that country teams can apply in conducting this assessment.

In the second step, country teams use the findings to construct three distinct KTP scenarios. Each scenario explores an organizational model for a KTP, including establishment considerations, possible policy-making activities, the organizational model's strengths and weaknesses and resource considerations. Stakeholders then convene to deliberate and assess each scenario against a set of criteria. Enriched by the tacit knowledge of stakeholders, the scenarios are submitted to the ministry of health and other key national stakeholders for final decision-making. The first and the second steps may take anytime between six months to a year.

Once a decision has been made about the type of KTP to pursue, in the third and final step, the country team (or other designee) develops a formal strategy to operationalize the KTP, often through the creation of a strategic plan, business plan and/or operational plan. Steps 2 and 3 are estimated to take between three months and one year depending on local context.



In many cases, country teams will hire consultants to lead specific aspects of the process. It is essential to secure, at minimum, one national consultant for 60 days to implement steps 1 and 2, and 10 working days for step 3. The WHO Secretariat of EVIPNet Europe at the WHO Regional Office for Europe assists in the development of KTPs throughout the Region, with an initial focus on low- and middle-income countries.

The EVIPNet Europe guidance documents for country teams developing a KTP are available from the WHO website (<http://www.euro.who.int/en/data-and-evidence/evidence-informed-policy-making/evidence-informed-policy-network-evipnet>).

3.2.2 Challenges in KTP establishment

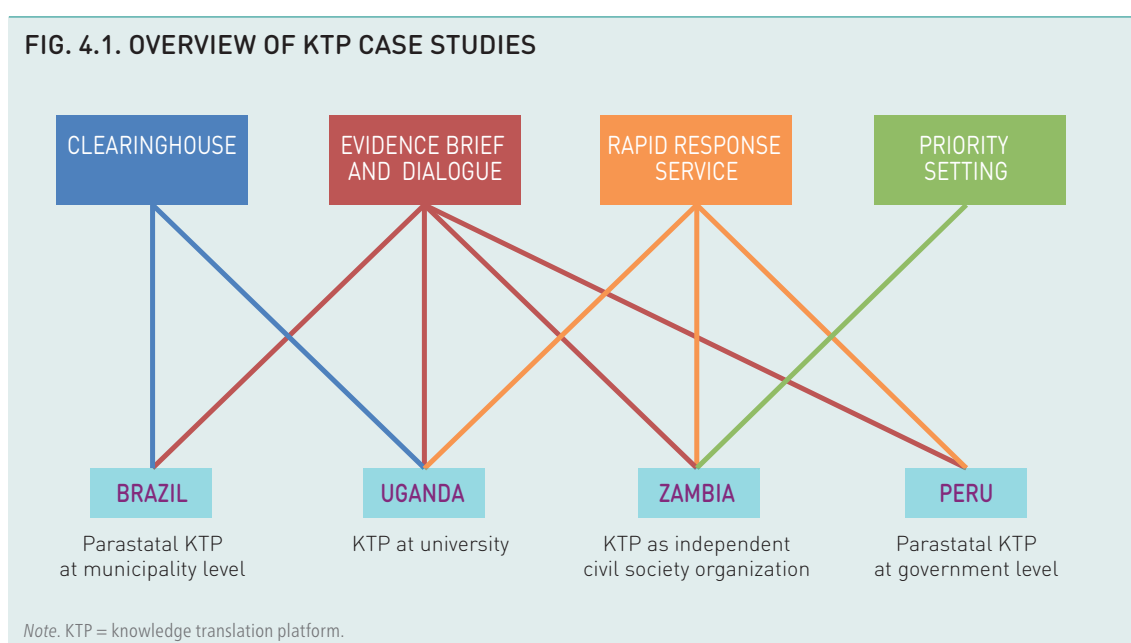
Country teams may encounter some challenges in establishing a KTP. For example, the purpose for establishing a KTP may not be clear; some may perceive it as a research organization, while others assume it is a policy organization. In most low- and middle-income countries, financial and human resources are limited, and thus existing organizations may perceive a KTP to be a competitor. Research institutions may see it as a threat to their funding sources, and as poaching their organizational expertise (e.g. by hiring their staff members). Policy institutions (e.g. a ministry of health) may see the knowledge translation processes pursued by the KTP as a threat to their domain (i.e. policy-making). As such they may elect not to participate in any of the KTP's programming, or may ignore the recommendations in, for instance, an evidence brief for policy.

Some ideas for navigating these challenges are set out below.

- In the establishment and planning phases, multistakeholder involvement is essential, ensuring that all are aware of the KTP, and are able to shape it such that it does not directly compete with existing organizations.
- If the KTP's governance structure includes a board of directors, it should involve key individuals from central organizations to ensure buy-in and to reduce real or perceived competition.
- A KTP must carefully consider the values it wishes to espouse. Credibility (e.g. neutrality and objectivity), transparency, accountability and learning – among others – are crucial to help navigate the challenges of being a new organization in an established hierarchy of organizations.
- Multistakeholder deliberation should be a routine feature of KTP operations. Where possible, KTP programming (e.g. strategy development, priority-setting exercises, situation analyses, evidence briefs and policy dialogues) should feature multidisciplinary, multistakeholder groups. This should “reduce individual bias, resolve institutional conflicts, draw upon much wider social networks, and orient the group beyond any particular sector or perspective” (23). Programmes should listen to or stimulate the participation of multiple actors and solicit a range of views before any decision or resolution is made.
- KTPs should use M&E to document these challenges, including the ways in which they were – or were not – surmounted. The KTP movement around the world is continually growing, and contributing to best practice through M&E measures is crucially important. More information on M&E of KTPs can be found in El-Jardali et al. (27), and on M&E relevant to specific knowledge translation interventions in Straus et al. (115).

4. KNOWLEDGE TRANSLATION PLATFORM CASE STUDIES

EVIPNet knowledge translation platforms (KTPs) have evolved differently throughout the world. This section describes case studies from four countries (Brazil, Peru, Uganda and Zambia) that have established KTPs. Various organizational structures were adopted depending on the specific country context (e.g. the social, political and economic circumstances) and opportunities (e.g. the available resources, capacities and events) (Fig. 4.1). These KTPs each employ a different set of knowledge translation mechanisms, ranging from evidence briefs for policy and policy dialogues to rapid response services, clearinghouses and priority-setting exercises.



