



The Health Policy Maker's Manual: Integrating Data and Evidence



المجلس الطبي السعودي
Saudi Health Council



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REIMBURSABLE ADVISORY SERVICES: TECHNICAL ASSISTANCE ON HEALTH POLICY

The Health Policy Maker's Manual: Integrating Data and Evidence

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CONTENTS

ACKNOWLEDGMENTS	ix
ABBREVIATIONS	xi
GLOSSARY	xiii
MISSION AND VISION OF THE SAUDI HEALTH COUNCIL	xvii
EXECUTIVE SUMMARY	xix
CHAPTER 1: PROMOTING EVIDENCE-INFORMED HEALTH POLICY MAKING	1
Introduction: About this Manual	1
Audience	1
Purpose and Scope	1
What the Manual Includes	2
Chapters	3
The Role of Evidence in Health Policy Making	6
Knowledge Translation	7
Proposed Knowledge Translation Strategy for the Saudi Health Council	10
Institutional Capacity for Promoting the Use of Evidence in Health Policy: Assessment Tool	14
References	15
CHAPTER 2: METHODS USED FOR PRIORITY SETTING IN POLICY DEVELOPMENT	17
Introduction	17
Priority Setting for Supporting the Policy-Making Process	17
Informal Priority-Setting Methods to Set the Research Agenda	18
Formal Priority-Setting Exercise	20
Annex 2A: Template for Priority Setting	39
References	45
CHAPTER 3: LITERATURE SEARCH FOR RELEVANT EVIDENCE	47
Introduction	47
Determining What Type of Evidence to Search for	48
Determining Where to Search for Relevant Evidence	49
Developing a Search Strategy	51
Screening Evidence	54

Ensuring a Critical Appraisal of Evidence	54
Synthesizing the Evidence	56
References	57
CHAPTER 4: PRACTICAL APPLICATIONS: USING RESEARCH EVIDENCE TO FRAME PROBLEMS, POLICY OPTIONS, AND IMPLEMENTATION CONSIDERATIONS	59
Introduction	59
Practical Application 1: How to Frame the Problem	59
Practical Application 2: How to Frame Policy Options to Address a Problem	65
Practical Application 3: How to Identify Implementation Considerations for an Option	76
Annex 4A: Template for Problem Framing	82
References	84
CHAPTER 5: DEVELOPING AND LEVERAGING KNOWLEDGE TRANSLATION TOOLS	87
Introduction	87
Overview of Knowledge Translation Tools	87
Policy Briefs	90
Merit Review	97
Policy Brief Evaluation Questionnaire	98
Annex 5A: Template for Policy Brief Outline	99
Annex 5B: Tracking Sheet for Key Informant Interviews	102
Annex 5C: Merit Review Guidelines for Brief	103
Annex 5D: Policy Brief Evaluation Questionnaire	106
Annex 5E: Policy Brief Template	109
Annex 5F: Summary of Relevant Systematic Reviews	118
References	119
CHAPTER 6: ESTABLISHING RAPID RESPONSE SERVICES	121
Introduction	121
Rapid Response Services	121
Preparatory Phase	122
Production Phase	125
Annex 6A: Question Clarification Form	132
Annex 6B: Rapid Response Templates	134
Annex 6C: Examples of 10- and 30-Day Rapid Response Products	144
Annex 6D: Internal Checklist for Rapid Response Products	145
Annex 6E: Merit Review Form	146
Annex 6F: Evaluation of Rapid Response Service Form	148
References	151

CHAPTER 7: CONVENING AND FACILITATING DELIBERATIVE DIALOGUES	153
Introduction	153
Case Scenario: The Policy Dialogue	153
Timing of a Policy Dialogue	155
Planning and Conducting a Policy Dialogue	155
Pre-Dialogue Phase	156
Policy Dialogue Phase	164
Post-Dialogue Phase	166
Alternative Dissemination Methods	168
Annex 7A: Template for Dialogue Summary Report	174
Annex 7B: Worksheet for Planning a Policy Dialogue	175
Annex 7C: Policy Dialogue Evaluation Questionnaire	178
References	180
CHAPTER 8: MONITORING AND EVALUATION	183
Introduction	183
Case Scenarios: Monitoring and Evaluation	183
Policy Tracing	185
Monitoring and Evaluation of KT Platforms	186
Indicators for the Monitoring and Evaluation of KT Platforms	187
Data Collection for Indicators	191
Annex 8A: KT Monitoring and Evaluation Tool	193
References	202
CHAPTER 9: THE POLITICAL ECONOMY OF HEALTH	203
Introduction	203
What Is the Political Economy of Health?	203
Rationale for Political Economy Awareness	204
The Significance of Political Economy Analysis in Shaping Health Policy	205
Examining the Political Economy of Health: Insights from Regional Case Studies	209
Examining the Political Economy of Health: Insights from Global Case Studies	213
Conclusions	220
References	220
Additional Readings on the Political Economy of Health	222
BOXES	
Box 1.1: Other Factors Influencing Health Policy Making	7
Box 1.2: Single Studies and Local Data Alone Insufficient to Inform Policy Decisions	12
Box 1.3: Rationale for the Proposed Saudi Health Council Knowledge Translation Platform	13

Box 2.1: Goals and Timing of a Prioritization Process	18
Box 2.2: Managing Priorities	19
Box 2.3: Example of a Priority-Setting Approach for Direct Requests Received from Policy Makers	19
Box 2.4: Checklist for Stakeholder Selection	27
Box 3.1: Developing a Search Strategy: Example 1	52
Box 3.2: Developing a Search Strategy: Example 2	53
Box 3.3: Gray Literature	54
Box 3.4: Example of AMSTAR Quality Scoring	55
Box 3.5: Guiding Questions for Assessing the Local Applicability of Systematic Reviews	55
Box 3.6: Tool for Assessing the Quality of Local Evidence	56
Box 4.1: Example of Problem Statement: Physical Inactivity in KSA	60
Box 4.2: Possible Underlying Factors of the Problem	63
Box 4.3: Sources of Evidence	65
Box 4.4a: Example 1 on Proposing Policy Options	66
Box 4.4b: Example 2 on Proposing Policy Elements	66
Box 4.5: Tips for How to Synthesize the Findings Section for Each Policy Option Format	73
Box 4.6: Unified Purchasing Policy for Purchasing Hospital Services from the Private Sector in KSA	75
Box 4.7: Tips for How to Write the Implementation Considerations	80
Box 5.1: Guide for Communicating and Presenting Evidence to Policy Makers	90
Box 5.2: WHO EVIPNET Policy Briefs	90
Box 5.3: Content of Policy Briefs	91
Box 5.4: Guiding Questions for Mapping	93
Box 5.5: Essential Questions to Ask during Key Informant Interviews	95
Box 5.6a: Sample Invitation Letter to Key Informant Interview Participants	95
Box 5.6b: Subject: Follow-Up: Key Informant Interview Invitation	96
Box 5.7: Response to Invitation Letter for Key Informant Interviews	96
Box 6.1: Preliminary Scope and Focus	124
Box 6.2: Template for a Detailed Description of Each Included Systematic Review	128
Box 6.3: Template for the Stratification of Findings across Systematic Reviews by Interventions or Outcomes	129
Box 7.1: Impact of Policy Dialogues	154
Box 7.2: Questions to Consider While Planning and Conducting Policy Dialogues	156
Box 7.3: Sample Dialogue Invitation Letter	158
Box 7.4: Checklist for Dialogues	166
Box 7.5: Sample Post-Dialogue Evaluation Survey	167

Box 7.6: Case Example of Mini-Dialogues: Addressing the Alarming Increase in Drug Use in Lebanon	168
Box 7.7: Pointers for a One-on-One Meeting	169
Box 7.8: Example Activity Sheet	173
Box 8.1: Description of Policy Tracing Technique	185
Box 9.1: The Political Economy of Health Defined	204
Box 9.2: Brazil's Tobacco Control Policy	206
Box 9.3: India's National Health Insurance Scheme	207
Box 9.4: South Africa's HIV/AIDS Policy	208

FIGURES

Figure 1.1: Development of the Manual	2
Figure 1.2: Stages of the Policy-Making Process	8
Figure 1.3: Role of Evidence	11
Figure 2.1: Phases of a Formal Priority-Setting Exercise	20
Figure 2.2: Methods of Data Collection	21
Figure 2.3: Sample Report Elements for the Prioritization Process	32
Figure 2.4: Groups of Stakeholders Participating in Dissemination	33
Figure 2.5: Items to be Considered as Part of the Revision Process	34
Figure 3.1: The Evidence Hierarchy Pyramid	49
Figure 3.2: Example of the Boolean Operators	51
Figure 5.1: Knowledge Translation Efforts	88
Figure 7.1: Pre-Dialogue Steps	157
Figure 7.2: Example Seating Plan	160
Figure 7.3: Power Analysis Matrix	163
Figure 7.4: Planning Process for Citizen Consultations	171
Figure 8.1: Monitoring and Evaluation: Purpose and Examples	184
Figure 8.2: Example of Process Indicators and Short-, Medium-, and Long-Term Outcome Indicators	187
Figure 8.3: Example of Data Collection Methods for Different Indicators	191
Figure 9.1 Supportive Role of Applied Political Economy Analysis in Policy Processes	206
Figure 9.2 Mechanisms for Learning	219

TABLES

Table 1.1: Manual Chapters and Tools	3
Table 1.2: Evidence Needed for Policy Making	7
Table 1.3: Summary of Knowledge Translation Activities, Outputs, and Impacts	9

Table 1.4: Proposed Activities and Outputs of the Saudi Health Council Knowledge Translation Platform	13
Table 1.5: Institutional Culture, Supports, and Tools	14
Table 2.1: Example of Initial List of Topics	22
Table 2.2: Stakeholder Mapping Form	24
Table 2.3: Summary of Common Research Priority-Setting Methods	28
Table 2.4: Prioritization Criteria	30
Table 2.5 Criteria for Selecting Priority Topics for KT Products	31
Table 2.6: Process Indicators and Their Data Sources	36
Table 2.7: Outcome Indicators and Their Data Sources	37
Table 3.1: Key Databases to Search for Systematic Reviews	49
Table 4.1: Key Questions for Detailed Problem Description	61
Table 4.2: Underlying Factors for Example 1 of the Problem Description	63
Table 4.3: Underlying Factors for Example 2 of the Problem Description	64
Table 4.4: Template for Expanding on Each Policy Option	68
Table 4.5: Types of Questions and Research Evidence to Expand on Policy Options	69
Table 4.6: Appropriate Databases of Research Evidence	69
Table 4.7: Expanding the Policy Option for Antimicrobial Resistance in Hungary	70
Table 4.8: Expanding the Policy Element for Physical Inactivity in KSA	71
Table 4.9: Weighing Desirable and Undesirable Consequences	74
Table 4.10: Barriers and Counterstrategies to Policy Implementation	77
Table 4.11: Example of Implementation Considerations from Hungary	78
Table 4.12: Example of Implementation Considerations from KSA	79
Table 5.1: Example of a Work Plan	92
Table 6.1: Overview of Infrastructural, Technical, and Skills Mix Requirements	123
Table 6.2: Timeframe for Rapid Response Products	125
Table 6.3: Question Type	126
Table 6.4: Content of a Rapid Response Product	129
Table 7.1: Differences between Dialogue and Debate	155
Table 7.2: Stakeholder Mapping Sheet	162
Table 7.3: Challenges and Solutions	165
Table 7.4: Example of Citizen Consultation Agenda	171
Table 8.1: Monitoring and Evaluation: Complementary Elements	184



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The SHC and the WB do not guarantee the accuracy of the data included in this work. The findings, interpretations, and conclusions expressed in this work are those of the authors, and do not necessarily reflect the views of The Saudi Health Council or the World Bank, their Boards of Directors, or the governments they represent.



ABBREVIATIONS

AIDS	acquired immunodeficiency syndrome
AMR	antimicrobial resistance
AMSTAR	A MeaSurement Tool to Assess systematic Reviews
ART	antiretroviral therapy
ASP	antimicrobial stewardship program
BMI	body mass index
EVIPNet	Evidence-Informed Policy Network
GCC	Gulf Cooperation Council
GDNHEP	General Directorate of National Health and Economic Policy (KSA)
HALE	health-adjusted life expectancy
HEP	Health Extension Program (Ethiopia)
HIV	human immunodeficiency virus
HNP	Health, Nutrition, and Population (Global Practice of the World Bank)
HSE	Health Systems Evidence
K2P Center	Knowledge to Policy Center
KSA	Kingdom of Saudi Arabia
KT	knowledge translation
MENA	Middle East and North Africa
MET-h	metabolic equivalent of task hours
NCDs	noncommunicable diseases
NGO	nongovernmental organization
ORACLe	Organizational Research Access, Culture and Leadership
PEA	political economy analysis
PPP	public-private partnership
RAS	Reimbursable Advisory Services

RCTs	randomized control trials
SDGs	Sustainable Development Goals
SHC	Saudi Health Council
STP	SUPPORT Tools for evidence-informed health Policymaking
UHC	universal health coverage
UHI Law	Universal Health Insurance Law (Egypt)
WB	World Bank
WHO	World Health Organization

Note: All dollar amounts are US dollars unless otherwise indicated.



GLOSSARY

AMSTAR (A Measurement Tool to Assess systematic Reviews) is a measurement tool that was developed to assess the methodological quality of systematic reviews.

Antimicrobial resistance (AMR) refers to the development of the ability of disease-causing microorganisms or bacteria to survive exposure to antibiotics that previously provided an effective treatment. This occurs because the bacteria undergo mutation or gene transfer as a result of inappropriate or indiscriminate overuse of antibiotics.

Antimicrobial stewardship programs are hospital programs designed to combat the rise of antimicrobial resistance and help clinicians improve clinical outcomes and minimize harms by improving antibiotic prescribing practices.

Body mass index (BMI) is a measure for indicating nutritional status in adults. It is derived from a person's weight in kilograms divided by the square of the person's height in meters (kg/m^2). The recommended levels are adapted from the global WHO recommendation of 18.5–24.9 as a normal BMI.

The Chatham House Rule refers to an agreement to use the information received during meetings freely, but without revealing the identity or the affiliation of the speaker(s), or that of any other participant. This rule ensures meeting confidentiality and, as such, facilitates the free speech in important meetings.

The Delphi technique (sometimes called the *Delphi method*) is a structured technique of communication that relies on a panel of experts. Based on the principle that forecasts from a structured group of individuals are more accurate than those from unstructured groups, the technique is one where experts respond to questionnaires in rounds. After each round, a facilitator provides an anonymous summary of the responses, along with the reasons for those responses. The experts can revise their earlier responses in light of the anonymous summary; eventually the answers will converge toward a “correct” answer. The process ends after a predetermined criterion (such as number of rounds, stability of results, consensus). This technique is used in many health-related fields.

Evidence-Informed Policy Network (EVIPNet) is a World Health Organization initiative that provides “a global network for evidence-informed health policy making [that] supports countries in leveraging the best available, actionable evidence to deliver high-quality and effective healthcare policies and sustainably strengthen national health systems” (see WHO <https://www.who.int/initiatives/evidence-informed-policy-network>).

Gray literature consists of information that is produced outside of traditional publishing and distribution channels. It includes reports, working papers, newsletters, government documents, urban plans, and so on. It usually does not go through a peer review process.

Health-adjusted life expectancy (HALE) is the average number of years that a person is expected to live in “full health” by taking into account years lived in less than full health due to disease and/or injury. It differs from life expectancy, which includes the number of years a person is expected to live with disability. HALE is based on specific population groups, not individuals.

Health Systems Evidence (HSE) is a free, continuously updated repository of syntheses of research evidence about governance, financial arrangements, and delivery arrangements within health systems. It also includes information about implementation strategies that can support change in health systems.

Knowledge translation (KT) the science and practice of strengthening the research-policy interface. The Canadian Institutes of Health Research defined KT as a dynamic and iterative process that includes synthesis, dissemination, exchange, and ethically sound application of knowledge to improve health, provide more effective health services and products, and strengthen the health care system. Put another way, it is the exchange, synthesis, and effective communication of reliable and relevant research results. According to the WHO, It focuses on promoting interaction among the producers and users of research, removing the barriers to research use, and tailoring information to different target audiences to expand the use of effective policies and interventions. Four efforts that link research to policy or action are user-push, user-pull, exchange methods, and integrated models.

A Likert scale is a rating system that is used to rate opinions, attitudes, or behaviors. It consists of a statement or a question followed by a series of possible answer statements. Respondents choose the option that best corresponds to how they feel about the statement or question. The use of Likert scales is common in survey research as well as in fields such as marketing, psychology, or other social sciences.

The nominal group technique (NGT) is a structured method for group brainstorming to generate ideas on a particular subject. Team members are asked to write down as many ideas as possible, then select the one they feel is best. Each member is asked to share one idea per round, which is recorded. After all ideas are recorded, they are discussed and prioritized by the group, using a point system. NGT combines the importance ratings of individual group members into the final weighted priorities of the group.

Noncommunicable diseases (NCDs) are also known as *chronic diseases*. They tend to be of long duration and are the result of a combination of genetic, physiological, environmental, and behavioral factors.

ORACLE (Organizational Research Access, Culture and Leadership) is a comprehensive system to measure and score organizational capacity to engage with and use research in policy making. It uses a structured interview with organization leaders. It is comprised of 23 questions inviting respondents to describe whether, and to what degree, a range of supports are in place within their organizations to facilitate research use. Responses to each question are later scored on a three-point scale. Typically, only one leader from each organization is required to complete ORACLE. ORACLE’s scoring system calculates total scores by assigning a different weight to each organizational capacity domain based on its relative importance. The scoring system calculates context-appropriate total scores and can inform organizations about areas where they could enhance their research use capacity.

Policy briefs (also referred to as *evidence briefs for policy*) are one of the most widely used KT tools for packaging research evidence for policy makers, according to multiple researchers, including EVIPNet Europe. These briefs are prepared by synthesizing and contextualizing the best available evidence about a problem; viable policy options to address it; and key implementation considerations through the

involvement of content experts, policy makers, and stakeholders. They provide the best available research evidence on high-priority issues, which should be the starting point of every brief.

Priority-setting is making explicit choices about what to fund and weighing the trade-offs between the various options in the process. Priorities in health care are reflected in the technologies and services paid for and in the investments made in training and infrastructure. Priority setting is not about cost control or cost cutting, although it can contribute to defining the least damaging and most explicit ways of cutting costs.

Tacit knowledge is a commonly used term in the context of evidence-informed policy making. It refers to the knowledge, skills, and abilities gained by an individual through their professional experience, and is often difficult to put into words.



MISSION AND VISION OF THE SAUDI HEALTH COUNCIL

The Vision

The Saudi Health Council (SHC)'s vision is to be an inspiring reference for a world-class Saudi health system.

The Mission

The SHC's mission is to establish regulations that ensure coordination and integration between health stakeholders to improve and promote health care.



EXECUTIVE SUMMARY

Objective of this Manual

The manual serves as a comprehensive guide to support the Saudi Health Council (SHC) in bridging the gap between research and policy through a standardized approach to knowledge translation (KT). It outlines the necessary steps, tools, and guidance for transforming the General Directorate of National Health and Economic Policy (GDNHEP) into a KT platform capable of producing evidence-based health policy and driving action at the national level.

Throughout the manual, there are case scenarios for each step along the way, templates for outlining and disseminating the evidence, and a handful of forms and chart maps for situations the GDNHEP team may face. Following the manual steps using these tools allows for easier identification of the gap between research and policy and areas in KT for which the team might need further support.

The manual contextualizes global best practices into a national KT health policy strategy and equips the GDNHEP team with the knowledge and skills needed to effectively generate evidence-based policies using appropriate dissemination channels and robust monitoring and evaluation methods. Thus, the manual enables the establishment of an evidence-based KT platform for health policy making in the Kingdom of Saudi Arabia (KSA) that aligns with global standards while considering the unique needs and circumstances of the country.

Overview

Chapter 1 discusses the importance of promoting evidence-informed health policy making within the context of the mission and vision of the SHC and the target audience. It also proposes a national KT strategy for the Council and highlights key elements for establishing a sustainable KT infrastructure for the Kingdom of Saudi Arabia that the Council's GDNHEP team should follow.

Chapter 2 discusses both informal and formal methods of priority setting in health policy development. Informal priority setting includes methods for eliciting priorities, priority management, and considerations for handling requests. The formal priority-setting exercise consists of three phases: pre-prioritization, prioritization, and post-prioritization, with specific components such as establishing a steering committee, generating a list of topics/questions, stakeholder mapping, using prioritization criteria, documenting, disseminating priorities, implementing priorities, and monitoring and evaluation. The chapter also includes a stakeholder mapping form and a priority-setting template.

Chapter 3 addresses enhancing efficiency in the literature search process for evidence relevant to health policy decisions. It outlines the following steps: determining the specific type of evidence to search for, identifying appropriate sources for the search, developing a search strategy, screening the

gathered evidence, conducting a critical appraisal of the selected evidence, and synthesizing the findings. By following these steps, policy makers can streamline their search process and ensure that they have access to high-quality evidence to inform their decision-making. The chapter provides a template for developing a search strategy and another template for documenting that search strategy.

Chapter 4 presents three practical applications that demonstrate the use of evidence. Each application is illustrated through a case scenario. Practical Application 1 focuses on framing the problem; providing guidance on developing a clear problem statement; describing the problem's magnitude, consequences, underlying factors; and determining where to find relevant evidence. Practical Application 2 explores framing policy options to address the problem, including proposing and expanding on policy options, weighing them, writing the policy, and identifying supporting evidence. Practical Application 3 addresses the identification of implementation considerations such as barriers and counterstrategies, finding evidence on implementation facilitators and barriers, and developing a policy implementation plan. The chapter also includes templates for problem framing and expanding on policy options, as well as tables that provide an overview of barriers, counterstrategies, and examples of implementation considerations.

Chapter 5 provides an overview of KT tools and explores the process of creating policy briefs in both the preparatory and production phases. The preparatory phase involves forming a core team, developing a work plan, and analyzing the relevant policy and political context. The production phase of a policy brief consists of problem framing, policy options, implementation considerations, an outline, and the full policy brief. The chapter includes guidelines, questionnaires, and templates, such as a policy brief outline template, a tracking sheet for key informant interviews, merit review guidelines, a policy brief evaluation questionnaire, and a template for a policy brief.

Chapter 6 provides a comprehensive overview of the steps involved in establishing rapid response services. It begins by discussing the preparatory phase, which includes building the necessary infrastructure and technical skills, defining the scope and focus of the service, and determining the timeframe for delivering products. The chapter then delves into the production phase: clarifying the question, conducting evidence searches, synthesizing the evidence, writing the rapid response product, submitting it, and implementing monitoring and evaluation. The chapter provides complementing tools: a form for question clarification, templates for rapid response products, examples of different response timelines, an internal checklist, a merit review form, and a rapid response service evaluation form.

Chapter 7 outlines the steps involved in planning and conducting policy dialogues, which are divided into three phases: pre-policy dialogue, policy dialogue, and post-policy dialogue. The pre-policy dialogue phase focuses on setting objectives, scheduling the dialogue, assembling the team, making logistical arrangements, and selecting participants. The policy dialogue phase involves opening the session, establishing rules of engagement, and determining the role of the facilitator. The post-policy dialogue phase includes preparing a dialogue summary report, conducting evaluations, and utilizing alternative dissemination channels. The chapter provides various resources such as a sample seating arrangement; stakeholder mapping sheets; a power analysis matrix; and a checklist related to facilitation, practical arrangements, and collaboration with participants during the dialogues. It also offers a template for a dialogue summary report and a worksheet for planning a policy dialogue.

Chapter 8 focuses on monitoring and evaluation in the context of KT. It presents two case scenarios: one on policy tracing and another on monitoring and evaluating KT platforms. The chapter then explores different categories of indicators that can be used for monitoring and evaluating KT platforms, including process indicators, reach and engagement indicators, usability indicators, use indicators, and collaboration and partnership indicators. Additionally, Annex 8A provides the KT Monitoring and Evaluation Tool for well-documented monitoring and evaluation.

Chapter 9 offers a thorough overview of the political economy of health, highlighting its significance to policy makers. The chapter examines the fundamental principles and structures of the political economy of health. It analyzes how these principles are applied in practice, affecting health policy making and population health through collective decision-making. The chapter then highlights the critical role of political economy analysis (PEA) in integrating economic and political factors into actionable health policies. It also presents regional and global case studies that illustrate the intricate relationship between economic and political factors and their effects on health policies and outcomes.



CHAPTER 1

PROMOTING EVIDENCE-INFORMED HEALTH POLICY MAKING

Introduction: About this Manual

In the Kingdom of Saudi Arabia (KSA), the General Directorate of National Health and Economic Policy (GDNHEP) within the Saudi Health Council (SHC) is involved in the production of evidence and recommendations with the aim of informing and influencing policies at the SHC. Recognizing the need to scale up national efforts to close the gap between research and policy, the SHC aims to establish a standardized approach for knowledge translation (KT) that can transform the GDNHEP into a KT platform and provide structured guidance to the team for how to effectively share their evidence and recommendations with policy makers and promote their translation into policies and actions.

Evidence-informed health policy making is an approach that aims to ensure that policy making is driven by research evidence and data. Worldwide, KT platforms have been established to facilitate the process of translating evidence into policy by aligning research topics with policy priorities; developing policy briefs and rapid responses; deliberating on priority health policy issues; and creating new spaces for policy makers, stakeholders, and researchers. Overall, the chapter highlights the importance of evidence in health policy making and the need for effective KT strategies to ensure research is translated into policy and action.

This chapter begins by introducing the manual's target audience along with its aims and objectives. It provides a list of the chapters and their elements with the associated tools and guides. The chapter then considers the role of evidence-informed policy making in the health arena, a proposed KT strategy for the SHC, and key elements for a sustainable KT infrastructure within the SHC.

Audience

This manual targets the team at the GDNHEP within the SHC. The manual will serve as a reference document for the GDNHEP team to bridge the data and evidence policy gap and help ensure that the evidence and recommendations generated feed and translate into policies and decisions made at the SHC.

Purpose and Scope

The overall aim of the manual is to transform the GDNHEP into a KT platform that can support evidence-informed health policy making and action. The manual provides step-by-step guidance on how to prepare, present, and disseminate evidence in the form of research and data. It also provides recommendations to policy makers and promotes their translation into policies and decisions as part of the newly formed KT platform. To enhance the knowledge and skills of the team, the manual encourages team members to take training courses and workshops as an excellent and engaging way to improve skills.

This aim will be realized through the following two objectives:

- To propose and operationalize a KT strategy that fits the GDNHEP context.
- To enhance the knowledge and skills of the team at the GDNHEP to:
 - Promote the role of evidence (research, data) in health policy-making processes;
 - Effectively search the literature for relevant evidence;
 - Use evidence to clarify the problems, identify policy options to address the problems, and assess implementation considerations;
 - Develop policy products with a focus on policy briefs (which are considered the most widely used policy product) and rapid response services to inform existing policies and realize impact;
 - Promote the uptake of evidence through different dissemination channels with a focus on policy dialogues to communicate findings with key stakeholders; and
 - Monitor and evaluate for impact.

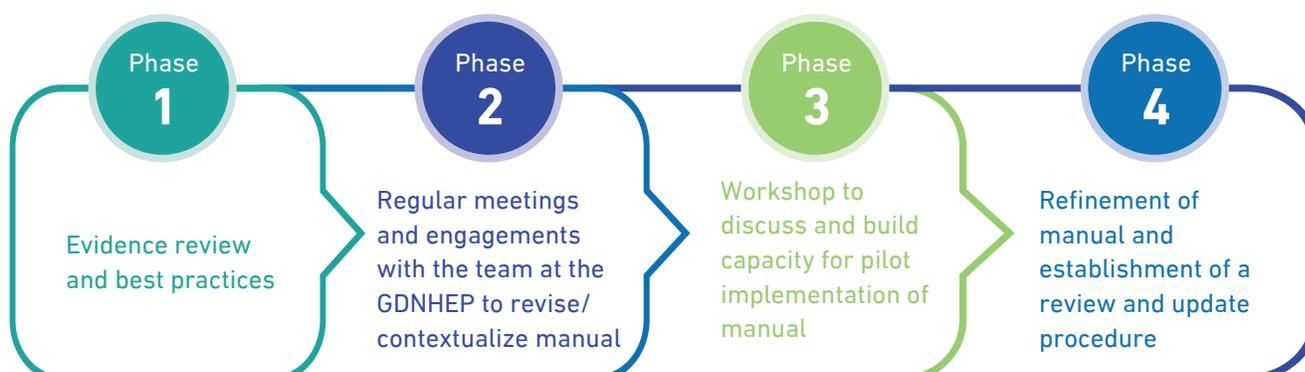
What the Manual Includes

To realize these objectives, the manual includes the following components:

- Details on the steps required throughout the continuum of preparing, developing, and disseminating evidence to influence policy
- Templates and checklists for the entire process
- Clear guidelines on how to fill in the templates
- Illustrative examples and case scenarios.

See figure 1.1 for a visualization of the phases of the manual's development.

Figure 1.1: Development of the Manual



Source: Original figure for this publication.

Note: GDNHEP = General Directorate of National Health and Economic Policy.

The manual has drawn heavily on the following four sources:

- Knowledge to Policy (K2P) Center. *K2P Policy Brief*. <https://www.aub.edu.lb/k2p/Pages/K2PPolicyBrief.aspx>.
- Mijumbi, R. M., A. D. Oxman, U. Panisset, and N. K. Sweankambo. 2014. "Feasibility of a Rapid Response Mechanism to Meet Policymakers' Urgent Needs for Research Evidence about Health Systems in a Low Income Country: A Case Study." *Implementation Science* 9 (114). <https://doi.org/10.1186/s13012-014-0114-z>.
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- World Health Organization, Regional Office for Europe. 2020. *Evidence Briefs for Policy: Using the Integrated Knowledge Translation Approach: Guiding Manual*. World Health Organization. Regional Office for Europe. <https://apps.who.int/iris/handle/10665/337950>. License: CC BY-NC-SA 3.0 IGO.

Chapters

The manual is divided into the chapters presented in table 1.1.

Table 1.1: Manual Chapters and Tools

Section/chapter	Elements	Tools/checklists/guides
1. Promoting Evidence-informed Health Policy Making	<ul style="list-style-type: none"> ▪ Role of evidence in health policy making ▪ Proposed KT strategy for the SHC ▪ Key elements for a sustainable infrastructure for KT within the SHC 	None
2. Methods Used for Priority Setting in Policy Development	<ul style="list-style-type: none"> ▪ Informal priority-setting method ▪ Infrastructure and technical skills ▪ Scope and focus ▪ Timeframe for products ▪ Formal priority-setting exercise ▪ Pre-prioritization phase ▪ Prioritization phase ▪ Post-prioritization phase 	<ul style="list-style-type: none"> ▪ Stakeholder mapping form ▪ Template for priority setting
3. Literature Search for Relevant Evidence	<ul style="list-style-type: none"> ▪ Type of evidence to search for ▪ Where to search for relevant evidence ▪ Development of a search strategy ▪ Screening of evidence ▪ Critical appraisal of evidence ▪ Synthesis of the evidence 	<ul style="list-style-type: none"> ▪ Template for developing search strategy ▪ Template for documenting search strategy

Section/chapter	Elements	Tools/checklists/guides
<p>4. Practical Applications: Using Research Evidence to Frame Problems, Policy Options, and Implementation Considerations</p>	<ul style="list-style-type: none"> ▪ Practical Application 1: How to frame the problem <ul style="list-style-type: none"> ◆ Forming a clear problem statement ◆ Describing the magnitude the problem ◆ Describing the consequences of the problem ◆ Describing the underlying factors of the problem ◆ Determining where to find the evidence to frame the problem ▪ Practical Application 2: How to frame policy options to address a problem <ul style="list-style-type: none"> ◆ Proposing policy options ◆ Expanding on policy option ◆ Weighing policy options in order to select the most promising alternatives in the current situation ◆ Writing the policy ◆ Determining where to find the evidence on policy options ▪ Practical Application 3: How to identify implementation considerations <ul style="list-style-type: none"> ◆ Identifying barriers and counterstrategies to policy implementation ◆ Determining where to find evidence on barriers and counterstrategies to implementation ◆ Developing the policy implementation plan 	<ul style="list-style-type: none"> ▪ Template for problem framing ▪ Template for expanding on policy option ▪ Template for barriers and counterstrategies to policy implementation
<p>5. Developing and Leveraging Knowledge Translation Tools</p>	<ul style="list-style-type: none"> ▪ Overview of KT tools ▪ Policy brief <ul style="list-style-type: none"> ◆ Preparatory phase ◆ Production phase 	<ul style="list-style-type: none"> ▪ Template for policy brief outline ▪ Tracking sheet for key informant interviews ▪ Invitation letter to key informant interview participants ▪ Response to invitation letter for key informant interviews ▪ Merit review guidelines for brief ▪ Policy brief evaluation questionnaire ▪ Full policy brief template

Section/chapter	Elements	Tools/checklists/guides
6. Establishing Rapid Response Services	<ul style="list-style-type: none"> ▪ Preparatory phase <ul style="list-style-type: none"> ◆ Step 1: Infrastructure and technical skills ◆ Step 2: Scope and focus ◆ Step 3: Timeframe for products ▪ Production Phase <ul style="list-style-type: none"> ◆ Step 1: Clarifying question ◆ Step 2: Searching for evidence ◆ Step 3: Synthesizing that evidence ◆ Step 4: Writing the rapid response product ◆ Step 5: Submitting the rapid response product ◆ Step 6: Monitoring and evaluation 	<ul style="list-style-type: none"> ▪ A form for question clarification ▪ An internal checklist for rapid response products ▪ A form for external merit review ▪ Templates for the 3-day and the 10- and 30-day rapid response programs ▪ A form for evaluation of rapid response service
7. Convening and Facilitating Deliberative Dialogues	<ul style="list-style-type: none"> ▪ Pre-policy dialogue phase <ul style="list-style-type: none"> ◆ Identify clear objectives ◆ Set date and agenda ◆ Assemble the team ◆ Complete logistical arrangements ◆ Map and select participants ▪ Policy dialogue phase <ul style="list-style-type: none"> ◆ Open a dialogue session ◆ Establish rules of engagement ◆ Establish the role of facilitator during dialogue ▪ Post-policy dialogue phase <ul style="list-style-type: none"> ◆ Dialogue summary report ◆ Dialogue evaluation ◆ Post-dialogue survey ▪ Alternative dissemination channels <ul style="list-style-type: none"> ◆ Mini dialogues ◆ One-on-one meetings ◆ Citizen engagement sessions 	<ul style="list-style-type: none"> ▪ Template for Dialogue Summary Report ▪ Worksheet for planning a policy dialogue ▪ Stakeholder mapping sheet ▪ Sample dialogue invitation letter ▪ Sample seating arrangements
8. Monitoring and Evaluation	<ul style="list-style-type: none"> ▪ Policy tracing ▪ Monitoring and evaluation of KT platforms ▪ Indicators for monitoring and evaluation of KT platforms 	<ul style="list-style-type: none"> ▪ KT Monitoring and Evaluation Tool

Section/chapter	Elements	Tools/checklists/guides
9. The Political Economy of Health	<ul style="list-style-type: none"> ▪ Definition of the discipline of the political economy of health ▪ The rationale for awareness of the political economy among policy makers and policy analysts ▪ The importance of political economy analysis (PEA) as a powerful tool used to understand and integrate political economy insights into health policy frameworks ▪ An overview of the complex interplay between political and economic determinants and their impact on health policy decisions across different regional and international contexts ▪ Examples of the use of PEA ▪ Regional case studies demonstrating the political economy in health policy 	<ul style="list-style-type: none"> ▪ None

Source: Original table for this publication.

Note: KT = knowledge translation; PEA = political economy analysis; SHC = Saudi Health Council.

The Role of Evidence in Health Policy Making

Governments around the world are responsible for protecting and advancing the interests of their societies, which includes sustaining health and providing equitable access to high-quality health care to their residents. However, a large number of people still cannot obtain the health services they need because these services are not available, not accessible, not affordable, or are of poor quality (WHO/EURO 2020). To address these challenges, policy makers need to make critical decisions about how to improve and strengthen their health systems. These decisions need to be informed by the best available evidence in order to lead to better health outcomes.

Evidence plays an important role in strengthening health systems, improving population health, and accelerating the attainment of the United Nations' Sustainable Development Goals (Jha et al. 2016; Langlois et al. 2016; WHO 2016). Evidence can inform critical health system decisions, including who delivers health services and where and how these services are financed and organized (Koon et al. 2013; WHO/EURO 2020). Furthermore, evidence provides an objective foundation for decision-making that enhances the public's accountability and trust in decision-makers and their choices.

Table 1.2 provides an overview of the types of evidence needed to inform policy making; box 1.1 presents some of the other factors that influence health policy making.

Evidence can inform the different stages of policy making. These stages include defining problems and setting the agenda, formulating policy options, adopting a policy design, ensuring effective implementation of policies once adopted, and the monitoring and evaluation of policies and programs (figure 1.2).

Table 1.2: Evidence Needed for Policy Making

Evidence type	Description	Sources
Local data	Factual information collected and used to support decision-making	<ul style="list-style-type: none"> Local collected data obtained from the routine health information system Large surveys or studies that can be disaggregated (national censuses, regional surveys of access to basic facilities, and national demographic and health surveys) Reports, statistical bulletins
Evidence from global research	Research evidence compiled from a review of the global literature (e.g., systematic reviews and primary studies)	<ul style="list-style-type: none"> Peer-reviewed academic work Research papers and evaluations
Tacit knowledge^a	Evidence assimilated from experiences of policy and practice interventions	<ul style="list-style-type: none"> Qualitative data Program documents, monitoring and evaluation data, formal evaluations, meetings, stakeholder consultations or roundtables
Participatory knowledge	Evidence acquired from residents drawing on their culture, challenges, setting as well as their environment	<ul style="list-style-type: none"> Interviews, surveys, focus-group discussions or consultation meetings/roundtables with residents, patients, and the general public

Source: Original table for this publication.

Note: a. “*Tacit knowledge* corresponds to individual knowledge acquired by professionals throughout their everyday practice and experience and is distinct from explicit knowledge (formally expressed and meant to be shared) as it is only occasionally shared in informal ways and contexts.” See Kothari et al. 2011.