At the end of section 4, readers should be able to describe:

- knowledge translation interventions in different national contexts, and how these contexts create unique opportunities for KTPs and EVIPNet;
- a variety of KTP organizational and partnership forms depending on the national context, including specific lessons around KTP creation; and
- the refinement and expansion of knowledge translation programming over time by KTPs.

4.1 EVIPNET REGIONAL NETWORKING

EVIPNet connects individuals and institutions dedicated to evidence-informed policy-making. It promotes networking to narrow the research and policy divide, with networks operating on three distinct levels. As a global network, it brings together like-minded experts and institutions from around the world in the EVIPNet Steering and Resource Group to design new approaches to knowledge translation, to determine best practice, and to offer

BOX 4.1. EVIPNET REGIONAL NETWORKS

EVIPNet operates through five different regional networks:

- **EVIPNet Africa:** This network was launched in 2006 and comprises 11 country teams: Burkina Faso, Cameroon, Central African Republic, Ethiopia, Kenya, Malawi, Mozambique, Nigeria, Sudan, Uganda and Zambia.
- **EVIPNet Asia (Western Pacific and South-East Asia):** This network was launched in 2005 and comprises networking among EVIPNet China (national), EVIPNet Shandong (subnational), EVIPNet Sichuan (subnational), EVIPNet Lao, EVIPNet Malaysia, EVIPNet Philippines and EVIPNet Viet Nam.
- **EVIPNet Americas:** Launched in 2007, this network comprises country teams from Brazil, Chile, Colombia, Costa Rica, Ecuador, USA-Mexico Border Office, Paraguay, Peru and Trinidad and Tobago – with several other teams currently being developed.
- **EVIPNet Europe:** Launched in 2012, the network currently comprises 19 member countries.
- **EVIPNet Eastern Mediterranean:** This network is still in the development phase, and includes 13 interested countries.

capacity-building and technical support. As a regional network, it brings together country teams from similar geographies, with networking often oriented to solving common yet complex problems. These country teams – which themselves are networks – represent the third and most active layer of EVIPNet. Country teams are typically knowledge translation platforms (KTPs) and are the fundamental unit of EVIPNet.

Regional networking is a central EVIPNet innovation. By connecting national KTPs at a regional level, each EVIPNet member country benefits in a number of ways.

- **Capacity development:** Capacity-building workshops on a variety of topics (e.g. evidence briefs for policy, policy dialogues, rapid response services) are held by the WHO regional offices or by a peer that has strength and experience in a particular knowledge translation innovation. For instance, a staff member of the EVIPNet KTP in Uganda trained network members from Burkina Faso, Cameroon and Zambia to build rapid response services.
- **Funding:** Rather than a single member country approaching global funders, forming a group of member countries with common funding needs may be effective. For example, the SURE project, which builds on and supports EVIPNet Africa and the REACH-Policy Initiative, receives significant funding from the European Commission, which is spread among EVIPNet country teams in Africa.
- **Methodology piloting and innovation:** Having a group of countries attempting similar innovations allows for greater piloting, validation and learning from success and failure.
- **Increased knowledge base:** A group of countries sharing common approaches leads to a robust knowledge base of experiences and lessons learned that each country can contribute to and draw upon. Country case studies also permit strong learning across contexts.
- **Influencing regional and global bodies:** A regional network creates a critical mass – a unified voice – that can be very influential within both regional and global bodies.

4.1.1 EVIPNet Africa

EVIPNet Africa has steadily evolved from its inception in 2006, and is the most developed of all the regional EVIPNet networks (see Fig. 4.2). As with any network, it has progressed through a series of “major moments”, and experienced alternating periods of innovation, consolidation and occasional stagnation. In early 2008 in Ethiopia, the network hosted the

first evidence-brief workshop, where all country teams discussed how to produce and evaluate evidence briefs, and then add context and nuance to these through policy dialogues. All teams worked on creating one evidence brief related to ways of supporting the widespread use of artemisinin-based combination therapies to treat uncomplicated falciparum malaria. This included supportive governance, finance and delivery arrangements within health systems, and implementation strategies. This work led directly to policy change in several of the member countries, while also contributing to the ongoing development of the evidence brief and policy dialogue as knowledge translation mechanisms to create policy change (116).

Another major moment for the network arose from the development of the rapid response service, initially in Uganda. This service has been in great demand in Uganda, and is the subject of much interest from other members of the network who want to establish their own. Through a Ugandan trainer, the network has directly contributed to establishing such services in Burkina Faso, Cameroon and Zambia.

All of this work has led directly to important grant synergies that have further deepened and strengthened the network. The European Commission-funded SURE project has provided sound support to the network in the creation of evidence briefs for policy, hosting of policy dialogues and preparation of rapid response services. A project funded by Canada's International Development Research Centre supported capacity-building fora, travel and exchange, and a "call for proposals" encouraging teams to develop innovative strategies for narrowing the evidence-policy divide.

Much of this work culminated in a 2012 conference in Ethiopia, bringing together network members from the country and the global level to share experiences. A preliminary day involved journalists and their many roles at the interface between research, policy and the general public, with the conference then moving into purely technical areas (e.g. costing policy options), pragmatic approaches (e.g. best practice in convening policy dialogues), training sessions, and exchange of lessons and experiences. This conference was a crowning moment for the network.

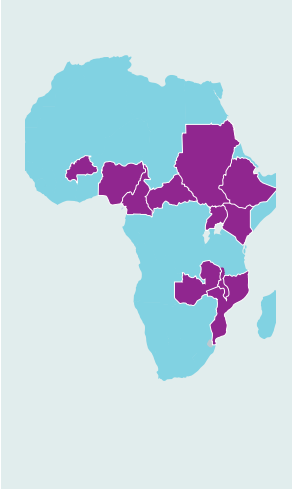
4.2 BRAZIL

KEY MESSAGES

- The Centre for Health Evidence (NEv Centre) in Piripiri municipality facilitates evidence-informed policy-making at the municipal level.
- The NEv Centre utilizes a working group of local health professionals, trained in using the SUPPORT tools for evidence-informed health systems policy-making to create evidence briefs and convene policy dialogues.
- The success of this initiative has led to the development of additional municipal knowledge translation platforms (KTPs) throughout Brazil.