Box 1.1: Other Factors Influencing Health Policy Making

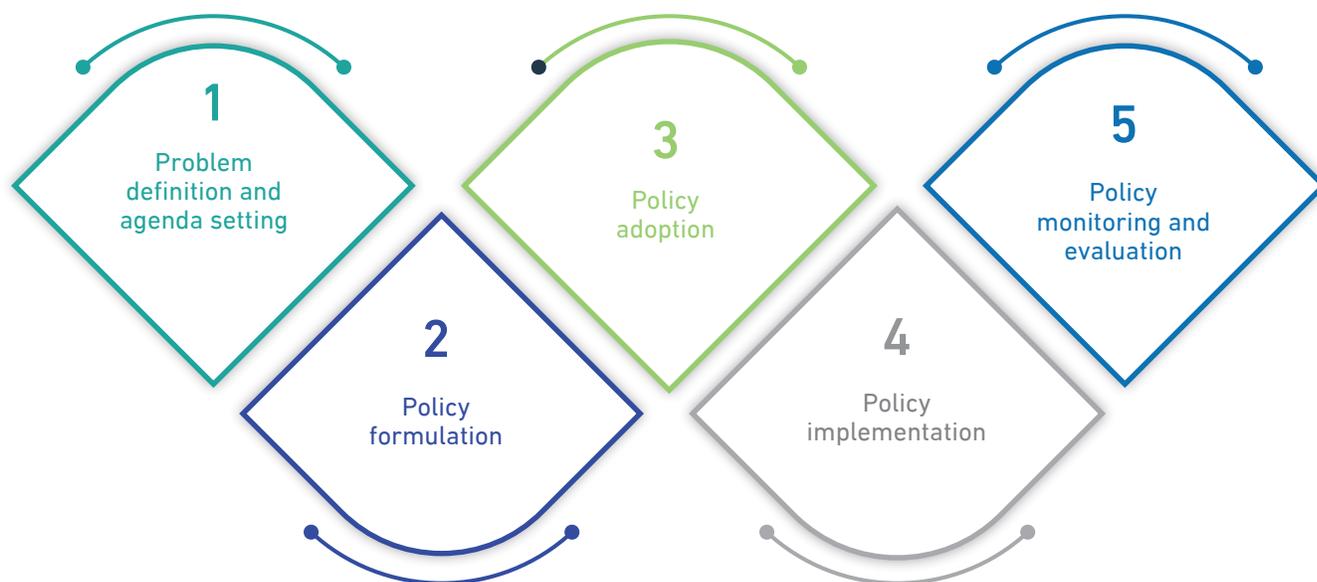
Evidence-informed health policy making is an approach that aims to ensure that policy making is well informed by the best available research evidence and data (Oxman et al. 2009).

Evidence (in the form of research and data) is not the only type of information needed to inform policy decision making; policy decisions are also influenced by factors such as institutional constraints, ideas (including values), interests, and external factors such as recessions. Nevertheless, strengthening the use of evidence and enhancing the ability of policy makers to make appropriate judgments about its relevance and quality holds the promise of helping to achieve significant health gains and a better use of resources (Oxman et al. 2009).

Knowledge Translation

Knowledge translation (KT) is the science and practice of strengthening the research-policy interface. The Canadian Institutes of Health Research defined KT as a dynamic and iterative process that includes synthesis, dissemination, exchange, and an ethically sound application of knowledge to improve health; provides more effective health services and products; and strengthens the health care system (CIHR 2018). Studies of KT have shown that policy makers prefer user-friendly summaries of evidence that highlight the key messages and address considerations related to quality, local applicability, and equity (El-Jardali et al. 2012; Hyder et al. 2011; Moat, Lavis, and Abelson 2013; Oliver et al. 2014). Examples of user-friendly KT tools include policy briefs, rapid response briefs, evidence summaries, and media bites (WHO/EURO 2020).

Figure 1.2: Stages of the Policy-Making Process



Source: Based on Howlett, Ramesh, and Perl 2003.

In response to growing calls to make better use of evidence in health policy making, KT platforms have been established worldwide to facilitate the process of translating evidence into policy and action by aligning research topics with policy priorities, responding to pressing issues by developing policy briefs and rapid responses, and convening dialogues to guide policy formulation and implementation—all while taking into consideration local and political context (El-Jardali, Bou-Karroum, and Fadlallah 2020; Partridge et al. 2020; WHO 2016).

KT platforms have collectively led to direct impacts on selected policy-making processes across a range of topics and settings. They have also led to the following additional outputs and outcomes (El-Jardali, Bou-Karroum, and Fadlallah 2020; Partridge et al. 2020; WHO 2016):

- Higher policy maker demand for KT products
- Strengthened relationships among policy makers, stakeholders, and researchers
- New spaces (such as physical or virtual platforms) for deliberations on priority health policy issues, which have been created through a network of local and global factors and agents
- Greater demand for KT tools among policy makers, stakeholders, and researchers as a result of a deliberative dialogue organized by the KT platform
- Increased awareness of the importance of initiatives supporting evidence-informed policy making.

A summary of the key activities and outputs conducted by KT platforms is provided in table 1.3 (Partridge et al. 2020).

Table 1.3: Summary of Knowledge Translation Activities, Outputs, and Impacts

Knowledge translation domain	Activities/outputs	Impacts
Building demand	Awareness raising	<ul style="list-style-type: none"> ▪ Increasing awareness among policy makers, stakeholders, and researchers about the importance of initiatives to support evidence-informed policy making is regarded as an organizational strength across KT platforms to build trust, enhance buy-in, and increase demand.
Prioritization and co-production	Priority-setting exercises for activities and outputs	<ul style="list-style-type: none"> ▪ Prioritizing research is consistently regarded as an organizational strength across KT platforms as they help promote policy-relevant research and KT products.
Packaging, push (disseminate knowledge for users), and support to implementation	Policy briefs/Evidence briefs	<ul style="list-style-type: none"> ▪ Policy/evidence briefs are highly regarded by policy makers and stakeholders—both in terms of whether they achieved their objective and in terms of their key design features—regardless of country, group, or issue involved. ▪ These briefs have led to strong intentions to act among participants. ▪ The briefs have had a direct effect on selected policy-making processes.
Facilitating pull	Rapid evidence services	<ul style="list-style-type: none"> ▪ These services are perceived as a desirable and user-friendly output by policy makers and stakeholders. ▪ These services have led to direct impacts on selected policy-making processes.
	Building capacity to use (and support the use of) research evidence for health policy advisory committee members	<ul style="list-style-type: none"> ▪ Building capacity has increased scientific knowledge and networks with researchers and increased awareness of the importance of research and evidence-based decision-making. ▪ Building capacity results in new skills as a benefit overall. ▪ Increased capacity improves participants' knowledge, understanding of policy making, and use of evidence. ▪ Training future policy makers is a key contributor to their success in influencing policy.

Knowledge translation domain	Activities/outputs	Impacts
Exchange	Deliberative dialogues	<ul style="list-style-type: none"> ▪ Deliberative dialogues are highly regarded as a tool for enhancing evidence-informed policy making. ▪ These dialogues are highly rated by policy makers and stakeholders—both in terms of whether they achieved their objective and in terms of their key design features—regardless of country, group, or issue involved. ▪ The dialogues led to strong intentions to act among dialogue participants. ▪ The dialogues had a direct impact on selected policy-making processes.
	Research-to-policy workshops	<ul style="list-style-type: none"> ▪ These workshops are perceived to have helped promote improved/new opportunities for collaboration and networks, increased/new knowledge and policy brief writing skills, and enhanced the understanding of the importance of research and evidence-based decision-making.

Source: Based on Partridge et al. 2020.

Proposed Knowledge Translation Strategy for the Saudi Health Council

This section considers the role of the SHC, a proposed strategy for KT, and key questions that provide an organizing framework for the KT strategy.

Proposed Knowledge Translation Strategy

The SHC aims to support the health policy-making process in order to improve public health and reduce health inequities in the KSA by implementing the following main strategic objectives:

- Use the best available evidence and data to produce outputs that can inform decisions in the health policy-making process.
- Promote the systematic use of evidence in the health policy-making process.
- Promote collaboration among policy makers, researchers, and other stakeholders.

The following questions provide an organizing framework for the proposed KT strategy within the SHC (Lavis et al. 2003):

1. What should be translated for decision-makers (the message)?
2. For whom should research knowledge be translated (the target audience)?
3. By whom should research knowledge be translated (the messenger)?

4. How should research knowledge be translated (what are the knowledge-translation processes and supporting communications infrastructure)?

Each of these questions is presented in detail below, along with an accompanying example case scenario.

What Should Be Translated for Decision-Makers?

Case Scenario: *You have been asked to prepare an evidence response to support the SHC or minister in solving the problem of physician shortages in rural and remote areas.*

When preparing your evidence response (as per the case scenario), you need to take the following points into consideration:

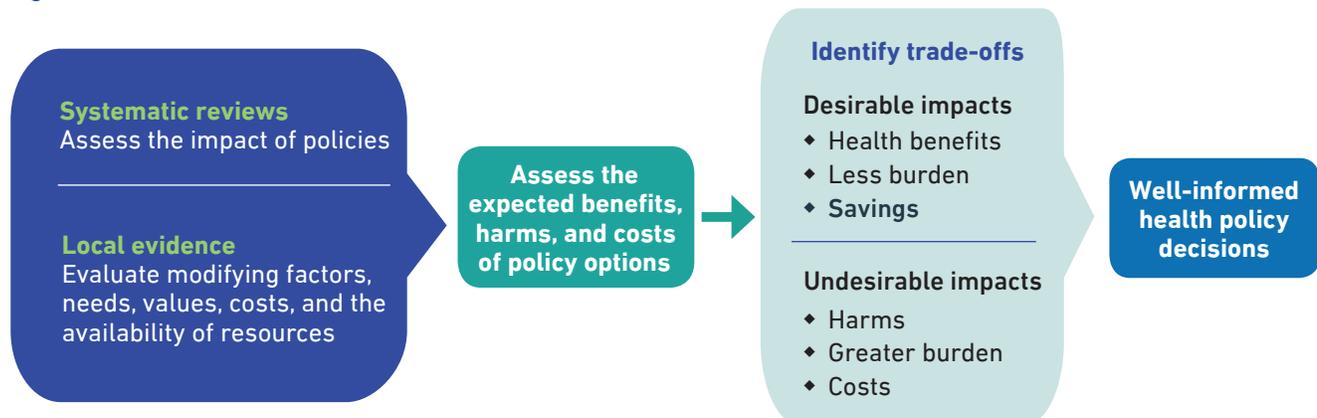
Not all research can or should have an impact. Some bodies of research knowledge will not generate a take-home message, either because the research has no apparent application for decision-makers or because the findings are not conclusive. Furthermore, studies of administrative data (for example, the number of local beds, number of primary health care centers) may not need to be translated.

Research organizations should translate actionable messages from a body of research knowledge, not simply a single research report or the results of a single study (see box 1.2). Enhanced validity provides one justification for this approach. Importantly, policy decisions require a combination of *global evidence* (the best available evidence from around the world)—ideally from systematic reviews—and different types of *local evidence* and tacit knowledge (Lavis et al. 2009a).

Knowledge translators need to identify the key messages for different target audiences and fashion these in language and KT products that are easily assimilated by different audiences. Over the past decade, a variety of different products have been developed targeting different audiences (for example, actionable messages and policy briefs for policy makers).

Figure 1.3 illustrates the role of evidence from systematic reviews together with local evidence in informing the judgments that need to be made about health policy decisions.

Figure 1.3: Role of Evidence



Source: Based on Lewin et al. 2009.

Box 1.2: Single Studies and Local Data Alone are Insufficient to Inform Policy Decisions

The results of individual studies need to be interpreted within the context of global evidence before deciding whether they are ready for knowledge translation (KT). In other words, the basic unit of KT should be up-to-date systematic reviews or other syntheses of the global evidence.

Policy makers should be cautious about using local evidence alone to assess the likely impacts of policy or program options. Local evidence may be more directly relevant than evidence from studies conducted elsewhere, but it may also be less reliable as a result of important limitations in the studies that were done locally. In addition, even when reliable local evaluations are available, they may be misleading because of random errors.

Sources: Grimshaw et al. 2012; Lavis et al. 2009; WHO/EURO 2020.

For Whom Should Research Knowledge Be Translated?

A message's target audiences should be clearly identified. The specifics of a knowledge-translation strategy should also be fine-tuned to the types of decisions that policy makers and stakeholders face and the types of decision-making environments in which they live or work.

By Whom Should Research Knowledge Be Translated?

Because the credibility of the messenger delivering the message is important to successful knowledge-translation interventions, the KT activities will be conducted by the GDNHEP (which is a credible entity in KSA) and reinforced through its team lead.

The GDNHEP will create demand and trust in its activities/outputs by sharing successes and impacts (for example, instances where evidence and data made the difference between the success or failure of a policy or program), enhancing awareness and capacity of decision-makers, being responsive to priorities and need, maintaining objectivity, and promoting accountability.

How Should Research Knowledge Be Translated (What Are the Knowledge-Translation Processes)?

This manual outlines five main types of activities or outputs for translating knowledge and promoting evidence-informed policy making. The menu of activities and outputs constitutes a tried and tested set of tools that have been successfully utilized to influence and impact policies and actions across topics and settings (Partridge et al. 2020; WHO 2016).

It is recommended for the GDNHEP within the SHC to start with a limited menu of activities and products and then gradually expand that menu to adjust to existing demand and capacity. The remainder of this manual will focus on providing step-by-step guidance on how to operationalize the menu of activities and outputs (see table 1.4).

Table 1.4: Proposed Activities and Outputs of the Saudi Health Council Knowledge Translation Platform

Knowledge translation domain	Menu of activities and outputs
Prioritization and co-production	Priority-setting exercises for activities and outputs
Presenting, push (disseminate knowledge to users), and support for implementation	KT products, with a focus on policy briefs (efforts can later be scaled to produce other types of products)
Facilitating pull	Rapid evidence services
Exchange	Deliberative dialogues
Cross-cutting the KT domain	Monitoring and evaluation

Source: Original table for this publication.

Note: KT = knowledge translation.

The following policy questions can be addressed by the SHC KT platform (once established):

- What is the magnitude of a given problem?
- What are the underlying causes of a problem?
- What are viable policy options for addressing a problem?
- What is the effectiveness of specific policy option?
- What are some implementation considerations associated with a policy option?
- What is the effect of a specific implementation strategy?

Box 1.3 provides a rationale for the proposed KT platform.

Box 1.3: Rationale for the Proposed Saudi Health Council Knowledge Translation Platform

Evidence of Impact

Collectively, the proposed menu of activities and outputs addresses the key challenges in linking research to policy making, as reported in numerous studies in the literature (El-Jardali et al 2012; El-Jardali et al. 2014; Lavis et al. 2006; Oliver et al. 2014; Tricco et al. 2015; Uneke et al. 2020). The ineffective presentation, dissemination, and communication of research results in:

- Limited value given to research as an input into policy making,
- Weak alignment between research and policy priorities,
- Poor dissemination and poor communication of research,
- Lack of timely access to good-quality and relevant research evidence, and
- Limited communication and exchange between policy makers and researchers.

Alignment with Global Trends

Additionally, the selection of menu options has been influenced by three major recent shifts in the focus of many efforts to present research evidence for policy makers (Lavis et al. 2009; WHO 2020). These are described below:

- There has been a shift from presenting single studies to presenting systematic reviews of studies that address typical policy-relevant questions. This shift has made it easier for policy makers to scan broadly across large bodies of research evidence to address key features of any policy issue of interest.

Contd...

Box 1.3: Contd...

- Complementary efforts to present systematic reviews (together with local research evidence) in the form of a new product—the *policy brief*—are utilized; these mobilize the best available research evidence (from global and local sources) on high-priority issues.
- There has also been a shift in the purpose for which presented research evidence has typically been produced. Policy briefs are increasingly used as an input into policy dialogues involving individuals drawn from the group of those who will be involved in, or affected by, decisions about a particular issue. These dialogues provide the opportunity for greater interaction between researchers and policy makers.

Institutional Capacity for Promoting the Use of Evidence in Health Policy: Assessment Tool

A baseline assessment of the institutional capacity of the GDNHEP to promote and facilitate the use of evidence in health policies and practice revealed the need to enhance the components of institutional culture, support, and tools in order to enable sustainable infrastructure for KT within the SHC (table 1.5).

Table 1.5: Institutional Culture, Supports, and Tools

Element	Element is present (insert checkmark) (Yes)	Element is not present (insert checkmark) (No)
Institutional processes to incentivize or mandate use of evidence in health policy		
Presence of committed budget line for KT and evidence-informed policy making		
Institutional programs to improve capacity in finding, appraising, and using evidence to inform policy-making processes		
A clearly designated unit for KT with standardized tools and templates for preparing KT products		
Staff with adequate capacity and skill mix to engage in efforts to support use of evidence in policies		
Accessible resources (such as handbooks and learning modules) on how to find, assess, and use evidence as well as subscriptions to relevant journals and databases		
A robust health information system that generates timely data		

Element	Element is present (insert checkmark) (Yes)	Element is not present (insert checkmark) (No)
Structured systems for collating evidence so that information relevant for decision-making (for example, research, data, tacit knowledge) is easily accessible		
Clear communication mechanisms for effective collaborations across different units within institutions		
Established methods for evaluating the use of evidence in policy and program planning		

Source: K2P Center (K2P Mentorship Program).

Note: Original finding from baseline assessment conducted of the institutional capacity of the GDNHEP to promote and facilitate the use of evidence in health policies and practice. The assessment tool was adopted from the Knowledge to Policy (K2P) Center. GDNHEP = General Directorate of National Health and Economic Policy; KT = knowledge translation

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CHAPTER 2

METHODS USED FOR PRIORITY SETTING IN POLICY DEVELOPMENT

Introduction

This chapter covers informal priority-setting methods and provides a formal priority-setting exercise.

Three areas of informal priority setting are described briefly. These include the use of different methods to elicit priorities, the management of priorities, and key considerations for enhancing the successful handling of requests.

The formal priority-setting exercise is composed of three phases: the pre-prioritization phase, the prioritization phase, and the post-prioritization phase. These are made up of the following components (see also figure 2.1):

- Pre-prioritization phase
 - Establishment of a steering committee
 - Generation of initial list of topics/questions
 - Stakeholder mapping.
- Prioritization phase
 - Methods for priority setting
 - Use of prioritization criteria.
- Post-prioritization phase
 - Documentation, dissemination, and implementation of priorities
 - Revision or appeal mechanism
 - Monitoring and evaluation.

This chapter also provides the stakeholder mapping form for the pre-prioritization phase (table 2.2) and, in annex 2A, a template for priority setting.

Priority Setting to Support the Policy-Making Process

Case Scenario: *One of your unit's goals is to support the Saudi Health Council (SHC) in using evidence to inform the policy-making process. Often, the research generated by your unit does not align with the needs and priorities of policy makers, which limits the uptake of research in decisions. You have been asked to establish a priority-setting approach to prioritize those topics requiring evidence to inform the decisions of policy makers.*

Groups or institutions supporting evidence-informed policy making should prioritize topics according to the needs of policy makers and stakeholders. A prioritization process can increase the likelihood that the best available evidence informs health policy goal setting and timing for decision-making (see box 2.1).

It can also promote optimal allocation of scarce resources in order to pursue the topics that are likely to have a significant impact on policy or practice (Akl et al. 2017). Furthermore, a carefully planned priority-setting process provides a platform for interaction and trust building among diverse stakeholders, both of which are important for the eventual uptake of research findings in decision-making.

Box 2.1: Goals and Timing of a Prioritization Process

The goals of a prioritization process are to:

- Increase the likelihood that the best available evidence informs health policy decision-making,
- Promote optimal allocation of scarce resources to areas of highest priorities, and
- Maximize the impact of your work.

The timing of when to prioritize rests on several considerations:

- Priority setting can be implemented at different intervals—which can be annual, short-term, mid-term, or long-term—within the policy and planning cycle (WHO 2016).
 - Priority setting can be conducted at different levels of the health system (national, regional, district) and on different system components (hospital reforms, COVID-19 response, and so on).
 - In most cases, priority setting should come after a situation analysis and before the decisions are made.
-

This chapter of the manual aims to provide users with a comprehensive and systematic approach to supporting evidence-informed policy making. Such an approach should provide a meaningful balance of *proactive approaches* (that is, a formal priority-setting exercise—such as an exercise to inform national strategic plans or provide strategic direction to the unit’s work over the next few months) and *reactive approaches* (that is, responding to informal or direct requests—for example, priority setting in response to issues that emerge on the front page of a newspaper or are discussed in the legislature).

Informal Priority-Setting Methods to Set the Research Agenda

Priority setting is understood as a notional approach to find out what to regard as more important or less important in health care. Research may be prioritized through informal priority-setting methods that do not necessarily include formal follow-up actions or systematic feedback loops (Conceição, Leandro and McCarthy 2009; WHO 2020).

Informal priority setting methods are generated in reaction to issues that emerge in a public setting. They do not necessarily use specified criteria and available data, but rather rely on an agile response from the team to informal or direct requests for priority assessments from stakeholders. Informal methods should be used in conjunction with formal ones. Informal priority setting is not always transparent and does not encourage accountability (WHO 2016). The list below highlights different informal priority-setting methods that can be used by the SHC in order to inform its health research agenda (see also box 2.2):

- Informal discussions with policy makers and stakeholders through personal encounters and meetings, even if the topic at hand is not the focus of the discussion
- Informal meetings with researchers and public health practitioners
- Conferences or activities conducted in other relevant institutions or ministries
- Direct requests received from policy makers and stakeholders regarding a specific policy priority (for example, commissioned work; see box 2.3)
- A search for relevant published work or websites.

Box 2.2: Managing Priorities

There is no agreement on how best to manage informal priority-setting requests, including direct requests from stakeholders.

Similarly, there is no gold standard when it comes to the number of priorities that should be addressed informally or via direct requests relative to a formal priority-setting exercise.

The priorities depend on the specific contexts of each country (its existing resources, capacity, relationship with stakeholders, political and research system, and so on).

To enhance the success of the response to requests received informally or directly from stakeholders, the following actions should be taken (Lavis et al. 2009):

- **Make clear the timelines that have been set for addressing high-priority issues in different ways.** By clarifying the timelines for different types of support (for example, 3, 10, or 30 working days for rapid response products), policy makers and stakeholders could then match the time constraint they are working under to the kind of support they could receive. If timelines to support evidence-informed policy making are negotiated on a case-by-case basis, policy makers will be unable to match the time constraints they face (for example, a half-day, a five-day, or a two-month period) to the support they could receive.
- **Incorporate explicit criteria for determining priorities.** When implicit criteria are used to set priorities, or when the priority-setting process is ad hoc, those policy makers whose needs for research evidence are not being met may become demoralized by the lack of attention to their program or disillusioned with the rhetoric of evidence-informed policy making. In order to address this issue, the Knowledge to Policy (K2P) Center has developed a list of 14 prioritization criteria to identify priorities both informally and formally (see also box 2.3).
- **Incorporate a communications strategy and a monitoring and evaluation plan.** In the absence of a communications plan or a monitoring and evaluation plan, policy makers will not know *why* their evidence needs are or are not being met, and they will be unable to learn whether and how their existing approaches can be improved.

Box 2.3: Example of a Priority-Setting Approach for Direct Requests Received from Policy Makers

A ministry's decision-support unit offers the following range of supports to ministry staff:

- A search for systematic reviews that address an issue (*support type 1*, which means a timeline of 1 day; number that can be provided per quarter: 16);
- A summary of the take-home messages from quality-appraised systematic reviews (*support type 2*, which means a timeline of 1 week; number that can be provided per quarter: 8); and
- A comprehensive assessment of the research evidence available to clarify a problem, policy options, and implementation considerations (*support type 3*, which means a timeline of 1 month; number that can be provided per quarter: 2).

The unit maintains an inventory of requests. Each request is evaluated and reviewed by two unit staff members who allocate a score between 1 and 7 points (ranging from "1 = strongly disagree" to "7 = strongly agree") for each of the following three criteria:

1. Addressing the underlying problem can result in significant health benefits, improve health equity, or guarantee other positive impacts in the short or long term.

Contd...

Box 2.3: Contd...

2. The topic has viable options that (if properly implemented) can address the underlying problem and lead to health benefits, improve health equity or lead to other positive impacts, reduce harms, save costs, or increase value for money.
3. Political events addressed could open windows of opportunity for change.

The score for the third criterion weighs twice as much as the score for the prior two as it is considered to be twice as important. The maximum score for criteria 1 and 2 is 14 whereas that for criterion 3 is 28. The total score for all three criteria is between 0 and 56.

The staff is also required to identify the nature of the support needed (that is, support type 1, 2, or 3 noted above) based on the request description and justification submitted by the requestor(s). The submitted request must address each of the three criteria using research evidence and data (when available), and it must include a description of the criteria used for prioritizing the problem.

Each week, the unit manager (along with all divisional directors) reviews the rank-ordered list of priorities for each support type. The team then collectively confirms that the top two requests for support types 1 and 2 will proceed as planned for that week. The team can also confirm that the top request for support type 3 is on track with preparations to begin a new assessment for the second-ranked request for support type 3. The unit manager facilitates these meetings, discusses the rationale for any ranking changes with staff, ensures that requests are comprehensive, and identifies areas requiring additional clarification. The unit manager then posts the decisions and ranking on the ministry's intranet and directs ministry staff whose requests have not been addressed within one month of submission to submit an updated request.

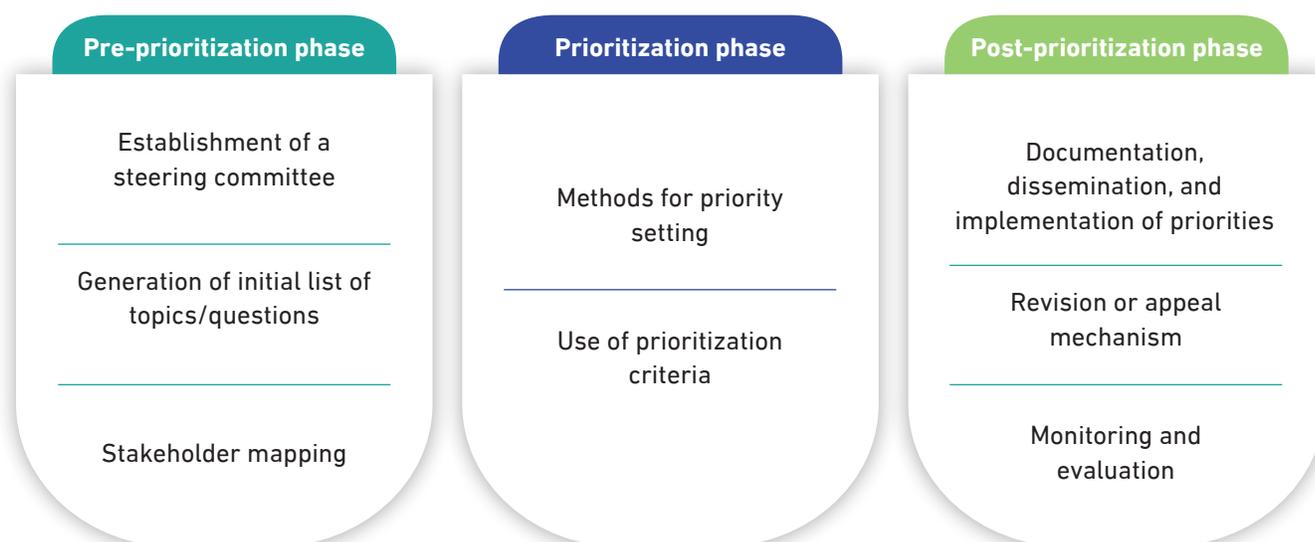
An assessment is conducted once a month with divisional directors, and the total number of submissions and appeals (and their resolutions) submitted to the unit are evaluated. Once a year, the unit re-evaluates its scale for outputs and determines whether they can provide additional services within shorter time frames. Every three years, the unit evaluates the impact of its work on the policy-making process.

Source: Based on Lavis et al. 2009.

Formal Priority-Setting Exercise

A formal priority-setting exercise encompasses three consecutive phases (see figure 2.1).

Figure 2.1: Phases of a Formal Priority-Setting Exercise



Source: Based on Fadlallah et al. 2020.

Pre-Prioritization: Generation of Initial List of Topics/Questions

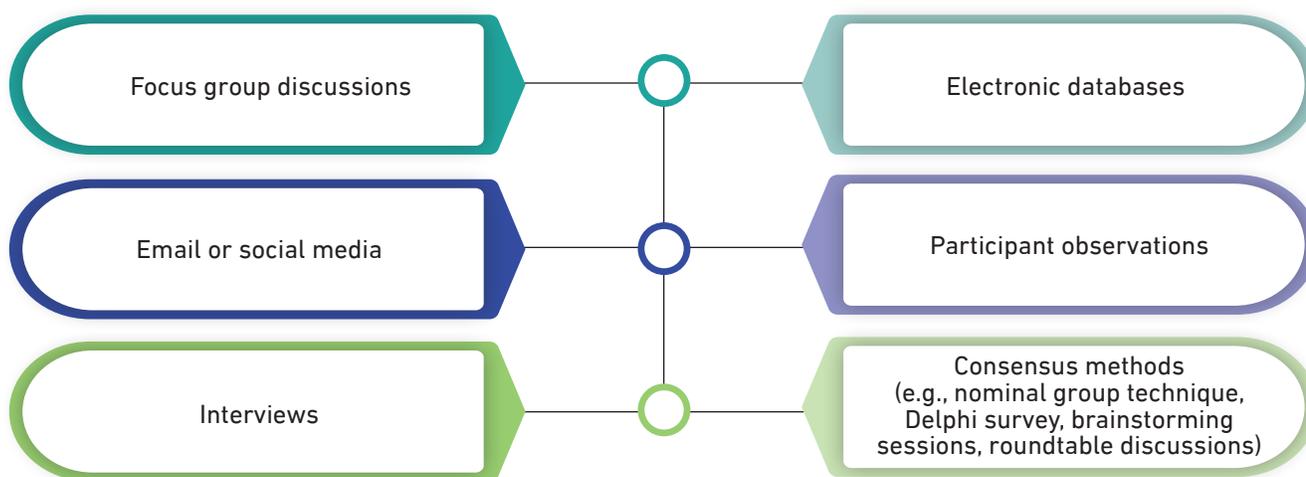
The first step toward the priority-setting process requires the generation of a preliminary list of topics/questions (Bhutan MOH 2019; Chanda-Kapata et al. 2018; NSW Ministry of Health 2019).

The initial list of topics can be generated from the following areas:

- **Previous research agenda.** Look at health research topics that were part of earlier research agendas. These can assist with the generation of a new research list (PNHRS 2016). Situational analysis may also be used to determine gaps in evidence or knowledge relevant to priority areas—for example, analysis through the Essential National Health Research or the Combined Approach Matrix model (PNHRS 2016) can identify these gaps.
- **Literature review.** Look at research (for example, systematic reviews) that has already been undertaken on relevant topics and the recommendations from that research (PNHRS 2016). Also consider other outputs such as technical data and relevant reports (Tong et al. 2019).
- **Information from stakeholders.** Inquire from stakeholders about potential research topics using different data collection methods. These inquiries can be performed face-to-face or virtually and can help compile a list of research topics (PNHRS 2016). Interviews may be more feasible than group meetings or focus group discussions for busy administrators (PNHRS 2016). Focus group discussions and participant observations may be more effective for the general public and marginalized groups (PNHRS 2016).

Data for generating the initial list of topics can be collected through one or a combination of the methods presented below (see figure 2.2). It is essential to remember that, in general, the initial list of topics will be long and diversified, and it will need to be consolidated. Duplicate topics may be removed and similar ones combined, while topics that are too broad may be rephrased or eliminated (PNHRS 2016). The team may also look over the literature to see whether there are any themes that have already been addressed (PNHRS 2016).

Figure 2.2: Methods of Data Collection



Source: Original figure for this publication.

The initial list of topics may be grouped by key themes, including:

- Health priority areas
- Health behaviors or risk factors
- Settings or essential population groups
- Other issues (for example, health systems access, health equity).

Within each topic area or theme, it is important to identify gaps in needs and knowledge as well as to identify its relevance to the decision-making processes (NSW Ministry of Health 2019; PNHRs 2016).

Table 2.1 provides an example of an initial list of 44 topics that have been generated through a review of the literature in the Kingdom of Saudi Arabia (KSA). The topics have been stratified by thematic areas. Before prioritizing the initial list of topics, the stakeholders that will be involved in priority setting must be determined. This is discussed in the next section.

Table 2.1: Example of Initial List of Topics

Thematic area	Topic
Primary health care and preventive care services	<ul style="list-style-type: none"> ▪ Interventions to enhance access to best practice primary health care for chronic disease management, prevention, and episodic care ▪ Chronic disease management interventions in primary care
Quality and safety of health care services	<ul style="list-style-type: none"> ▪ Establishment of standardized quality and safety indicators for hospital performance and benchmarking ▪ Effective regulatory interventions to enhance quality of care and patient outcomes in hospitals ▪ Addressing medical errors in health care systems ▪ Improving and regulating the quality of ambulatory care ▪ Enhancing patient safety and service quality in home health care ▪ Enhancing patient trust and communication with providers and the health system ▪ Promoting patient-centered approaches to care delivery ▪ Interventions to promote occupational health and safety ▪ Promoting safe disposal of medical waste
Health-sector workforce	<ul style="list-style-type: none"> ▪ Strategies to ensure appropriate qualification of workers in health care centers and institutions to meet the requirements of health work ▪ Incentive systems for recruitment and retention of primary care doctors ▪ Interventions to address health workforce shortages and maldistribution ▪ Interventions to strengthen the role of community health workers for noncommunicable diseases prevention and control
Public-private partnership in the health sector	<ul style="list-style-type: none"> ▪ Models of public-private engagement for health services delivery and financing ▪ Performance-based contracting for regulation of public and private hospitals

Thematic area	Topic
Information and communication technology (e-health) in health systems	<ul style="list-style-type: none"> ▪ Integration of electronic health records into the health care system ▪ Effective information and communication technology to prevent and control noncommunicable diseases ▪ Mobile health technologies to improve health care service delivery processes ▪ Telemedicine in the management of chronic heart disease
Road safety	<ul style="list-style-type: none"> ▪ Interventions for improving road safety and reducing the toll of road traffic injuries and deaths
Preventable preterm birth and stillbirth	<ul style="list-style-type: none"> ▪ Interventions/policies for reducing preventable preterm births and newborn deaths ▪ Interventions/policies to reduce the burden of stillbirths
Mental health	<ul style="list-style-type: none"> ▪ Health systems interventions for addressing adolescent mental health ▪ Enhancing access to mental health care services in primary health care settings
Health services for those aged 65 or above and people with disabilities	<ul style="list-style-type: none"> ▪ Promoting access to health care services for people with intellectual disability ▪ Integrating palliative care into the health system ▪ Interventions to prevent pre-frailty and frailty progression in older adults
Noncommunicable disease risk factors: smoking, diet, and physical activity	<ul style="list-style-type: none"> ▪ Health education and awareness interventions to reduce smoking prevalence and promote physical activity and healthy eating ▪ Primary care and health promotion interventions for smoking prevention and cessation ▪ Community-level interventions to promote a healthy lifestyle
Burden of cardiovascular diseases and diabetes mellitus	<ul style="list-style-type: none"> ▪ Effective health care system interventions for cardiovascular disease prevention and control ▪ Interventions to reduce risk behaviors and risk factors for cardiovascular disease ▪ Effective interventions aimed at reducing the burden of type 2 diabetes mellitus ▪ Educational and organizational interventions to improve the management of hypertension in primary care ▪ Effective systematic risk assessment (screening) for the prevention of cardiovascular disease ▪ Self-care for the prevention and management of cardiovascular disease and stroke
Continuity of care and emergency medical services	<ul style="list-style-type: none"> ▪ Strategies to strengthen emergency medical services ▪ Strategies and interventions to strengthen referral systems across primary, secondary, and specialized health care services

Thematic area	Topic
Medication use	<ul style="list-style-type: none"> Promoting rational prescribing of pharmaceutical drugs in the health care system Interventions for reducing medication errors in primary care Increasing the supply of medicines in health facilities Interventions to improve medication adherence in patients with cardiovascular diseases

Source: Original table for this publication.

Pre-Prioritization: Stakeholder Mapping

It is important to map out in advance which stakeholders are essential to engage in the priority-setting exercise for the sustainable and feasible implementation of the established priorities (Viergever et al. 2010). The priority-setting exercise should engage stakeholders with different areas of expertise, with the goal of balanced regional and gender participation (Viergever et al. 2010). Areas of consideration for identifying stakeholders include:

- Geographical focus:* Stakeholders from different regions must be adequately represented.
- Gender representation:* Emphasis on gender equity is important.
- Nongovernmental organization (NGO)/researcher interface:* The process must not be dominated by researchers/academics, but there is adequate representation from governments and policy makers, NGOs, civil society, community-based organizations, consumer organizations, human rights groups, and marginalized or patient groups.

Stakeholder mapping should be accomplished through an agreed-upon and transparent process to manage any potential conflicts of interest relevant to personal, commercial, or professional areas (Viergever et al. 2010). The form in table 2.2 can be used for stakeholder mapping. While the list is not exhaustive, it can be useful in organizing the process of identifying the stakeholders.

Table 2.2: Stakeholder Mapping Form

Specific role/ category	Descriptive position titles	Name	Contact information
Directors in national/regional health authorities and other national bodies	Saudi Health Council directors		
	Directors of other councils and national bodies		
	Cluster leads		
Directors in the Ministry of Health responsible for health policy decisions on behalf of the nation	Minister of health or deputy minister/ undersecretary/secretary general		
	Advisors and members of councils		
	Head of financial and administrative departments (for example, the department of budget & expenditure)		

Specific role/ category	Descriptive position titles	Name	Contact information
	Head of health policy & planning (for example, health information, health economics, projects management)		
	Head of health and human resources (for example, the head of personnel, medical professionals, education and training)		
	Head of primary health care (for example, quality, private hospitals, regional health services, outpatient clinics)		
	Head of public health program (for example, school health, occupational health, reproductive health, health promotion, maternal health & health media)		
	Head of pharmaceuticals and laboratories (for example, microbiology, radiology chemistry, and pathology labs, drug control)		
Other health-related ministries	Directors in other health-related ministries (for example, ministry of education, ministry of finance, ministry of social affairs, ministry of labor)		
<p>Manager in a nongovernmental organization (NGO) (for example, the United Nations) in the largest city</p> <p>Most senior director responsible for strategy or planning or policy in an NGO (for example, director, vice-president)</p>	Managers of international NGOs		
	National NGO/civil society actors (when available)		
	Representatives from private sector entities (when available)		
Staff/member of a health professional association or group	Presidents of national medical associations (for example, physicians, dentists, laboratory technicians, physiotherapists)		

Specific role/ category	Descriptive position titles	Name	Contact information
Most senior manager/director (that is, nonelected representative) in charge of strategy or planning or policy for the:	President of national nursing association		
	President of national pharmacists' association		
	President of national hospital association		
Director in a donor agency (for example, the European Community) or international organization (for example, the World Health Organization) Most senior manager within the country office	Director of US-based donor agency		
	Director of a Europe-based donor agency		
	World Health Organization director		
Manager in a health care institution (for example, hospital, primary health care center)	Most senior manager in a healthcare institution		
Researchers	Researchers in a national research institution		
	Researchers in a university		
	Researchers in health committees of the legislative power		
	Researchers in other institutions		

Source: Based on Lavis, Hammill, and Bourgeault 2006; El-Jardali et al. 2010.