In response to its large population and geographical size, EVIPNet Brazil forms unique relationships with municipalities to create local KTPs able to deliver knowledge translation

FIG. 4.2. EVIPNET AFRICA COUNTRIES (IN BURGUNDY)



interventions. In partnership with the Pan American Health Organization/BIREME, EVIPNet Brazil has supported the creation of the Virtual Health Library's Centres for Health Evidence (Núcleos de Evidências e Estações da Biblioteca Virtual de Saúde). These centres are tasked with building local capacities to incorporate scientific knowledge into the management of health systems and services. To date, four NEv centres have been implemented in different Brazilian municipalities: Piripiri, Sobral, Recife and Brasília.

4.2.1 The Centre for Health Evidence in Piripiri

In March 2010, the NEv Centre was established in Piripiri municipality (Fig. 4.3), to promote the use of research evidence at a policy level to address local health system problems (117). The NEv Centre is supported by EVIPNet at the country, regional and global levels, and within Brazil by BIREME, the federal government, and most importantly, the Municipal Health Council of Piripiri.

The NEv Centre was established in conjunction with EVIPNet's Virtual Health Library, a user-friendly clearinghouse that unites, organizes and offers integrated access to health information in English, Spanish and Portuguese (117). The NEv Centre contains computer workstations with internet access for not only the working group, but also patient group representatives, municipal council members and other health professionals. This is to encourage and facilitate the use of research evidence in the policy-making process (117).

4.2.2 NEv Centre activities

At the NEv Centre, knowledge translation activities are driven by a working group comprising local health professionals (medical doctors, nurses) trained in the use of the SUPPORT tools methodology (99). While no researchers were in this working group, its primary advantage lies in developing local resources and capacity that will be retained in the long term. The working group is also cost-efficient, an important consideration for any resource-constrained health system. Importantly, local health professionals are highly familiar with the health issues of their region, which allows the working group to quickly and dynamically immerse themselves into essential knowledge translation activities. The working group generates evidence briefs for policy and has convened policy dialogues to inform the planning and creation of health programmes.

Writing evidence briefs has been the NEv Centre's central activity so far – largely in response to requests from policy-makers in local government. The first evidence brief exercise focused on the priority issue of reducing the incidence of cardiovascular-related diseases, which accounted for almost half of Piripiri's deaths over the previous five years (117). After a policy dialogue, the process concluded with the implementation of a "gym in the square" programme in Piripiri's College Square. This programme provides the opportunity for aerobic physical activity for residents as an effective intervention to reduce the prevalence of hypertension, while also promoting community involvement and improving individual prognoses (117). Since then, additional evidence brief and policy dialogue exercises have focused on policies to attract and retain human resources in primary care, and the control of dengue fever in urban areas.

FIG. 4.3. LOCATION OF PIRIPIRI MUNICIPALITY WITHIN PIAUÍ STATE, BRAZIL



4.2.3 NEv Centre and policy-making

The NEv Centre is an example of how scientific evidence can be integrated into the policy-making process at the municipal level, where often minimal investments for evidence to inform policy-making can yield significant outcomes (117). Furthermore, the EVIPNet Brazil country team found that training local health professionals to form the NEv Centre's working group reduced costs, built capacity within the local health system and catered to the interests of local professionals. Based on the success of the Piripiri experience, additional EVIPNet teams are being formed in a further six municipalities across Brazil.

4.3 UGANDA

KEY MESSAGES

- Uganda's EVIPNet knowledge translation platform (KTP), called REACH Uganda, is located at Makerere University.
- REACH Uganda partners with EVIPNet to deliver high-quality knowledge translation interventions to facilitate evidence-informed health systems policy-making.
- The rapid response service is REACH Uganda's most popular service, helping policy-makers clarify and refine their policy issue, while providing timely access to user-friendly research evidence for their health system policy-making needs.

The EVIPNet collaborating platform in Uganda is part of the Ugandan National Health Research Organization and is formally housed at Makerere University in Kampala. It was originally established as the Regional East African Community Health (REACH) Policy Initiative in 2005, at the headquarters of the East African Community in Arusha, Tanzania. The project moved to Uganda in 2008 to take advantage of an offer by the university to help staff and operationalize the project. As the country's largest educational institution, Makerere made the ideal location for a KTP, allowing the country team to work more closely with researchers, policy-makers and stakeholders (5).

From the outset, REACH Uganda has been at the global forefront of developing, testing and implementing knowledge translation mechanisms and methodologies. This includes work on an online clearinghouse, various evidence briefs and policy dialogues, and EVIPNet's first rapid response service for evidence-informed health systems policy-making.

4.3.1 REACH Uganda's rapid response service

The rapid response service began as a six-month pilot with modest expectations. However, ongoing collaboration between REACH Uganda, EVIPNet and the SURE project allowed the pilot to spearhead the idea with receptive policy-makers. Since then, the pilot has extended for an additional two years, arguably becoming their most successful programme to date.

The rapid response service's success arises from how it responds to the needs of the requestor, – providing Ugandan policy-makers with syntheses of requested research evidence anywhere between several days and several weeks (29,113). Since policy-makers are often unclear in their needs, the rapid response team works through a problem clarification process with the requestor to refine the problem into a tangible policy issue

and/or question. Then the team conducts comprehensive literature searches, with all relevant evidence then synthesized into a user-friendly summary. As of September 2012, the rapid response team had conducted 67 rapid response syntheses for policy-makers within and beyond Uganda's borders – part of a larger culture shift valuing how evidence can inform policy-making (29) (see Box 4.2 for an example of two very successful responses).

BOX 4.2. REACH UGANDA RAPID RESPONSES

Is mandatory food fortification an efficient strategy for the alleviation of micronutrient deficiency? (118)

Answer: Yes. Food fortification is "effective, cost effective, has the potential to achieve high coverage and has been tested in many rigorous research studies".

How can the sustainability of a public health (food fortification) programme be ensured? (119)

Answer: "Sustainability starts with the beginning of program development and as such, should not be conceived as a final phase of development...."



The success of REACH Uganda's rapid response service has attracted the attention of other KTPs seeking to develop a similar service through active mentorship from Ugandan staff. As a result, REACH Uganda has trained KTP staff throughout the African region (notably in Burkina Faso and Zambia) and worldwide (in Canada).

4.3.2 REACH Uganda's evidence brief and policy dialogue exercises

To date, REACH Uganda has produced four evidence briefs for policy and held seven policy dialogues, spanning topics from increasing access to skilled attendance at delivery to palliative care in Uganda (112). The evidence briefs have been widely disseminated while policy dialogues have involved parliamentarians, policy-makers, researchers, civil society and the media.

4.3.3 REACH Uganda's clearinghouse

To improve the long-term accessibility of research evidence, REACH Uganda developed an online clearinghouse specific to the needs of health systems policy-makers in Uganda (112). The Uganda Clearinghouse for Health Policy and Systems Research includes a collaborative space for researchers and policy-makers, a repository of all REACH policy publication products, and links to sources of global evidence for policy-making. The clearinghouse can be accessed at: www.uchpsr.org (112).

4.4 PERU

Peru's EVIPNet-supported KTP sits in the Unidad de Análisis y Generación de Evidencias en Salud Pública (UNAGESP), a unit dedicated to evidence generation and analysis for public health. The unit is part of the technical arm of the National Institute of Health, which is located outside of the Ministry of Health in order to protect against sudden political shifts that might affect the KTP's stability and operations (120).

KEY MESSAGES

- UNAGESP, a unit within the National Institute of Health, is EVIPNet’s collaborating knowledge translation platform (KTP) in Peru.
- Experiences from evidence briefs for policy and policy dialogues influence future activity implementation.
- UNAGESP plans to contribute to the development of a national health research system, facilitating linkages between researchers and policy-makers.
- The composition of participants in a policy dialogue clearly influences the type of discussions.

From its establishment in 2009, UNAGESP has relied on EVIPNet mechanisms and methodology to create:

1. systematic reviews focusing on priority topics as designated by policy-makers
2. rapid response services meeting policy-maker demands
3. economic evaluations of interventions for the Ministry of Health
4. evidence briefs for policy and policy dialogues.

4.4.1 Evidence briefs and policy dialogues

The Peruvian team has had a variety of valuable experiences with two evidence brief and policy dialogue exercises. Each exercise took a different approach, generating lessons learned that will influence how they implement future briefs and dialogues.

The first brief and dialogue exercise focused on which health system policy options could be used to reduce the numbers of patients abandoning anti-tuberculosis treatments (121). This was a priority issue identified by policy-makers, and as such was the driving force for the project. The Peruvian team was supported technically through a training workshop led by EVIPNet Americas for the development and planning of the evidence brief and policy dialogue. After the EVIPNet team completed the brief, a policy dialogue was convened to allow the research evidence to be considered alongside the views, beliefs and tacit knowledge of those likely to be affected by a decision. Participants from diverse backgrounds came to the dialogue, including policy-makers, researchers, patient group representatives and other stakeholders. Though the discussions went smoothly, an abrupt change in government months later affected the prospects of possible policy changes stemming from this dialogue process.

The second brief and dialogue exercise focused on the use of multinutrient supplements to treat anaemia in children. This researcher-driven initiative stemmed from a WHO guideline, which served as the evidence base for the brief and dialogue. Similarly, a policy dialogue was convened, but the invited participants were largely policy-makers. This composition of participants led to a focus on implementation strategies informed by the local evidence, in contrast to the more theoretical discussions (e.g. quality of evidence) of the earlier dialogue. A key lesson learned was that the composition of participants clearly influences the type of discussions. A balance of different participant types is essential to ensure that the necessary theoretical and practical elements (e.g. local evidence) are sufficiently considered.

FIG. 4.5. PERU’S LOCATION IN SOUTH AMERICA



The Peruvian team is planning to expand their evidence-informed health policy-making activities. By 2016, they will contribute to the implementation of a national health research system. This governance and linkage system will engage researchers with public health priorities – as identified by policy-makers – and likewise encourage policy-makers to include research evidence in their policy-making processes.

4.5 ZAMBIA

KEY MESSAGES

- The Zambia Forum for Health Research (ZAMFOHR) was one of the world's first knowledge translation platforms (KTPs), a civil society organization led by a senior knowledge broker and governed by a multistakeholder board of directors.
- ZAMFOHR has launched and fine-tuned many knowledge translation innovations, including databasing, evidence briefs for policy and policy dialogues, capacity-building, and a rapid response service.
- One of ZAMFOHR's core innovations was the creation of research-to-action groups (RAGs) that galvanize multistakeholder communities on specific issues.

As in most countries in sub-Saharan Africa, the research and policy communities in Zambia have historically been very separate. To address this separation, in 2005, one of the world's first KTPs, ZAMFOHR, was born. The KTP moved from idea to civil society organization through a planning process that lasted over a year. During this time, a senior knowledge broker – with support from an international funder – conducted various situation analysis exercises to document and understand the prevailing situation between the research and policy communities. Two strategic planning retreats were held over the planning process, involving a number of actors from across the spectrum, including researchers, policy-makers from the Ministry of Health, the media, the University of Zambia and civil society. These retreats created ZAMFOHR's first strategic plan, and set the stage for ZAMFOHR to become a fully staffed organization.

4.5.1 ZAMFOHR's knowledge translation programming

Since 2006, ZAMFOHR has launched many different knowledge translation activities. These include: capacity development workshops on systematic reviews, evidence retrieval, and evidence briefs and policy dialogues; creating a (virtual and physical) national database of local evidence; leading evidence brief and policy dialogue processes on mental health (122) and reproductive health (123); and creating a rapid response service – with essential technical assistance from REACH Uganda.

The establishment of RAGs; a multidisciplinary, multisectoral board of directors; and international partnerships have played an important role in the Zambian experience.

FIG. 4.6. ZAMBIA'S LOCATION IN AFRICA



4.5.2 Research-to-action groups

RAGs focus on knowledge translation activities on specific issues including mental health, reproductive health and human resources for health. These RAGs are led by someone other than ZAMFOHR's Executive Director under a decentralized leadership, and identify relevant stakeholders and dynamics within that issue (6). Importantly, RAGs take ownership of their particular issue, and have wide knowledge of the stakeholders and attendant power dynamics. This leads to a depth of approach that a national KTP on its own may not be able to achieve.

4.5.3 Board of directors

It was critical for ZAMFOHR to establish a Board of Directors that was multidisciplinary, intersectoral and representative of both the research and policy communities. The establishment of such a board was a critical early achievement of ZAMFOHR and led directly to buy-in among the community. "Convincing local, national and even global stakeholders of ZAMFOHR's function and utility is a phenomenon common to any new institution, but particularly acute when the field (KT) [knowledge translation] is itself relatively new and largely misunderstood."(6)

4.5.4 International partnerships

Another aspect central to ZAMFOHR's success has been its international partnerships. Membership of EVIPNet Africa has brought ZAMFOHR a number of benefits. It has shared the innovations and experience of like-minded KTPs in other African countries, received funds from global agencies, and had international technical support to help develop and implement knowledge translation mechanisms. This demonstrates the high value of regional networking.