Once the stakeholder mapping form has been filled out and the stakeholders have been identified and their participation confirmed, it is important to assess whether or not all the stakeholders needed for a sustainable priority-setting process are included. Box 2.4 presents a checklist for this purpose.

Box 2.4: Checklist for Stakeholder Selection

- Are the interests of all partners represented?
- Are the policy makers adequately represented?
- If so, what level of representation?
- Among the researchers, are various disciplines represented—for example, economics, other social sciences, education, public health?
- Are you happy with the quality of representation? Usually top decision-makers are too busy, and they may choose to send people who are too junior for effective decision-making.
- If you are not happy with the quality, what mechanism do you have to ensure credible representation from the top?
- Are the private sector and nongovernmental organizations (NGOs) adequately represented? It may be necessary to obtain a listing of all private health care providers and NGOs working in health to ensure adequate representation.
- Is there sufficient community representation? Avoid the trap of accrediting an elite minority that ignores the needs of the poor, illiterate, women, children, or other disadvantaged groups.

Source: Based on Okello, Chongtrakul, and the COHRED Working Group on Priority Setting 2000.

It is very important to involve a wide selection of stakeholders from the beginning of the priority-setting exercise to increase their awareness around the process and ensure their buy-in and uptake of the final set of priorities (WHO 2020). While there is no agreed-upon optimal number of stakeholders, this could range from 15 to 30 for in-person priority-setting exercises, depending on resource availability, scope of the exercise, and complexity of the topics being addressed.

Benefits of broad stakeholder involvement (multidisciplinary and multisectoral) to the outcomes of a health research priority-setting exercise include:

- Reducing the likelihood of having health research topics overlooked, as each stakeholder tends to prioritize research in different ways.
- Fostering ownership of the agreed-upon priorities among involved stakeholders, which may increase implementation of priorities.
- Enabling priorities to be tailored to the needs of those who will implement or benefit from the research priorities. The research priorities will therefore better align with societal and policy needs, enhancing the exercise's general credibility and potential impact on health and health equity.
- Possibly minimizing the changes made by an unnecessary duplication of prioritization efforts, and thus preventing wasted resources.
- Possibly increasing the changes made by funding agencies to direct their research funds toward priority research concerns.

It is important to note that, for an institutional-level priority-setting exercise, stakeholder selection may be limited to individuals within the institution while taking into consideration balance across a number of variables, including positions; departments, units, and programs; and gender. Stakeholders that work directly with the institution or that are affected by the decisions taken by the institution (for example, policy implementers, health care organizations, other health authorities, selected NGOs, patients) may also be invited to the priority-setting exercise.

Prioritization Phase: Methods for Priority Setting

A diverse range of methods can be used as part of priority-setting exercises. These include stakeholder surveys and questionnaires, calls for submissions, stakeholder interviews, workshops, roundtables, focus groups, public input sessions, the Delphi technique, and the nominal group technique (see table 2.3 for details), which were all shown to be used to generate research priorities (Bryant et al. 2014). Each of these methods is outlined in table 2.3, along with its advantages and disadvantages.

Workshops and roundtables are the most commonly used approaches for ranking priorities. These can be conducted physically or virtually (for example, through interactive webinars). In some cases, they may be supplemented by surveys or questionnaires to elicit the inputs of relevant stakeholders who could not attend the workshop/roundtable. In the context of the SHC, it is recommended that a combination of workshops/roundtables and surveys or questionnaires be used when it is not feasible for all stakeholders to be present at the same time. Topics can be ranked by using selected prioritization criteria (see the next section on the use of prioritization criteria).

Table 2.3: Summary of Common Research Priority-Setting Methods

Method	Summary	Advantages	Disadvantages
Workshops, focus groups, or roundtables	<ul style="list-style-type: none"> This is used by the majority of priority-setting approaches to bring stakeholders together and generate health research priorities. It brings together stakeholders with different points of view and experiences to debate a common problem or situation guided by a specific discussion topic. 	<ul style="list-style-type: none"> This method allows different opinions to be debated. 	<ul style="list-style-type: none"> Some participants may dominate the discussion, which may neglect concerns and opinions of others.
Stakeholder surveys or questionnaires	<ul style="list-style-type: none"> Survey responses are typically refined, collated, and arranged into themes or categories that become the basis for further debate or prioritization. 	<ul style="list-style-type: none"> This method allows for the engagement and reach of a wide range of stakeholders. 	<ul style="list-style-type: none"> There are difficulties in constructing surveys that are appropriate for stakeholders with a variety of backgrounds and levels of competence. Interpreting and collating responses to open-ended questions is challenging.
Calls for submissions or comments	<ul style="list-style-type: none"> This utilizes stakeholders' professional and/or personal expertise and perspective to generate priority areas. Criteria are developed by the steering committee to drive the discussion. 	<ul style="list-style-type: none"> This method allows for the engagement and reach of a wide range of stakeholders. It is inexpensive and does not require a lot of resources for the commissioning organization. 	<ul style="list-style-type: none"> This requires stakeholders to have a level of written expertise to respond.

Method	Summary	Advantages	Disadvantages
Nominal group technique	<ul style="list-style-type: none"> ▪ This technique is a systematic group information gathering process that tries to bring together idea generation and consensus building in one meeting. ▪ A question is proposed and then participants' comments are solicited, compiled, and shared with the larger group. Participants are then asked to rank the priorities presented by the larger group in order of importance. 	<ul style="list-style-type: none"> ▪ This method requires equal participation of all participants. ▪ It reduces the likelihood of having one participant dominate the discussion. ▪ It generates a list of prioritized solutions or recommendations that the majority of participants democratically approve. 	<ul style="list-style-type: none"> ▪ This is a structured approach that can decrease the possibilities of discussions and the generation and refinement of ideas.
Delphi technique	<ul style="list-style-type: none"> ▪ This is a structured model primarily conducted using surveys. Participants fill out a questionnaire, and the results (typically a statistical representation of the group response) are then distributed to all participants or shared via round discussions. Participants are invited to update their initial responses in light of the responses of others, allowing for the exchange of knowledge and reasoning. ▪ Typically, two or more Delphi rounds are done, with the participants' responses converging toward consensus. 	<ul style="list-style-type: none"> ▪ This method can be done virtually, reducing the risk for social bias as well as the likelihood that one participant will dominate the responses. ▪ It is inexpensive. ▪ It can engage a large number of stakeholders through online surveys. ▪ Priorities can be ranked and analyzed through a database. ▪ It is useful as a first step in collecting perceptions and opinions. ▪ It may be helpful in developing a preliminary set of health research priorities. 	<ul style="list-style-type: none"> ▪ It requires expertise to develop the questions and criteria. ▪ There is limited opportunity for discussion. ▪ It may be subject to response bias and survey fatigue due to repeated surveys.

Source: Original table for this publication.

Prioritization Phase: Use of Prioritization Criteria

Prioritization criteria comprise an element in the priority-setting process that involves a set of measures that participants use to weigh and identify which issue should be chosen as a priority in decision-making. Clear criteria provide guidance for those involved in the priority-setting process and facilitate communication of the rationales for choosing priority decisions to stakeholders. Additionally, prioritization criteria play a key role in improving the quality of the decisions by maintaining consistency, promoting objectivity, and strengthening the validity of the choices (Kapiriri and Razavi 2022).

To increase the benefits of the priority-setting process and ensure the buy-in and ownership of participants and stakeholders, it is recommended that both participants and stakeholders be engaged in setting the prioritization criteria (WHO 2020). By involving participants and stakeholders in this step, the priority-setting exercise can be backed up with reliable and transparent criteria that show how the priorities were determined (WHO 2020). The suggested criteria will be used to keep the conversation focused on research priorities while also ensuring that essential concerns are not neglected (WHO 2020).

The menu shown in table 2.4 is an accumulation of prioritization criteria that have been used in previous priority-setting exercises across the world (Fadlallah et al. 2020). You can engage the core team alone or consult with participants to narrow and select the prioritization criteria that best fit KSA and the SHC context. The selected set of criteria may further be tailored to each priority-setting exercise.

Table 2.4: Prioritization Criteria

Domain	Criteria
Problem-related considerations	<ul style="list-style-type: none"> ▪ Public health burden ▪ Economic burden ▪ Burden on health care system ▪ Equity consideration
Practice considerations	<ul style="list-style-type: none"> ▪ Uncertainty for decision-makers and practitioners ▪ Variation in practice
Existing systematic reviews	<ul style="list-style-type: none"> ▪ Availability of systematic reviews ▪ Quality of available systematic reviews ▪ Relevance of available systematic reviews to topic of interest ▪ Currency of available systematic reviews
Existing primary studies	<ul style="list-style-type: none"> ▪ Availability of primary studies ▪ Potential to change conclusions
Answerability of topic/question	<ul style="list-style-type: none"> ▪ Translation of issue into answerable topic/question
Urgency	<ul style="list-style-type: none"> ▪ Urgency of the issue
Implementation considerations	<ul style="list-style-type: none"> ▪ Applicability of research, capacity, resources, and political will
Ethical and moral considerations	<ul style="list-style-type: none"> ▪ Social responsibility, ethical concerns, moral obligations
Interest of the topic	<ul style="list-style-type: none"> ▪ Health professionals ▪ Consumers ▪ National-level stakeholders ▪ Regional-/global-level stakeholders ▪ Systematic review team
Expected impact of applying evidence	<ul style="list-style-type: none"> ▪ Health policy and practice ▪ Health outcomes ▪ Economic outcomes ▪ Patient experience of care ▪ Equity ▪ Health systems

Source: Fadlallah et al. 2020.

Example of Prioritization Criteria

In order to determine whether the chosen problem or issue is a priority, the K2P Center has a set of criteria in the form of yes/no questions (see the numbered list below). Ideally, an issue should have a “Yes” response to at least 12 of the 14 questions to be prioritized.

The criteria for selecting priority topics for KT products are shown in table 2.5.

Table 2.5: Criteria for Selecting Priority Topics for KT Products

Criteria	Yes	Not sure	No
Is the topic important to policy makers and stakeholders?			
Has the topic already been recognized as a policy challenge?			
Has the topic already been integrated into the policy cycle?			
Is there public interest on the topic?			
Is there sufficient local evidence?			
Are there viable options available to address the topic?			
Is there an opportunity for change?			
Is there important uncertainty about the topic and potential solutions?			
Is relevant research evidence available?			
Is there interest in informed deliberation about the problem and potential solutions?			
Does the topic have national and regional relevance?			
Is it feasible for the center to track outputs, outcomes, and impacts of the use of evidence in policy?			
Does addressing the topic yield long-term versus short-term wins?			
Is the topic clear and well defined?			

Source: Original table for this publication.

Proposed Prioritization Criteria for the SHC

This manual proposes some basic prioritization criteria for the SHC to use, building on the K2P Center's criteria laid out in table 2.5. The nine criteria shown below can be adapted to fit a particular context. Further refinements can be made with stakeholders, depending on the purpose and scope of the exercise. Each criterion can be scored on the three-point Likert scale, with points designated *Low*, *Medium*, and *High*. The criteria categories are:

- Magnitude: Does the topic address an issue of large magnitude?
- Relevance: Is the topic relevant to policy/community concerns?
- Urgency: Is the evidence on this topic needed within the next year?
- Applicability: Once we have evidence on this topic, can it drive policy changes?
- Feasibility: Is this topic do-able in your country? Essentially, is it possible to implement the proposed solutions?
- Impact on health: Will addressing this topic lead to improvements in health outcomes?

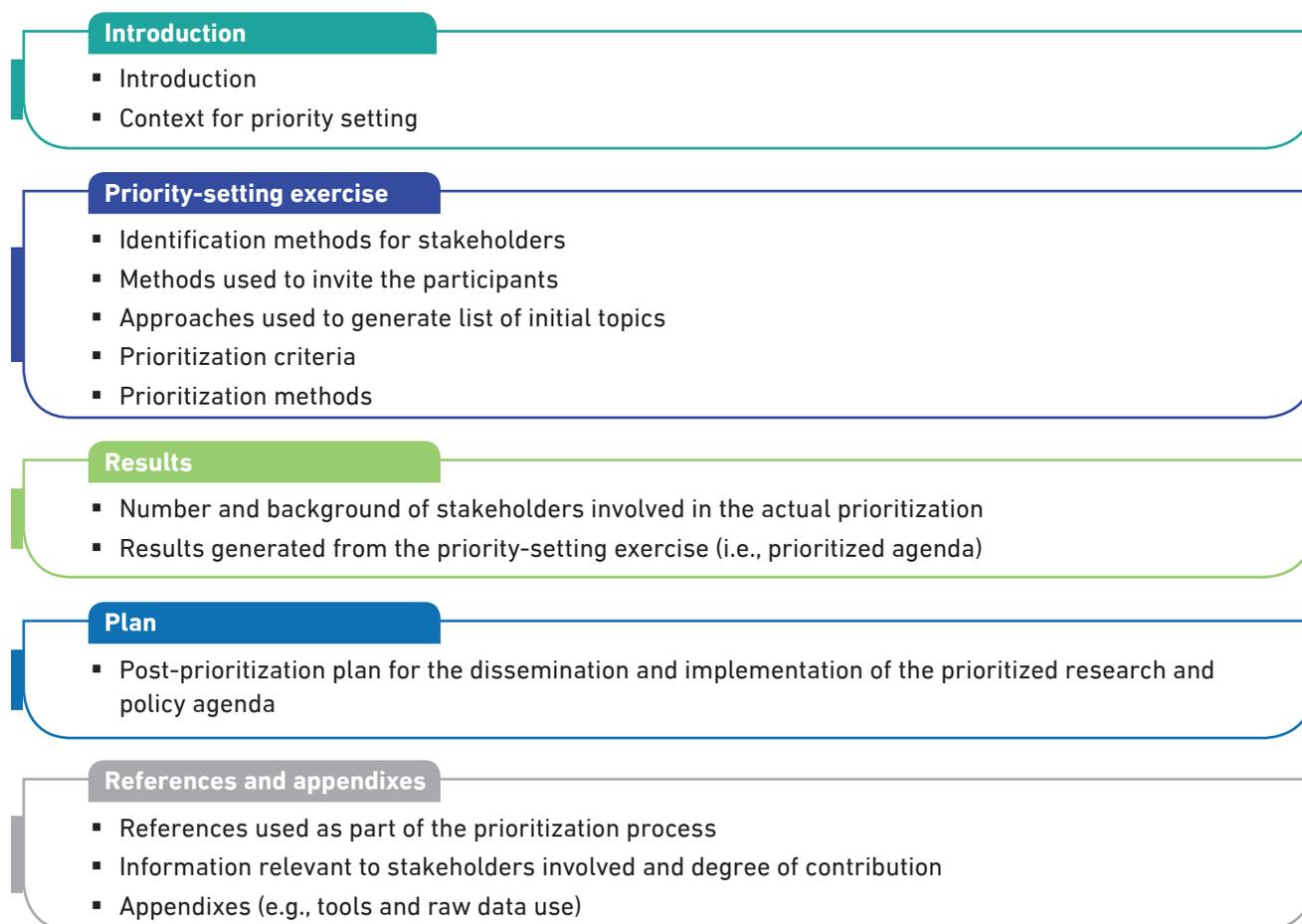
- Impact on economy: Will addressing this topic lead to improvements in economic outcomes?
- Political acceptability: Is addressing this topic acceptable to or desired by the involved ministries and policy leaders? Once we have evidence on this topic, can it drive policy changes?
- Answerability: Is relevant evidence available to address this topic?

Post-Prioritization Phase: Documentation, Dissemination, and Implementation of Priorities

Documentation

The full prioritization process, along with its results, should be documented in a clear and transparent report (PHNRS 2016). The report should include the following items: context for priority setting, the basis and process for selecting stakeholder/participants, the prioritization criteria, the methods used when deciding on priorities, and the resulting prioritized agenda (PHNRS 2016). It is critical to be as transparent as possible when producing the summary report on the priority-setting process (Viergever et al. 2010). Potential implementers of the prioritized research and policy agenda are more likely to adopt or implement the priorities if they are fully informed about all components of the process (Viergever et al. 2010). Figure 2.3 highlights the items that need to be reported as part of the summary report.

Figure 2.3: Sample Report Elements for the Prioritization Process



Source: Original figure for this publication.

Note: When developing the summary report, the order of the sections may be developed differently, based on the desired priority highlights.

Dissemination

Effective dissemination of the priorities is necessary if they are to influence the research and policy agenda as well as the funding agendas of stakeholders (NSW Ministry of Health 2019). Therefore, a dissemination strategy should be established to outline the different methods that will be adopted to inform the stakeholders about the priorities (NSW Ministry of Health 2019).

During the implementation phase, you may:

- Identify stakeholders who support you by amplifying your key messages (WHO 2020). These stakeholders may be part of the steering committee (WHO 2020).
- Gather your stakeholders online or face-to-face to identify different potential ways to disseminate the priorities (WHO 2020).
- Use editorials, conferences, and online webinars for dissemination. The team may aim to prepare dissemination material, including PowerPoint slides, to be used by stakeholders when discussing the agreed priorities (WHO 2020).
- Use social media to circulate the priorities (WHO 2020). Appropriate images and text may maximize the impact of the priority-setting exercise on different platforms (WHO 2020).

As a first step, the list of research and policy priorities should be made available to the key stakeholders who contributed to their identification and development. Other groups may be considered as part of the dissemination strategy, as outlined in figure 2.4.

Figure 2.4: Groups of Stakeholders Participating in Dissemination



Source: Original figure for this publication.

Note: SHC = Saudi Health Council.

When developing a dissemination plan, the following items should be considered:

- Stakeholders' information and communication requirements, including:
 - Who needs the information?
 - When will they need the information?
 - How will the information be provided to them?
 - What type of information do they need?
 - Why do they need this information?

- Distribution criteria of information, including:
 - Information that will be disseminated,
 - Format in which the information will be disseminated,
 - Dissemination channels that will be used, and
 - Schedule of information dissemination.

Implementation of Priorities

Strategies to implement priorities could include informing and gathering support from the government, funding agencies, and policy makers to allocate funding and resources toward the identified priorities as well as collaborating with researchers to develop proposals (Tong et al. 2019).

Post-Prioritization Phase: Revision or Appeal Mechanism

Mechanisms should be established to allow for adequately updating the prioritized agenda based on an appeal from the stakeholders. This will ensure that the agenda is responsive to their evolving needs (PHNRS 2016).

Updating the prioritized research and policy agenda necessitates assessing and re-evaluating its implementation (PHNRS 2016). This step can be conducted on a regular basis (for example, yearly) or on an ad hoc one (NSW Ministry of Health 2019; PHNRS 2016). When carried out on a regular basis, the frequency with which the agenda is updated should be specified and related to monitoring and evaluation activities (PHNRS 2016). Changing epidemiological and socioeconomic landscapes, new political leadership, or a transformed health policy environment are the most common reasons that require a revision of the prioritized agenda (PHNRS 2016). Figure 2.5 outlines the different items that need to be taken into account as part of the review process.

Figure 2.5: Items to be Considered as Part of the Revision Process



Source: Original figure for this publication.

Though efforts will have been made to ensure that stakeholders are included and appropriately represented throughout the implementation phase, there may still be conflict over what should be included in the prioritized agenda during the post-implementation phase (PHNRS 2016). Stakeholders should be permitted to appeal in order to address their complaints in a transparent and fair manner. The steering committee will need to set up a clear and transparent appeals process (PHNRS 2016).

Post-Prioritization Phase: Monitoring and Evaluation

The success of a priority-setting exercise is the result of a combination of awareness, implementation, translation, and uptake of the prioritized agenda (WHO 2020). Regularly monitoring how research for priorities is integrated into the agenda yields critical information for measuring the success of the priority-setting cycle and determining whether the present priority list needs to be revised and updated (COHRED 2010). Therefore, a plan needs to be put in place by the steering committee to monitor and evaluate the impact of the priority-setting exercise.

The monitoring and evaluation plan is usually established during the initial phase of priority setting (COHRED 2010). However, some deviations from the established plan may occur during implementation (COHRED 2010). When necessary, the monitoring and evaluation strategy prepared during the preparatory phase should be revised. If no modifications are required, the strategy can proceed as planned (COHRED 2010; PHNRS 2016).

When developing a monitoring and evaluation strategy, some items need to be taken into consideration. These include, but are not limited to, the following:

- Identification of quality standards applicable to the priority-setting exercise
- Availability of a performance evaluation schedule
- Identification of outcomes that should be monitored and evaluated as performance indicators
- Specification of appeal procedures that can be used for challenging and resolving disagreements about priority-setting decisions
- Regulation measures that are specified to ensure that ethical standards are met (transparency, relevance, revision)
- Methods through which the evaluation will be conducted.

The monitoring process is frequently guided by the use of indicators that are quantitative or qualitative variables or factors. This involves both process and outcome indicators. *Process indicators* refer to how things are being conducted (see table 2.6). *Outcome indicators* may include but are not limited to changes in awareness, knowledge, attitudes, behaviors, skills, practices, opinions, decision-making, and/or policy development (Graham et al. 2012) (see table 2.7).

To develop the monitoring and evaluation plan, select the list of indicators (from the menu of indicators presented in tables 2.5 and 2.6) that best fits the institutional context. When choosing the indicator to use for the specific monitoring process, ensure that it is *valid* (for example, it measures what it is supposed to measure); *acceptable* (for example, it works for the target being assessed or person undertaking the assessment); *feasible* (for example, it encompasses the extent to which reliable, consistent, and valid data are available for data collection); *reliable* (for example, it results in minimal measurement error and in reproducible findings); *sensitive to change* (for example, it can detect changes in measurements); and has *predictive validity* (for example, it can predict relevant outcomes).

Process indicators include but are not limited to those presented in table 2.6.

Table 2.6: Process Indicators and Their Data Sources

Process indicator	Suggested source of data
<p>Resources</p> <ul style="list-style-type: none"> ▪ Human resource allocation to the health research ▪ Budgetary resource allocation to the health research 	<ul style="list-style-type: none"> ▪ National budget documents
<p>Stakeholder engagement</p> <ul style="list-style-type: none"> ▪ The ministry of health (or other related ministry) has identified relevant internal and external stakeholders and involved them successfully in the decision-making process ▪ Number of stakeholders engaged in the priority-setting exercise _____ ▪ Number of opportunities provided to each stakeholder to express his/her opinion _____ ▪ Adequate representation of stakeholders in the priority-setting process 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Media or other special reports ▪ Attendance/registration sheets
<p>Use of explicit process (for example, the priority-setting process was transparent to all stakeholders)</p> <ul style="list-style-type: none"> ▪ Stakeholders know who is making the decisions ▪ Stakeholders know how decisions are being made ▪ Stakeholders are informed of why decisions were made 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Surveys ▪ Focus group discussions or interviews with stakeholders
<p>Clear priority-setting process and methods</p> <ul style="list-style-type: none"> ▪ Use of a priority-setting framework ▪ Documentation of the priority-setting process ▪ Documentation or priority-setting criteria 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Media or other special reports
<p>Efficiency of the priority-setting process</p> <ul style="list-style-type: none"> ▪ Proportion of consultation time spent on priority-setting _____ ▪ Number of timely decisions made _____ 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Annual budget documents ▪ Health system reports
<p>Use of evidence</p> <ul style="list-style-type: none"> ▪ Number of times available data is resourced _____ ▪ Number of studies that are commissions _____ 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Media or other special reports
<p>Information management (for example, information is made available to decision-makers during the priority-setting exercise)</p> <ul style="list-style-type: none"> ▪ Decision-makers are informed of what information was used ▪ Decision-makers are informed of what was perceived by participants in the priority setting to be lacking ▪ Decision-makers are informed of how the information was collected and summarized 	<ul style="list-style-type: none"> ▪ Pre-/post-priority-setting survey when applicable (immediate and follow-up surveys) ▪ Key informant interviews or focus group discussions ▪ Internal to ministry staff yearly surveys with rating scales

Process indicator	Suggested source of data
<p>Consideration of context and value (for example, priority-setting decisions are based on grounded reasons that are explicit and made with clear value choices)</p> <ul style="list-style-type: none"> ▪ Priority-setting decisions integrate the values of the organization ▪ Priority-setting decisions integrate the values of staff within the organization ▪ Priority-setting decisions integrate the values of other stakeholders 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Media or other special reports
<p>Revision of appeal mechanisms</p> <ul style="list-style-type: none"> ▪ Availability of an appeal mechanism ▪ Number of decisions from the priority-setting exercise appealed _____ ▪ Number of decisions from the priority-setting exercise revised _____ 	<ul style="list-style-type: none"> ▪ Observations ▪ Meeting minutes ▪ Media or other special reports

Source: Original table for this publication.

Note: The proposed process indicators can be adapted to a country's particular context.

Outcome indicators include but are not limited to those in table 2.7.

Table 2.7: Outcome Indicators and Their Data Sources

Outcome indicator	Suggested source of data
<p>Improved stakeholder understanding</p> <ul style="list-style-type: none"> ▪ Gained understanding of the priority setting process (for example, goals, rationales for process and for decisions) ▪ Gained understanding of the organization (for example, its mission, vision, values, strategic plan) 	<ul style="list-style-type: none"> ▪ Email feedback surveys ▪ Key informant interviews or focus group discussions
<p>Shift in priorities and/or reallocation of resources</p> <ul style="list-style-type: none"> ▪ Changes in allocation of budget across the agenda (for example, the proportion of increase in health research budget) ▪ Changes in employment of physical or financial resources ▪ Changes in strategic directions ▪ Change in grant size (volume) of research funding from baseline established during the planning phase 	<ul style="list-style-type: none"> ▪ Yearly reports from the Global Observatory on Health Research and Development ▪ National budget and other fiscal documents ▪ Survey of national and international funders
<p>Improved decision-making quality</p> <ul style="list-style-type: none"> ▪ Proper use of available evidence ▪ Constancy of reasoning ▪ Institutionalization of the priority-setting exercise ▪ Alignment of priorities with the goals of the exercise ▪ Compliance with the agreed-upon process for the priority-setting exercise 	<ul style="list-style-type: none"> ▪ Physical observations ▪ Meeting minutes

Outcome indicator	Suggested source of data
<p>Stakeholder acceptance and satisfaction (for example, what stakeholder participants thought of the exercise)</p> <ul style="list-style-type: none"> ▪ Percentage of stakeholders who want to participate in the priority setting process ▪ Percentage of stakeholders reporting satisfaction with the process ▪ Percentage of stakeholders who are supportive of the outcome of the exercise ▪ Percentage of stakeholders who have changed their behavior as a result of the exercise 	<ul style="list-style-type: none"> ▪ Pre-/post-priority-setting survey when applicable (immediate and follow-up surveys) ▪ Key informant interviews or focus group discussions ▪ Internal to ministry staff yearly surveys with rating scales
<p>Positive externalities</p> <ul style="list-style-type: none"> ▪ Positive media coverage ▪ Changes in health policy to identified priorities ▪ Research contribution to health system goals based on identified priorities ▪ Changes to legislations or practice ▪ Number of times decisions and rationales appear in public documents 	<ul style="list-style-type: none"> ▪ Policy documents ▪ Databases for research such as Pubmed, Web of Sciences, Google Scholar ▪ Analytics including Vimeo analytics, Google Analytics, Facebook analytics, and Twitter and YouTube analytics ▪ Media reports
<p>Awareness (for example, stakeholders' awareness of the priorities and the need to reference them)</p> <ul style="list-style-type: none"> ▪ Number of views and downloads of published reports ▪ Number of references to priority-setting document available in the academic literature ▪ Number of references to priority-setting document in strategy documents of national/international funders or country ministries, policy briefs ▪ Number of references to priority-setting document in health product profiles 	<ul style="list-style-type: none"> ▪ Altmetric score ▪ Google analytics ▪ References in newsletters ▪ Links in other websites ▪ Databases such as PubMed, Google Scholar, Web of Sciences
<p>Improved health</p> <ul style="list-style-type: none"> ▪ Improved health impact measures such as the health-adjusted life expectancy (HALE) over time (for example, health gains or changes in HALE since the research was carried out) 	<ul style="list-style-type: none"> ▪ Collective review from the all measures listed above

Source: Original table for this publication.

Note: It is important to take into consideration that direct attribution of changes to the priority-setting exercise is difficult and that the time period between carrying out the research and realizing the impacts might be decades.

Annex 2A: Template for Priority Setting

Note: This annex is based on the K2P Mentorship Program; details are available at <https://www.aub.edu.lb/k2p/Pages/K2PMPDescription.aspx>.

This template is intended to support the drafting of a tailored priority-setting approach and tool for the actual priority-setting exercise that you plan to conduct in your country or region. It helps country teams define the specific steps to be taken in the pre-prioritization, prioritization, and post-prioritization phases to conduct the priority-setting exercise. The approach and tool can be tailored to future priority-setting exercises.

Priority-Setting Process

While there is no consensus on a gold standard when it comes to setting priorities for health research, countries need to tailor the different steps to their own contexts and needs. All the steps listed in box 2A.1 should be applied in an ideal priority-setting exercise.

Box 2A.1: Priority-Setting Exercise

Pre-Prioritization Phase

- Establishment of a steering committee
- Generation of initial list of topics/questions
- Stakeholder mapping

Prioritization Phase

- Methods for priority setting
- Use of prioritization criteria

Post-Prioritization Phase

- Documentation, dissemination, and implementation of priorities
 - Revision or appeal mechanism
 - Monitoring and evaluation
-

Scope, Focus, and Guiding Principles

To clarify the scope, focus, and guiding principles for the priority setting exercise, steering committee members can write a brief description of each element in the following form.

Element	Description
Purpose of the priority-setting exercise	
Scope of work (e.g., knowledge translation products addressing health policy and systems research topics)	
Level of priority setting (national, regional)	
Expected outputs (e.g., a list of top five topics ranked by priority)	

Element	Description
Mechanism for promoting accountability and/or management of potential conflict of interest (e.g., clear communication process, disclosure of conflict of interest forms); if not applicable, please insert N/A.	
Political environment (are there any political/regulatory/legal considerations that may influence the priority-setting process and must be accounted for); if not applicable, please insert N/A.	

Phase 1: Pre-Prioritization Phase

1. Establishment of the Steering Committee

Describe the constituency of the steering committee and its core function, and designate the leader. You can refer to figures 2.2 and 2.3, respectively, for guidance.

Constituent	Function(s)

2. Generation of Initial List of Topics

Describe the methods for generating an initial list of topics that will feed into the actual prioritization phase (for example, literature review, stakeholder input, health information system, media analysis, review of previous priority-setting exercises, or a combination of all these).

3. Stakeholder Mapping

Please list here all the potential stakeholders, by category, who would be involved in the priority-setting process. You are required to fill in only the categories that apply to your context. For each selected stakeholder, indicate his/her level of interest in the topics/themes and their level of power (for example, the extent to which they can influence action on the topics/themes as well as the extent to which they are influenced by action on the topics/themes).

Category	Stakeholder	Interest	Power
Government and policy makers			
Researchers/ academia			
Health service providers and managers			
Professional associations			
Members of the public, patients, and community members			
Health system payers			
Research funders			
Private sector (including nongovernmental organizations)			

Total number of stakeholders : _____

Timeline for sending invitations : _____

Sample Priority-Setting Tool

Theme and topic	Criterion														
	L	M	H	L	M	H	L	M	H	L	M	H	L	M	H
Theme 1															
Topic/question															
Topic/question															
Topic/question															
Theme 2															
Topic/question															
Topic/question															
Topic/question															
Theme 3															
Topic/question															
Topic/question															
Topic/question															

Note: In some cases, the topics/questions may not need to be grouped under specific themes, particularly if the topics/questions address the same theme. Each criterion can be scored on the three-point Likert scale, with points designated *Low*, *Medium*, or *High*. H = high; L = low; M = medium.

Phase 3: Post-Prioritization Phase

1. Documentation, dissemination, and implementation of priorities

Indicate how you plan to document and disseminate your list of generated priorities. Also indicate who will be held responsible for the development of research/knowledge translation products addressing the generated priorities.

Task Time Estimate

The table below will help you track your progress with the actual priority setting exercise that you plan to conduct, including the related time frames.

Phase	Description of progress	Projected start and end dates	Actual start and end dates
Phase 1			
Phase 2			
Phase 3			

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CHAPTER 3

LITERATURE SEARCH FOR RELEVANT EVIDENCE

Introduction

This chapter is concerned with efficiency in the literature search for evidence relevant to informing policy decisions. It covers the following steps:

- Determining what type of evidence to search for
- Determining where to search for relevant evidence
- Developing a search strategy
- Screening evidence
- Ensuring a critical appraisal of evidence
- Synthesizing the evidence.

This chapter also provides a template for developing a search strategy and another template for documenting that search strategy. The chapter has adapted materials from the following sources:

- Oxman and Hanney's 2009 SUPPORT Tools for evidence-informed health Policymaking (STP): Guides, available at <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-7-supplement-1>.
- The WHO/EURO 2020 *Evidence Briefs for Policy: Using the Integrated Knowledge Translation Approach: Guiding Manual*, available at <https://apps.who.int/iris/bitstream/handle/10665/337950/WHO-EURO-2020-1740-41491-56588-eng.pdf?sequence=1&isAAllowed=y>. The manual was primarily developed by the Knowledge to Policy (K2P) Center.

The following case scenario provides an example of how to proceed with an efficient literature search.

Case Scenario: *The Saudi Health Council (SHC) is interested in tackling the issue of the misdistribution of health workers in urban-rural areas in the Kingdom of Saudi Arabia (KSA). They request evidence of the extent of the problem in KSA and effective policy options/interventions to address this growing problem in your country. How do you proceed?*

Once priority problems and issues have been identified, the next stage is to conduct a comprehensive literature search to identify the best available evidence about the problem, the policy options available to address it, and the implementation considerations.

To respond to the case scenario, you will need to take each of the steps identified above. The subsequent sections elaborate on each one.

Determining What Type of Evidence to Search for

As discussed in previous chapters, policy decisions require a combination of *global evidence* (the best available evidence from around the world)—ideally from systematic reviews—and different types of *local evidence* to inform the judgments that need to be made about health policy decisions (Lewin et al. 2009).

A literature search will be conducted to gather local data and global research evidence. The evidence hierarchy pyramid (figure 3.1) can guide the type of research evidence to prioritize.

Global Research Evidence

Systematic reviews provide the highest quality of research evidence. They are increasingly considered to be a key source of information in policy making, particularly in terms of the effectiveness of options and solutions, factors that modify those effects, and implementation considerations. If systematic reviews are lacking about a specific topic, high-quality primary studies can be considered.

Local Data

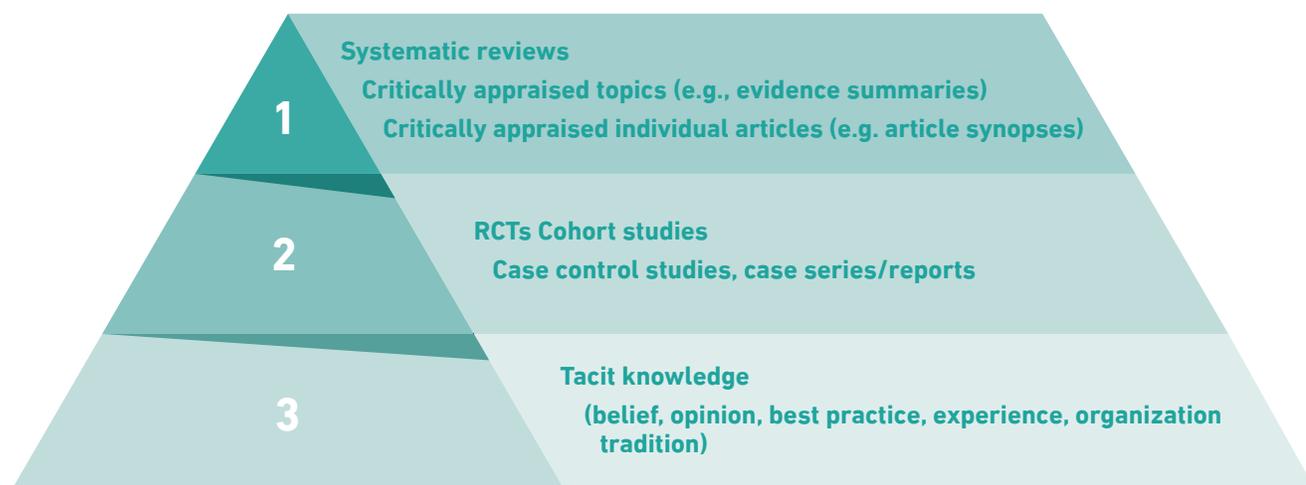
Local data are important to contextualize the problem and to establish its magnitude and its underlying factors. These local data can be obtained from published reports and indicators of relevant governmental bodies (for example, ministries and departments of health) and from national, regional, and international organizations (for example, the World Health Organization, or WHO; United Nations, or UN, agencies). In addition, these data can be obtained from published peer-reviewed studies from the country of interest. Examples of local data include a country's burden of a disease, the prevalence of a risk factor, availability of resources, and existing health system arrangements.

Evidence Hierarchy

Evidence that is valid and reliable enhances the decision-making process. For this reason, it is imperative to be able to distinguish which evidence is the “best”—that is, which evidence is the most valid and reliable (CEBMa, no date). To that end, a hierarchy of quantitative evidence has been suggested to guide the weighing of different levels of evidence when taking decisions and to indicate that some study designs are deemed stronger than others and have less bias (Ciliska 2015; Minkow 2014). No study is free from bias; however, as you go down the hierarchy, the likelihood of bias increases (Ciliska 2015) (see figure 3.1).