5. RESOURCES

5.1 ANNOTATED LIST OF KNOWLEDGE TRANSLATION RESOURCES

Despite the relative youth of the knowledge translation field, many excellent resources are available to assist individuals and knowledge translation platforms (KTPs) in expanding their work. This section features a short descriptive analysis of some of these knowledge translation resources, including peer-reviewed papers, e-books and videos. Resources are divided into four sections:

- practical guides for knowledge translation practitioners
- knowledge translation frameworks and theory
- empirical papers
- videos.

5.1.1 Practical guides for knowledge translation practitioners

SUPPORT tools for evidence-informed health policy-making (STP)

SUPPORT tools are the most comprehensive set of tools for knowledge translation thus far. They are peer-reviewed papers offering strong insights into a range of different knowledge translation innovations. Each of these 18 articles provides a straightforward description and analysis of a particular tool, and presents a wealth of resources for the reader.

1. What is evidence-informed policy-making?
2. Improving how your organisation supports the use of research evidence to inform policy-making
3. Setting priorities for supporting evidence-informed policy-making
4. Using research evidence to clarify a problem
5. Using research evidence to frame options to address a problem
6. Using research evidence to address how an option will be implemented
7. Finding systematic reviews
8. Deciding how much confidence to place in a systematic review
9. Assessing the applicability of the findings of a systematic review
10. Taking equity into consideration when assessing the findings of a systematic review
11. Finding and using evidence about local conditions
12. Finding and using research evidence about resource use and costs
13. Preparing and using policy briefs to support evidence-informed policy-making
14. Organising and using policy dialogues to support evidence-informed policy-making
15. Engaging the public in evidence-informed policy-making
16. Using research evidence in balancing the pros and cons of policies
17. Dealing with insufficient research evidence
18. Planning monitoring and evaluation of policies

Oxman A, Hanney S, editors. SUPPORT Tools for evidence-informed health Policy-making (STP). Special supplement of Health Research Policy and Systems. 2009;7(1). (<http://www.health-policy-systems.com/supplements/7/s1>, accessed 20 November 2015).

World report on knowledge for better health

This is the seminal global report on knowledge translation that got the ball rolling on an international scale in terms of emphasizing the need for knowledge translation processes for supporting evidence-informed policy and systems in low- and middle-income countries.

World report on knowledge for better health. Geneva: World Health Organization; 2004. (<http://www.who.int/rpc/meetings/pub1/en/>, accessed 20 November 2015).

Priority setting for health policy and systems research

This is a helpful overview and guide for those interested in research priority-setting processes.

Priority setting for health policy and systems research. Briefing note 3. Geneva: Alliance for Health Policy and Systems Research; 2009. (http://www.who.int/alliance-hpsr/resources/AllianceHPSR_Brief_Note3_ENG.pdf, accessed 20 November 2015).

The knowledge translation toolkit: bridging the know-do gap: a resource for researchers

An important tool for researchers who want a comprehensive assessment of the range of activities they can undertake to get their research into policy and practice.

Bennett G, Jessani N. The Knowledge Translation Toolkit: bridging the know-do gap: a resource for researchers. Ottawa: International Development Research Centre; 2011. (<http://www.idrc.ca/EN/Resources/Publications/Pages/IDRCBookDetails.aspx?PublicationID=851>, accessed 20 November 2015).

Using linkage and exchange to move research into policy at a Canadian foundation

This is a seminal article that clearly makes the case for greater interactions between researchers and policy-makers as a way to support the uptake of research evidence into policy-making processes. This underpins the entire idea of convening policy dialogues.

Lomas J. Using linkage and exchange to move research into policy at a Canadian foundation. *Health Affairs*. 2000;19(3):236–40 (http://www.sandy-campbell.com/sc/Knowledge_Translation_files/using%20linkage%20and%20exchange.pdf, accessed 20 November 2015).

The SURE guides for preparing and using evidence-based policy briefs

Based on the SUPPORT tools, these guides provide concrete guidance to individuals and teams going through an evidence brief and policy dialogue process. These guides have been extensively tested and refined by the KTPs that comprise EVIPNet Africa. As of 2011, there are 8 individual guides:

- Getting started with the SURE guides
- Prioritizing topics for policy briefs
- Clarifying the problem
- Deciding on and describing policy options
- Identifying and addressing barriers to implementing policy options

- Clarifying uncertainties and needs for monitoring and evaluation
- Organizing and running policy dialogues
- Informing and engaging stakeholders

The SURE guides for preparing and using evidence-based policy briefs. Version 2.1 [updated November 2011]. The SURE Collaboration; 2011 (<http://global.evipnet.org/SURE-Guides/>, accessed 11 August 2014).

The knowledge translation curriculum

This comprehensive teaching guide touches on many of the core knowledge translation competencies, mixing discussions of knowledge translation theory with its application (primarily in a low- and middle-income country context). Three modules cover knowledge translation, situation analysis and priority setting. Each module is divided into lessons, and each lesson contains links to peer-reviewed papers and other web resources.

Campbell S. The Knowledge Translation Curriculum. Ottawa: The Canadian Coalition for Global Health Research; 2012 (<http://www.ccgdr.ca/resources/knowledge-translation/>, accessed 20 November 2015).

5.1.2 Knowledge translation frameworks and theory

Pathways to evidence-informed policy and practice: a framework for action

This article features some strong analysis of the central problem knowledge translation seeks to address.

Bowen S, Zwi AB. Pathways to evidence-informed policy and practice: a framework for action. *PLoS Medicine*. 2005;2(7) (<http://www.plosmedicine.org/article/fetchObject.action?uri=info%3Adoi%2F10.1371%2Fjournal.pmed.0020166&representation=PDF>, accessed 20 November 2015).

Guide to knowledge translation planning at CIHR: integrated and end-of-grant approaches

This guide explores the differences between end-of-grant knowledge translation (essentially dissemination of findings) and integrated knowledge translation (a partnership approach that encourages the participation of policy-makers).

Guide to knowledge translation planning at CIHR: integrated and end-of-grant approaches. Ottawa: Canadian Institutes of Health Research; 2012 (http://www.cihr-irsc.gc.ca/e/documents/kt_lm_ktplan-en.pdf, accessed 20 November 2015).