Systematic reviews are considered to provide the highest quality of evidence within the evidence hierarchy (figure 3.1), where there are explicit methods of searching for, including, appraising, and synthesizing evidence (Djulgovic and Guyatt 2017; Murad et al. 2016). However, it is important to consider that all systematic reviews may not be of the same quality, or they may not exactly and directly capture the problem at hand, or they may be from a different context that is not entirely transferable to the relevant context. When multiple systematic reviews are available, you should consider the date or years included in the search in order to know how current the publication is (Ciliska 2015). When the systematic reviews are more recent and shown to be of high quality, no additional primary studies may be needed unless those are published after the search dates used in the systematic reviews (Ciliska 2015). If systematic reviews are lacking about a specific topic, high-quality primary studies can be considered (again following the evidence hierarchy). If your topic is not answered by the literature, you may decide to seek tacit knowledge (for example, expert opinion) on the matter to guide your decision-making process (Ciliska 2015).

Figure 3.1: The Evidence Hierarchy Pyramid



Source: Based on Campbell 2012.

Note: The darker the color in the figure, the higher the quality of the evidence. RCTs = randomized controlled trials.

Determining Where to Search for Relevant Evidence

Systematic Reviews

Table 3.1 presents some key databases to search for systematic reviews. You can search one or more of the below databases, depending on the nature of topic (for example, whether the topic is concerned with the health system or with a social or public or clinical topic).

Table 3.1: Key Databases to Search for Systematic Reviews

Database	Description	Website	Details
Health Systems Evidence	Systematic reviews addressing health system arrangements and implementation strategies	www.healthsystemsevidence.org	<ul style="list-style-type: none"> Log in (or register) Click on “Advanced search” Copy and paste the search into the field (or select an appropriate health system arrangement in the taxonomy) Click on “Filter document by” to filter by type of document, country, date, sector, and health system arrangement
Social Systems Evidence	Systematic reviews about strengthening 16 government sectors and program areas, and about achieving the 17 Sustainable Development Goals (SDGs)	www.socialsystemsevidence.org	<ul style="list-style-type: none"> Log in (or register) Click on “Advanced search” Copy and paste the search into the field (or select an appropriate health system arrangement in the taxonomy) Click on “Filter document by” to filter by program and services, SDG, country, sector, and so on

Database	Description	Website	Details
Health Evidence	A database of systematic reviews evaluating the effectiveness of public health interventions	http://www.healthevidence.org/	<ul style="list-style-type: none"> Go to the website Copy and paste the search into the "Search" field Use "Advanced search" option for detailed search strategy
The Cochrane Library	Systematic reviews addressing clinical programs and services or drugs	http://www.cochranelibrary.com/	<ul style="list-style-type: none"> Click on "The Cochrane Library" in the top right corner Copy and paste search into open search field Click "Go"
PubMed	Quantitative and qualitative studies addressing clinical and public health programs and services	https://www.ncbi.nlm.nih.gov/pubmed/	<p>For quantitative studies</p> <ul style="list-style-type: none"> Select "Advanced Search" Click "Edit" and copy and paste the search into the field Select "Search" Click on "Customize" in the top left corner Click on "Systematic review" to limit to systematic reviews <p>For qualitative studies</p> <ul style="list-style-type: none"> Click on "Topic-Specific Queries" Select "Health Services Research (HSR) Queries" Click on "Qualitative research" from the list of categories

Source: Based on WHO/EURO 2020.

Local Data

Local evidence may be obtained from the following sources (Lewin et al. 2009):

- Routine health information systems (national, district, or other local health authorities; or other organizations in the health system).
- Larger surveys or studies that can be disaggregated (for example, national censuses, regional surveys of access to basic facilities, and national demographic and health surveys).
- Specific studies that have collected or analyzed data on a local level.

It is worth noting that there may be variations in the results of local evidence on a particular health issue across sources for one or more of the following reasons:

- Differences in the ways in which data were collected and analyzed across the sources.
- Differences between the individuals, groups, or entities about whom data were collected.
- Differences in the way in which the issue was defined and measured.
- Differences in the comparators used.
- Differences in the interventions delivered (where applicable).

According to Lewin et al. (2009), some questions to keep in mind when considering variations in results of local evidence are:

- Is the variation potentially important from a clinical or policy perspective?
- If the variation is important, is a reasonable explanation clear from the data sources, or can a reasonable explanation be hypothesized (for example, differences in recruitment, measurement, analysis, and so on)?
- Are there other sources of information against which the local evidence can be compared?

Importantly, you should document any decisions taken regarding the interpretation of the evidence and note any uncertainties.

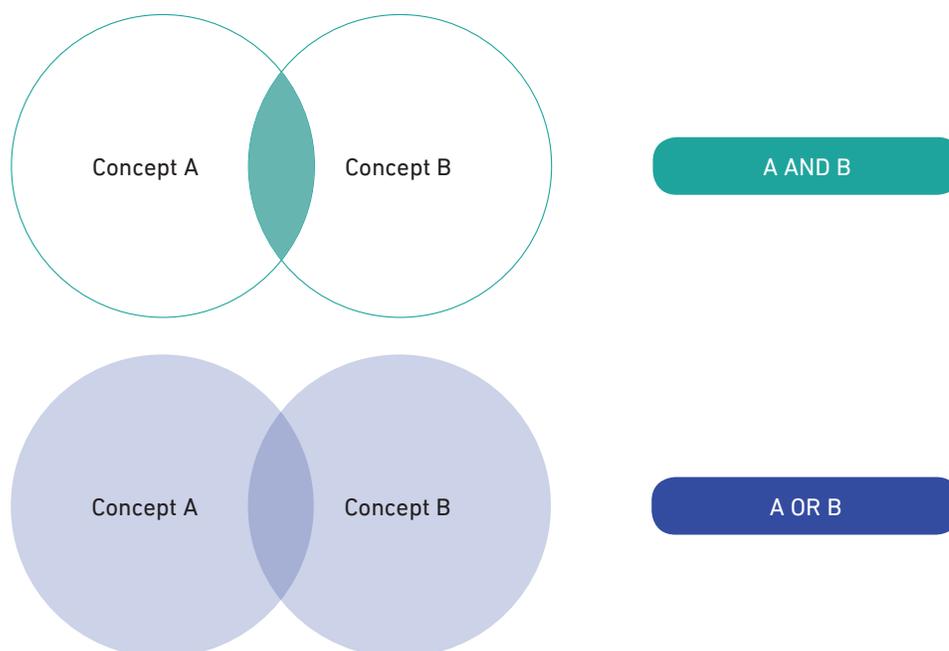
Developing a Search Strategy

1. The first step is to split the problem statement into two or three concepts.
2. Once you have identified your key concepts, the next step is to generate search terms for each concept. You can identify search terms through consultation with content experts, search strategies used in previous studies, and relevant articles on the topic.

Use truncations to capture word variations. Truncations such as * can be used to find different forms of a word. For example, you can use *prescri** to capture the words *prescribing*, *prescribe*, *prescribed*, *prescription*.

Combine **concepts** using Boolean operator (**AND**) and **search terms** within each concept using Boolean operator (**OR**) (see figure 3.2).

Figure 3.2: Example of the Boolean Operators



Source: Based on WHO/EURO 2020.

Template for a Search Strategy

A template for a search strategy using the concepts and terms you have generated is provided below.

Template: Search Strategy
The Problem:
Concepts (up to three can be generated): Concept A: Concept B: Concept C:
Search terms for each concept (you can use *): Concept A: (x OR y OR z) Concept B: (a OR b OR c* OR d*)
Combine concepts using Boolean operators (AND/OR): (x OR y OR z) AND (a OR b OR c* OR d*)

Boxes 3.1 and 3.2 provide examples of developing a search strategy.

Box 3.1: Developing a Search Strategy: Example 1

The Problem
High prevalence of obesity among children
Concepts: Concept A: Obesity Concept B: Children
Search terms for each concept (you can use*): Concept A: obesity OR obese OR overweight OR adipos* OR overeat* OR BMI OR "body mass index" Concept B: child OR children OR infant* OR student* OR pupil OR adolescent* OR youth* OR teenage* OR boys OR girls
Combine concepts and search terms using Boolean operators (AND/OR): (obesity OR obese OR overweight OR adipos* OR overeat* OR BMI OR "body mass index") AND (child OR children OR infant* OR student* OR pupil OR adolescent* OR youth* OR teenage* OR boys OR girls)

Box 3.2: Developing a Search Strategy: Example 2

The Problem

Shortages of health professionals practicing in rural and other underserved areas

Concepts:

Concept A: Health professionals

Concept B: Underserved areas

Search terms for each concept (you can use *):

Search terms for Concept A: (recruit* OR retain* OR retention OR density OR turnover OR brain drain* OR shortage OR understaff* OR maldistribution OR rural/urban imbalances)

Search terms for Concept B: (rural OR remote OR underserved OR village* OR town OR nonmetropolitan OR deprived)

Combine concepts and search terms using Boolean operators (AND/OR):

(Professional* OR workforce* OR physician* OR clinician* OR doctor* OR nurse OR nurses OR "human resource*" OR manpower OR provider* OR staff OR practitioner* OR midwife OR midwives OR "health manager*" OR "health technician*" OR "community health worker*") **AND** (recruit* OR retain* OR retention OR density OR turnover OR 'brain drain*' OR shortage* OR understaff* OR maldistribution OR "rural-urban imbalance*" rural OR remote OR underserved OR village* OR town OR nonmetropolitan OR deprived)

3. The third step is to validate the search strategy for each of the databases in consultation with an information specialist or a librarian.
4. The fourth step is to save and document the search strategy in a word document including the date of the search and number of hits. The template below highlights the information needed to document your search strategy.

Template for Documenting a Search Strategy

A template for documenting the search strategy is provided below.

Template: Search Documentation			
Database searched (date of last search)	Search strategy (concepts and search terms used)	Filters applied	Number of relevant studies retrieved

5. The next and fifth step is to export the results of each electronic database search to a reference software system such as Endnote where duplicates will be removed.

Gray literature is something that should be considered only when necessary (see box 3.3).

Box 3.3: Gray Literature

Gray literature is the term for information that is “produced on all levels of government, academics, business, and industry in print and electronic formats but which is not controlled by commercial publishers” (NYAM 2003; WHO/EURO 2020, p. 57). Gray literature includes documents that have not been formally published in a peer-reviewed format. It includes unpublished research, government or organization reports, theses, dissertations, conference proceedings or abstracts, technical reports, and policy briefs.

Some databases that can be searched for the gray literature include Open Grey, Grey Literature Report, POPLINE, ProQuest Dissertations and Theses, and Google.

Because searching the gray literature can be a difficult and time-consuming task, it will be searched only when the topic necessitates it or when there is insufficient evidence on the topic in peer-reviewed articles.

Sources: NYAM 2003; WHO/EURO 2020.

Screening Evidence

After conducting your search strategy, quickly scroll through your results. If you identified:

- A low number of hits (fewer than 100): scroll through all the results to check their relevance and to determine whether your search strategy was sensitive enough. If irrelevant studies were identified, consider revising the search strategy.
- A high number of hits: scroll through the first three to four pages to check for relevant systematic reviews or export the results to Endnote and scroll through the title and abstract of all the exported results.

After finalizing the literature search, you should conduct title and abstract screening for all the hits as first step in selecting relevant studies.

You can use a reference management system (for example, Endnote or Refworks) to conduct the title and abstract screening. You should save those studies identified as relevant to the topic of interest as PDF format in a separate file.

Ensuring Critical Appraisal of Evidence

Systematic Review

The most commonly used appraisal tool and system for reviewing systematic reviews is A MeaSurement Tool to Assess systematic Reviews (AMSTAR) (Shea et al. 2017).

The AMSTAR tool is recommended for critically appraising systematic reviews. It consists of 11 items, each of which is categorized into a standardized set of four possible responses: “yes,” “no,” “can’t answer,” or “not applicable.” Systematic reviews retrieved from Health Systems Evidence and Social Systems Evidence databases will have been appraised using this tool.

AMSTAR scores are divided into categories such that the evidence is of high, medium, or low quality (see box 3.4 for an example).

Box 3.4: Example of AMSTAR Quality Scoring

The key findings were extracted from the identified reviews. Each review was also assessed in terms of its quality (A MeaSurement Tool to Assess systematic Reviews, or AMSTAR, rating of 0–11). The quality of evidence was classified as follows:

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

Sources: Based on Hajdu et al. 2018; WHO/EURO 2020.

In addition to assessing the quality of systematic reviews, it is important to identify the extent to which systematic review evidence is applicable and appropriate for the local context: any decisions made using that evidence must consider its applicability as well as its strength. To assess the local applicability of systematic reviews, some guiding questions should be asked—see the checklist in box 3.5.

Box 3.5: Questions for Assessing the Local Applicability of Systematic Reviews

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

Source: Lavis et al. 2009.

Local Data

Like all other forms of evidence, the quality of local evidence needs to be assessed. You can use the tool in box 3.6 to guide assessments of the quality of local evidence.

Box 3.6: Tool for Assessing the Quality of Local Evidence

Main quality criteria	Subquestions
Is the evidence representative?	<ul style="list-style-type: none"><input type="checkbox"/> Is there a clear description of the source of the evidence?<input type="checkbox"/> If the evidence is drawn from a sample of the population of interest, is there a clear description of how the sampling was conducted?<input type="checkbox"/> Was the sampling approach appropriate (where applicable)?<input type="checkbox"/> Is there a description of how any inferences or generalizations were made to the wider population?
Is the evidence accurate?	<ul style="list-style-type: none"><input type="checkbox"/> Is there a clear description of who collected the data?<input type="checkbox"/> Were the data collectors appropriately trained and supported in this task?<input type="checkbox"/> What tools were used for data collection?<input type="checkbox"/> Were appropriate tools used?<input type="checkbox"/> When were the data collected?<input type="checkbox"/> Was the quality of the data collected monitored and shown to be adequate?<input type="checkbox"/> How were the data analyzed?<input type="checkbox"/> Was the method of analysis reported clearly?<input type="checkbox"/> Were any data limitations discussed?
Are appropriate outcomes reported?	<ul style="list-style-type: none"><input type="checkbox"/> Is there a clear description of the outcome/s measured?<input type="checkbox"/> Is the outcome measure reliable?<input type="checkbox"/> Were these outcomes measured appropriately?<input type="checkbox"/> Do these outcomes provide a reasonable assessment of the health issue?

Source: Lewin et al. 2009.

Synthesizing the Evidence

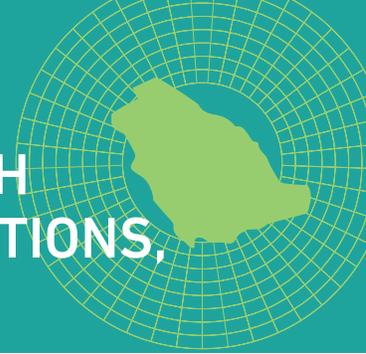
Once all the relevant systematic reviews for specific policies and policy options have been accumulated and critically appraised, they need to be considered alongside local data and other health information (for example, tacit knowledge gathered through key-informant interviews) so that it all contributes to decision-making. Such cohesive evidence will help inform the final body of evidence to support the options or implementation considerations for policy decisions (WHO/EURO 2020).

Currently there is not a single, agreed framework for synthesizing diverse forms of evidence, but it is important that a systematic and transparent approach be adopted. The approach most commonly used to combine the different sources and types of evidence together is a narrative synthesis of different systematic reviews, qualitative research, local data, and research. This approach allows for the systematic review evidence on effectiveness to be complemented by the local context to enable meaningful interpretation at the country level. This is particularly important for implementation considerations that need to be grounded within the local setting (WHO/EURO 2020).

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PRACTICAL APPLICATIONS: USING RESEARCH EVIDENCE TO FRAME PROBLEMS, POLICY OPTIONS, AND IMPLEMENTATION CONSIDERATIONS



Introduction

This chapter covers three practical applications related to the use of evidence. Each is presented through a case scenario.

Practical Application 1, How to Frame the Problem, provides details about what goes into framing a clear problem statement and then describing the magnitude the problem, the problem's consequences, its underlying factors, and where to find evidence to apply this framing.

Practical Application 2, How to Frame Policy Options to Address a Problem, addresses proposing policy options, expanding on those policy options, weighing them, actually writing the policy, and where to find evidence for those options.

Practical Application 3, How to Identify Implementation Considerations for an Option, considers barriers and counterstrategies to policy implementation, where to find evidence of these barriers and facilitators of implementation, and the development of a policy implementation plan.

Annexes at the end of the chapter provide templates for problem framing and expanding on policy options; tables in the body of the chapter provide an overview of barriers and counterstrategies to implementation (table 4.10) and examples of implementation considerations (tables 4.11 and 4.12).

Materials have been adapted from the following sources:

- Oxman and Hanney's 2009 SUPPORT Tools for evidence-informed health Policymaking (STP): Guides, available at <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-7-supplement-1>.
- The WHO/EURO 2020 *Evidence Briefs for Policy: Using the Integrated Knowledge Translation Approach: Guiding Manual*, available at <https://apps.who.int/iris/bitstream/handle/10665/337950/WHO-EURO-2020-1740-41491-56588-eng.pdf?sequence=1&isAllowed=y>. The manual was primarily developed by the Knowledge to Policy (K2P) Center.

Practical Application 1: How to Frame the Problem

Case Scenario: *You have been asked to prepare a policy document about a health system problem. All that you have been told is that the problem is about vulnerable citizens not having access to primary health care services. You want guidance on how to clarify the problem in a systematic and comprehensive way.*

Framing the problem should be evidence-informed, contextualized, and engaging, and it should be focused on health and economic outcomes.

Problem framing involves the following components:

- A clear problem statement
- Description of the magnitude the problem

- Description of the consequences of the problem
- Description of the underlying factors of the problem
- Where to find the evidence to frame the problem

Each of these components is briefly discussed below.

A Clear Problem Statement

The problem statement should be a concise statement (maximum three to five sentences) describing the main problem in context, along with its size, its main consequences, and its underlying factors. The problem statement should not contain details related to the solution. It is the 30- to 60-second description of the problem (that is, the “elevator pitch”) that makes policy makers, when they hear it, want to know more and be motivated to act.

Drafting the problem statement is both a science and an art (see box 4.1). Science is important because the problem statement has to be based on evidence and data. Art is important because the problem statement has to be engaging and resonate with the target audience.

Box 4.1: Example of Problem Statement: Physical Inactivity in KSA

Science: Data on the Problem

Science applies to drafting the problem statement through considering applicable data points. For this example, the relevant data points are:

- The prevalence of physical inactivity is estimated to be 71 percent among males and 91 percent among females in the Kingdom of Saudi Arabia (KSA) (General Authority for Statistics 2018).
- A household survey found that the percentage of individuals practicing sports is low in KSA, with the lowest being 2.06 percent among those ages 65 years or over and the highest being 18.08 percent among adolescents (15–19 years). Consistently, females from all age groups were practicing sports less than males, with the highest of 3.79 percent among those 20–24 years old (General Authority for Statistics 2018).
- Northern and central regions of KSA have the highest levels of physical inactivity (Al-Zalabani, Al-Hamdan, and Saeed 2015); the southern region exhibits the lowest levels (Al-Nozha et al. 2007).
- An estimated 18 percent of the burden of disease in KSA is attributed to the physical inactivity (Lee et al. 2012).
- Direct health care costs of physical inactivity in KSA are estimated to be \$869,019 (in 2013 int'l dollars), or 1.71 percent of the total health care costs; indirect productivity costs are estimated to be \$169,442 (Ding et al. 2016).

Art: Combining Data in an Engaging Way to Craft a Problem Statement

KSA has one of highest prevalence of physical inactivity and sedentary lifestyles in the region. Approximately 81.01 percent of the Saudi population (71 percent of males and 91 percent of females) do not practice sports (General Authority for Statistics 2018). Furthermore, sedentary lifestyle and behaviors appear to be highly prevalent among Saudi children and adolescents, where 91.2 percent of females and 84 percent of males spend more than 2 hours behind screens on daily basis (General Authority for Statistics 2018).

This problem is exacerbated by social, cultural, and environmental factors that hinder proper physical activity levels, as well as a lack of national policies, legislation, and community-based initiatives that facilitate active lifestyles. If left unaddressed, physical inactivity increases the risk of noncommunicable diseases such as obesity, hypertension, stroke, cancer, diabetes mellitus, and coronary artery diseases (Global Burden of Disease Collaborative Network 2018), contributing to 18 percent of all-cause mortality in KSA (Lee et al. 2012). Furthermore, physical inactivity in KSA has huge cost implications, increasing direct and direct health care costs by \$1,038,461,000 (in 2013 int'l dollars) (Ding et al. 2016).

Source: Based on the K2P Center Policy Brief 2020 (unpublished).

Description of the Magnitude of the Problem

While the problem statement is the succinct elevator pitch and serves to grab the immediate attention of policy makers, a more detailed description of the problem and its magnitude is needed to discuss all its dimensions. The subsequent few paragraphs should describe the local magnitude of the problem and then discuss its status in comparison with other countries.

An overview of key questions to guide the problem description, based on Lavis et al. 2009, is provided in table 4.1.

Table 4.1: Key Questions for Detailed Problem Description

Key questions	Description
What is the problem?	<ul style="list-style-type: none"> ▪ A risk factor, disease, or condition ▪ The programs, services, or drugs currently being used to address the risk factor, disease, or condition ▪ The current health system arrangements within which programs, services, and drugs are provided: <ul style="list-style-type: none"> ◆ Governance arrangements ◆ Financial arrangements ◆ Delivery arrangements ▪ The current degree of implementation of an agreed-upon course of action <p><i>Note:</i> The problem can relate to one or more of the above.</p>
How did the problem come to attention?	<ul style="list-style-type: none"> ▪ A focusing event (e.g., a medical error case that led to amputation of limbs of a child) ▪ A change in an indicator (e.g., high suicide rate reported in the country) ▪ Feedback from the operation of current policies and programs (e.g., internal evaluation report identifies operational challenges in getting drug supplies to primary care practices)
What indicators can be used, or collected, to establish the magnitude of the problem?	<ul style="list-style-type: none"> ▪ National and community surveys and vital registries are examples of good sources of indicators about a risk factor, disease, or condition. ▪ Health care administrative data (sometimes called <i>health management information systems</i>), monitoring and evaluation data, community surveys, and health care provider surveys can be good sources of indicators about the programs, services, and drugs currently being used. ▪ Legislation, regulation, policies, drug formularies, and policy maker surveys can be good sources of indicators about governance arrangements. ▪ Health expenditure surveys and health care provider surveys can be good sources of indicators about financial arrangements. ▪ Health care administrative data can be good sources of indicators about delivery arrangements. ▪ Community surveys and health care provider surveys, as well as health care administrative data, can be good sources of indicators about the current degree of implementation of an agreed-upon course of action.
What comparisons can be made to measure progress (or lack thereof) in addressing the problem?	<ul style="list-style-type: none"> ▪ Comparison of data indicating progress (or lack thereof) in addressing the problem over time within a country ▪ Comparison of progress (or lack thereof) in addressing the problem between countries and other appropriate comparators

Key questions	Description
	<ul style="list-style-type: none"> ▪ Comparison of progress (or lack thereof) in addressing the problem against targets/ goals set in national plans (if available) ▪ Comparison of progress (or lack thereof) in addressing the problem with expectations that policy makers and/or stakeholders predicted or wanted
<p>How can a problem be framed (or described) in a way that will motivate your audience?</p>	<ul style="list-style-type: none"> ▪ Framing the problem positively or negatively should be based on the target audience ▪ Example of alternative framings is presented here for antimicrobial resistance (AMR): <ul style="list-style-type: none"> ◆ “Unavailability of laws that regulate the use of antibiotics in agriculture and animals” may resonate with nongovernmental organizations and activists ◆ “A rise in AMR” may resonate with public health professionals ◆ “No efforts to educate students on AMR and reasonable Antibiotic use in a regular manner” may resonate with parents and stakeholders in the education system ◆ Comparison of the country with peers may resonate with politicians

Source: Based on Lavis et al. 2009.

Description of the Consequences of the Problem

Highlighting the consequences of a problem or issue along with the consequences of inaction can incentivize stakeholders to act on the problem you are describing. The consequences of a certain problem or issue can be increased mortality, morbidity, disability; increased financial expenditure for health care; reduced efficiency or effectiveness of certain intervention/program; and delay in achieving global targets.

Local evidence can reliably highlight local consequences. However, if local data are not available or are not comprehensive, then regional and international evidence can be used to describe the problem’s consequences.

Questions to guide the description of the consequences of the problem include:

- What are the consequences of inaction or inefficient action?
- What is the current and projected impact of the problem on health and economic outcomes?
- What are some equity considerations in terms of different PROGRESS groups (O’Neill 2014): Place of residence, Race/ethnicity/culture/language, Occupation, Gender/sex, Religion, Education, Socioeconomic status, Social capital?

Description of the Underlying Factors of the Problem

Once the magnitude of the problem has been established, the next step is to assess its underlying factors. Once these have been identified, possible solutions can become evident.

The underlying factors that the local, regional, and international evidence have documented should be discussed, as well as the underlying factors identified from the tacit knowledge of the stakeholders involved (make sure to mention that this information was based on tacit knowledge).

See box 4.2 for a summary of underlying factors of the problem that could relate to one or more categories noted in the box:

Box 4.2: Possible Underlying Factors of the Problem

For **health care–related topics**, the following categorizations can be used:

- Current health system arrangements
- Governance arrangements (how decisions about care are made)
- Financial arrangements (how care is paid for)
- Delivery arrangements (how care is organized)
- Degree of implementation of an agreed course of action (for example, a policy) (that is, how change can be brought about).

For **social topics and health in all policy topics** (for example, physical inactivity, obesity), the following categorizations can be used (in alignment with the socioecological model):

- Individual factors
- Interpersonal factors (family ties, friends, networks, and so on)
- Organizational/community factors (rules and regulations of organizations, relationship between organizations, cultural values, norms, built environment, and so on)
- Macro-level factors (laws, legislations, public policies regulations, and so on).

Example 1 of Problem Description and Underlying Factors

The problem: Inappropriate prescribing quality and pattern of drugs (see table 4.2).

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

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

Table 4.2: Underlying Factors for Example 1 of the Problem Description

Level	Underlying factors
Governance arrangement	<ul style="list-style-type: none">▪ Absence of laws and legislation to regulate physician-industry interactions▪ Inadequate systems to monitor the quality of drugs at the national level▪ Weak clinical governance (standardized clinical guidelines, clinical pharmacy services and systems for prescription audits, and feedback)▪ Weak institutional policies on conflict of interest▪ Poor consumer involvement in shared decision-making related to medication use
Financial arrangement	<ul style="list-style-type: none">▪ Physicians are paid on a fee-for-service basis▪ High out of pocket expenditures on pharmaceuticals▪ No proper incentive systems to encourage generic drug use
Delivery arrangement	<ul style="list-style-type: none">▪ Absence of guidelines for pharmaceutical prescriptions
Degree of implementation of an agreed course of action (e.g., a policy)	<ul style="list-style-type: none">▪ Lack of enforcement of the recently launched Codes of Ethics for Medicinal Products Promotion (WHO/EURO 2020)

Source: WHO/EURO 2020.

Example 2 of Problem Description and Underlying Factors

The problem: High prevalence of physical inactivity (see table 4.3).

The problem statement: Please refer to box 4.1 for the problem statement.

Risk factor, disease, or condition: Rising prevalence of obesity, type 2 diabetes, noncommunicable diseases (NCDs), and premature deaths.

Table 4.3: Underlying Factors for Example 2 of the Problem Description

Level	Underlying factors
Individual	<ul style="list-style-type: none"> ▪ Unwillingness to practice sports ▪ Heavy reliance on cars ▪ Lack of time ▪ Fear of violence and outdoor crime ▪ Perception of environmental barriers ▪ High screen time for leisure ▪ Obesity ▪ Premium is placed on comfort ▪ Knowledge about healthy behaviors ▪ Low self-esteem and motivation to practice sports or other physically demanding activities ▪ Preoccupation with studying or work ▪ Lack of resources ▪ Having injuries or impairments
Interpersonal	<ul style="list-style-type: none"> ▪ Income level ▪ Parental preferences favor spiritual and educational activities ▪ Social gatherings are the main leisure activity ▪ Lack of peer support for physical activities ▪ Perception of physical exertion as associated with lower status occupations
Community/organizational	<ul style="list-style-type: none"> ▪ Rapid urbanization and lifestyle transformation characterized by a sedentary lifestyle ▪ Limited availability and accessibility of designated areas available for physical activity across Saudi Arabia for men and women ▪ Cultural norms that hinder female mobility ▪ Absence of female school physical activity program (Al-Hazzaa 2018) ▪ Limited accessibility and affordability of specialized physical activity facilities for women compared to men in Saudi Arabia ▪ High-density traffic ▪ Extreme weather and poor air quality ▪ Lack of social support networks ▪ Built environment that promotes a car culture (e.g., lack of suitable sidewalks and parks) ▪ Limited physical activity opportunities in schools and workplaces
Macro-level (laws, policies and regulations)	<ul style="list-style-type: none"> ▪ Limited national, subnational, and organizational policies and legislation to promote physical activity and active lifestyle for all segments of the population, including children, women, and the elderly ▪ Despite the presence of numerous initiatives aimed at promoting physical activity in Saudi Arabia, a common belief is that these initiatives were fragmented, short-term attempts that lacked a coordinating body (Al-Hazzaa and AlMarzooqi 2018) ▪ The majority of physical activity initiatives lacked objective evaluations of their outcomes (Al-Hazzaa and AlMarzooqi 2018) ▪ No governmental regulation to validate and authorize the establishment of community-driven interest clubs for sports

Source: Based on the K2P Center Policy Brief 2020 (unpublished).

Where to Find the Evidence to Frame the Problem

Framing the problem should be based mainly on local evidence, which can be found in published research; gray literature; and reports of ministries, institutions, and nongovernmental organizations. Comparing the local magnitude of the problem across time and its regional and international standing can also help to highlight the importance of acting upon the problem (see box 4.3).

Annex 4A at the end of this chapter provides a template to use for problem framing.

Box 4.3: Sources of Evidence

Local evidence sources include:

- Published research in the country of interest (primary studies, systematic reviews)
- Surveys
- Governmental reports and statistical bulletins
- Administrative and routine data
- Reports of nongovernmental organizations (for example, WHO and UN agencies)
- Regional studies (for comparison purposes).

While the primary source of data is local evidence, global evidence (from systematic reviews) may also be used to supplement local evidence. This includes:

- Systematic reviews on the prevalence of the problem/issue worldwide (for comparison purposes)
 - Systematic reviews on the consequences of the problem/issue (for example, on health, economy, equity)
 - Systematic reviews on the underlying causes of the problem.
-

Practical Application 2: How to Frame Policy Options to Address a Problem

Case Scenario 1: *The government has released a recent report examining in great depth the problem of shortages of physicians in rural areas in your country. You have been asked to propose policy options to address this problem. All that you have been told is that the report should present three options and focus only on what the research evidence says about each option. You are concerned about whether you have included a reasonable set of options and whether the options are framed in a way that will enable policy makers to make appropriate decisions.*

Case Scenario 2: *The government is considering unifying the purchasing of hospital services from public and private sectors as one policy option to manage the rising costs of health care in KSA. You have been consulted to advise the government on whether this policy option is deemed an appropriate solution.*

Proposing Policy Options

As illustrated by the case scenarios, policy options can be used for three main situations, depending on context (Lavis et al. 2009):

- To maximize the benefit, reduce the risks, ensure cost-effectiveness, and improve implementation of existing decisions
- To present an assessment of policy options for a policy-making process underway
- To present policy options for a problem that has not yet entered the policy-making process.

When proposing policy options, you are either introducing, refining, or discontinuing policy options that affect either or both of the following:

- The provision of a cost-effective program, service, or drug; and
- The health system arrangements that determine whether cost-effective programs, services, or drugs are provided to those who need them. Examples of such arrangement are:
 - Delivery arrangements
 - Financial arrangements
 - Governance arrangements.

Initial work should focus broadly on the options from the global evidence that could address the problem that has been identified. On average, three to four policy options are presented to address the problem or issue at hand. The options should address the problem (and its underlying causes) in your specific context. A key next step is to consider whether these options can stand alone or whether they can be bundled together.

Options can either be mutually exclusive, where stakeholders can decide to choose one rather than the other, or they can be bundled together to form new options appropriate to specific local contexts. In such cases, the terminology would change from *Options* to *Elements of a comprehensive approach* to address the problem (see boxes 4.4a and 4.4b).

Box 4.4a: Example 1 on Proposing Policy Options

Policy options for addressing the problem of antibiotic resistance in Hungary

Policy option 1: Develop a national antimicrobial stewardship program (ASP), complemented by evidence-informed guidelines on the diagnosis and treatment of common infections

Policy option 2: Strengthen undergraduate and postgraduate medical, dental, and pharmacy education on prudent antibiotic prescribing and training on prudent antibiotic prescribing

Policy option 3: Raise awareness of prudent antibiotic use through information campaigns, leaflets, and interpersonal communication

Note: The proposed policy options can be applied as elements of a comprehensive approach to address the problem.

Box 4.4b: Example 2 on Proposing Policy Elements

Elements of a comprehensive approach for addressing the problem of physical inactivity in KSA

Element 1: School-based health-enhancing physical activity policies

- Element 1.1: Update physical education curricula and increase the number and duration of physical activity classes during school hours
- Element 1.2: Increase the availability and types of school playground spaces and equipment as part of recess
- Element 1.3: Implement physical activity programs after school hours

Element 2: Workplace health-enhancing physical activity policies

- Element 2.1: Support workplace wellness through tax credits
- Element 2.2: Implement worksite policies to change workplace design and environment
- Element 2.3: Promote worksite policies for integrating physical activity into organizational routine

Box 4.4b: Contd...

Element 3: Improving urban design and land use

- Element 3.1: Integrate zoning regulations and land use mix
- Element 3.2: Enhance street lighting, crossings, traffic calming measures
- Element 3.3: Implement point-of-decision prompts to encourage the use of stairs

Element 4: Public transportation and travel policies

- Element 4.1: Improve availability of and access to public transportation
- Element 4.2: Impose taxation and road-user charges (individual car transportation)

Note: The proposed elements can be applied as options where stakeholders can decide to choose one rather than the other.

Sources: Hajdu et al. 2018; K2P Center; WHO/EURO 2020.

Expanding on Each Policy Option

Once an appropriate option or set of options has been identified, policy makers will need additional information to be able to make informed and appropriate decisions about the option. A policy or program can be deemed to be an appropriate solution if it is effective, fits within dominant values, and is feasible in terms of cost implications.

Specifically, for each policy option, the following questions—which reflect the different dimensions of the option—need to be answered (Lavis et al. 2009):

- What benefits are important to those who will be affected, and which benefits are likely to be achieved with each option?
- What harms are important to those who will be affected, and which harms are likely to arise with each option?
- What equity considerations are important to those who will be affected, and which inequities are likely to arise with each option? Equity considerations could be assessed in terms of different PROGRESS groups (O'Neill et al. 2014): for example, considerations could include Place of residence, Race/ethnicity/culture/language, Occupation, Gender/sex, Religion, Education, Socioeconomic status, Social capital.
- What are the local costs of each option and is there local evidence about their cost-effectiveness?
- What adaptations might be made to any given option to contextualize it and could those adaptations alter the option's benefits, harms, and costs?
- What are the equity considerations for each one of the options in terms of financing, delivery, and governance? Does it address all populations in an equitable manner? Does it harm or benefit specific groups but not others?

Strong evidence about the benefits of a certain option (and the key requirements for its impactful implementation—see the next section for more details) can be the start of this process. Then the harms, cost-effectiveness, and equity considerations can help in deciding whether to adopt that option as is or to adapt it first to the context to minimize the harms and improve its cost-effectiveness. A template for this expansion is provided in table 4.4.

Table 4.4: Template for Expanding on Each Policy Option

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

Sources: Based on WHO/EURO 2020’s EVIPNet Europe Template for policy briefs, adapted from McMaster Health Forum, <https://www.mcmasterforum.org/find-evidence/products>.

Where to Find the Evidence for Policy Options

Systematic reviews are the preferred source of evidence to identify the options/elements and identify the potential harms, benefits, and implementation considerations. In case systematic reviews are not available for an option, then high-quality primary studies can be considered (please refer to the evidence hierarchy pyramid in figure 3.1).

Two phases of searching the literature may be needed to fully develop your policy options (see also tables 4.5 and 4.6):

- Phase 1: A broad search strategy for general policy options addressing the problem.
- Phase 2: A specific search strategy for each policy option/element to capture all the information needed for an evidence-informed decision.

Table 4.5: Types of Questions and Research Evidence to Expand on Policy Options

Question	Type of research evidence
What benefits are important to those who will be affected, and which benefits are likely to be achieved with each option/element?	<ul style="list-style-type: none"> Systematic reviews of effectiveness studies Randomized control trials
What harms are important to those who will be affected, and which harms are likely to arise with each option/element?	<ul style="list-style-type: none"> Systematic reviews of effectiveness studies or observational studies
What are the costs of each option/element and is there local evidence about their cost-effectiveness?	<ul style="list-style-type: none"> Cost-effectiveness analysis
What adaptations might be made to a given option/element and might they alter its benefits, harms, and costs?	<ul style="list-style-type: none"> Systematic reviews of qualitative studies
Which stakeholders' views and experiences might influence the acceptability of an option/element and its benefits, harms, and costs?	<ul style="list-style-type: none"> Systematic reviews of qualitative studies, observational studies and qualitative studies, Tacit knowledge identified through key informant interviews

Source: Based on WHO/EURO 2020.

Table 4.6: Appropriate Databases of Research Evidence

Type of option or element	Database
If your option involves health system arrangements or implementation strategies	Health Systems Evidence
If your option involves public health programs and services	Health Evidence
	Cochrane Library
	PubMed
If your option involves social systems, programs and services or is related to the SDGs	Social Systems Evidence
If your option/element involves clinical programs and services or drugs	Cochrane Library

Source: Based on WHO/EURO 2020.

Note: See table 3.1 for more information about these databases. SDGs = Sustainable Development Goals.

It is worth noting that, while systematic reviews are considered the best starting point for judgments about the effects of policy options, local evidence can inform the policy options by (Lewin et al. 2009):

- Contextualizing evidence from systematic reviews of the effects of interventions and to make this evidence relevant.
- Informing judgments about values and preferences regarding policy options (that is, the relative importance that those affected attach to possible impacts of policy options) and views regarding these options.

- Estimating the local costs (and savings) of the policy options.
- Examining the effects of a policy option on particular local groups.

Example 1: Expanding the Policy Options

To address the problem of antimicrobial resistance in Hungary, one of the policy options that can be considered is “Develop a national antibiotic stewardship program (ASP), complemented by evidence-informed guidelines on the diagnosis and treatment of common infections.” Table 4.7 presents details for expanding this policy option, and box 4.5 provides tips for synthesizing the findings section of each.