Knowledge exchange processes in organizations and policy arenas: a narrative systematic review of the literature

This outstanding, extensive piece examines knowledge and knowledge translation processes from an organizational perspective.

Contandriopoulos D, Lemire M, Denis JL, Tremblay E. Knowledge exchange processes in organizations and policy arenas: a narrative systematic review of the literature. *The Milbank Quarterly*. 2010;88(4):444–83 (http://www.milbank.org/uploads/documents/featured-articles/pdf/Milbank_Quarterly_Vol-88_No-4_2010.pdf, accessed 20 November 2015).

Lost in knowledge translation: time for a map?

This paper has a good overview of the various attempts to define knowledge translation and to develop knowledge translation frameworks.

Graham I, Logan J, Harrison MB, Straus SE, Tetroe J, Caswell W et al. Lost in knowledge translation: time for a map? *The Journal of Continuing Education in the Health Professions*. 2006;26:13–24 (<http://onlinelibrary.wiley.com/doi/10.1002/chp.47/pdf>, accessed 20 November 2015).

Assessing country-level efforts to link research to action

Very useful for those planning KTPs, this piece provides a framework for the ways in which knowledge translation interventions and approaches might work at the national level.

Lavis JN, Lomas J, Hamid M, Sewankambo NK. Assessing country-level efforts to link research to action. *Bulletin of the World Health Organization*. 2006;84:620–28 (<http://www.who.int/bulletin/volumes/84/8/06-030312.pdf?ua=1>, accessed 20 November 2015).

Conceptualizing and combining evidence for health system guidance

This paper was one of the first to look at the many different types of evidence that may be required for any policy discussion.

Lomas J, Culyer T, McCutcheon C, McAuley L, Law S. Conceptualizing and combining evidence for health system guidance. Final report. Ottawa: Canadian Health Services Research Foundation; 2005 (http://www.cfhi-fcass.ca/migrated/pdf/insightAction/evidence_e.pdf, accessed 20 November 2015).

Do we really understand tacit knowledge?

This author is a leading thinker in promoting the value and role of tacit knowledge in arriving at a comprehensive picture – be it in policy or in everyday life.

Tsoukas H. Do we really understand tacit knowledge? In: Easterby-Smith M, Lyles MA, editors. *The Blackwell handbook of organizational learning and knowledge management*. Oxford: Blackwell Publishing; 2005.

Knowledge for theory and practice

This highly regarded piece advances the idea of engaged scholarship (which complements knowledge translation very effectively) while also exploring some of the dynamics within the term “knowledge”.

Van de Ven AH, Johnson PE. Knowledge for theory and practice. *Academy of Management Review*. 2006;31(4):802–21 ([http://www.sandy-campbell.com/sc/KTC_Module_1_files/2.1a](http://www.sandy-campbell.com/sc/KTC_Module_1_files/2.1a%20Van%20de%20Ven%20and%20Johnson%202006.pdf) Van de Ven and Johnson 2006.pdf, accessed 20 November 2015).

5.1.3 Empirical papers

Researchers and policymakers: travelers in parallel universes

This paper provides an excellent analysis of the divisions and gaps between research and policy communities, and is an oft-cited resource.

Brownson RC, Royer C, Ewing R, McBride TD. Researchers and policymakers: travelers in parallel universes. *American Journal of Preventive Medicine*. 2006;30(2):164–72 (http://www.sandy-campbell.com/sc/KTC_Module_1_files/1.1a%20Brownson%20et%20al%202006.pdf, accessed 23 November 2015).

A randomized controlled trial evaluating the impact of knowledge translation and exchange strategies

While the field of knowledge translation science – studying what knowledge translation interventions work, for whom and under what circumstances – is growing, little to date has been published. This however, is one of a very few randomized control trials on the subject.

Dobbins M, Hanna SE, Ciliska D, Manske S, Cameron R, Mercer SL et al. A randomized controlled trial evaluating the impact of knowledge translation and exchange strategies. *Implementation Science*. 2009;4(61) (<http://www.implementationscience.com/content/pdf/1748-5908-4-61.pdf>, accessed 23 November 2015).

Health policy-makers perceptions of their use of evidence: a systematic review

This piece was one of the first to examine the barriers and facilitators in evidence-informed policy, with its observations remaining relevant to this day.

Innvaer S, Vist G, Trommald M, Oxman A. Health policy-makers perceptions of their use of evidence: a systematic review. *Journal of Health Services Research & Policy*. 2002;7(4):239–44 ([http://www.sandy-campbell.com/sc/KTC_Module_1_files/KTC Module 1 - 3.1d - Innvaer et al 2002.pdf](http://www.sandy-campbell.com/sc/KTC_Module_1_files/KTC%20Module%201%20-%204.1b%20-%20Jackson%20et%20al%202002.pdf), accessed 23 November 2015).

Focus on knowledge brokering

This piece (not from a peer-reviewed journal) provides a good overview of the field of knowledge brokering.

Jackson-Bowers E, Kalucy I, McIntyre E. Focus on knowledge brokering. Adelaide: Primary Health Care Research & Information Service; 2006. (http://www.sandy-campbell.com/sc/KTC_Module_1_files/KTC%20Module%201%20-%204.1b%20-%20Jackson%20et%20al%202006.pdf, accessed 23 November 2015).

Developing good taste in evidence: facilitators of and hindrances to evidence-informed health policy-making in state government

Like Innvaer et al. (2002), this piece has a strong overview of the barriers and facilitators to evidence-informed policy-making. While its data is from the United States of America, it is of great relevance for other contexts.

Jewell CJ, Bero LA. Developing good taste in evidence: facilitators of and hindrances to evidence-informed health policy-making in state government. *The Milbank Quarterly*. 2008;86(2):177–208 (http://www.milbank.org/uploads/documents/featured-articles/pdf/Milbank_Quarterly_Vol-86_No-2_2008.pdf, accessed 23 November 2015).

Creating a knowledge translation platform: nine lessons from the Zambia Forum for Health Research

This is one of the few peer-reviewed articles analysing one country's experience in creating a national-level KTP in civil society. Its nine lessons have high value for those planning a KTP in any context.

Kasonde J, Campbell S. Creating a knowledge translation platform: nine Lessons from the Zambia Forum for Health Research. *Health Research Policy and Systems*. 2012;10(31) (<http://www.health-policy-systems.com/content/pdf/1478-4505-10-31.pdf>, accessed 23 November 2015).

- **Towards systematic reviews that inform health care management and policy-making**
- **Working within and beyond the Cochrane Collaboration to make systematic reviews more useful to healthcare managers and policy-makers**
- **How can we support the use of systematic reviews in policymaking?**

This trio of papers looks at the role systematic reviews might play in policy-making, particularly at how this core knowledge translation resource can become better adapted to policy-making realities and needs.

Lavis JN, Davies H, Oxman A, Denis J, Golden-Biddle K, Ferlie E. Towards systematic reviews that inform health care management and policy-making. *Journal of Health Services Research and Policy*. 2005;10(1):35–48 (http://hsr.sagepub.com/content/10/suppl_1/35.full.pdf+html, accessed 23 November 2015).

Lavis JN, Davies H, Gruen RL, Walshe K, Farquhar CM. Working within and beyond the Cochrane Collaboration to make systematic reviews more useful to healthcare managers and policy-makers. *Healthcare Policy*. 2006;1(2) (<http://www.ncbi.nlm.nih.gov/pmc/articles/PMC2585325/pdf/policy-01-21.pdf>, accessed 23 November 2015).

Lavis JN. How can we support the use of systematic reviews in policymaking? *PLoS Medicine*. 2009;6(11) (<http://www.plosmedicine.org/article/info%3Adoi%2F10.1371%2Fjournal.pmed.1000141>, accessed 23 November 2015).

Evidence-informed health policy: 1. Synthesis of findings from a multi-method study of organizations that support the use of research evidence

This piece looks at some of the commonalities among organizations in terms of how and under what conditions they demand or use research evidence.

Lavis J, Oxman AD, Moyihan R, Paulsen EJ. Evidence-informed health policy: 1. Synthesis of findings from a multi-method study of organizations that support the use of research evidence. *Implementation Science*. 2008;3(53) (<http://www.implementationscience.com/content/pdf/1748-5908-3-53.pdf>, accessed 23 November 2015).

Improving research dissemination and uptake in the health sector: beyond the sound of one hand clapping

This paper is close to 20 years old but has some essential observations about the different types of knowledge. It discusses some of the misperceptions policy-makers have about research, and that researchers have about policy-makers. Note that this is a shortened version of the original piece.

Lomas J. Improving research dissemination and uptake in the health sector: beyond the sound of one hand clapping. Policy Commentary C97-1. Hamilton: McMaster University, Centre for Health Economics and Policy Analysis; 1997 (http://www.cfhi-fcass.ca/migrated/pdf/mythbusters/handclapping_e.pdf, accessed 23 November 2015).

Evidence summaries tailored to health policy-makers in low- and middle-income countries

This piece is self-explanatory, and worth a look to understand the ways in which knowledge translation practitioners have reached policy-makers.

Rosenbaum SE, Glenton C, Wiysonge CS, Abalos E, Mignini L, Young T et al. Evidence summaries tailored to health policy-makers in low- and middle-income countries. *Bulletin of the World Health Organization*. 2011;89(1):54–61 (<http://www.who.int/bulletin/volumes/89/1/10-075481.pdf>, accessed 23 November 2015).

5.1.4 Video resources

A number of videos featuring members of EVIPNet Africa can be found at: <http://vimeo.com/43001338>. They speak about networking in knowledge translation, the rapid response service, EVIPNet generally and EVIPNet Africa in particular.

An overview of a policy dialogue process in Cameroon can be found at: <http://vimeo.com/38883972>.

5.2 GLOSSARY OF KNOWLEDGE TRANSLATION TERMS

Below are some of the key terms used in this document.

TERM	DEFINITION(S)
actors (also called stakeholders)	Actors or stakeholders refer to individuals, groups, organizations and/or networks that have a stake or vested interests in a specific issue. Their roles, rights and/or ownership related to an issue are critical in the implementation and success of any policy or policy change (23). In the context of EVIPNet, actors or stakeholders refer to, but are not limited to, policy-makers, researchers, civil society and funders who share the goal of improving health system performance and health outcomes through evidence-informed policy-making. (See Introduction)
best available evidence	This refers to a synthesis of high-quality evidence from global databases (e.g. systematic reviews), which is combined with local evidence to design context-specific solutions (99,124). It can also be complimented with tacit knowledge, especially when explicit knowledge from local contexts is of poor quality or is not available (125). (See section 1.2.2)
clearinghouses	Clearinghouses are continuously updated repositories of documents, serving as a “one-stop shop” for users seeking reliable and relevant research evidence on a given topic. They typically contain systematic reviews that are high quality and optimally packaged for policy-makers and other stakeholders, and may also house other types of documents relevant to the subject area (74,106). (See section 2.5)
colloquial evidence	See “tacit knowledge”
context-free evidence	Context-free and context-sensitive evidence are types of explicit knowledge. Context-free evidence is from systematic and methodologically rigorous clinical research (126) such as medical effectiveness or biomedical research (43,127). (See section 1.2.1)
context-sensitive evidence	Context-sensitive evidence is a type of explicit knowledge that is context-based and operational or relevant to a particular setting (43,126,127). (See section 1.2.1)
data	Data are all the given facts of a study or work, in qualitative or quantitative form, before they are arranged, sorted and summarized. In public health, data usually refers to statistical data (usually numerical), routine data, survey data or data collected through observations in the form of monitoring and evaluation activities to be used for communication and interpretation (40,128,129).
evidence	Evidence refers to “findings from research and other knowledge that may serve as a useful basis for decision-making in public health and health care” (130). Evidence is a combination of explicit and tacit knowledge (42,43). The term “evidence” is often used synonymously with “knowledge”. (See section 1.2.1)
evidence brief for policy	Evidence briefs for policy – also known as policy briefs – provide direct support to policy-making by packaging the research evidence in a way that it is accessible, relevant, easy to use and applicable at the local level (98). They start with the priority policy issue (not the research evidence). Thereafter, they use the best available evidence to clarify the problem and its causes, and identify and frame policy options to address the problem (26). They often feature issues related to governance, financing and delivery, along with important implementation considerations. (See section 2.2)