Table 4.7: Expanding the Policy Option for Antimicrobial Resistance in Hungary

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

Source: Adapted from WHO/EURO 2020, based on the EVIPNet Hungary policy brief (Hajdu et al. 2018).

Note: ASP = antimicrobial stewardship.

Example 2: Expanding the Policy Elements

To address the problem of physical inactivity in KSA, one of the policy elements that can be considered is “School-Based Health-Enhancing Physical Activity Policies.” Table 4.8 presents details for expanding this policy option or element, and box 4.5 provides tips for synthesizing the findings section of each.

Table 4.8: Expanding the Policy Element for Physical Inactivity in KSA

Category of finding	Element 1
Benefits (health and equity)	<p><i>Element 1.1: Update physical education curricula and increase the number and duration of physical activity classes during school hours</i></p> <ul style="list-style-type: none"> ▪ Two overviews of systematic reviews and six systematic reviews found that increasing the number and quality of physical education lessons during school hours and integrating more physical activity into the curriculum are effective in increasing overall physical activity and fitness in youth (both during the school day and outside of school on the weekends) (Barr-Anderson et al. 2011; Brown and Summerbell 2009; Demetriou and Höner 2012; Erwin et al. 2013; Kriemler et al. 2011; McGoey et al. 2016; Messing et al. 2019; Van Sluijs, McMinn, and Griffin 2007). ▪ One systematic review showed that school-based policies among students (mean age less than 9 years old) consisting of 2 hours extra physical education per week for a duration of up to 6 months significantly improved body mass index (BMI) compared with control group (Brown and Summerbell 2009). Also, it found a greater magnitude of change in girls compared with boys and in obese compared with non-obese children, suggesting that physical activity policies may be more successful for younger children and for girls (Brown and Summerbell 2009). ▪ A systematic review found that up to an hour of daily physical activity programs can be added to a school curriculum by taking time from other subjects without negatively affecting students’ academic achievement in those subjects (Erwin et al. 2013). Conversely, taking time from physical education and adding it to the academic curriculum does not enhance either the students’ grades in these subjects or their physical fitness (Erwin et al. 2013). The suggested reason for this effect is that physical activity improves students’ learning efficiency (Erwin et al. 2013). <p><i>Element 1.2: Increase the availability and type of school playground spaces and equipment as part of recess</i></p> <ul style="list-style-type: none"> ▪ One review of systematic reviews and five systematic reviews have demonstrated that providing access to a range of spaces and facilities at schools such as playground markings plus physical structures are effective in increasing the physical activity of schoolchildren during recess in the short to medium term by increasing a sense of choice and providing supportive environments that facilitate active behaviors (Broekhuizen, Scholten, and de Vries 2014; Escalante et al. 2014; McGoey et al. 2016; Messing et al. 2019; Parrish et al. 2013; Ridgers et al. 2012). ▪ One systematic review suggested that recess provides more effective opportunities for children to accumulate daily physical activity at school than curriculum-based programs (McGoey et al. 2016). Another systematic review highlighted that such policies are most effective for young children and for those who were less active at baseline (Escalante et al. 2014).

Category of finding	Element 1
	<p><i>Element 1.3: Implement physical activity programs after school hours</i></p> <ul style="list-style-type: none"> ▪ One review of systematic reviews, one meta-analysis, and two systematic reviews indicated that after-school physical activity programs (extracurricular programs) can be effective in improving physical activity levels (Beets et al. 2009; McGoey et al. 2016; Messing et al. 2019; Pate and O'Neill, 2009), physical fitness, body composition, and blood lipid profiles of children and young adolescents (Beets et al., 2009; Pate and O'Neill 2009). These findings support the after-school setting (including after-school clubs or the provision of health education programs focused on healthy eating and physical activity after school) as a context in which health-enhancing levels of physical activity can be promoted (Beets et al. 2009).
Potential harms	<ul style="list-style-type: none"> ▪ No evidence of harm was identified.
Cost and/or cost-effectiveness in relation to the status quo	<ul style="list-style-type: none"> ▪ One overview of 18 systematic reviews identified multicomponent school-based physical activity policies as particularly cost-effective (Abu-Omar et al. 2017). ▪ Two systematic reviews highlighted school-based policies as one of the most cost-effective policies to increase physical activity (Laine et al. 2014; Wu et al. 2011). In one of the reviews, school health education programs generated US\$0.056/MET-h (metabolic equivalent of task hours gained per person per day) (Laine et al. 2014). In the other review, school-based physical activity policies (e.g., physical activity education, promotion of out-of-school physical activity) were relatively cost effective when no additional school staff's labor costs were required, generating a median of 0.48 MET-hours, which is equivalent to 16 percent of the recommended physical activity for youth (Wu et al. 2011). ▪ One review found some school-based policies to be cost-effective (e.g., dance classes and walking school bus programs), whereas others were found to be cost-effective only for a particular group of children (e.g., curriculum-based policies for healthy diet and physical activity in girls only), or not cost-effective at all (e.g., free-swimming classes) (Ubido et al. 2010).
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the approach element were pursued)	<ul style="list-style-type: none"> ▪ One systematic review found moderate evidence of an effect of the provision of playground equipment on physical activity levels of children at preschools and primary, secondary, or mixed schools (Broekhuizen, Scholten, and de Vries 2014). However, there was inconclusive evidence of an effect of the allocation of playground markings and more play space or of multicomponent policies on children's health in terms of physical activity, cognitive, and social outcomes (Broekhuizen, Scholten, and de Vries 2014). ▪ One systematic review reported that in younger children (6–12 years old) there was inconclusive evidence that multicomponent school-based policies have a positive impact on child obesity in the European context (De Bourdeaudhuij et al. 2011). ▪ One meta-analysis found that policies to promote afterschool physical activity programs to date have had mixed effectiveness on increasing moderate physical activity levels (Mears and Jago 2016). ▪ One systematic review of controlled trials reported that there is limited evidence of an effect of interventions targeting low socioeconomic populations and environmental interventions through multicomponent school-based policies for promoting physical activity (Van Sluijs, McMinn, and Griffin 2007). This raised questions about the usefulness of targeting interventions toward children from ethnic minority populations (Van Sluijs, McMinn, and Griffin 2007).

Category of finding	Element 1
Key elements of the policy option (if it was tried elsewhere)	<p><i>Element 1.1: Update physical education curricula and increase the number and duration of physical activity classes during school hours</i></p> <ul style="list-style-type: none"> ▪ Combining dietary and physical activity ▪ Integrating physical education for students with disabilities ▪ Prohibiting schools from using physical activity as a punishment ▪ Adopting school-based daily physical activity policies ▪ Involving staff in physical activity policies <p><i>Element 1.2: Increase the availability and type of school playground spaces and equipment as part of recess</i></p> <ul style="list-style-type: none"> ▪ Organized recess activities ▪ Active supervision during recess ▪ Zoning the playground for different activities <p><i>Element 1.3: Implement physical activity programs after school hours</i></p> <ul style="list-style-type: none"> ▪ Providing transportation for students for after school programs ▪ Identifying general elements for successful implementation ▪ Including parents, family, and community <ul style="list-style-type: none"> ◆ Two systematic reviews highlighted the effectiveness of school-based policies including family or community involvement in increasing physical activity or fitness in children and young people (McGoey et al., 2016; Van Sluijs, McMinn, and Griffin 2007). Another systematic review highlighted that school-based policies with direct parental involvement have the potential to improve children’s weight status, physical activity and sedentary behaviour (Verjans-Janssen et al. 2018). ▪ Providing a supportive school climate <ul style="list-style-type: none"> ◆ A systematic review highlighted the importance of the contextual appropriateness of the policy, delivery agent efficacy, supportive organizational climate and training, and technical support as important success factors to consider when designing school based physical activity policies (Naylor et al. 2015).

Source: Based on the K2P Center Policy Brief 2020 (unpublished).

Box 4.5: Tips for How to Synthesize the Findings Section for Each Policy Option Format

In general, each option or element ideally would have the following:

- In text (in two to three paragraphs):
 - ◆ Provide an overview of the current context around the option (rather than the problem). This section should cover the local readiness for this option/element, such as the available programs, interventions, resources, and policies that can be leveraged.
 - ◆ Provide a general description of the option, its benefits (and costs), where it has been adopted, and the number and quality of the systematic reviews supporting it.
 - ◆ Detail key considerations to make the option effective, based on previous experiences.
- In a policy option table, outline in bullet points the main:
 - ◆ Benefits and harms;
 - ◆ Resource use, costs and/or cost-effectiveness;
 - ◆ Uncertainty regarding benefits and potential harms;
 - ◆ Key elements of the policy option if it was tried elsewhere; and
 - ◆ Stakeholder’s views and experiences around it.

Contd...

Box 4.5: Contd...

The totality of evidence around a certain option or element should be synthesized in a way that is both easily understood and conveys the main ideas needed to support decisions.

Example

Seven systematic reviews support the finding that x can lead to y . However, if x was to be implemented, it has to have a and b to be effective. To further enhance the presentation and interpretation of the evidence, you must:

- Mention the type and quality of evidence (based on AMSTAR rating)
- Be objective and concise, and avoid medical/research jargon.

Weighing Policy Options

Research alone does not make decisions. Judgment is always needed, including judgment about what evidence to use, how to interpret that evidence, and the degree of confidence in the existing evidence base. More importantly, decisions about options require judgments about whether the anticipated desirable consequences outweigh the undesirable consequences (see table 4.9) (Oxman et al. 2009). In addition to making judgments about the likely magnitude of the impact, decision-making processes require judgments about the importance of the impacts, the resources needed to implement the option, and the extent to which the option is a priority relative to other alternatives for which the resources might be used.

Table 4.9: Weighing Desirable and Undesirable Consequences

Desirable effects	Undesirable effects
▪ Improvements in health	▪ Unintended effects on health (harms)
▪ Improved access to health services	▪ Reduced access to health services
▪ More appropriate utilization of health services	▪ Less appropriate utilization of health services
▪ Savings	▪ Costs
▪ Reduced inequities	▪ Increased inequities
▪ Ethical consequences such as increased autonomy	▪ Ethical consequences such as decreased autonomy

Source: Oxman et al. 2009.

The questions below can be used to inform judgments about the pros and cons of health policy and program options (Oxman et al. 2009):

- What are the options that are being compared?
- What are the most important potential outcomes of the options being compared?
- What is the best estimate of the impact of the options being compared for each important outcome?
- How confident can policy makers and others be in the estimated impacts?
- Is a formal economic model likely to facilitate decision-making?

Writing the Policy

According to the Ontario Agency for Health Protection and Promotion (Bergeron 2018), written policy usually has five components:

- **Rationale:** This outlines who created the policy and its intended beneficiary, as well as the problem the policy addresses.
- **Glossary:** This provides definitions of key terms used in the policy.
- **Policy content:** This details the rules, regulations, and sanctions of the policy as well as its goals, objectives, plans, procedures, laws, strategies, regulations, and the course of action related to an issue.
- **Date:** This refers to the date the policy is approved and the date of any amendments.
- **Supporting material:** Such material includes the enforcement procedures intended to address noncompliance, communication procedures, procedures for monitoring and evaluating the policy, and any other supporting material.

An example of detailed list of the content of elements needed for a policy is provided in box 4.6.

Box 4.6: Unified Purchasing Policy for Purchasing Hospital Services from the Private Sector in KSA

This policy contains details about the following elements:

1. Preamble
2. Rationale for unified purchasing policy
3. Purpose
4. Goals
5. Guiding principles
6. Purchasing organization
7. Roles and responsibilities
8. Services purchased
 - 8.1. Scope of services
 - 8.2. Needs/market analysis
 - 8.3. Eligible beneficiaries
 - 8.4. Referral process
9. Provider selection
 - 9.1. Procedure for selecting provider organizations
 - 9.2. Selection criteria
10. Pricing of services
11. Provider payment mechanisms
12. Transaction process
13. Inspection and monitoring
14. Performance contracting
15. Reporting requirements
16. Contractual agreement
17. Policy implementation
 - 17.1. Foundational phase
 - 17.2. Initial implementation

Support for Policy Implementation

Key considerations for supporting the implementation of policy options include (1) the need to develop a progress reporting structure to track successes, challenges, and additional support needed—a typical progress reporting structure includes monthly updates and a review of the action plan with the person(s) responsible for the activities and/or tasks; (2) the need to determine who will lead the reporting of the progress of the action plan; (3) the need to ensure that everyone who needs to can access the most recent version of the plan; and (4) the need to develop a response system to communicate what is happening (changes, key messages) to stakeholders, including decision-makers and influencers. Implementing the action plan could take weeks, months, or years, depending on the topic.

According to the Ontario Agency for Health Protection and Promotion (Bergeron 2018), implementation pitfalls to be avoided include a lack of ownership, a lack of commitment, no accountability, viewing the action plan as separate from day-to-day work, a plan that is overwhelming (too many activities, shifting priorities), and a plan that is meaningless (not enough detail about how the plan moves toward policy development).

Practical Application 3: How to Identify Implementation Considerations for an Option

Case Scenario: *You have been assigned responsibility for the rollout of a new reform program in the health services. You want to ensure that implementation takes place as effectively as possible.*

Traditionally, implementation has been assumed to be a routine function: once a decision has been made, it will be automatically carried out smoothly. This is a recipe for failure. To be successful, you need to:

- *Adopt a structured approach to identify barriers to implementation at different levels and provide counterstrategies to overcome those barriers.*
- *Involve policy and program implementers in the design and execution of the policy or program while also considering organizational goals, strategies, and incentives.*
- *Develop a clear implementation plan with designated roles and responsibilities as well as follow-up mechanisms.*

Barriers and Counterstrategies to Policy Implementation

A structured approach to identifying barriers can help ensure that important barriers are not overlooked and that undue attention is not paid to unimportant one. To do this, you need to identify the level(s) where there are potential barriers to (and facilitators of) the successful implementation of a policy option or element (table 4.10). These can be at the level of patients/citizens (for example, awareness of the availability of a free program); the level of providers of care (for example, adherence to guidelines); the level of organizations (for example, performance management to ensure the delivery of high-quality care); the level of the system (for example, enforcement of regulations); or the level of society and politics (for example, prevailing norms, political stability).

Several key considerations should be taken into account when identifying and addressing barriers to implementing a particular policy. These include identifying the barriers to implementing each policy, determining what strategies already exist to address those barriers, and determining what is known about the effects of those strategies. Finally, it is crucial to decide how to summarize information about barriers and the likely effects of strategies for addressing them.

Table 4.10: Barriers and Counterstrategies to Policy Implementation

Level	Potential barriers	Counterstrategies to consider
Patients/citizens	<ul style="list-style-type: none"> ▪ Inadequate knowledge ▪ Inadequate competency ▪ Poor attitudes ▪ Inadequate access to care/supplies ▪ Lack of motivation to change 	<ul style="list-style-type: none"> ▪ Information or education provision ▪ Skills and competencies development ▪ Behavior change support ▪ (Personal) support ▪ Communication and decision-making facilitation
Providers of care	<ul style="list-style-type: none"> ▪ Inadequate knowledge ▪ Inadequate competency ▪ Poor attitudes ▪ Inadequate access to care/supplies ▪ Lack of motivation to change 	<ul style="list-style-type: none"> ▪ Educational materials/meetings ▪ Audit and feedback ▪ Reminders and prompts ▪ Tailored interventions ▪ Patient-mediated interventions ▪ Multifaceted interventions
Organizations	<ul style="list-style-type: none"> ▪ Weak performance management ▪ Time constraints ▪ Resistance to the implementation of new policies, programs and/or services 	<ul style="list-style-type: none"> ▪ Content, context and process model ▪ Five whys ▪ SWOT (strengths, weaknesses, opportunities, and threats) analysis ▪ Total quality management ▪ Learning organization ▪ Action research
Health systems	<ul style="list-style-type: none"> ▪ Inadequate financial resources ▪ Inadequate human resources ▪ Inadequate training ▪ Inadequate communication 	<ul style="list-style-type: none"> ▪ Strategies for generating the necessary resources or reducing the cost of implementing the option ▪ Task shifting, adjusting incentives to recruit and retain health workers where they are needed ▪ Change training programs or develop new programs ▪ Structured referral systems ▪ Leadership capacity ▪ Formal agreements and arrangements for monitoring
Social and political constraints (if applicable)	<ul style="list-style-type: none"> ▪ Ideology, norms, conflicting interests, opinion leaders, political instability, donor practices, etc. 	<ul style="list-style-type: none"> ▪ More transparent decision-making processes ▪ More systematic and transparent approaches to making judgments about the pros and cons of options, exposure of conflicts of interest, and declaration and management of conflicts of interest in policy-development processes

Source: Fretheim et al. 2009.

Where to Find Evidence for Barriers and Facilitators of Implementation

Different sources of evidence can be consulted to develop implementation considerations. These include systematic reviews of the options, qualitative evidence synthesis, and qualitative systematic reviews of implementation considerations themselves: local context and considerations derived from local data, along with key informant interviews and stakeholder-structured brainstorming. In some cases, barriers and facilitators can be retrieved from different articles.

Example 1: Identifying Implementation Consideration

This example (table 4.11) considers the identification of implementation considerations that might arise on multiple levels if three options (developing a national antimicrobial stewardship program, raising the public awareness, and strengthening undergraduate and postgraduate education) were to be implemented to address the problem of antibiotic misuse in Hungary (Hajdu et al. 2018).

Table 4.11: Example of Implementation Considerations from Hungary

Level	Barriers	Counterstrategies
Patient	None were identified	N.A.
Professional	Physicians are often primarily concerned with their individual patients' direct clinical outcomes, and the risk of antibiotic resistance is a factor likely to influence their antibiotic choices only marginally.	In hospitals, incorporating antimicrobial stewardship program (ASP) into the mandatory induction training for new medical staff and regular in-house training of clinical personnel would be an easy way to ensure that each and every staff member is aware of the requirements for prudent antibiotic prescribing.
	General practitioners may not necessarily follow and apply the latest professional guidance owing to time constraints.	The future tasks of leading peer general practitioners at the district level could include advocacy of ASP directives and guidelines as well as monitoring compliance among general practitioners.
	Shortage of time during patient–doctor visits impedes detailed discussions and the communication of key messages.	The Primary Health Care Act, which entered into force in August 2015, emphasizes the expansion of preventive services and definitive health care within primary care, which would further support opportunities for communication.
Organizational	The introduction of a new subject or educational course may necessitate a revision of and reductions in the training time dedicated to other disciplines, possibly leading to conflicts of interest among the stakeholders concerned.	While respecting university autonomy, the Ministry of Human Capacities (which incorporates the state secretariats for Healthcare and Education) defines the subject matter of mandatory postgraduate core courses within the current legal framework.
System	The application of individual import schemes is time consuming, and thus inconvenient for securing the availability of essential antibiotics for the treatment of acute infections.	The assessment of prescribing practices should be based not only on quantitative but also on qualitative measures. For this to be achieved, data collection and database systems should be developed. Linking antibiotic prescription to clinical diagnoses could be an important step forward.
	Developing and periodically updating national guidelines to support prudent antibiotic prescribing is labor intensive, so it requires institutional and budgetary support.	The recent launch of a number of national projects on patient safety has created the opportunity to invest in the development of professional guidelines and related training materials.

Source: Based on WHO/EURO 2020.

Note: ASP = antimicrobial stewardship program; N.A. = not applicable.

Example 2: Identifying Implementation Considerations

This example (table 4.12) considers the identification of implementation considerations that might arise on multiple levels if school-based physical activity policies were to be implemented to address the problem of obesity in KSA.

Table 4.12: Example of Implementation Considerations from KSA

Level	Policy Element(s)	Barriers	Counterstrategies
Individual	Updating physical education curricula and increasing the number and duration of physical activity classes during school hours	One systematic review identified personal barriers to participation for children with disabilities in physical activity classes because of a lack of skills (physical and social), preference for activities other than physical activities, fear of participating in physical activity classes, and a lack of knowledge about exercise (Shields, Synnot, and Barr 2011).	<p>Implement structured programs with a variety of activities, noncompetitive, small group, and age-appropriate programs, which were seen as facilitators (Shields, Synnot, and Barr 2011).</p> <p>Recruit disability-aware staff who are knowledgeable about how to modify activities so that children with disabilities can be included, and who can also facilitate engagement in activity.</p> <p>Provision of information about programs to parents by schools, by other parents, and by physical activity providers was regarded as an important facilitator (Shields, Synnot, and Barr 2011).</p>
	Implementing physical activity programs after school hours	Children from low-income families may not be able to participate in traditional fee-based activity classes or lessons and may need assistance with transportation (Pate and O'Neill 2009).	It is recommended to provide transportation for students from the school setting to home after school hours since this was proven to be linked to higher students' attendance at after-school programs and should be a primary consideration for program budgeting (Beets et al. 2009; Pate and O'Neill 2009).
Professional	Updating physical education curricula and increasing the number and duration of physical activity classes during school hours Implementing physical activity programs after school hours	Lack of trained staff in the schools and in the after-school clubs for physical education, poor teacher attitude toward physical activity, lack of teacher motivation to implement physical activity, and competing curriculum priorities have been directly linked to a decrease in physical activity for the children (Dimyan 2016; Nathan et al. 2018).	<p>Provide physical education teachers and trainers with workshops and new curriculum in addition to training on providing services tailored to the needs of individuals with disabilities.</p> <p>Another recommendation for schools or programs is to use volunteers, particularly college students with training in adapted physical education, physical education or therapeutic recreation (Dimyan 2016).</p>

Level	Policy Element(s)	Barriers	Counterstrategies
Organizational	Updating physical education curricula and increasing the number and duration of physical activity classes during school hours	Many states, districts, and schools in the United States allowed students to be exempt from participating in physical education even though a national policy was adopted stating that schools will teach physical education (Lee et al. 2007).	To improve school compliance with national physical education policy it is suggested to require written reports from schools to document compliance, use teacher evaluations or classroom monitoring, or use teachers to mentor other teachers (Lee et al. 2007).
	Updating physical education curricula and increasing the number and duration of physical activity classes during school hours	Time constraints (time to prepare and deliver the physical activity component, competing demands, and teacher overload) were noted as a key barrier to implementation of school-based physical activity initiatives (Naylor et al. 2015).	Every teacher experiences limited time as a barrier, but teachers should be encouraged to prioritize a physical activity program and deliver it despite these constraints, based on the value they place on it and knowing the health benefits it has for their students (Naylor et al. 2015).
System	All elements	A systematic review reported that the lack of school board support for physical activity and that physical activity is not culturally accepted in certain contexts act as a barrier for implementation of such policies (Nathan et al. 2018).	Strategies to improve the relative priority of policy adherence in schools—for example, through school leadership endorsement of physical activity policy and the use of systems to monitor implementation performance of schools could be considered to support school policy promoting physical activity (Nathan et al. 2018).

Source: Based on the K2P Center Policy Brief 2020 (unpublished).

Box 4.7: Tips for How to Write the Implementation Considerations

- You can segregate the implementation considerations per option/element, or you can report on all the implementation considerations to address the problem in one combined table.
- The policy options should be analyzed in terms of the barriers to their implementation as reported by national, regional, and international evidence along with the stakeholder interviews.
- Counterstrategies or facilitators for these barriers should also be identified to increase the chances of successful implementation of the policy options.
- The evidence should be summarized in a way that is both easily understood and conveys the main ideas needed to support decisions.
- Do not forget the references and adding the type of the evidence for each.

Policy Implementation Plan

Once a policy option has been prioritized and potential barriers and facilitators have been identified, you can develop an implementation plan that includes clearly defined policy goals, strategies, action plans, timelines, monitoring mechanisms, and operational guidelines. The implementation plan should include the following steps:

- Promote regular interactions among staff responsible for program implementation, monitoring and evaluation, and management.
- Allocate sufficient resources (time, money, staff) for policy implementation and regular reviews and monitoring of the implementation process. This should include taking corrective action to alleviate identified barriers and/or communicate recommended action for other organizations.
- Establish mechanisms to ensure compliance with policy directives and understand incentives for compliance; also establish sanctions for noncompliance.
- Establish indicators or performance standards to determine whether adequate progress is being achieved and to assess the effects of changes in medicines policy objectives. Independent consultants or external professionals may be invited to complement a national evaluation team.
- Implement systems to routinely collect and analyze quantitative and qualitative data from various sources (for example, periodic assessments, activity appraisals, client satisfaction surveys) and stakeholders (beneficiaries, implementers, and policy makers).
- Link performance-related budget to the policy to promote adequate implementation (and monitoring).
- Reassess from time to time and revise as appropriate.

Annex 4A: Template for Problem Framing

Political or policy issues within the context of this problem/issue
.....
.....
.....
.....

Problem statement
.....
.....
.....
.....

Size of the problem	
Indicators to establish the magnitude of the problem
Comparators to assess progress (or lack thereof) in addressing the problem	Comparison over time within a country
	Comparison between countries
	Comparison against plans/what policy makers predicted/wanted

Consequences of inaction
Consequences of inaction, or of inefficient action
Current and projected impact on health and economic outcomes

Consequences of inaction	
Equity considerations	
.....	
.....	
.....	
.....	

Underlying causes of the problem	
Current health system arrangements within which programs, services, and drugs are provided	Delivery arrangements
	Financial arrangements
	Governance arrangement
Current degree of implementation of an agreed upon course of action (e.g., a policy)	

Note: For social and health in all policy topics, the domains can be replaced with the socioecological model. See box 4A.1 for tips in framing the problem.

Box 4A.1: Tips for Framing the Problem

- Avoid medical and research jargon.
- Do not focus on the methodology of the studies you are mentioning; report instead on the main result and the conclusion from the study.
- Avoid merely listing the results of different papers. Instead, try to synthesize all the evidence in an engaging way.
- Try to use a few figures, graphs, info graphs, and tables to highlight on the most important facts.
- Discuss the missing evidence, not only the available evidence. Whenever needed, mention the limitations of the evidence if this limitation is critical for an informed decision-making process.

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CHAPTER 5

DEVELOPING AND LEVERAGING KNOWLEDGE TRANSLATION TOOLS

Introduction

This chapter provides an overview of knowledge translation (KT) tools and then considers policy briefs in both the preparatory and production phases. The *preparatory phase* of a policy brief encompasses the formation of a core team and a work plan and then maps the relevant policy and political context. The brief's *production phase* has five components: problem framing, policy options to address the problem, implementation considerations for an option, an outline of the brief, and the full policy brief.

The chapter also presents relevant guidelines and questionnaires. Templates are provided in annexes at the end of the chapter. Annex 5A provides a template for a policy brief outline, annex 5B provides a tracking sheet for key informant interviews, annex 5C provides merit review guidelines, annex 5D is a policy brief evaluation questionnaire, annex 5E is a template for a policy brief, and annex 5F is a summary of relevant systematic reviews, materials have been adapted from the following sources:

- Oxman and Hanney's 2009 "SUPPORT Tools for evidence-informed health Policymaking (STP) 1: Guides," available at <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-7-supplement-1>.
- The WHO/EURO 2020 *Evidence Briefs for Policy: Using the Integrated Knowledge Translation Approach Guiding Manual*, available at <https://apps.who.int/iris/bitstream/handle/10665/337950/WHO-EURO-2020-1740-41491-56588-eng.pdf?sequence=1&isAllowed=y>. The manual was primarily developed by the Knowledge to Policy (K2P) Center.
- Knowledge to Policy (K2P) Center. K2P Policy Brief, available at <https://www.aub.edu.lb/k2p/Pages/K2PPolicyBrief.aspx>.
- McMaster Health Forum | Our Products, available at <https://www.mcmasterforum.org/find-evidence/products>.

Overview of Knowledge Translation Tools

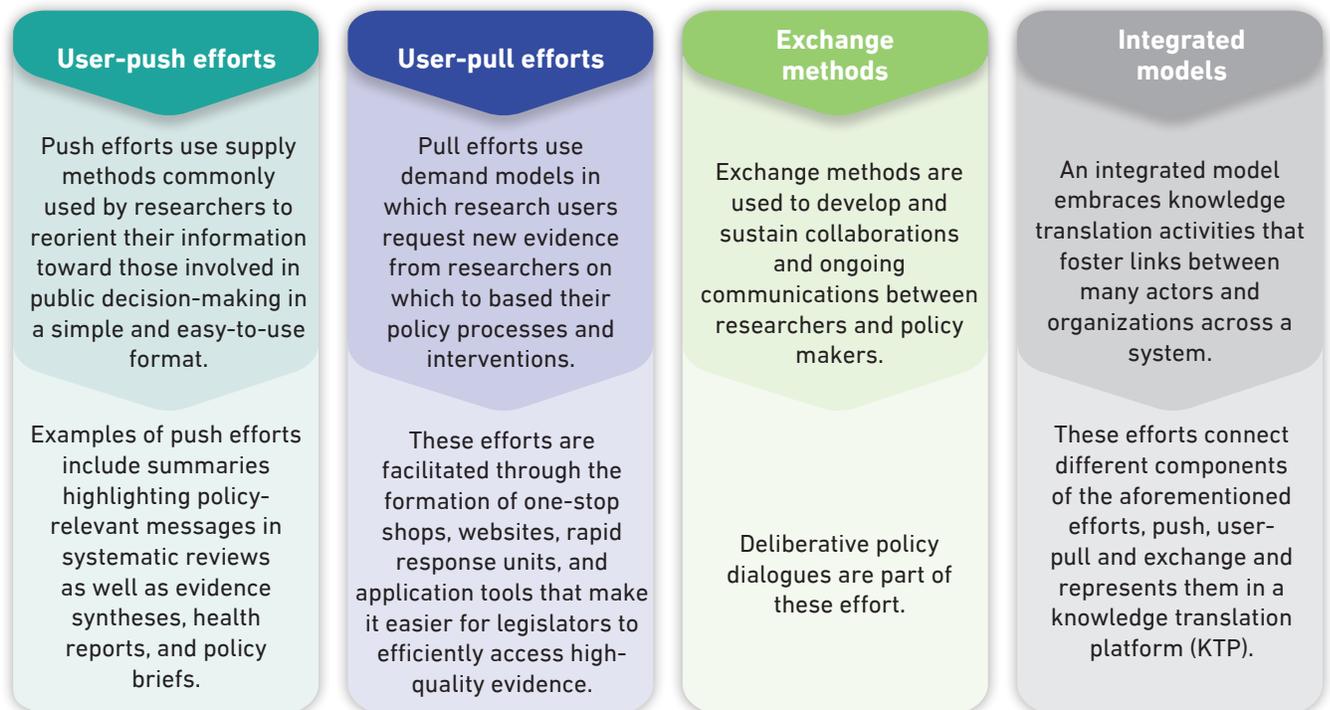
Knowledge translation (KT) is defined as the exchange, synthesis, and effective communication of reliable and relevant research results. Its focus is on promoting interaction among the producers and users of research, removing the barriers to research use, and tailoring information to different target audiences so that effective policies and interventions are used more widely (WHO 2004).

There are four KT efforts that link research to policy or action: user-push, user-pull, exchange methods, and integrated models (see figure 5.1) (Lavis et al. 2006; Oxman et al. 2009; WHO 2012):

- *User-push efforts* are supply methods that allow researchers to identify and tailor key messages arising from research evidence to potential users including policy makers and to disseminate the messages through the most credible sources.

- *User-pull efforts* are demand models that concentrate on how policy makers extract research evidence from the research community for their decisions.
- *Exchange methods* are collaborative approaches that help bridge the gap between researchers and research users by promoting mutual trust between the two and enhancing recognition of the complexities and realities of the research and policy making processes.
- *Integrated models* are a combination of activities that connect different components of user-push, user-pull, and exchange efforts, and then typically present them in a KT platform.

Figure 5.1: Knowledge Translation Efforts



Source: Original figure for this publication.

KT products allow research evidence (which is generated from the systematic reviews) and local data to be packed in user-friendly formats and written in understandable language, increasing the likelihood it will be used by policy makers.

The basic unit of KT is the pre-existing evidence base; specifically systematic reviews. Knowledge translators need to identify their key messages for different target audiences and fashion these messages in language that is easily assimilated by those audiences.

KT products use different communication techniques as targeted, tailored, or framed messages. They use narratives or a combination of techniques to improve the user's ability to take up and apply evidence—hence, to support evidence-informed policy making (Chapman et al. 2021). These techniques or strategies include:

- *Targeting the message*: This is a communication technique directed toward specific subgroups based on their affiliation or characteristics (for example, gender, age, race, ethnicity, language, and so on). This can be done by incorporating visual elements, music, or language reflecting the subgroup(s).

- *Tailoring the message:* This technique is devised for an individual, based on input from that individual. It can be achieved by using a database of messages from an individual's responses, an algorithm to tailor messages from an individual's input, direct messages related to an individual's behavior of interest, and individualized feedback for a participant.
- *Framing the messages:* This technique is intended to convey the same messages in alternative ways tailored to the needs and interests of different audiences.
- *Using narratives:* Messages can also be communicated using narratives in the form of stories, testimonials, case studies, experience sharing, and entertaining education.
- *Using a multicomponent approach:* The understanding of evidence can be enhanced using a multicomponent approach achieved by combining more than one of the above strategies.

Preferences for Evidence Presentation and Communication

Research communication is not a one-size-fits-all approach (Smith et al. 2022). Consequently, researchers and knowledge brokers must consider how to properly communicate with policy makers and stakeholders to successfully promote the uptake and use of evidence in policy and practice, taking into consideration their preferences, values, priorities, and level of understanding (Smith et al. 2022). As a result, effective communication depends on different factors, including:

- Relevant and understandable research;
- Visually appealing presentation of data and information;
- Clear key messages related to the evidence produced;
- Multiple, tailored approaches to utilizing research findings when responding to policy questions;
- The engagement of policy makers in the planning and implementation of the research; and
- A strong relationship with policy makers based on trust and credibility.

When communicating evidence, it is important to identify the target audience, the purpose of communicating that evidence and the intended outcomes, the channel(s) or tool(s) to be used, and the format and presentation of evidence (Arnautu and Dagenais 2021; Campbell et al. 2009; Chapman et al. 2021; Dobbins, DeCorby, and Twiddy 2004; Lavis et al. 2009; Marquez et al. 2018; Mijumbi-Deve et al. 2017; Pittore, Meeker, and Barker 2017; Rosenbaum et al. 2010) (see box 5.1).

Although no specific recommendations can be conclusively determined regarding the use of particular interventions to promote evidence to policy makers because of a lack of evidence on the effectiveness of these tools (Chapman et al. 2021), common actions that have proven useful can be considered:

- Understand the policy process and the key actors involved in the process as well as the challenges that may be encountered at different levels of the policy-making process.
- Consider accessibility and timeliness when generating research evidence.
- Start early, take the initiative to contact policy makers, and try to engage them in the planning stage of research.
- Enhance policy makers' engagement, acquiring their support and integrating evidence champions or brokers as intermediaries connecting researchers with policy makers.

Box 5.1: Guide for Communicating and Presenting Evidence to Policy Makers

Target audience

- Content should be tailored and targeted to the audience's needs and interest.

Purpose and intended outcomes

- Content should follow the main purpose and intended outcome.

Choice of tool(s) for communicating evidence

- The choice of tool(s) should follow the type of target audience as well as the intended purpose and outcomes.

Evidence format

- Information is concise and clear.
- Key messages and main findings are presented separately (that is, in a graded entry format—for example, key message, executive summary, and full document).
- Language is user-friendly (plain language in easy-to-read format with minimal technical language).
- Key messages and recommendations are action oriented.
- Presentation of information is visually appealing (for example, it uses icons, charts, images, infographics, and bullets).

Note: Crowded images and texts with multiple fonts and packed information can make a page hard to read.

- Present evidence in a clear, understandable, and accessible format including tailored messages, careful language, and language specific to the needs of the policy makers.
- Avoid restricting communication and dissemination strategies to push and pull efforts only; instead, use strategies that can distribute knowledge more broadly.

Policy Briefs

Policy briefs (also referred to as *evidence briefs for policy*) are one of the most widely used KT tools for packaging research evidence for policy makers (Arnautu and Dagenais 2021; Moat, Lavis, and Abelson 2013; WHO 2016). These briefs are prepared by synthesizing and contextualizing the best available evidence about a problem; viable policy options to address it; and key implementation considerations through the involvement of content experts, policy makers, and stakeholders (WHO/EURO 2020). They provide the best available research evidence on high-priority issues, which should be the starting point of every brief.

Policy briefs, particularly those that follow the World Health Organization Evidence-Informed Policy Network (WHO EVIPNet) style (which is the focus of this manual; see box 5.2), are highly regarded by policy makers and stakeholders—both in terms of achieving their intended objective and in terms of their key design features—regardless of country, group, or issue involved. They have also been shown to have direct impacts on selected policy-making processes (Arnautu and Dagenais 2021; Moat et al. 2013; Murphy et al. 2022; WHO 2016; Yehia and El-Jardali 2015).

Box 5.2: WHO EVIPNET Policy Briefs

WHO Evidence-Informed Policy Network (EVIPNet) policy briefs bring together the three main types of evidence to inform policy decisions: (1) global research evidence (from systematic reviews), (2) context-specific and local data, and (3) tacit knowledge (through the engagement of content experts and stakeholders).

Policy briefs are primarily pre-circulated in policy dialogues to inform deliberations about the issue at hand (see the section on Policy Brief Evaluation Questionnaire, which discusses dialogues).

A key strength of these policy briefs is that they serve as a one-stop shop that provides all the information needed to effectively inform decisions—from in-depth diagnosis of the problem and its underlying causes to evidence-based policy options to address it and implementation considerations for each proposed option. Additionally, these briefs are not static—they are iteratively refined and tailored to the specific context through the accumulation of tacit knowledge from structured interviews with key stakeholders. A summary of the content of a policy brief is provided in box 5.3.

Box 5.3: Content of Policy Briefs

Problem framing

- Problem framing sets out a policy problem that summarizes the best available evidence to clarify the size and nature of the problem and its underlying causes.

Options or elements to address problem

- Three or more viable policy and programmatic options must be described.
- An alternative is to describe three or more elements of a potentially comprehensive approach.

Implementation considerations

- These considerations look at potential barriers to implementing the options/elements and strategies for addressing those barriers.

Not included

- A policy brief does not provide recommendations for action.
-

The rest of this chapter provides details about the steps involved in preparing a WHO EVIPNet-style policy brief.

In the preparatory phase, these steps are:

- Forming the core team
- Establishing a work plan
- Mapping policy and political context

In the production phase, they are:

- Framing the problem
- Identifying policy options to address the problem
- Identifying implementation considerations for an option
- Developing a policy brief outline
- Conducting key informant interviews
- Developing a full policy brief.

Preparatory Phase

This phase involves forming the core team, establishing a work plan, and mapping policy and political context.