TERM	DEFINITION(S)
evidence-informed health policy-making	Evidence-informed health policy-making is an approach to policy decisions that aims to ensure that decision-making is well-informed by the best available research evidence. It is characterised by the systematic and transparent access to, and appraisal of, evidence as an input into the policy-making process (14,131).
evidence synthesis	An evidence synthesis is a core mechanism of knowledge translation and refers to a process of summarizing information from a wide range of research findings in a rigorous, systematic and transparent manner to repackage a large body of evidence (66,132). Evidence synthesis products include systematic reviews, summaries of systematic reviews and evidence briefs for policy. This term is used interchangeably with "knowledge synthesis".
exchange effort	This is one of the four models of knowledge translation and refers to the interactions, partnerships and joint actions between researchers, policy-makers and other stakeholders to increase shared understanding and ownership of the use of research in decision-making. Exchange efforts might include undertaking collaborative research projects and convening policy dialogues (13,66). (See section 1.1.4)
explicit knowledge	This refers to structured, verifiable and replicable evidence. Explicit knowledge can be categorized in two ways. One is to describe it as either context-free or context-sensitive evidence (38,43). Another way is to rank explicit knowledge according to the scientific rigor or data collection methodology and strength of evidence, which can be displayed as a hierarchy of evidence from strongest to weakest (42,47). (See section 1.2)
health information	"Information is facts that have been arranged and/or transformed to provide the basis for interpretation and conversion into knowledge."(133). Health information is "generated by both population-based (e.g. surveys, censuses and civil registration) and institution-based (e.g. service records, individual records) data sources" providing support to decision-making at all levels of the health system (39). Health information includes "descriptions of health status and mortality of populations over time, analysis of causation of health problems, quantification of associations between health outcomes and risk or protective factors, and assessment of the effectiveness of public health interventions"(134). "The activities necessary to obtain health information and bring this information into the health policy-making process can be described as public health monitoring and reporting"(2) . (See section 1.2.1)
integrated effort	This effort brings together push, user-pull and exchange efforts (see definitions in this glossary) for knowledge translation (13,135). An example is a knowledge translation platform. (See section 1.1.4)
knowledge	Knowledge refers to a combination of values, experiences, expert insights and contextual information, as well as research findings (115,136). It includes both explicit and tacit knowledge and may serve as an aid for decision-making (137–139). Explicit knowledge refers to structured, verifiable and replicable evidence. Explicit knowledge can be categorized in two ways. One is to describe it as either context-free or context-sensitive evidence (38,43). Another way is to rank explicit knowledge according to the scientific rigor or data collection methodology and strength of evidence, which can be displayed as a hierarchy of evidence from strongest to weakest (42,47). Tacit knowledge refers to knowledge comprised of expertise, opinions, tradition and belief that compliment explicit knowledge. It is particularly critical where the evidence is inconclusive, lacking or non-existent (42,47).

TERM	DEFINITION(S)
knowledge broker	This is often a senior, well-connected and respected individual or an organization whose core function is to connect people to exchange knowledge (23). A broker brings stakeholders together, builds relationships, cements coalitions and alliances, and helps to build new skills and capacities (75). (See section 1.4)
knowledge brokering	This refers to activities that facilitate the transfer of knowledge between stakeholders, including policy-makers, researchers and civil society (66). The goal of knowledge brokering is to build and maintain partnerships or networks for knowledge translation and promote mutual understanding about each other's roles and cultures (140). (See section 1.4)
knowledge synthesis	See "evidence synthesis"
knowledge translation	This refers to "the exchange, synthesis, and effective communication of reliable and relevant research results. The focus is on promoting interaction among the producers and users of research, removing the barriers to research use, and tailoring information to different target audiences so that effective interventions are used more widely"(4,141). (See section 1.1)
knowledge translation platform (KTP)	A KTP promotes and creates an environment that supports both research use in policy-making and policy needs in research design (6). It may be a formal organization, department or network, focusing on bringing actors together, synthesizing explicit and tacit knowledge, and leading networking in knowledge translation (110). A KTP leads the development of evidence briefs and policy dialogue exercises, offers rapid response services, conducts priority-setting exercises and performs clearinghouse functions. (See section 3)
policy brief policy dialogue	See "evidence briefs for policy" These dialogues allow the best available research evidence to be considered among the real-world factors influencing the policy-making process (71). They are informed by an evidence brief for policy, which is subsequently considered alongside tacit knowledge of local health policy-makers and stakeholders to inform future policy decisions (26). (See section 2.3)
priority setting	Priority setting is a knowledge translation mechanism used in shaping a policy and/or research agenda. It is a transparent and explicit process for guiding decisions on how resources should be used among competing issues and agenda items (142). Priority setting brings together stakeholders including policy-makers, researchers and civil society (143), and is led by a KTP in the context of EVIPNet. (See section 2.1)
push effort	A push effort describes the tailoring and targeting of key messages from research evidence to make it more accessible and easier to use for policy-makers (13,115) (14,117). (See section 1.1.4)
rapid response service	A rapid response service responds to a question or issue arising from a policy-maker, producing a synthesis of research evidence on a timescale of hours to days to weeks (49,104). (See section 2.4)

TERM	DEFINITION(S)
research	<p>A systematic investigation, inquiry or examination which aims to generate and contribute to new scientific knowledge through discovering and interpreting health-related phenomena and observable facts or testing hypotheses (4,143).</p> <p>Public health research, in particular, refers to health research at population and organisational level using statistical, social and behavioural science methods". Public health research "includes both research aimed directly at prevention of disease (and promotion of health) and also research on systems and services for health and healthcare" (143).</p>
research use	<p>Research evidence can be used in an instrumental, conceptual, symbolic or strategic way (49–52) these opportunities include developing actionable messages for decision-makers (only 30 percent of research organizations frequently or always do this). (See section 1.2.3)</p>
situation analysis	<p>EVIPNet Europe conducts situation analysis as the first step towards establishing a KTP at a national level. It facilitates understanding of the national context, the health system and health research system and any existing evidence-informed policy-making processes. It provides information on opportunities and barriers in organizing and establishing a KTP (7). (See section 3.2)</p>
tacit knowledge	<p>This refers to knowledge comprised of expertise, opinions, tradition and belief that compliment explicit knowledge. It is particularly critical where the evidence is inconclusive, lacking or non-existent (42,47).</p> <p>Tacit knowledge is also referred to as "colloquial evidence" (43). (See section 1.2)</p>
user-pull effort	<p>This effort is made by users of research or policy-makers who demand research evidence from the research community. It can take the form of one-stop shops, which provide access to high-quality and relevant research evidence (13,115). (See section 1.1.4)</p>

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