Forming the Core Team

Identifying the right mixture of expertise is key to a successful team. This team will be responsible for developing the policy brief and conducting the key informant interviews. Overall, the team needs to include at least one member with expertise in the following areas:

- The methods of writing a policy brief (that is, “Knowledge Translation Science”).
- Evidence search, appraisal, and synthesis.
- Content/technical expertise on the topic that is being addressed in the policy brief.

Establishing a Work Plan

A work plan is essential to ensure that the deliverable is finalized on time. A work plan is also an important tool for internal and external coordination and communication of work, so that everyone can plan ahead and know their roles and the deadlines. One team member should be responsible for following up on the deadlines around deliverables. This team member should also update the document regularly.

On average, the policy brief process could take between three and four months to complete, depending on the complexity of the issue being addressed. An example of a work plan is provided in table 5.1.

Table 5.1: Example of a Work Plan

Process	Estimated timeline	Status
Establishment of core team	2 weeks	
Literature search	2 weeks	
Draft outline for policy brief	3–4 weeks	
Schedule and conduct key informant interviews	3–4 weeks	
Writing process (Draft 1)	3 weeks	
Internal merit review	7 working days	
Writing process (Draft 2)	2 weeks	
External merit review	10 working days	
Final policy brief (including draft title, cover page, key messages, executive summary, references, description of methods, acknowledgments, funders)	2 weeks	
Formatting and publication	1 week	

Source: Original table for this publication.

Mapping Policy and Political Context

Understanding the policy and political context around the problem/issue is essential to designing the proper response. Knowledge of the context can help shape the policy brief itself, the selection of stakeholders, the deadlines set for the product—for example, to align it with an upcoming window of opportunity such as International Days (for example, World Cancer Day, the issuance of a law)—the communication plan, and the uptake plan.

Box 5.4 provides some guiding questions that can outline essential areas to keep in mind when thinking about the context, including the history of the problem and the political context around it, what has been done, and what was successful, as well as what is still missing and why.

Box 5.4: Guiding Questions for Mapping

What is the problem or issue at hand?

What is the specific aspect of this issue/problem to tackle?

What progress has been made on the issue/problem so far in your country?

- What brought the issue/problem into focus?
- Are there any previous policies, laws, decisions, or interventions around it?
- If yes, outline them and describe who was involved and how these were developed.

Is the issue/problem at hand within the policy/political agenda?

- Do policy makers intend to address the issue/problem? How high is it on the ladder of their priorities?
- If not, then should it be on the policy/political priority agenda? If so, what will it take to get it on the agenda?

Is there a window of opportunity that you can use to start discussions/find solutions for the issue/problem at hand?

Referring to the current problem at hand and the possible solutions, what is required to reach the health policy objectives? Is it a law, a decision, an intervention, a strategy, an institutional policy?

Depending on the answer to the question above, how are the strategies/laws/decrees developed and passed in your country?

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

Source: WHO/EURO 2020.

Production Phase: Writing the Policy Brief

Once you have identified the topic and understood its local political and policy context, there should be a clear description of its extent, consequences, and underlying factors.

Framing the Problem

A first step in developing the policy brief is to have a clear framing of the problem. This should be evidence-informed, contextualized, and engaging, with a focus on health and economic outcomes. Once the magnitude of the problem has been established, the next step is to assess the underlying causes of the problem. Once you identify the real underlying factors of the problem, you are closer to finding solutions. See chapter 4 for details.

Identifying Policy Options to Address the Problem

Following a thorough description of the problem and its underlying factors, the next step is to present policy options/elements to address it.

An evidence brief for policy describes the options identified by the literature as effective in addressing the problem/issue at hand and its underlying factors. The options could be comprehensive enough to cover all the identified underlying factors or could cover only a few underlying factors while still

acknowledging the need to work on the others. See chapter 4 for details on how to frame the options to address a problem.

Identifying Implementation Considerations for an Option

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

In the next section of your policy brief, an answer to those questions is essential to ensure that once this option is implemented in your local context, its implementation will be successful so that it will yield the expected benefits. See chapter 4 for details on how to identify implementation considerations for an option.

Developing a Policy Brief Outline

The policy brief outline template provided in annex 5A can be used to develop content for the first draft of your full policy brief. It is typically four to five pages long and should highlight preliminary findings pertaining to each section of the full brief. Items to be covered include:

- Problem framing and underlying causes (at this stage, you can present the framing of the problem and some of the key underlying causes without going into details about the size of the problem).
- Policy options to address the problem (at this stage, you can propose the policy options alone and provide a brief description of the emerging evidence in terms of benefits, costs, and so on, without filling in the table for each policy option).
- Implementation considerations (at this stage, you could present the key implementation considerations across options, without going into the details of each).

The policy brief outline will inform the key informant interview discussions to make sure that the brief is on track—that is, that the problem is framed in way that will resonate with key stakeholders and proposed options/elements are appropriate for the local context.

Conducting Key Informant Interviews

Once the policy brief outline is complete, key informant interviews are conducted with key selected stakeholders to elicit their opinions and feedback on the problem framing, the proposed policy options, and their implementation considerations. This will enable co-production of the brief with key stakeholders.

These interviews are not the regular qualitative research interviews. The notes taken during those interviews are more general and serve to inform the development of the policy brief, without verbatim transcription and thematic analysis.

The process of conducting key informant interviews takes about three to four weeks, and consists of the following steps:

- Select eight to ten participants (content experts, stakeholders, and policy makers that relate to the topic of interest). You can refer to the stakeholder mapping form in table 2.2.
- Send an invitation email to the potential participants (a sample invitation letter is provided in box 5.6a). The participants are usually given five working days to reply. If the participant does not reply within that time frame, then send a reminder note (box 5.6b).

- If the participant agrees to participate in the key informant interview, then essential questions (see box 5.5), along with the policy brief outline, are sent to the participants before the time of the interview.
- High-level comments provided during the key informant interview are consolidated into one document and shared with the team for discussion. Changes are made accordingly.

An overview of essential questions to guide the key informant interviews is provided in box 5.5. These should be considered prior to conducting the interview.

Box 5.5: Essential Questions to Ask during Key Informant Interviews

- Does the wording of the title engage policy makers and key stakeholders?
- Was the description of the problem appropriate?
- Was the description of the size of the problem comprehensive and relevant?
- Was the description of the underlying factors of the problem comprehensive, clear, and relevant?
- Did the option/elements proposed appropriately address the described problem in a reasonable manner?
- Is there any other literature on the topic you think would be particularly useful to policy makers in framing the problem and proposed elements?
- Are there any stakeholders who you believe are important to engage on this issue?
- Is there any other literature on the topic you think would be particularly useful to policy makers in framing the problem and proposed elements?

The tracking sheet provided in annex 5B can be used to track the interviews. A sample invitation letter is provided in box 5.6a and a sample response letter in box 5.7.

Box 5.6a: Sample Invitation Letter to Key Informant Interview Participants

Subject: Request for Short Interview [*Title of Policy Brief*]

Dear Dr./Mr./Ms./Mrs. [*Name*],

I hope you are doing well.

In response to emerging issues related to the [*Problem summary*], the Saudi Health Council is working on developing a Policy Brief entitled “[*TITLE*]”. This is being done in collaboration with the [*state collaborators, if any*].

Before we proceed with the write up of the Policy Brief, we usually conduct key informant interviews (with around 10 to 15 key stakeholders) to gather their input and suggestions regarding the nature, size, and underlying factors of the problem and the proposed policy options for consideration. Also, we seek suggestions for any additional literature or reports that we should review in case anything is missing.

You have been identified as a key stakeholder organization to consult with. We request 30 to 40 minutes of your time to meet with you in order to gather your input about the draft outline for the Policy Brief that is being produced to support a national policy dialogue that will be conducted in [*Month, Year*].

To this end, I would very much appreciate it if you could provide us with a suitable date and time to meet you during the [*1st/2nd/3rd/4th*] week of [*Month, Year*]. Once you confirm the date, we will send the draft outline (5 pages max) of the Policy Brief for your review.

Please don't hesitate to contact me via email [*email address*] or phone [*#*] for more details. For planning purposes, we would appreciate your kind response by [*Day, Month, Year*].

Best Regards,

[*Name, Title*]

Box 5.6b: Subject: Follow-Up: Key Informant Interview Invitation

Dear Dr./Mr./Ms./Mrs. [Name],

I hope you are doing well.

I am writing to follow up on my previous invitation to participate in a key informant interview regarding [insert title of policy brief].

If you haven't had the chance to review the initial invitation, you can find the details below: [Include a brief summary of the initial invitation, including date, time, and any other relevant information.]

We understand that your time is valuable, and we appreciate your consideration of this invitation. Please let us know if you have any questions or if any adjustments are needed to accommodate your schedule.

Thank you for your time.

Best regards,

[Name, Title]

Box 5.7: Response to Invitation Letter for Key Informant Interviews

Dear Dr./Mr./Ms./Mrs. [Name],

Once again, thank you for agreeing to meet for an interview on [Date: Day and Month] at [Time].

For your review before our meeting, please find attached the draft outline for the policy brief.

During our meeting, we will use the following questions to guide our discussion. You can consider these questions during your review:

1. Does the wording of the title engage policy makers and key stakeholders?
2. Is the description of the problem appropriate?
3. Is the description of the size of the problem comprehensive and relevant?
4. Is the description of the underlying factors of the problem comprehensive clear and relevant?
5. Do the elements proposed appropriately address the described problem in a reasonable manner?
6. Is there any other literature on the topic you would think would be particularly useful to policy makers in framing the problem and proposed elements?
7. Are there any stakeholders who you believe are important to engage on this issue?

Thank you and looking forward to our meeting.

Best Regards,

[Name, Title]

Another approach to engaging stakeholders in policy brief production is *structured brainstorming*, which is where a group of stakeholders with expertise relevant to the topic meet and brainstorm ideas to improve the policy brief, find solutions, and focus attention on the promising aspects of the brief (The SURE Collaboration 2011). While not mandatory, this approach could be a valuable complement to the key informant interviews.

Developing a Full Policy Brief

The policy brief is characterized by its graded-entry format (1 page of key messages, a 3–5 page executive summary, and 25 pages for the full brief). These are set up in the following manner:

- Key messages (1 page)
 - One page of bullet points summarizing the most important take-home messages around the problem, its size, its main underlying factors, and the headlines of the policy options/elements. Those are the simple and concise messages that you would share with a decision-maker if you had only 5 minutes with them.
- Executive summary (3–5 pages)
 - This is a synopsis of the problem, policy options, and implementation considerations. These are detailed descriptions of the problem and the policy options for the decision-makers who have 20 minutes to read.
- Full report (25 pages).

The full report contains the full description of the problem, policy options, and implementation considerations. The section of the report on the problem describes how it came to the attention of the public and the stakeholder/policy maker, the problem statement, the problem's size, the consequences of inaction, the factors underlying of the problem, and all equity considerations related to the problem.

The section of the full report describing policy options is concerned with local readiness for the option; the likely impacts of implementation of the policy option on health, equity, and so on (that is, its benefits and harms); and any equity, cost, and cost-effectiveness considerations. Implementation considerations in the report are concerned with barriers to implementing the option and identifying facilitators or implementation strategies.

The report then provides a section on next steps (1 page), which considers how the policy brief will be moved toward uptake and impact; this includes the policy dialogue and following up on the implementation and the evaluation of the policy options.

The full report concludes with references (it is important to maintain a uniform referencing style between the in-text citation and the full bibliography) and all appendixes, which include the summary of the studies included in the policy brief and their quality and any other relevant information that could not be added to the full policy brief (annex 5E provides a policy brief template).

Merit Review

Once the full policy brief has been completed, the draft is sent to at least one content expert and one topic expert for merit review. You should allow roughly 10 working days as a response time. When you have the reviewers' comments back, update the policy brief draft based on those comments, then finalize the content of the policy brief, proofread it, translate it into local language/s, and print it.

Merit review guidelines for the full policy brief can be found in annex 5C.

Policy Brief Evaluation Questionnaire

The questionnaire below can be distributed to the participants upon registration during the policy dialogue, then collected before the dialogue starts or at the end of the dialogue. It can also be sent via email after the stakeholders have read the policy brief.

This questionnaire rates multiple process and outcome objectives on a scale of 1 to 7, ranging from very unhelpful (1) to very helpful (7). It covers the main areas and sections within the brief, the general goal of the brief, and some background information about the participants. The questionnaire should be filled anonymously.

The questionnaire has been pilot-tested in diverse settings across the globe (Lavis, Boyko, and Gauvin 2014; Moat et al. 2013; Yehia and El-Jardali 2015).

See annex 5D for an example policy brief evaluation questionnaire.

Annex 5A: Template for Policy Brief Outline

Annex 5A provides a template for the policy brief outline, adapted from the McMaster Health Forum templates. To make policy briefs visually appealing, consider the following:

- Use tailored and target messages.
- Use graded-entry formats.
- Present evidence in an understandable, short, easy-to-read format with minimal technical language (evidence that is condensed and too complex loses its value and credibility).
- Knowledge should be accessible, visually appealing, and user-friendly (for example, use icons, charts, images, infographics, bullets).
- Include a methods section (as side bar).

Provisional title (tip: try to start with an active verb progressive tense such as “improving” or “promoting”)_____.

1. Context and scope

Identify the context within which the brief is being prepared

Question(s)	Provisional/Draft responses
What important political or policy issues should be considered within the context of this brief?

Define the scope of the brief

Question(s)	Provisional/Draft responses
What concepts should be defined and what definitions should be used?
What <i>should</i> the brief address?
What should the brief <i>not</i> address?

2. The problem and its underlying causes

Question(s)	Provisional/Draft responses
Problem statement

Question(s)	Provisional/Draft responses
<p>How does the problem relate to the current health system arrangements within which programs, services, and drugs are provided?</p>	<p>Delivery arrangements</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Financial arrangements</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Governance arrangements</p> <p>.....</p> <p>.....</p> <p>.....</p>
<p>How does the problem relate to current degree of implementation of an agreed upon course of action (e.g., a policy)?</p>	<p>.....</p> <p>.....</p> <p>.....</p>

3. Policy or programmatic options to address the problem

Question(s)	Provisional/Draft Responses
<p>What are three viable policies or programmatic options to address the problem?</p>	<p>Option 1:</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Brief description of option and summary of findings (in terms of benefits/costs)</p>
	<p>Option 2:</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Brief description of option and summary of findings (in terms of benefits/costs)</p>
	<p>Option 3:</p> <p>.....</p> <p>.....</p> <p>.....</p>
	<p>Brief description of option and summary of findings (in terms of benefits/costs)</p>

4. Implementation considerations

Question(s)	Provisional/Draft Responses
What are the potential barriers that could influence the successful implementation of these policies or programmatic options?	Option 1:
	Option 2:
	Option 3:

Annex 5C: Merit Review Guidelines for Brief

Note: This annex is based on WHO/EURO 2020 and is adapted from templates developed by McMaster Health Forum.

Title, Key Messages, and Executive Summary

1. From a policy maker's perspective, did the wording of the title engage you? Yes No

If not, please indicate why not.

.....

.....

2. Do the key messages clearly illustrate the problem, its magnitude, and what is known about the three policy options and implementation barriers and strategies? Yes No

If not, please indicate why not.

.....

.....

3. Does the three-page executive summary provide sufficient information? Yes No

If not, please indicate where it is insufficient and why.

.....

.....

4. Are there any changes you would suggest to the title, key messages, and executive summary? Yes No
-
-

Context and Problem

5. Given what you know about the problem being addressed, was the description of the context comprehensive? Yes No

If not, please indicate where and why not.

.....

.....

6. Does the description of the problem and its underlying factors comprehensively and accurately reflect reality? Yes No

If not, please indicate where the description falls short and why.

.....

.....

Options

7. Did the options proposed in the brief appropriately address the described problem? Yes No

If not, please indicate what was missing and why the options do not appropriately address this problem.

.....

.....

8. Was the description of the benefits, harms, costs, and stakeholder reactions to the options comprehensive, clear, and logical? Yes No

If not, please indicate where and why.

.....

.....

9. Was the description of the implementation barriers, local applicability, and strategies comprehensive, clear, and logical? Yes No

If not, please indicate where and why.

.....

.....

General

10. Did the brief appropriately take into account equity and applicability considerations? Yes No

If not, please indicate where and why.

.....

.....

11. Was the use of local, regional, and international evidence informative and relevant to the context of [country]? Yes No

If not, please indicate where and why.

.....

.....

12. Are there any additional documents that we should review in developing this policy brief further? Yes No

If yes, please indicate them.

.....

.....

13. Was the brief written in an objective manner?

Yes No

If not, please indicate where and why.

.....
.....

14. Was the brief written in a clear and understandable language?

Yes No

If not, please indicate what was confusing.

.....
.....

15. Was the brief organized in a way that highlights decision-relevant information?

Yes No

If not, please indicate where and why.

.....
.....

16. Was the format of the brief (graded entries), appropriate?

Yes No

If not, please indicate where and why.

.....
.....

Annex 5D: Policy Brief Evaluation Questionnaire

Note: This annex is based on WHO/EURO 2020 and is adapted from templates developed by McMaster Health Forum.

Average scores are computed for each individual item in the questionnaire. Items garnering an average score of 5 and above are deemed to have been “successfully achieved,” demonstrating excellence. Conversely, items with an average score of 3 or below are categorized as “failed,” indicating areas for improvement. Those falling within the range of 3 to 5 denote a mid-way performance, suggesting a moderate level of achievement.

Title of the Brief

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

	Very unhelpful	Moderately Unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1. The policy brief described the context for the issue being addressed.	1	2	3	4	5	6	7
2. The brief described different features of the problem, including (where possible) how it affects particular groups.	1	2	3	4	5	6	7
3. The brief described elements of an approach for addressing the problem.	1	2	3	4	5	6	7
4. The brief described what is known, based on synthesized research evidence, about each of the elements/options and where there are gaps in what is known.	1	2	3	4	5	6	7
5. The brief described key implementation considerations.	1	2	3	4	5	6	7
6. The brief took quality considerations into account when discussing the research evidence.	1	2	3	4	5	6	7
7. The brief took local applicability considerations into account when discussing the research evidence.	1	2	3	4	5	6	7

	Very unhelpful	Moderately Unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
8. The brief did not conclude with particular recommendations.	1	2	3	4	5	6	7
9. The brief employed a graded-entry format (e.g., a list of key messages and a full report).	1	2	3	4	5	6	7

Overall Assessment of the Policy Brief

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

Completely Failed	Moderately failed	Slightly Failed	Neutral	Slightly achieved	Moderately achieved	Achieved
1	2	3	4	5	6	7

11. Additional comments:

.....

.....

.....

.....

.....

.....

Your Role and Background

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

Broad role category	Specific role category	Tick (✓)
Policy maker	Public policy maker (i.e., elected official, political staff, or civil servant) in the national government	
	Manager in a district/region (if it does not have independent policy making authority)	
	Manager in a health care institution (e.g., hospital, primary health care)	
	Manager in a nongovernmental organization (NGO)	
Stakeholder	Staff/member of a civil society group or community-based NGO	
	Staff/member of a health professional association or group	

Broad role category	Specific role category	Tick (✓)
	Staff of a donor agency	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

I have been working in my current position for _____ years.

Annex 5E: Policy Brief Template

Note: This policy brief template is based on WHO Regional Office for Europe (2017) and is adapted from WHO/EURO 2020.

Policy brief

[*Insert title*]

[*Insert date*]

[*Insert name of organization/initiative producing/publishing the policy brief*]
.....
.....

[*Insert brief description of organization/initiative*]
.....
.....

Authors [*Insert names and affiliations of authors*]
.....
.....

Funding [*Insert details about funding, both for the production of the policy brief and for the training workshops that supported it*]
.....
.....

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

Merit review [*Insert details of any review by researchers, policy makers, and stakeholders in order to ensure the policy brief's scientific rigor and system relevance*]
.....
.....

Acknowledgments [*Insert any appropriate acknowledgments to individuals who supported the production of the policy brief but who are not named authors*]
.....
.....

Citation [*Insert citation as you would like it to appear*]
.....
.....

TABLE OF CONTENTS

KEY MESSAGES (a one-pager of clear and concise take-home messages)

What's the problem?

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

.....
.....

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

Option 1 – *[Insert brief description of the option]*

.....

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

.....

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

.....

What implementation considerations need to be borne in mind?

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

.....
.....
.....
.....

EXECUTIVE SUMMARY (a three-page executive summary with more details and resources for interested decision-makers and practitioners)

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

What's the problem?

[Insert a brief description of the problem and underlying causes of the problem being addressed by the brief]

.....
.....

[Problem statement]

.....
.....

[Underlying causes of the problem]

.....
.....

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

Option 1 – *[Insert brief description of the option]*

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

.....
.....

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

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

.....
.....

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

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

.....
.....

What implementation considerations need to be borne in mind?

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

.....
.....

FULL REPORT (a 25-page synthesis with full details and resources for interested decision-makers and practitioners)

THE PROBLEM

Definition and framing of problem

[Insert text]

.....
.....

Size of the problem

[Insert text]

.....
.....

Factors underlying the problem (causes)

Insert text]

.....
.....

Consequences of the problem

[Insert text]

.....
.....

Box 1: Background to Policy Brief

A policy brief brings together global research evidence, local evidence, and context-specific knowledge to inform deliberations about health policies and programs. It is prepared by synthesizing and contextualizing the best available evidence about the problem and viable solutions and options through the involvement of content experts, policy makers, and stakeholders.

The preparation of the policy brief involves the following steps:

1. Selecting a priority topic.
2. Selecting a working team who deliberates to develop an outline for the policy brief.
3. Developing and refining the outline, particularly the framing of the problem and the viable elements.
4. Conducting key informant interviews with up to *X* selected policy makers and stakeholders to frame the problem and make sure all aspects are addressed.
5. Identifying, appraising, and synthesizing relevant research evidence about the problem, elements, and implementation considerations.
6. Drafting the brief in such a way as to present concisely and in accessible language the global and local research evidence.
7. Undergoing a merit review.
8. Finalizing the policy brief based on the input of merit reviewers, translating into Arabic, validating translation, and disseminating through policy dialogues and other mechanisms.

THREE OPTIONS FOR ADDRESSING THE PROBLEM

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

.....
.....
.....
.....
.....
.....

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

Box 2: Process for Identification, Selection, and Synthesis of Research Evidence

The available research evidence about options for addressing the problem was sought primarily from systematic reviews. We searched the following key databases in [insert date]: [insert name of databases]. We used the following search strategy: [insert search strategy]. Each review was also assessed in terms of its quality (AMSTAR rating).

We identified **local studies** relevant to KSA by searching the following sources [insert name] using the following key terms: [insert key terms]

Option 1: [Insert brief description of the option]

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

A short description of the current status in the specific health system context on implementing the proposed option. This may be completely new or may have been implemented only partially. You should ensure that the new dimension of the proposed option is clear.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in table 1. For those who want to know more about the systematic reviews contained in table 1 (or obtain citations for reviews), a fuller description of the systematic reviews is provided in annex 5F.

Table 1: Summary of Key Findings from Systematic Reviews Relevant to Option 1 – [Insert description of option]

Category of finding	Key findings
Benefits	[Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]
Potential harms	[Insert one or more bulleted key messages about the harms that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]
Resource use, costs, and/or cost-effectiveness	[Insert one or more bulleted key messages about the resource use, costs, and/or cost-effectiveness that have been found for each component of the option]

Category of finding	Key findings
Uncertainty regarding benefits and potential harms (so monitoring and evaluation could be warranted if the option were pursued)	<p>Uncertainty because no systematic reviews were identified <i>[Insert a brief description of option components for which no reviews were identified]</i></p> <p>Uncertainty because no studies were identified despite an exhaustive search as part of a systematic review <i>[Insert a brief description of option components for which “empty” reviews were identified]</i></p> <p>No clear message from studies included in a systematic review <i>[Insert a brief description of option components for which there is insufficient evidence]</i></p>
Key elements of the policy option if it was tried elsewhere	<i>[Insert one or more bulleted key messages about the key elements of the policy option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]</i>
Stakeholders' views and experiences	<i>[Insert one or more bulleted key messages about stakeholders' views and experiences, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]</i>

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

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

A short description of the current status in the specific health system context on implementing the proposed option. This may be completely new or may have been implemented only partially. You should ensure that the new dimension of the proposed option is clear.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in table 2. For those who want to know more about the systematic reviews contained in table 2 (or obtain citations for reviews), a fuller description of the systematic reviews is provided in annex 5F to this brief.

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Table 2: Summary of Key Findings from Systematic Reviews Relevant to Option 2 – *[Insert description of option]*

Category of finding	Key findings
Benefits	<i>[Insert one or more bulleted key messages about the benefits that have been found for each component of the option, ensuring that findings are presented with reference to the recency, quality, local applicability, prioritized group applicability, and issue applicability]</i>

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

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

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

A short description of the current status in the specific health system context on implementing the proposed option. This may be completely new or may have been implemented only partially. You should ensure that the new dimension of the proposed option is clear.

Synthesized research evidence is available about a number of strategies that address many of the components of this option. A summary of the key findings from this synthesized research evidence is provided in table 3. For those who want to know more about the systematic reviews contained in table 3 (or obtain citations for reviews), a fuller description of the systematic reviews is provided in annex 5F to this brief.

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Table 3: Summary of Key Findings from Systematic Reviews Relevant to Option 3 – [Insert description of option]

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

Implementation Considerations

[Insert description of potential barriers to implementing the options]

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Annex 5F: Summary of Relevant Systematic Reviews

A Description of the Systematic Reviews Relevant to the Different Options/Elements

Option/Element	Focus of systematic review	Key findings	AMSTAR (quality) rating	Proportion of countries relevant to context
<i>[Insert phrase denoting option component]</i>	<i>[Insert the focus of the review]</i>	<i>[Insert the review authors' summary of the key findings]</i>	<i>[Insert the AMSTAR rating]</i>	<i>[Insert proportion]</i>

Note: AMSTAR = A MeaSurement Tool to Assess systematic Reviews.

Examples of Full Policy Briefs

- McMaster Health Forum, available at https://www.mcmasterforum.org/docs/default-source/product-documents/evidence-briefs/pain-symptom-management-cancer-eb.pdf?sfvrsn=835455d5_3.
- WHO Regional Office for Europe, available at <https://iris.who.int/bitstream/handle/10665/325029/php-4-2-161-169-eng.pdf?sequence=1>.
- K2P Center, available at https://www.aub.edu.lb/k2p/Documents/FINAL_K2P_PolicyBrief_Pharmaceuticals_English_Oct%2011%202016-.pdf.

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CHAPTER 6

ESTABLISHING RAPID RESPONSE SERVICES

Introduction

This chapter covers the steps involved in establishing a rapid response service. It begins with the three preparatory phase steps—infrastructure and technical skills, scope and focus, and the time frame for products. It then considers the steps of the production phase: clarifying the question; searching for evidence; synthesizing that evidence; writing the rapid response product; submitting the rapid response product; and, finally, monitoring and evaluation.

The chapter concludes with annexes containing the following checklists, examples, forms, and templates:

- A form for question clarification (annex 6A)
- Templates for rapid response products (annex 6B)
- Examples of 10- and 30-day rapid response products (annex 6C)
- An internal checklist for rapid response products (annex 6D)
- A merit review form (annex 6E)
- A rapid response service evaluation form (annex 6F).

We have adapted materials from the following sources:

- SURE Rapid Response Guides, available at https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/SURE-Guides-v2.1/Collectedfiles/sure_guides.html.
- McMaster Health Forum | Rapid Response, available at <https://www.mcmasterforum.org/about-us/products>.
- Mijumbi et al.'s 2014 article on Rapid Response Service in Uganda, available at <https://doi.org/10.1186/s13012-014-0114-z>.
- Knowledge to Policy (K2P) Center, Rapid Response product, available at <https://www.aub.edu.lb/k2p/Pages/K2PRapidResponse.aspx>.

Rapid Response Services

Case Scenario: *The government is considering school re-opening during the pandemic. You were asked to provide a rapid response on effective preventive measures within the next 10 days. You need guidance on how to systematically respond to this request while balancing urgency with the depth of the synthesis.*

On a daily basis, decision-makers require urgent evidence-informed answers to a number of policy questions. The need to provide the right evidence at the right time to decision-makers necessitates

the creation of rapid response services. Such services provide access to well-packaged, relevant, and updated syntheses of the best available evidence in short time frames (that is, a few weeks) in direct response to a decision-maker's request for evidence. Rapid syntheses are time-sensitive and can be tailored to user needs, and thus they are among the more promising strategies currently emerging to help address the challenges to and facilitate policy makers' use of research evidence for policy (Eljardali, Bou-Karroum, and Fadlallah 2020; Mansilla et al. 2018; Mijumbi et al. 2014; Mijumbi et al. 2017; Wilson, Lavis, and Gauvin 2015).

Rapid response services are perceived as a desirable and user-friendly output by policy makers and stakeholders and have led to direct impacts on selected policy-making processes (Mansilla et al. 2017; Mijumbi et al. 2017; Partidge et al. 2020). They have played increasingly important roles during COVID-19 pandemic where there was a critical need for evidence within short periods of time (El-Jardali, Bou-Karroum, and Fadlallah 2020).

To establish rapid response services in situations such as the one presented in the case scenario, two complementary phases with the following steps are involved:

Preparatory Phase

- Step 1: Infrastructure and technical skills
- Step 2: Scope and focus
- Step 3: Time frame for products.

Production Phase

- Step 1: Clarifying the question
- Step 2: Searching for evidence
- Step 3: Synthesizing that evidence
- Step 4: Writing the rapid response product
- Step 5: Submitting the rapid response product
- Step 6: Monitoring and evaluation.

Preparatory Phase

This section provides details about each of the three steps of the preparatory phase.

Step 1: Infrastructure and Technical Skills

A critical starting point for developing a rapid response service is to ensure that the right infrastructural, technical, and skills mix requirements are in place (see table 6.1). The establishment of appropriate infrastructure with the right technical processes is a major factor that influences the uptake of a rapid response service (Mijumbi-Deve and Sewankambo 2017). Additionally, the qualifications and skills of the team may determine whether the service produces quality and credible work, which in turn gives users the confidence to utilize the service (Mijumbi-Deve and Sewankambo 2017).

Table 6.1: Overview of Infrastructural, Technical, and Skills Mix Requirements

Infrastructural and technical requirements	Skills mix
Standard operating procedures (set of rules and processes for how to make a request and develop and disseminate products)	Understanding of policy environments, needs, and health systems
Standardized templates for rapid response products	Experience in systematically searching literature
Good systems for managing a rapid response product (e.g., facilitating interaction at key decision points)	Basic understanding of systematic reviews
Access to relevant databases	Ability to synthesize multiple types of evidence
Internet access and speed	Skills in writing and communicating with policy audience, and also skills in relationship building
Policies on issues around contracting, intellectual property and publication	Project management and time management

Source: Based on Mijumbi-Deve and Sewankambo 2017.

The core team assigned to the rapid response service shall be responsible for:

- Responding to calls and email messages from potential users,
- Filling in the initial contact form,
- Assisting with clarifying the question,
- Conducting searches,
- Preparing rapid response product reports,
- Disseminating the product to users, and
- Conducting follow-up interviews.

Step 2: Scope and Focus

The preliminary scope of the rapid response service should be limited. The service should target only a few users who understand the program and its purpose before gradually expanding to accommodate the available demand and capacity. This helps ensure that the supply side is not overwhelmed, while at the same time properly managing and meeting expectations from the demand side (Mijumbi-Deve and Sewankambo 2017). Box 6.1 provides a summary of elements that need to be considered when establishing the scope and focus of the service.

Box 6.1: Preliminary Scope and Focus

Target Audience

The service will initially target senior policy makers within the Saudi Health Council—ideally those who understand the purpose of the service and are likely to benefit from it. The service can later scale up to cater to the needs of other decision-makers in KSA.

Focus of Research

Research will initially focus on public health, health service, and health systems. Clinical, biomedical, and basic science research will be excluded.

Types of Requests

The service will address questions about arrangements for organizing, financing, and governing health systems and about strategies for implementing changes. Additional questions can be added once the service scales up. Initial questions should address the following issues:

- Policies/interventions to address a problem
- Effectiveness of specific policy(ies)/intervention(s)
- Implementation strategies for specific policy(ies)/interventions(s)
- Effects of a specific implementation strategy.

Number of Requests per Quarter

The service will initially respond to two to three requests per quarter before gradually scaling up once capacity has been established.

Timeline for Requests

The service will initially offer 10- and 30-day timelines (a *day* is considered to be a business day). The 3–business day timeline will be added later.

Step 3: Time Frame for Products

This service feature involves both establishing the timelines in which a rapid synthesis can be completed and defining the scope of activities and products that can be done within each timeline (table 6.2). Three different timelines have been identified in which a request can be made to the rapid-response program (3, 10, and 30 business days), as well as what can and cannot be done within each of those timelines (Wilson, Lavis, and Gauvin 2015).

The rapid response service will start by offering the 10– and 30–business day timelines. Once sufficient capacity has been acquired, the 3–business day timeline will be added to the service.

Table 6.2: Timeframe for Rapid Response Products

	3 business days	10 business days	30 business days
Included	<ul style="list-style-type: none"> ▪ Key messages ▪ A summary-of-findings table that includes: <ul style="list-style-type: none"> ◆ Key findings from systematic reviews ◆ Quality appraisals (only if already available) ◆ Countries in which included studies are conducted (only if available) 	<ul style="list-style-type: none"> ▪ Key messages ▪ Brief narrative summary of findings from systematic reviews (and relevant primary studies) ▪ A summary-of-findings table that includes: <ul style="list-style-type: none"> ◆ Key findings from systematic reviews and relevant primary studies ◆ Quality appraisals (only if already available) ◆ Countries in which included studies are conducted (only if available) 	<ul style="list-style-type: none"> ▪ Everything that is done in 10 days ▪ Detailed summary of the available research evidence ▪ What other countries are doing ▪ Implementation considerations ▪ Internal and external merit reviews
Excluded	<ul style="list-style-type: none"> ▪ Identification of primary research studies of gray literature ▪ Quality appraisal of systematic reviews not appraised in the HSE database ▪ Detailed summary of key findings ▪ What other countries are doing ▪ Internal and external merit reviews 	<ul style="list-style-type: none"> ▪ Gray literature ▪ Quality appraisal of systematic reviews not appraised in the HSE database ▪ A detailed summary of key findings ▪ What other countries are doing or implementation considerations ▪ External merit review 	<ul style="list-style-type: none"> ▪ Preparation of a full systematic review

Source: Based on Wilson, Lavis, and Gauvin 2015 and the K2P Center Rapid Response.

Note: HSE = Health Systems Evidence.

Production Phase

This phase reflects the actual production of the rapid response products.

In the production phase, the staff receives requests from policy makers by telephone, email, or physical meetings. They then review the question with the policy maker to ensure that the question is clear and asked in an answerable manner, and that it falls within the scope handled by the service. Requests that fall outside the scope of the service in terms of topic or urgency (where information is needed in more than 30 days or fewer than 10 days) will be rejected (Mijumbi et al. 2014).

When demand exceeds available resources, the following actions should help to prioritize some requests over others (Wilson, Lavis, and Gauvin 2015):

- Complete requests from those whose requests are less frequent or who have not recently accessed the program;
- Request resubmission at a later date for topics that are deemed less urgent (either by the requesters themselves, by the steering committee, or both); and/or
- Engage the service lead to help decide which requests should be prioritized (for example, through a voting or ranking process over email).

Step 1: Clarifying the Question

Upon receiving a question or request from stakeholders, a core team member is assigned to manage the request from question clarification to product delivery. The assigned member is required to (1) check the type of question it is (see table 6.3 for examples), (2) clarify the question to ensure it is in an answerable form, (3) determine whether the question is within the scope of the rapid response service, and (4) agree on a timeline for responding to the requester. The assigned member can then coordinate with other team members to search the literature and prepare the rapid response product.

It is important to remember that question clarification should ideally be done when the request is submitted or within 48 hours of initial contact.

The rest of this section provides some guidance on how to clarify the question and establish a timeline for response. This will facilitate filling in the Question Clarification Form provided in annex 6A.

Clarifying the question

The type of question can be determined by considering the points set out in table 6.3.

Table 6.3: Question Type

Type of question	Points of clarification
Assessment of size of a problem	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Outcomes of interest (e.g., risk factor, condition, access, or utilization)
Assessment of causes of a problem	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Exposures (likely causes of problem) ▪ Outcomes of interest
Policy(ies)/interventions to address a problem	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Range and/or types of interventions of interest ▪ Outcomes of interest (including desired outcomes and any specific concerns about adverse effects or resource utilization) ▪ Primary and secondary outcomes of interest
Effectiveness of specific policy(ies)/interventions	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Outcomes of interest (including desired outcomes and any specific concerns about adverse effects or resource utilization) ▪ Primary and secondary outcomes of interest
Implementation strategies to address specific policy(ies)/intervention(s)	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Range and/or types of interventions of interest ▪ Outcomes of interest (including desired change and any specific concerns about adverse effects or resource utilization) ▪ Primary and secondary outcomes of interest
Effects of a specific implementation strategy	<ul style="list-style-type: none"> ▪ Settings and/or populations of interest ▪ Outcomes of interest (including desired changes and any specific concerns about adverse effects or resource utilization) ▪ Primary and secondary outcomes of interest

Source: Based on Mijumbi et al. 2014.

What is the clarified question?

The clarified question should specify the settings and/or populations of interest, the policy(ies)/ interventions or exposures (if relevant), and the outcomes of interest. It is important to confirm with the user that the clarified question is correct and that it has not been distorted by trying to focus it in an inappropriate way.

Is the clarified question within the scope of the rapid response service?

A question is considered to be beyond the scope of the rapid response service if it does not need to be answered within 10 to 30 days (that is, if evidence is needed in more than 30 days or fewer than 10 days), or it is clinically oriented.

Note: If a question is beyond the scope of the rapid response service, the reason should be noted and explained to the user. If possible, alternative sources of information or support should be suggested.

When is the response needed?

Agree on a practical time and date for delivering a response that meets user needs. Be sure to make it clear to the requester that the countdown to the agreed date of the delivery of the response will begin once a question has been clarified (that is, the period between receiving a request and clarifying the question should act as a buffer), and note the agreed time and date by which a response is needed.

Step 2: Searching for Evidence

Once a request has been clarified, a comprehensive literature search should be conducted to identify the best available evidence to answer the question. This section provides guidance on the type of evidence to prioritize, which databases to search, and how to assess the methodological quality of systematic reviews.

What Type of Evidence Should Be Prioritized?

Systematic reviews and overviews of systematic reviews addressing the question of interest should be searched first when preparing rapid response products.

Primary studies should be included *only* if high-quality up-to-date systematic reviews could not be found, or if the primary study was conducted after the publication date of the identified systematic reviews. You can also use primary studies to provide background information or context-specific knowledge on the question of interest.

The search strategy should be saved in a separate word document. Once you run the search strategy, you need to screen the retrieved studies and select those that are relevant (see chapter 2 for details on the search strategy). Given the short timeline, the search may not need to be validated by an external source.

Which Databases Should Be Searched?

The following specialized electronic databases should always be searched first, depending on the topic at hand: Health Systems Evidence, Social Systems Evidence, Health Evidence, and Cochrane Library. If no relevant systematic review is located, then PubMed should be searched for systematic reviews (and high-quality primary studies). Additional databases can be searched depending on the topic at hand. A detailed description of the different databases is provided in chapter 2.

How Should the Methodological Quality of Systematic Reviews Be Assessed?

The quality of systematic reviews is assessed using the checklist from A Measurement Tool to Assess Systematic Reviews (AMSTAR). AMSTAR is an instrument used in assessing the methodological quality of systematic reviews. The tool consists of 11 items, each of which is categorized into a standardized set of four possible responses: “Yes,” “No,” “Can’t answer,” and “Not applicable.” Final grading of the methodological quality is reported as *High* (9–11), *Medium* (5–8), or *Low* (0–4) (see chapter 2 for details).

Because it may not be efficient to manually calculate the AMSTAR score, the *pre-existing* AMSTAR score should be obtained directly from the above-mentioned specialized databases. It is not recommended to manually calculate the AMSTAR score for those systematic reviews that have not been pre-appraised.

Step 3: Synthesizing the Evidence

Currently the evidence is synthesized using narrative synthesis approaches. After all the relevant systematic reviews (and primary studies) have been collated and critically appraised, they are synthesized in narrative form to help inform policy decisions (WHO/EURO 2020). The totality of evidence around a policy/intervention should be synthesized in a way that is both easily understood and captures the main areas a policy maker might be interested in. For example: *seven systematic reviews support that x can prevent y. However, if x were to be implemented, it would have to have a, b, and c to be effective. Furthermore, two systematic reviews have shown that x might lead to d and e harms unless f and g were to be implemented.*

Adding the Evidence to the Rapid Response Template

The details about each included systematic review can be added to table template provided in box 6.2. This table will be added as an annex to the rapid response document.

Box 6.2: Template for a Detailed Description of Each Included Systematic Review

Systematic review and/or primary study	Objective	Countries covered	Description of context/intervention	Results	Quality of systematic review (using AMSTAR)
[Insert title, author’s last name and date]	[Insert key objectives of the review]	[Insert the number of countries and list them (if possible) or mention the proportion of studies from your region]	[Insert a brief description of context/intervention]	[Insert key findings]	[Insert the AMSTAR or SURE rating]

Note: AMSTAR = A Measurement Tool to Assess systematic Reviews; SURE = Supporting the Use of Research Evidence.

The findings across systematic reviews can then be synthesized into a narrative and stratified by interventions or outcomes using the table template provided in box 6.3. This table will be added to the main text of the rapid response product.

Box 6.3: Template for the Stratification of Findings across Systematic Reviews by Interventions or Outcomes

Stratification by [<i>specify whether interventions or outcome</i>]	Focus of systematic review	Key findings	AMSTAR	Countries included
[<i>Insert phrase describing interventions or outcome</i>]	[<i>Insert the focus of the review</i>]	[<i>Insert the review authors' summary of the key findings</i>]	[<i>Insert the AMSTAR or SURE rating</i>]	[<i>Insert the number of countries and list them (if possible) or mention the proportion of studies from your region</i>]

Note: AMSTAR = A MeaSurement Tool to Assess systematic Reviews; SURE = Supporting the Use of Research Evidence.

Step 4: Writing the Rapid Response Product

Content of a Rapid Response Product

The content that should be included in a rapid response product is described in table 6.4.

Table 6.4: Content of a Rapid Response Product

Graded entry	Content
Key messages	<ul style="list-style-type: none"> ▪ The key messages should be in bullet points and should not extend beyond two pages. ▪ The key messages should include the following subheadings: (1) <i>question</i>, (2) <i>relevance of issue being addressed</i>, and (3) <i>synthesis of the evidence found</i>. ▪ Under <i>Question</i> <ul style="list-style-type: none"> ◆ State the clarified questions(s). ▪ Under <i>Relevance of issue being addressed</i> <ul style="list-style-type: none"> ◆ Provide a one- to two-bullet point summary on the relevance of the issue and the current situation in the local context. ▪ Under <i>Synthesis of the evidence found</i> <ul style="list-style-type: none"> ◆ Provide one bullet point on the total number of systematic reviews (and primary studies) informing this document. ◆ Provide one to two bullet points on the interventions/outcomes being investigated (as applicable). ◆ Use remaining bullets to summarize key findings from the systematic reviews (and primary studies).
Full synthesis question	<ul style="list-style-type: none"> ▪ This section should start by stating the question(s) being addressed by the rapid response document.
Relevance of issue being addressed	<ul style="list-style-type: none"> ▪ This section should comprise two to three short paragraphs on the relevance of the issue and the current situation in the local context. ▪ It should end with a short paragraph on the aim of the rapid response document.

Graded entry	Content
Synthesis of the evidence found	<ul style="list-style-type: none"> ▪ This section should start with a broad description of the identified evidence: <ul style="list-style-type: none"> ◆ One paragraph should highlight the number of systematic reviews and primary studies identified. ◆ One paragraph should describe the key focus of the identified evidence (in terms of populations, settings, interventions, and outcomes). ▪ This description should be followed by an overview of key findings stratified by outcomes or interventions or sub-questions (if more than one question is posed): <ul style="list-style-type: none"> ◆ One paragraph should highlight the number of systematic reviews and primary studies corresponding to the specific outcomes/interventions or sub-question being investigated (as applicable). ◆ One paragraph or several bullet points should highlight key findings for the corresponding outcome/intervention/sub-question. ▪ This overview should end with a <i>Table of findings</i> summarizing the key findings from the identified systematic reviews. Depending on the question(s) of interest, one may opt to fill one or several of the tables of findings provided in the template. <p><i>Note:</i> Ideally, researchers should use the standard formatted tables provided in the rapid response product templates. However, the format can be changed to clarify the findings—for example, a column for comments can be added or the <i>Intervention</i> column can be relabeled (and if needed split into multiple columns or even separate tables).</p>
What other countries are doing	<ul style="list-style-type: none"> ▪ This section should be filled in only for 30-day rapid response products (if applicable). ▪ Although a standard table is provided in the rapid response product template (see annex 6B), the table's format can be changed to help clarify the finding.
Implementation considerations	<ul style="list-style-type: none"> ▪ This section should be filled for both the 10- and 30-day rapid response products. ▪ It includes bullet-point summaries of implementation considerations. ▪ A table on barriers and counterstrategies should also be provided.
Insights for action	<ul style="list-style-type: none"> ▪ This section includes bullet-point summaries of the applicability and implications of the findings to a given context (taking into consideration research evidence and local evidence).
References	<ul style="list-style-type: none"> ▪ This should include a list of all the references consulted.
Annexes	<ul style="list-style-type: none"> ▪ Annex 1: This annex comprises a glossary of any technical terms used. ▪ Annex 2: This annex provides detailed descriptions of the systematic reviews included in this document. It is required only for the 10- and 30-day rapid response programs.

Source: Original table for this publication.

Step 5: Submitting the Rapid Response Product

Once the rapid response product is completed, it is sent for external merit review (for 30-day rapid response products). You can refer to the Merit Review Form in annex 6E to conduct the merit review.

The final product should be sent to the requester either via email or mail. In some cases, depending on the requester's preference, the product can be disseminated in a one-on-one personalized briefing where key findings are visually presented (for example, as a PowerPoint presentation) with opportunities for deliberations and additional clarifications.

Step 6: Monitoring and Evaluation

Monitoring and evaluation of the rapid response service—including its ease of access, degree of user satisfaction, and whether the products are being used in any way—is critical to tailoring the service to the context and requester’s needs. An evaluation form can be filled by the requester at least one month after a request has been delivered to him/her. The evaluation covers the following aspects (see the Evaluation of Rapid Response Service Form in annex 6F):

- Service organization
- Rapid response product
- Influence on behavioral intention to use research evidence.

Findings can help refine the service organization and product design to meets users’ needs, which in turn can help increase uptake of the service and enable its smooth scale-up.

Annex 6A: Question Clarification Form

Note: This form is adapted from Mijumbi et al. 2014. It should be filled in for each new request.

Date request is first made:

Name of researcher managing request:

Name of requester:

Note: If the person is asking the question on behalf of someone else or in response to someone else, please indicate who initially asked the question,

Email address of requester:

Telephone of requester:

Position of requester

- Senior policy maker
- Policy analyst
- Health care manager
- Health care provider
- Researcher
- Other, please specify

What is the question being asked? Write the question in the words of the person asking it:

.....

.....

.....

.....

Is the question within the scope of the rapid response service?

- Is the question not clinically oriented
 - Yes
 - No (stop here)
- Does the question need to be answered within 3 to 30 days?
 - Yes
 - No (stop here)

If you answer “No” to either of these two criteria, then the question is **not** within the scope of the service and you can stop here. The reason should be noted and explained to the user. If possible, alternative sources of information or support should be suggested.

If you answer “Yes” to both these criteria, continue with this form.

What type of question is it? Check all that apply:

- Assessment of the size of a problem
- Assessment of the causes of a problem
- Identification of options to address a problem
- Assessment of one or more options
- Assessment of the need for monitoring or evaluation
- Identification of barriers to implementation
- Identification of implementation strategies
- Assessment of one or more implementation strategies
- Assessment of the need for monitoring or evaluation
- Other (specify).

What is the population of interest (if any)?

.....

.....

What is the setting of interest (if any)?

.....

.....

What types of interventions or exposures (if any) are of interest?.....

.....

.....

What are the outcomes of interest (if any)?

.....

.....

What is the clarified question?

.....

.....

When is the response needed? Insert the agreed-upon time and date for delivering a response.

.....

Note: The countdown to the response data should begin once a question has been clarified (that is, the period between receiving a request and clarifying the question should act as a buffer).

Annex 6B: Rapid Response Templates

Note: These templates are adapted from the K2P Center. They should be filled for each new request.

Template for 3-Day Rapid Response Products

Authors

.....
.....
.....

Funding

.....
.....
.....

Conflict of interest

.....
.....
.....

Citation

This rapid response product should be cited as:

.....
.....
.....

Key messages

Question [Insert question being addressed]

.....
.....
.....

Synthesis of the evidence found

[mention the number of systematic reviews and/or primary studies informing this document]

.....
.....
.....

[Provide 1–2 bullet points on the problem/interventions/outcomes being investigated]

[key finding]

.....
.....
.....

[key finding]

.....
.....
.....

[key finding]

.....
.....
.....

Current issue and question

Question(s)

[Insert text of question(s)]

.....
.....

Purpose

The aim of this Rapid Response document is to [insert]

.....
.....

Text Box 1: Background to Rapid Response Product

A rapid response product provides access to optimally packaged, relevant, high-quality research evidence over short periods of time ranging from 3 days to a 10-day and a 30-day time frame.

This rapid response was prepared in a [insert time frame] time frame and involved the following steps:

1. Formulating a clear review question on a high-priority topic requested by policy makers and stakeholders from [insert institution].
2. Establishing what is to be done in what timelines.
3. Identifying, selecting, appraising, and synthesizing relevant research evidence about the question.
4. Drafting the rapid response product in such a way that the research evidence is presented clearly and concisely.

Not included:

- Recommendations
- Detailed descriptions

Synthesis of the evidence found

[Insert number of systematic reviews identified]

.....
[Insert brief overview of outcomes/interventions identified]
.....
.....
.....
.....

Text Box 2: Identification and Selection of Research Evidence

We searched the following databases:

..... [[Insert name(s) of database(s) searched] using the following key words [insert key words] and limiting the search to [mention any limitations to the search strategy—e.g., dates, region]

[Mention number of reviewers] reviewers assessed the studies for inclusion. A systematic review was included if it met the following criteria:

- [Insert criteria]
- [Insert criteria]

Summary of key findings

Outcome/ intervention	Number of systematic reviews	Countries included	Key findings	Quality of study findings (AMSTAR)

References

.....
.....
.....
.....
.....
.....
.....
.....
.....
.....

Templates for 10- and 30-Day Rapid Response Products

Authors

.....
.....
.....

Funding

.....
.....
.....

Conflict of Interest

.....
.....
.....

Merit Review

The rapid response undergoes a merit review process. Reviewers assess the rapid response based on merit review guidelines.

.....
.....
.....

Citation

This rapid response product should be cited as

.....
.....
.....

Key Messages

Question

.....
.....
.....

Relevance of issue being addressed

.....
.....
.....

[Current situation in the local context]

.....
.....
.....

Synthesis of the evidence identified

[Mention the number of systematic reviews and/or primary studies informing this document]

.....

[Provide 1–2 bullet points on the interventions/outcomes being investigated]

[key finding]

.....
.....
.....

What other countries are doing (only for 30-day rapid response product)

.....
.....
.....

Current issue and question

[The context]

.....

Purpose

The aim of this rapid response document is to:

.....

.....

.....

Text Box 3: Background to Rapid Response Product

A rapid response product provides access to optimally packaged, relevant, high-quality research evidence over short periods of time ranging from 3 days to a 10-day and a 30-day timeframe.

This rapid response was prepared in a *[insert timeframe]* timeframe and involved the following steps:

1. Formulating a clear review question on a high-priority topic requested by policy makers and stakeholders from *[insert institution]*.
2. Establishing what is to be done in what timelines.
3. Identifying, selecting, appraising, and synthesizing relevant research evidence about the question.
4. Drafting the rapid response product in such a way that the research evidence is presented clearly and concisely.

✗ Not included:

- Recommendations
 - Detailed descriptions
-

Synthesis of the evidence found

Description of the identified evidence

[One paragraph highlighting the number of systematic reviews and primary studies identified]

.....

.....

.....

[One paragraph describing the key focus of the identified evidence (in terms of population, settings, intervention(s) and outcome(s)]

.....

.....

.....

Overview of key findings, stratified by outcomes or interventions or sub-question

Outcome/intervention/sub-question 1

.....

.....

.....

Text Box 4: Identification and Selection of Research Evidence

We searched the following databases:

[Insert name(s) of database(s) searched] using the following key words *[insert key words]* and limiting the search to *[mention any limitations to the search strategy—e.g., dates, region]*

[Mention number of reviewers] reviewer assessed the studies for inclusion. A systematic review was included if it met the following criteria:

- *[inset criteria]*
- *[insert criteria]*

In the absence of systematic reviews, we included high-quality single studies.

For each review included in the synthesis, we documented the search date, the countries of the included primary studies, the key findings, and the methodological quality.

[One paragraph highlighting the number of systematic reviews and primary studies corresponding to the specific outcomes(s)/intervention(s) or sub-question being investigated (as applicable)]

.....
.....
.....

[One paragraph or several bullet points highlighting key findings for the corresponding outcome/intervention/sub-question]

[key finding]

.....
.....
.....

Outcome/intervention/sub-question 2 (as applicable)

.....
.....
.....

[One paragraph highlighting the number of systematic reviews and primary studies corresponding to the specific outcomes(s)/intervention(s) or sub-question being investigated (as applicable)]

.....
.....
.....

[One paragraph or several bullet points highlighting key findings for the corresponding outcome/intervention/sub-question]

[key finding]

.....
.....
.....

Table of findings summarizing the key findings

Depending on the question(s) of interest, one may opt to fill one or several of the tables of findings provided in the template.

For effectiveness studies, use the following table:

Outcome/intervention	Summary of key findings
[Outcome 1]	[include number of systematic reviews] of [mention quality] found that
[Outcome 2]	[include number of systematic reviews] of [mention quality] found that

Outcome/intervention	Summary of key findings
[Outcome 3]	<i>[include number of systematic reviews]</i> of <i>[mention quality]</i> found that
[Additional outcomes, if any]	For each additional outcome: <i>[include number of systematic reviews]</i> of <i>[mention quality]</i> found that

Note: The subheadings can be edited to fit the specific questions. Additional columns and rows can be added as appropriate.

What Other Countries Are Doing

Countries	Approach	Advantage/success	Disadvantage/challenges

Note: This section should be filled in only for the 30-day rapid response products.

Implementation Considerations

[key finding]

.....

.....

.....

[key finding]

.....

.....

.....

[key finding]

.....

.....

.....

Potential barriers	Suggested counterstrategies to overcome barriers

Potential barriers	Suggested counterstrategies to overcome barriers

Note: This section should be filled in only for the 30-day rapid response products.

Insights for Action

[key finding]

.....

[key finding]

.....

[key finding]

.....

References for this template

.....

Annex 1

Details about each included systematic review

Systematic review and/or primary study	Objective	Countries covered	Description of context/ intervention	Results	Quality of systematic review (using AMSTAR)

Annex 6C: Examples of 10- and 30-Day Rapid Response Products

Examples of completed 30-day rapid response products can be found at the following links:

- **The McMaster Rapid Synthesis:** Identifying Tax Benefits or Incentives to Reduce Poverty Among Older Adults, available at https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/identifying-tax-benefits-or-incentives-to-reduce-poverty-among-older-adults.pdf?sfvrsn=317e54d5_3.
- **The K2P Center Rapid Response Document:** Informing the Salt Fluoridation Law in Lebanon, available at https://www.aub.edu.lb/k2p/Documents/K2P%20Rapid%20Response_Salt%20Fluoridation_with%20Annexes.pdf.

Examples of completed 10-day rapid response products can be found at the following links:

- **The McMaster Rapid Synthesis:** Assessing the Effectiveness of Virtual Care for Adults with Mental Health and/or Addictions Issues, available at https://www.mcmasterforum.org/docs/default-source/product-documents/rapid-responses/assessing-the-effectiveness-of-virtual-care-for-adults-with-mental-health-and-or-addictions-issues.pdf?sfvrsn=8f0f56d5_3.
- **The K2P Center Rapid Response Document:** How Can Excise Taxation Be Utilized to Improve Health Outcomes in Lebanon? Available at https://www.aub.edu.lb/k2p/Documents/K2P%20Rapid%20Response_Taxation_March%208%202017_.pdf.

Annex 6D: Internal Checklist for Rapid Response Products

Once a rapid response product is completed, the assigned team member should go over this checklist to ensure the product meets the minimum set requirements.

Scope of service

- The question is not clinically oriented
- The answer is needed within 3 to 30 days

Key messages

- The key messages cover the question, the issue, and key findings
- The key messages are expressed using simple language
- The key messages do not exceed two pages

Current issue and question

- The description of the purpose and current issue is succinct and informative
- The question that the rapid response addresses is clear and sensible
- The method for identification and selection of research evidence has been described (in a side box)
- At least one of the following databases have been searched: Health Systems Evidence, Social Systems Evidence, Health Evidence, Cochrane Library, PubMed (filtered for systematic reviews)
- The quality of included systematic reviews has been assessed using AMSTAR (whenever provided)

Synthesis of identified evidence

- The text describing the findings is succinct and informative
- The main results are summarized in a summary of findings table
- A detailed table of the findings from the systematic review is provided in the annex (not applicable for 3-day rapid response product)

Additional information

- The references are complete
- The names of the people who prepared the response are reported
- A statement on conflicts of interest has been included
- The document has been sent for merit review (not applicable to the 3-day product)
- The people who were consulted or reviewed the document have been acknowledge (not applicable to the 3-day product)

Annex 6E: Merit Review Form

Note: This form is adopted from the SURE Guides listed in the opening of this chapter. See https://epoc.cochrane.org/sites/epoc.cochrane.org/files/public/uploads/SURE-Guides-v2.1/Collectedfiles/sure_guides.html.

Title

Does the wording of the title engage policymakers and key stakeholders?

.....

.....

.....

Key messages

Are the key messages clear, informative, and consistent with the research findings?

.....

.....

.....

Is there any key message that should be edited or deleted or added?

.....

.....

.....

Are there any changes that you would suggest to the background or key messages?

.....

.....

.....

Current issue and question

Is the background succinct and informative?

.....

.....

.....

Is there any background information that should be included to make sense of the key messages and the findings?

.....

.....

.....

Synthesis of identified evidence

Is the summary of the research findings clear, relevant and appropriate?

.....
.....
.....

Are there critical findings that are missing and should be added?

.....
.....
.....

Are the tables understandable?

.....
.....
.....

Additional information

Are you aware of any research that addresses the same question that is not included in the document and should have been?

.....
.....
.....

Is it OK to acknowledge you for reviewing this summary?

.....
.....
.....

Thank you

Annex 6F: Evaluation of Rapid Response Service Form

This form should be filled out by the requestor at least one month after a request has been delivered to him/her.

A. Service organization

1. How did you learn about our rapid response service?

- Colleagues
- Director
- Online search
- Media
- Personal contact by members of the core team
- Other; please specify:

2. Is the rapid response service organized in a way that allowed you to efficiently make a request?

- Yes
- Neutral
- No

3. Did the rapid response service provide a timely response to your request?

- Yes
- Neutral
- No

4. How satisfied are you with how the service responded to your request?

- Very satisfied
- Satisfied
- Neither satisfied nor unsatisfied
- Unsatisfied
- Very unsatisfied

5. What were the strengths of the service in terms of responding to your requests?

.....

.....

.....

6. What were the weaknesses of the service in terms of responding to your requests?

.....

.....

.....

7. Do you have any suggestions for how the service could be improved?

.....
.....
.....

B. Rapid response product

8. Was the rapid response product presented in a way that was easy to understand?

- Yes
- Neutral
- No

9. Which feature of the rapid response product did you find most helpful in answering your question?

.....
.....
.....

10. Which feature of the rapid response did you find least helpful in answering your question?

.....
.....
.....

11. How confident are you that the answer provided was an appropriate answer to the question that was asked?

- Very confident
- Confident
- Neither confident nor unconfident
- Unconfident
- Very unconfident

12. What, if any, additional information could have been provided that was important and may have affected how confident you are with the answer or the decision?

.....
.....
.....

13. How satisfied are you with the answer that was provided to the question?

- Very satisfied
- Satisfied
- Neither satisfied nor unsatisfied
- Unsatisfied
- Very unsatisfied

C. Influence on behavioral intention to use research evidence

14. How did you, or others, use the rapid response product (please select all that apply)

- To help understand how to think about an issue
- To persuade others to a point of view or course of action
- To make critical decisions about policy content or direction
- To inform the implementation of a policy or program
- To respond to my organization's requirement to use research
- Other, please specify

15. Please describe how the evidence was used (or not) in influencing policy decisions and/or practice. Also, indicate what possible actions were taken (or are being planned) as a result of the evidence provided in the document.

.....

.....

.....

16. How likely are you to use the rapid response service in the future?

- Very likely
- Likely
- Neutral
- Unlikely
- Very unlikely

Thank you

References

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9. Wilson, M. G., J. N. Lavis, and F. P. Gauvin. 2015. "Developing a Rapid-Response Program for Health System Decision-Makers in Canada: Findings from an Issue Brief and Stakeholder Dialogue." *Systematic Reviews* 4 (1): 1–11.



CHAPTER 7

CONVENING AND FACILITATING DELIBERATIVE DIALOGUES

Introduction

This chapter covers the steps involved in planning and conducting policy dialogues. It looks at three phases in this area: the pre-policy dialogue phase, the policy dialogue phase, and the post-policy dialogue phase.

The *pre-policy dialogue phase* is concerned with how to identify clear objectives, set the date and agenda for the dialogue, assemble the team, complete logistical arrangements, and map and select participants. The *policy dialogue phase* is concerned with opening a dialogue session and establishing the rules of engagement, and the role of facilitator during the dialogue. The *post-policy dialogue phase* is concerned with the dialogue summary report, the dialogue evaluation, and the post-dialogue survey. The chapter ends with a discussion of alternative dissemination channels, including mini dialogues, one-on-one meetings, and citizen engagement sessions.

Included in the chapter are a sample dialogue invitation letter (box 7.3); a sample seating arrangement (figure 7.2); a stakeholder mapping sheet (table 7.2); a power analysis matrix (figure 7.3); and a checklist related to facilitation, practical arrangements, and collaboration with participants during the dialogues (box 7.4).

Annexes to the chapter provide a template for a dialogue summary report (annex 7A) and a worksheet for planning a policy dialogue (annex 7B).

This chapter has adapted material from the following sources:

- Oxman, A. and S. Hanney's 2009 "SUPPORT Tools for evidence-informed health Policymaking (STP) 1: Guides," available at <https://health-policy-systems.biomedcentral.com/articles/supplements/volume-7-supplement-1>.
- The WHO/EURO 2020 *Evidence Briefs for Policy: Using the Integrated Knowledge Translation Approach: Guiding Manual*, available at <https://apps.who.int/iris/bitstream/handle/10665/337950/WHO-EURO-2020-1740-41491-56588-eng.pdf?sequence=1&isAllowed=y>. The manual was developed primarily by the Knowledge to Policy (K2P) Center.
- McMaster Health Forum | Our Products, available at <https://www.mcmasterforum.org/about-us/products>.

Case Scenario: The Policy Dialogue

Case Scenario: *You have been assigned to organize a national dialogue on the topic of obesity in the Kingdom of Saudi Arabia (KSA). The dialogue will be informed by a pre-circulated policy brief you have developed; this brief provides the best available evidence on the problem, policy options, and*

implementation considerations. You need guidance on how best to organize the dialogue and ensure that the right mix of stakeholders is involved.

A policy dialogue is one of the most common knowledge translation (KT) tools. It aims to inform health policy decisions through structured and evidence-informed deliberations relevant to a particular problem or policy issue (Cochrane 2011; Lester et al. 2020; WHO/EURO 2016). Policy dialogues are increasingly being used to influence the use of evidence in health policy and decision-making across diverse settings (see also box 7.1) (Lavis et al. 2009; Lester et al. 2020; Moat et al. 2013; Partridge et al. 2020; Yehia and El-Jardiali 2015) because they:

- Enable interactions and exchanges between multidisciplinary and multisectoral stakeholders (among others), including policy makers, other key decision-makers, researchers, and representatives of non-state actors;
- Allow for the timely interpretation of the evidence-informed policy options to address a priority issue;
- Allow for the timely identification of the points of intersection between the research evidence and the values and goals of the policy makers and the stakeholders who will be involved in, or affected by, future decisions about the high-priority issue; and
- Are characterized by being participatory and consultative, inclusive, and transparent.

Box 7.1: Impact of Policy Dialogues

Policy dialogues are:

- Highly regarded as a tool for enhancing evidence-informed policy making;
- Highly rated by policy makers and stakeholders—both in terms of whether they achieve their objective and in terms of their key design features—regardless of the country, group, or issue involved;
- Have led to strong intentions to act among dialogue participants; and
- Have had direct impacts on selected policy-making processes across diverse settings.

Policy dialogue features several unique characteristics. It involves structured deliberations that are usually guided by the problem, proposed policy options, and implementation considerations elaborated in an evidence brief previously developed (WHO/EURO 2016). It allows research evidence to be considered together with the views, experiences, and tacit knowledge of those who will be involved in, or affected by, future decisions about a high-priority issue (Lavis et al. 2009). It engages a wide range of stakeholders (for example, policy makers, practitioners, nongovernmental organizations, and other key stakeholders) that share common interests around a policy issue or problem (Nabyonga-Orem, Gebrikidane, and Mwisongo 2016). And it encourages different participants to engage in the policy process and increases buy-in and ownership of the policy options, resulting in responsive policies (Nabyonga-Orem et al. 2016).

According to Lavis et al. (2009), there are several important differences between dialogue and debate. These are presented in table 7.1.

Table 7.1: Differences between Dialogue and Debate

Dialogue	Debate
Collaborative	Oppositional
Establishes common ground	Sets up win-or-lose proposition
Enlarges perspectives	Affirms perspectives
Searches for agreement	Searches for differences
Causes introspection	Causes critique
Looks for strengths	Looks for weaknesses
Re-evaluates assumptions	Defends assumptions
Listens for meaning	Listens for countering
Remains open-ended	Implies a conclusion

Source: Based on Lavis et al. 2009.

Timing of a Policy Dialogue

Policy dialogues can be implemented at different times during the policy-making process (Chrodis 2018; EU-Luxembourg-WHO 2015). Examples of times that are appropriate for initiating a policy dialogue include:

- *When an urgent need is perceived.* In this case, these dialogues are conducted early in the policy-making process and focus primarily on clarifying and framing the problem, identifying feasible solutions, and reaching consensus on a decision (Chrodis 2018; Cochrane 2011; EU-Luxembourg-WHO 2015).
- *When the circumstances or problem enable a longer time frame.* In this case, they can be conducted later in the policy-making process and may focus on the benefits and drawbacks of the policy options and implementation consideration (Chrodis 2018; Cochrane 2011; EU-Luxembourg-WHO 2015).

Planning and Conducting a Policy Dialogue

Planning for a dialogue takes, on average, three to four months of preparation. Special attention should be given to the timing and type of meeting selected, the methodology by which the discussion will be organized and managed, pre-circulated materials, and the selection of who will facilitate and participate in the dialogue, in addition to other general arrangements (see the checkbox in box 7.2) (Biermann et al. 2018; WHO/EURO 2016).

Box 7.2: Questions to Consider While Planning and Conducting Policy Dialogues

- Does the dialogue address a high-priority issue?
- Does the dialogue provide opportunities to discuss the problem, options to address the problem, and key implementation considerations?
- Is the dialogue informed by a pre-circulated policy brief and by a discussion about the full range of factors that can influence the policy-making process?
- Does the dialogue ensure fair representation among those who will be involved in, or affected by, future decisions related to the issue?
- Does the dialogue engage a facilitator, follow the Chatham House Rule (a rule about not attributing comments to individuals), and not aim for consensus?
- Are outputs produced and follow-up activities undertaken to support action?

Source: Based on Lavis et al. 2009.

Preparation for the dialogue encompasses the following three phases (please also refer to the detailed template for a policy dialogue summary report in annex 7A and a questionnaire for policy dialogue evaluation in annex 7C):

Pre-dialogue phase

- Identify clear objectives
- Set date and agenda
- Assemble the team
- Complete logistical arrangements
- Map and select participants

Dialogue phase

- Opening a dialogue session
- Rules of engagement
- Role of facilitator during the dialogue

Post-dialogue phase

- Dialogue summary report
- Policy dialogue evaluation
- Post-dialogue survey

Pre-Dialogue Phase

This phase involves the steps laid out in figure 7.1.

Figure 7.1: Pre-Dialogue Steps



Source: Original figure for this publication.

Identify Clear Objectives

- Clear, focused objectives should be established for a successful policy dialogue (Cochrane 2011; Nabyonga-Orem, Gebrikidane, and Mwisongo 2016; WHO/EURO 2016; WIEGO 2013).
- Objectives are shared with all participants through the invitation letter, where they are explicitly laid out.
- Markers of success are set in line with objectives (for example, a clear action plan is established).

During this first step, the following important points should be taken into consideration. First, the policy dialogue should be scheduled appropriately for when the decision has to be taken. Second, the extent to which the purpose of the dialogue is intended to reach consensus must be clearly laid out. Furthermore, the means by which the policy dialogue contributes to the development and implementation of the policy must be decided on.

Set Date and Agenda

To ensure the date is adapted to the policy processes to maximize attendance confirmation, consider:

- Possible windows of opportunity (examples are International Days, such as World Cancer Day, which offers an opportunity to shed light on a concern) or focusing events (that is, an event that is sudden and relatively uncommon, the occurrence of which can make decision-makers aware of the existence of a problem)
- The availability of the essential participants
- Avoid public holidays
- Enquire about other participant commitments (for example, meetings or events).

If the issue being addressed is complex and encompasses various stakeholders, consider establishing a steering committee with key stakeholders. This can support planning for the policy dialogue and giving feedback on the agenda that is set.

Plan the agenda while considering an appropriate length for the policy dialogue (for example, three hours, half a day, or a full day). The dialogue agenda is typically organized to cater to the different sections of the KT product (for example, the policy brief). Typically, three rounds of deliberations are conducted:

- Round 1: The problem and its underlying causes
- Round 2: Policy options to address the problem
- Round 3: Implementation considerations.

The dialogue concludes with deliberations around next steps and the action plan moving forward.

A sample invitation letter and half-day dialogue agenda are presented in box 7.3.

Box 7.3: Sample Dialogue Invitation Letter

Dear [Name],

On behalf of the [name of institution] and the [name of collaborator, e.g., ministry of health], we would like to invite you to the upcoming policy dialogue about [topic] that will take place on [date and time] at [address]. Please find attached the policy dialogue agenda.

In preparation for the meeting, we kindly ask you to read the Policy Brief that has been prepared to inform the discussion (please find attached). It is critical that every participant reviews the Policy Brief before the dialogue meeting to ensure active participation and fruitful discussion.

In case you have a very busy schedule between now and the actual meeting, we propose:

- If you have only 5 minutes, please read the Key Messages.
- If you have 10–15 minutes, please read the Executive Summary.
- If you have 20–25 minutes, please read the full Policy Brief.

Also, please find attached an Arabic version of the Policy Brief for those who prefer to review in Arabic.

Thank you and looking forward to stakeholders' deliberations and action to improve [insert objective/purpose of dialogue—e.g., the prescribing quality and pattern of pharmaceutical drugs] in KSA.

Sincerely,

[Official signature]

Example of Half-Day Dialogue Agenda

8:30–9:00 am	Registration
9:00–9:15 am	Welcome, introductions, and rules of engagement
9:15–10:20 am	Deliberations about the problem and current situation
10:20–10:40 am	Coffee break
10:40–12:40 pm	Deliberations about the policy options and implementation considerations
12:40–1:00 pm	Next steps and closing remarks
1:00–2:00 pm	Lunch

Assemble the Team

To ensure a successful policy dialogue, a core team with clearly defined roles and responsibilities should be assembled. In addition to research staff members (particularly those involved in synthesizing the evidence to address the problem—that is, the policy brief) and administrative personnel (to facilitate bookings, invitation, logistics, and so on), the organizer, the facilitator, and the rapporteur are critical to the success of the dialogue. The role of each is discussed in this section.

Organizer

The organizer's main role is to manage the expectations of the participants to ensure they are realistic and align with the aims of the policy dialogue. This person is responsible for key tasks to ensure an efficacious discussion. The organizer:

- Oversees the entire policy dialogue planning process;
- Assists in the selection and invitation of participants;
- Ensures that the official letter of invitation is shared with relevant stakeholders and that it includes the dialogue's objectives and relevant documents;
- Introduces the policy dialogue prior to the facilitator in a way that clarifies its purpose, expectations, and rules of engagement;
- Pre-prepares a set of questions to guide the discussion, which may include introductory questions to discuss the problem in hand, questions that ensure a smooth flow from broad themes to specific topics, and key questions to address key issues to be explored in the dialogue;
- Ensures that the discussion concentrates on tangible next steps;
- With help of the rapporteur, ensures that a dialogue report with clear action plans is completed after the policy dialogue; and
- Communicates with the team leaders during the policy dialogue and follow-up activities.

Note: In some instances, the organizer can also assume the role of facilitator.

Facilitator

The facilitator's key part is played during the day of the policy dialogue. She or he ensures that the flow of the discussion is maintained and directs the participants to agree on tangible actions (Chrodis 2018). Key considerations for the facilitator/moderator include the following:

- Ideally, the facilitator is external to the organization to ensure an active yet neutral moderation (Chrodis 2018).
- The facilitator leads the discussion after the official welcome is given by the organizer (if facilitator and organizer are different).
- The facilitator introduces him- or herself and the rapporteur while giving a brief explanation of their roles, and asks the participants to introduce themselves.
- The facilitator outlines the aim of the dialogue and clarifies key points covered in the policy brief.
- The facilitator explains the instructions of the dialogue and how confidentiality will be maintained in the dialogue report.
- The facilitator should have a certain set of skills, including:
 - Experience in facilitating
 - Knowledge about the content of the evidence document
 - Knowledge of health systems, social policies, and health policies in general
 - Neutrality
 - An understanding of the underlying politics between and among the stakeholders
 - The ability to be confident, transparent, trustworthy, respectful, professional, and assertive
 - The ability to interpret contributions to the discussion appropriately, and know how and when to intervene
 - The ability to incorporate the comments or participants and summarizes salient points.

During the policy dialogue, the facilitator should try to maintain the 80:20 rule, which says that participants should be able to talk for 80 percent of the time and the facilitator for 20 percent. The facilitator should

adopt the 7-second pause-and-inquire approach, meaning that she or he should ask clear questions and should be able to pause for responses from participants (Chrodis 2018).

Rapporteur

The rapporteur's main role is to precisely record and report the discussion of the policy dialogue (Chrodis 2018). The following characteristics should be considered for a successful rapporteur:

- Highly skilled minutes taker
- Follows the Chatham House Rule, which dictates that participants can use information received but neither the affiliation nor identity of the speaker, nor those of any participant, may be revealed
- Excellent listener with proven ability to capture the spirit of what people say and mirror it in his or her writing
- Excellent writing and editing skills for effective reporting documents (that is, the dialogue summary report).

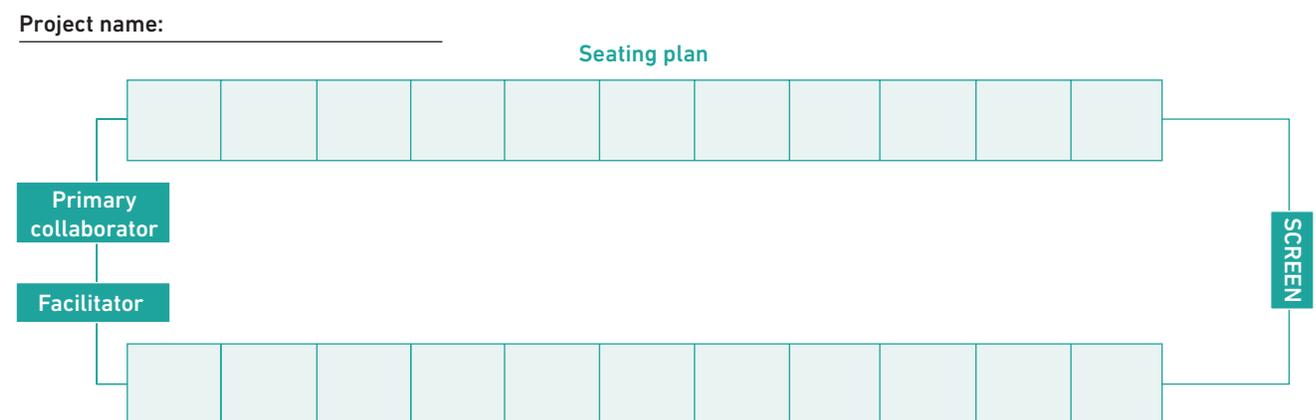
Complete Logistical Arrangements

Logistical considerations are critical to ensure a smooth flow of the dialogue. These include the choice and booking of a venue for the policy dialogue that is suitable for stakeholders and policy makers to maximize attendance confirmation (WHO/EURO 2016; WIEGO 2013). The considerations in the following checklist must be taken into account.

The venue must:

- Be easy to reach
- Include an efficient seating plan that allows participants to see each other (for example, a U-shaped setup; see figure 7.2 for an example). Avoid seating individuals from the same organization or specialty next to each other to avoid side discussions and encourage diverse discussions)
- Have even and natural lighting
- Have good ventilation
- Have access to electrical outlets and an LCD projector.

Figure 7.2: Example Seating Plan



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

Source: WHO/EURO 2020, based on the K2P Center.

Participants selected for the policy dialogue must be invited early on (Cochrane 2011; WHO/EURO 2016). Depending on the context, invitations should be sent three weeks to three months prior to the dialogue date. The organizer should ensure that an official invitation letter is sent to the participants and includes clearly stated objectives for the policy dialogue. She or he should follow up on invitees, keeping track of invitees and answering their concerns and questions. Once participation is confirmed, the organizer should share the policy brief, the agenda, and other relevant documents guiding the policy dialogue with participants at least two weeks prior to the event. Furthermore, the organizer must make travel requirements and arrange transportation for participants to ensure their arrival and departure on time (as applicable).

Finally, the organizer must prepare materials that will be used to inform the policy dialogue. These tasks include:

- Printing copies of the KT product (for example, the policy brief) and distributing this to each participant.
- Preparing a PowerPoint presentation for the day of the event. The presentation should highlight the key findings from the KT product. It should be organized in terms of the problem and its underlying factors, the policy options to address the problem, and implementation considerations.
- Considering additional visuals, infographics, and short videos to convey the key messages emerging from the evidence.

Map and Select Participants

A policy dialogue should be inclusive and should involve a fair and balanced representation of stakeholders and experts. Thus, participants should be well identified to present a range of interests, expertise, values, and perspectives. To ensure this result, it is recommended that the organizer (1) recognize stakeholders with diverse interests, skills, and perceptions with an ability to inform and implement policies; (2) involve policy implementers who can aid in pinpointing the different facilitators and barriers and provide their recommendation on the policy implementation process; (3) explore the ability of stakeholders to influence the direction of the policy; (4) ensure a balanced representation among stakeholders and (5) ascertain the implication and risk of excluding certain interested parties.

To do this, it is important to map the stakeholders/decision-makers and create a list of people, groups, or organizations with an interest in the problem or policy issue (Cochrane 2011; WHO/EURO 2016). These may include but are not limited to (1) policy makers or political staff at national and subnational levels of government; (2) managers in health care institutions, nongovernmental organizations, and other relevant organizations; (3) civil society groups (for example, industry association, health professional associations); (4) researchers (for example, those from universities, national research institutions); and (5) local funding partners.

Then map the experts needed with relevance to the policy issue (Cochrane 2011; WHO/EURO 2016). Experts may include but are not limited to (1) researchers from various disciplines; (2) health professionals from various specialties; (3) civil servants or managers from relevant programs; and (4) professionals, consumers, or service providers with practical experience.

The organizer of the dialogue needs to consult with relevant stakeholder organizations to identify and nominate a representative with relevant expertise and viewpoints (Cochrane 2011; WHO/EURO 2016). A list of criteria for selecting participants may be prepared and shared with stakeholder organizations to ensure the proper identification of representatives (Cochrane 2011; WHO/EURO 2016).

Next, it is important to understand the interests and power of stakeholders and experts, including their perceptions, their values, and their abilities to influence the direction of the policy during the policy dialogue (WHO/EURO 2016). Select individuals who will be invited to the policy dialogue (for example, ensure that their contact information such as phone number and email is available) (Cochrane 2011). While there is no magic number for group size, it is suggested that 18–25 participants is an appropriate size group for a national dialogue. Consider inviting several people from key organizations to ensure the presence of a representative in the case where someone fails to attend.

The following are some guide points that aid in identifying key stakeholders:

- Stakeholder mapping
- Draw a matrix (power/interest)
- Outline a summary table including all information related to participants’ background, achievements, affiliations, interests, and confirmation status (with regard to dialogue attendance).

Stakeholder Mapping

You can adapt table 7.2 for your stakeholder mapping exercise. This table can be used in conjunction with the stakeholder mapping form in table 2.2. While the list in table 7.2 is not exhaustive, it can be useful in organizing the process of identifying the stakeholders. It can also help with the documentation process and with following up with participants.

Table 7.2: Stakeholder Mapping Sheet

Stakeholder category	Name	Affiliation	Influence (high/low)	Position (ally/opponent)	Contact information	Confirmation status
Government and policy makers						
Health providers/ managers/ authorities						
Professional associations						
Public, patients, and community members						
Health system payers						

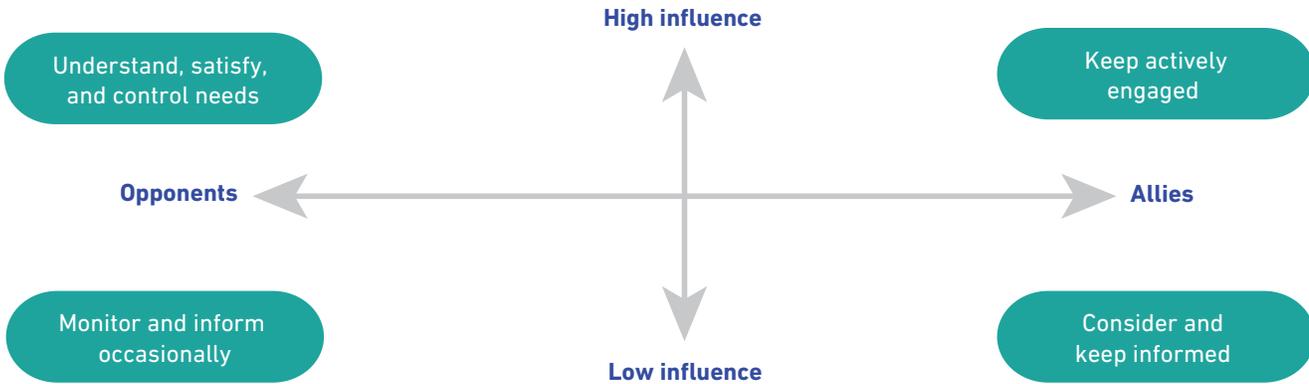
Stakeholder category	Name	Affiliation	Influence (high/low)	Position (ally/opponent)	Contact information	Confirmation status
Research funders						
Researchers/academia						
Private sector (including nongovernmental organizations)						

Source: Original table for this publication, adapted from WHO/EURO 2020.

Stakeholder Power Analysis

Once you identify the position of your stakeholders, you can map them on the power analysis matrix (figure 7.3). This step can be conducted at multiple intervals throughout the process, as the positions of stakeholders might change or become clarified (WHO/EURO 2020).

Figure 7.3: Power Analysis Matrix



Source: Based on WHO/EURO 2020.

According to the World Health Organization (WHO), determining the stakeholders involved and the power interplay among and between them is crucial (WHO/EURO 2020). The following guiding questions help with this determination:

Who are the stakeholders involved in this issue/problem?

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

What is the power interplay among and between these stakeholders?

- Who supports the change in this issue?
- Who opposes the change in this issue?
- What is the level of power of each: low, neutral, or high?

Policy Dialogue Phase

This section considers the necessary steps of the policy dialogue phase in detail.

Opening a Dialogue Session

The opening of a dialogue session is critical because it sets the tone for the rest of the dialogue. Pay close attention to the following elements:

- Transparency is key.
- Introduce yourself.
- Provide a brief overview of the hosting center.
- Disclose any potential conflict of interest.
- Explain the purpose of the dialogue and the expected outcomes.
- Outline the rules of the policy dialogue to participants.
- Provide a brief rationale for the selection of participants.
- Be motivated and encourage participation and active engagement.

Rules of Engagement

An overview of key rules of engagement is provided below.

Guidelines for engaging in productive deliberative dialogue. Such guidelines can provide structure to the discussion and create an environment where participants feel free to speak.

Non-attribution rules are important when dealing with complex issues that involve high stakes in order to establish safe ground for exploring ideas and values, as well as to promote trust among participants (Lavis et al. 2009; Wade 2004). *The Chatham House Rule* refers to the situation when you agree to freely use the information received, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed. This rule ensures meeting confidentiality and, as such, facilitates speaking freely in important meetings. Do not allow media or nonparticipants to attend (Wade 2004).

Do not aim for consensus. The principle of not aiming for consensus is important when discussing a complex policy issue (Lavis et al. 2009). Since policy development involves a complex set of interactions among government officials and stakeholders, it is unlikely that policy makers would commit themselves to a solution to a policy problem without further input from other dialogue processes, stakeholders, or parts of government, or returning to the organizations or communities with which they are affiliated (Lavis et al. 2009).

Role of Facilitator during the Dialogue

During the policy dialogue, the facilitator should:

- Be well prepared (goals of the policy dialogue, material, PowerPoint presentation, background on the issue).
- Clarify objectives, expectations, and outcomes of the policy dialogue.
- Clarify rules (for example, the Chatham House Rule).
- Avoid aiming for consensus but concentrate instead on tangible next steps.
- Create a friendly atmosphere but be prepared for disruptive participants.
- Listen closely and intervene when needed.
- Demonstrate neutrality.
- Demonstrate motivation and encourage participations and active engagements.
- Give people a sense of importance.
- Clarify differences of opinion.
- Ask for clarification or examples.
- Encourage participants to use jargon-free, plain language and person-first vocabulary.
- Focus on ideas not persons.
- Push toward tangible formulation of next steps (that is, be action-oriented).

(This list is adapted from WHO/EURO 2016.)

Several challenges might occur during a policy dialogue. Table 7.3 presents some common challenges a facilitator might face during a policy dialogue and possible recommendations for solutions to avoid and/or solve these challenges.

Table 7.3: Challenges and Solutions

Challenges	Solutions
Participants not available to attend	<ul style="list-style-type: none"> ▪ Plan properly ▪ Identify alternative dates
Last-minute participant cancellations	<ul style="list-style-type: none"> ▪ Arrange several follow-up meetings prior to the dialogue to brief participants on the purpose and outcomes of the dialogue
Irrelevant participant contribution	<ul style="list-style-type: none"> ▪ Interrupt the participant politely, if needed ▪ Re-direct the dialogue toward the main topic
Tension among participants during the dialogue	<ul style="list-style-type: none"> ▪ Calm down participants ▪ Re-elucidate the main purpose of the dialogue and the importance of accepting and understanding each other's perspectives ▪ Avoid getting defensive and engaging in discussions that are out of control ▪ Redirect the dialogue to its main topic

Source: WHO/EURO 2016.

Box 7.4 provides a checklist related to facilitation, practical arrangements, and collaboration with participants during the dialogues. You can adapt this checklist as necessary for the particular context of a specific dialogue.

Box 7.4: Checklist for Dialogues

Facilitation	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Introduce and allow brief introductions of participants <input checked="" type="checkbox"/> Introduce the policy dialogue topic <input checked="" type="checkbox"/> Clarify the objectives and expectations of the policy dialogue <input checked="" type="checkbox"/> Define and present the rules of engagement (e.g., the Chatham Rule)
Practical Arrangements	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Ensure proper documentation of the dialogue to inform the report <input checked="" type="checkbox"/> Use name tags <input checked="" type="checkbox"/> Consider having good rapporteurs to capture participants' contributions properly <input checked="" type="checkbox"/> Ensure that presentation materials are available and all set up
Collaboration with participants	<ul style="list-style-type: none"> <input checked="" type="checkbox"/> Demonstrate neutrality <input checked="" type="checkbox"/> Make eye contact with participants <input checked="" type="checkbox"/> Encourage participants who are not able to prove themselves enough <input checked="" type="checkbox"/> Make sure everyone is participating <input checked="" type="checkbox"/> Inform participants about how their feedback will be integrated into the revised policy brief and will feed into the action plan moving forward <input checked="" type="checkbox"/> Paraphrase and elucidate differences in opinions

Post-Dialogue Phase

The policy dialogue process does not end on the day of the dialogue. Following the dialogue, some activities may be implemented to ensure that the dialogue objectives are met. These activities include but are not limited to the following:

- Prepare a policy dialogue summary report (see the next section).
- Update the policy brief based on the policy dialogue report and share this with participants.
- Consider dissemination activities (for example, engage with the media, prepare a press release, conduct a press conference).
- Evaluate the policy dialogue based on the dialogue evaluation questionnaire filled out by participants either at the end of the dialogue (in person) or after the dialogue (via email).
- Establish a feedback loop to enable participants to stay in touch, clarify points, or raise concerns; provide support as needed to overcome barriers to the implementation process.
- Conduct a post-dialogue survey to identify actions taken by stakeholders since the dialogue.

The Dialogue Summary Report

The dialogue summary report is a tool used to capture the results of the discussions in the policy dialogue. It serves as the roadmap for how to move on this priority issue or problem based on the deliberations that took place. The dialogue summary report should be completed within a maximum of two weeks after the policy dialogue date.

The dialogue summary will then be disseminated to:

- All the dialogue participants via email
- Websites
- Media, social media sites (Facebook, X [formerly Twitter], others), and other outlets
- Other key stakeholders, partners, policy makers, and/or organizations and advocacy groups
- In some instances, few key stakeholders might have missed attending the dialogue; in this case, consider having an individualized meeting with them to discuss the policy brief and the dialogue summary.

A template for a dialogue summary report is provided in annex 7A.

Policy Dialogue Evaluation

The policy dialogue evaluation is conducted to evaluate the process and outcomes of the dialogue. The questionnaire provided in annex 7C can be distributed to the participants after completing the policy dialogue. It can also be sent via email after the dialogue. This questionnaire rates multiple process and outcome objectives on a seven-point scale ranging from very unhelpful (1) to very helpful (7), covering the main parts of the policy dialogue, the dialogue's general goal, and some background information about the participants. Nonetheless, the questionnaire should remain anonymous.

The questionnaire has been pilot-tested in diverse settings across the globe (Lavis et al. 2014; Moat et al. 2013; Yehia and El-Jardali 2015).

Post-Dialogue Survey

Six months following the dialogue, the team can circulate a short survey to key policy dialogue participants from different agencies that championed the issue targeted in the policy brief, each in their own capacity. You should select those participants deemed the most knowledgeable about the latest developments happening around the issue. The survey will follow up on the deliberations that took place, track progress, identify actions taken by stakeholders, and identify implementation issues encountered in translating the policy options that were discussed at the dialogue into action (WHO/EURO 2020).

While the six-month period is appropriate for examining short-term developments following the activities, a longer period might be needed to capture further changes that might have materialized.

Sample questions to ask during the post-dialogue survey are provided in box 7.5.

Box 7.5: Sample Post-Dialogue Evaluation Survey

- Please list at least one to three important actions that you personally have undertaken over the past five months in regard to the issue of [*insert issue addressed in the dialogue*].
- Please list at least one to three important actions (of which you are aware) that have been undertaken by policy makers, stakeholders, and/or researchers over the past five months in regard to the issue of [*insert issue addressed in the dialogue*].
- Please highlight challenges you encountered in moving the options or recommendations that were discussed at the dialogue meeting forward into action.
- Besides the policy brief and deliberative dialogue, what other strategies do you think should be implemented in order to promote the [*insert options/recommendations discussed at the dialogue meeting*]?

Source: WHO/EURO 2020.

Alternative Dissemination Methods

Although national policy dialogues are considered key dissemination methods for KT, other dissemination methods can take place either independently or as a continuation of the national dialogue. These include mini dialogues, one-on-one meetings, and citizen engagement sessions, each of which is discussed in detail below.

Mini Dialogues

In some instances, because of time and resource constraints, it may not be feasible to conduct a national dialogue. As an alternative, mini dialogues can include anywhere between 4 and 12 individuals per session (see box 7.6 for a case example). As you set them up, keep the following elements in mind:

- *Organization:* The mini dialogues can be organized by stakeholder groups (for example, health care professionals, policy makers, vulnerable populations) or by the specific policy options proposed in your brief (for example, people from different backgrounds deliberating about a specific option—in this case you may have three to four mini dialogues, tailored to each of your options).
- *Timing:* These mini dialogues can be conducted prior to a national policy dialogue, after a national policy dialogue, or entirely independently from a national policy dialogue.
- *Purpose:* They can also serve different purposes:
 - When an urgent need is perceived, they can be conducted early in the policy-making process and focus primarily on clarifying and framing the problem, identifying feasible solutions, and reaching consensus on a decision.
 - When the circumstances or problem enable a longer time frame, they can be conducted later in the policy-making process and may focus on the benefits and drawbacks of the policy options and implementation consideration.
 - When policy options have already been selected and approved, they can be used to operationalize and develop an implementation plan for the selected policy options.

Box 7.6: Case Example of Mini Dialogues: Addressing the Alarming Increase in Drug Use in Lebanon

To address the increase in illegal drug use in Lebanon, three strategic meetings were convened to discuss three major themes. The first meeting, concerning drug use prevention, convened on November 26, 2018; the second, concerning drug addiction treatment, convened on January 25, 2019; and the third, concerning criminal and social justice, convened on February 15, 2019.

Around 10–12 stakeholders from a variety of backgrounds participated in each meeting. The purpose of these meetings was to gain a better understanding of the problem of increasing drug use in Lebanon and the current situation, as well as to contextualize the evidence-informed recommendations.

Source: WHO/EURO 2020, based on an unpublished K2P Center case study.

One-on-One Meetings

Particularly for policy audiences, one-on-one individual meetings may be an effective way to communicate ideas about a particular issue. The one-on-one meeting can serve either as the main dissemination method or as an add-on to the policy dialogue where the key deliberations that took place are reiterated and the action plan presented as part of efforts to push the agenda forward.

These one-on-one meetings target key selected stakeholders who have a strong say and the ability to mobilize change around the issue. A summary presentation and an elevator pitch are typically prepared prior to the meeting (see box 7.7 for pointers for preparing for such a meeting).

Box 7.7: Pointers for a One-on-One Meeting

When preparing for a one-on-one meeting with a policy maker, here are a few key pointers:

- Select a primary spokesperson if a group is meeting the official.
- Be brief: cover only one or two main topics (that is, focus on the most important messages you want to convey).
- Have a few pieces of key data that support your position at your fingertips.
- Provide an illustration of the program or policy impact—a human interest story often works best.
- Know precisely what action you are suggesting.
- Anticipate questions so that your answers are well thought out.
- Be cordial and always thank the official for his or her time.
- Follow-up with a brief note later.

Source: Based on Brownson et al. 2018.

Citizen Engagement Sessions

Citizen engagement sessions or consultations may be conducted to elicit the input of specific target groups (for example, citizens' communities) and engage them in the policy-making cycle. Nowadays, there has been a growing emphasis on incorporating those who may be impacted by policies by including citizens in the policy-making process (Biermann et al. 2019).

Citizen engagement ensures that health policies are more equitable and inclusive (Bierman et al. 2019). It also enriches the policy-making process with additional knowledge from citizens (for example, caregivers or teachers may know more than policy makers about the implementation issues linked to offering healthy food in nursery schools, and therefore their input is valuable in understanding the context and identifying applicable policy options) (Bierman et al. 2019).

Citizen engagement also empowers citizens and holds policy makers accountable (Bierman et al. 2019); increases citizens' understanding and sense of responsibility in regard to policy issues (Sheedy 2004); increases the legitimacy of public decisions (Sheedy 2004); and increases the chance of developing of policies that are sensitive to the citizens' priorities, needs, and expectations (Saleh et al. 2019).

The following two case studies offer examples of different ways of convening citizen engagement sessions.

Case Study 1: The Citizen Panel from McMaster University

McMaster University in Canada has invested time and effort in empowering citizens by providing *citizen panels* (McMaster Health Forum 2021). Characteristics of a citizen panel are that:

- It is conducted prior to a policy dialogue to capture key messages in the policy brief or evidence brief that will inform the dialogue.
- It gathers 14–16 citizens of different backgrounds, socioeconomic levels, genders, and experience.

- It is informed by a plain-language citizen brief (which is shared with participants prior to the panel).
- It enables citizens to deliberate about a problem or policy issue, its underlying factors, proposed policy options to address it, and key implementation considerations.
- It captures the values and beliefs of citizens, allowing it to influence what actions are taken to address the issue.

At the end of each citizen panel, participants are apprised that their insights will inform the deliberations of key stakeholders during a policy dialogue (and stakeholders will have access to the insights of citizens through a policy brief and the policy dialogue). Furthermore, a panel summary is developed and shared on the McMaster Health Forum website; the citizen brief is updated based on the panel summary; and the policy brief is updated based on the panel summary to inform the policy dialogue.

A topic overview informed by the panel's summary and the policy dialogue are shared in the McMaster Health Forum website, which is accessible to everyone. A panel's summary and an updated citizen brief are also shared on the website. Access to these products may help health system leaders, policy makers, and stakeholders download and read their content and determine whether their topic of interest has been addressed directly. It also empowers citizens to use the products and influence decision-making about the health system (McMaster Health Forum 2021).

Case Study 2: Citizen Consultation on School Policies for Childhood Obesity and Overweight Prevention in Lebanon

A *citizen consultation* is a formal approach through which citizens provide their views and inputs on policies or other options established by the government (TAP Network 2019). The K2P Center adapted the literature toward a contextual model for citizen consultations in health policy and decision-making in Lebanon that may be adapted in the Eastern Mediterranean (PLOS Guest Blogger 2019). One successful example of a citizen consultation conducted by the K2P Center engaged citizens to explore the topic of "School Policies for Childhood Obesity and Overweight Prevention in Lebanon" (Saleh 2019). Figure 7.4 describes the planning process for a citizen consultation.

Building on the experience of the K2P Center, we provide the below guidance, using an example from Lebanon, on how to conduct citizen consultations. Citizen consultations:

- Are conducted prior to a policy dialogue to capture key messages in the policy brief or evidence brief that will inform the dialogue;
- Are guided by a previously prepared and pre-circulated evidence bulletin that synthesized a previously developed policy brief on "School Policies for Childhood Obesity and Overweight Prevention in Lebanon";
- Are convened in order to elicit citizen expectations, values, and experiences around a pressing public health problem in Lebanon and its policy options based on the pre-prepared policy brief;
- Focus on the underlying factors of the problem and the typical three to four policy options identified by the literature in relevance to the problem;
- Gather citizens from various backgrounds and different regions in the country; and
- Do not aim for consensus—however, they bring participants' experiences, views, and tacit knowledge to the deliberations.

Figure 7.4: Planning Process for Citizen Consultations



Source: Original figure for this publication.

Note: Different colors serve only to differentiate the elements of the process.

Identify Dates and Agenda for the Citizen Consultation

Citizen consultations should ideally be conducted in different regions and hence will need to be distributed among several days. Appropriate dates for the consultations should be considered while taking into account public holidays and participants' commitments. The agenda should be planned while considering an appropriate length for the citizen consultation (for example, a maximum of 2.5 hours) so that participants do not get overwhelmed (see table 7.4 for a sample agenda).

Table 7.4: Example of Citizen Consultation Agenda

9:00–9:15 am	Introduction and purpose of the citizen consultation
9:15–10:00 am	Deliberation about the problem and context
10:00–10:15 am	Coffee Break
10:15–11:25 am	Working Groups and Discussion around the policy options
11:25–11:30 am	Next steps and Closing Remarks

Source: K2P Center.

Map and Select Citizens for the Citizen Consultations

The selection of citizens for the citizen consultation can be decentralized: local authorities can be responsible for selecting participants relevant to the topic. Depending on the context, the selection of citizens should be representative of the population. In the case of the citizen consultations conducted by the K2P center, local municipalities and primary health care centers helped in the identification and selection of participants (for example, 71 participants from different backgrounds and occupations were selected for the consultations).

Implement Logistical Considerations

Suitable venues should be selected for the citizen consultations to maximize attendance while taking into consideration the issues identified in the following checklist:

- The venue should be easy to reach by citizens (that is, it must present no burden in terms of transportation).

- The venue should include an efficient seating arrangement that allows participants to see each other (for example, a U-shaped setup).
- The venue should ideally have even and natural lighting.
- The venue must have good ventilation.
- The venue must have access to electrical outlets and an LCD video projector.

Material to be used during the citizen consultation should be prepared at least three weeks prior to the consultation and should include:

- A PowerPoint presentation for the day of the event (for example, a presentation that includes the problem or policy issue, the underlying factors, the policy options, and next steps);
- An evidence bulletin (an alternative to the policy brief that is tailored to citizens and uses plain language to translate and summarize key findings from the policy brief);
- Other visualization tools or videos describing the problem and proposed policy options;
- Activity sheets to be completed by the participants; and
- Evaluation sheets for the citizen consultation (both pre- and post-evaluation).

Participants should be invited to the citizen consultation early (two weeks in advance):

- An invitation letter sent to the participants must include clearly stated objectives of the citizen consultation, the timing, and the date.
- Following acceptance, an evidence bulletin is shared with the participants prior to the citizen consultation (one week before).
- Transportation should be arranged for participants to ensure their on-time arrival and departure.

Conduct the Citizen Consultation

During the consultation, a facilitator should guide the deliberations and a rapporteur should precisely record and report the discussions. The Chatham House Rule—which says that “Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed” (Chatham House, no date)—should be followed. The sessions should start with a deliberation around the problem and the underlying factors, and an illustrative video can be presented to participants to describe the problem and underlying factors further.

An activity session can be implemented that divides participants into smaller groups and provides them with an activity sheet for deliberations around the policy elements, barriers, and underlying factors (see Box 7.8 for an example of an activity sheet). A facilitator then guides the discussion in between each group and a rapporteur records the results.

Box 7.8: Example Activity Sheet

Policy Option 1: Control the standards, availability, affordability, accessibility, and marketing of the food and drinks in the canteens, vending machines, and school cafeterias

.....

.....

Question 1: Within the context of policy option 1, please specify the context-specific recommendations that can be implemented in your context.

.....

.....

Question 2: What are some barriers and counterstrategies that need to be taken into consideration when it comes to implementing policy option 1 in your context?

.....

.....

Barriers:

.....

.....

Counterstrategies:

.....

.....

Follow-Up Activities after the Citizen Consultation

The outcomes of a citizen consultation vary and are dependent on the policy issue or problem being addressed. Activities that can be implemented after the citizen consultation include the following:

- Prepare a citizen consultation summary that includes key features of the citizen consultation; details about the elected participants (for example, their different occupations, the number of participants); the locations of the citizen consultations; a summary of the discussion around the problem and its underlying factors; a summary of the results from the activity (for example, suggested context-specific recommendations for the policy options, barriers, and counterstrategies); and next steps (for example, the citizen consultation may inform the policy dialogue and the policy brief).
- Update the policy brief based on the citizen consultation summary.
- Evaluate the citizen consultation based on pre- and post-evaluations sheets filled in by the participants.

Annex 7A: Template for Dialogue Summary Report

This template for a Dialogue Summary Report is based on WHO/EURO 2020.

Authors and Acknowledgments

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

- Authors
- Funding
- Acknowledgments
- Dialogue description (time, date, place, facilitator's name and institution)
- Citation

Section 1: Introduction

This section includes an introduction to the Policy Dialogue:

- Time
- Date
- Place
- Number of stakeholders attending
- Participants' general un-identifiable affiliations (for example, "*The dialogue was attended by 2 representatives from the Ministry of Health and 1 from the Ministry of Education,*" but without names or positions that could make them identifiable. This is the only section in which the affiliation can be brought up).

Section 2: Deliberations about the Problem

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

Section 3: Deliberations about the Underlying Factors

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

Section 4: Deliberations about the Elements/Options of an Approach for Addressing the Problem

Segregate this section into the different elements/options present in the policy briefs. Describe opinions of the participants on each of those elements/options in a way that shows their future recommendations and future steps on the issue. However, the affiliations and the names of the participants should not be disclosed.

Add a section at the end of each element/option to list key implementation considerations discussed and how to overcome the barriers for the implementation.

Section 5: Recommendations and Next Steps

This section should reflect the action-oriented discussions about the next steps in the dialogue. It should provide a roadmap for action, segregated by the party involved in moving it forward.

Annex 7B: Worksheet for Planning a Policy Dialogue

Task	Responsible party	Target date	Comments
Before the Policy Dialogue			
Finalize all documents that need to be shared with stakeholders and experts (e.g., policy brief, agenda).			
Agree on policy expert, facilitator/moderator, rapporteur, and organizer of the policy dialogue.			
Establish the objectives of the dialogue.			
Decide on date and venue for the dialogue.			
Map stakeholder and experts for the dialogue.			
Select stakeholder and experts for the dialogue and ensure that their contact information is available.			
Draft invitation letters (PDF format, includes the objective of the dialogue) along with email text for each participant (invitation email and follow-up email).			
Send invitation letter to participants.			
Secure a venue for the dialogue.			
Follow-up on attendance (e.g., call participants who did not reply to confirm their attendance at least 2 weeks prior to the dialogue).			
Send second email to attending participants with pre-prepared documents (e.g., agenda, policy brief).			
Secure and book transportation for attending participants.			
Prepare a seating plan for the day of the dialogue in accordance with the set-up.			
Arrange for snacks and refreshments (lunch, if the dialogue lasts all day).			

Task	Responsible party	Target date	Comments
Prepare name tags for the policy dialogue team.			
Prepare tent cards for the participants (e.g., include their names written large so that participants can identify one another during the discussion).			
Print pre-circulated material.			
Secure translator if translation is needed.			
Arrange for photography (e.g., contact and book a photographer for the day of the event). <i>Note: This task is optional.</i>			
Finalize the PowerPoint presentation and include it on a USB drive.			
Print the required documents (e.g., evaluation forms, seating plan, agenda, consent forms for video interviews if needed, registration sheet).			
During the Dialogue			
Arrive early to the dialogue (1.5–2 hours before it starts).			
Arrange banners if available for the Ministry of Health.			
Set up the laptop and open the PowerPoint presentation(s).			
Test the projector when applicable and ensure the availability of electric outlets, extension cords, and Wi-Fi.			
Test microphones (these may be embedded in the table or provided).			
Arrange tables with required folders and documents (e.g., policy brief, agenda, post-dialogue evaluation forms).			

Task	Responsible party	Target date	Comments
Arrange registration desk (e.g., ensure registration forms and pre-dialogue evaluation forms are available for participants at registration).			
Ensure detailed notes are captured by the rapporteur.			
Ensure photographs are taken.			
Ask participants to fill in the pre-dialogue evaluation forms upon arrival and collect forms when completed.			
Ask participants to fill in the post-dialogue evaluation forms at the end of the event and collect forms when completed.			
Conduct interviews with participants during the break (5–6 participants), if applicable.			
Prepare or edit press release for the media, if applicable.			
After the Dialogue			
Prepare dialogue summary report based on notes from the rapporteur and with the help of the organizer.			
Revise policy brief based on the dialogue summary, if applicable.			
Share dialogue summary report with participants.			
Develop a press release in relation to the policy dialogue, if applicable.			
Conduct post-dialogue survey with key selected participants six months after the dialogue.			

Source: Based on WHO/EURO 2020.

Annex 7C: Policy Dialogue Evaluation Questionnaire

[Insert Dialogue Title]

How much do you agree with each of the following statements? Please circle the number that corresponds to your answer:

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

Overall assessment of the policy dialogue

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

Failed	Moderately failed	Slightly failed	Neutral	Slightly achieved	Moderately achieved	Achieved
1	2	3	4	5	6	7

Comments (if available):

.....

.....

.....

Your Role and Background

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

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

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

Thank you

Source: Lavis et al 2009; WHO/EURO 2020.

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CHAPTER 8

MONITORING AND EVALUATION

Introduction

This chapter covers monitoring and evaluation. It presents two case scenarios for this purpose, looking in detail first at policy tracing, and then at the monitoring and evaluation of knowledge translation (KT) platforms. The chapter then considers the following categories of indicators to use for the monitoring and evaluation of KT platforms:

- Process indicators
- Reach and engagement indicators
- Usability indicators
- Use indicators
- Collaboration and partnership indicators.

Annex 8A provides the KT Monitoring and Evaluation Tool.

Monitoring and evaluation should be integrated as key components of KT right from the very start. Such evaluations allow us to measure whether, how, and why research evidence was used or not used in a policy, and whether the policy achieved its intended outcomes and impact.

Case Scenarios: Monitoring and Evaluation

Case Scenario 1: *Following the implementation of the unified purchasing policy in the Kingdom of Saudi Arabia (KSA), you are asked to monitor and evaluate its success in achieving the desired outcomes and impacts.*

Case Scenario 2: *In preparation for the new funding cycle at your institution, you have been asked to demonstrate the impact of the new KT platform.*

In addressing the two scenarios, two questions immediately come to mind: what should we evaluate? And are we interested in the KT process or its outcomes and impact?

With the increased attention given to KT, more than ever there is a need to determine whether KT efforts are effective and worthy of investment. The evaluation of KT activities ensures that the intended impact is reached, provides a rationale for funding, and enhances existing processes to ensure better knowledge uptake and more effective policy making.

Both phases of monitoring and evaluation are equally important and complementary when it comes to developing a framework for analyzing performance and identifying impact (see table 8.1).

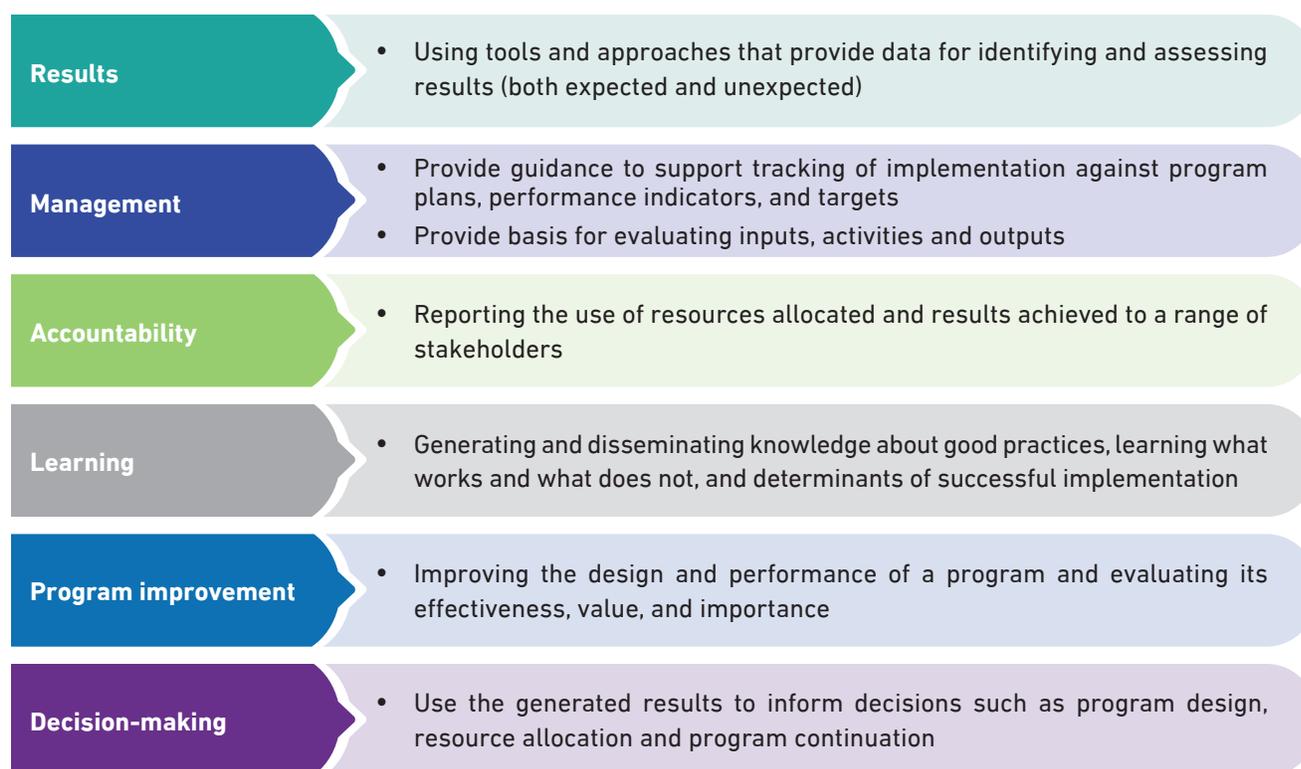
Table 8.1: Monitoring and Evaluation: Complementary Elements

Monitoring	Evaluation
<ul style="list-style-type: none"> ▪ Clarifies program objectives ▪ Links activities and their resources to objectives ▪ Translates objectives into performance indicators and sets targets ▪ Routinely collects data on these indicators and compares with targets ▪ Reports progress to managers and alerts them to any prevailing problem 	<ul style="list-style-type: none"> ▪ Analyzes why intended results were or were not achieved ▪ Assesses specific causal contributions of activities to results ▪ Examines implementation process ▪ Explores unintended results ▪ Provides lessons, highlights significant accomplishments or program potential, and offers recommendations for improvement

Source: Based on Kusek and Rist 2004.

Monitoring and evaluation frameworks can address a range of different purposes (Markiewicz and Patrick 2016) (figure 8.1). For KT platforms, the purpose of a monitoring and evaluation plan is to review the progress and achievements made thus far and enhance existing processes to ensure better knowledge uptake and more effective policy making.

Figure 8.1: Monitoring and Evaluation: Purpose and Examples



Source: Based on Markiewicz and Patrick 2016.

Monitoring and evaluation can focus on a specific policy (for example, policy tracing) or it can focus on the combination of outputs and activities carried out by the KT platform. Both alternatives are discussed below.

Policy Tracing

Policy tracing can be conducted to assess whether the desired policy objectives have been achieved. It also enables better understanding of the factors that influenced the success or failure of a policy and traces the role and uptake of evidence in the policy-making process. The decision to conduct policy tracing depends on the availability of financial and human resources and the added value that policy tracing can bring to the process.

In addition to the policy tracing technique, the long-term impact of a policy can be evaluated by collecting data on selected indicators and comparing them with baseline indicators. However, it is hard to attribute the observed change to the policy and the options provided by the policy brief and the related activities, as many factors might interfere. For details about policy tracing, see box 8.1.

Box 8.1: Description of Policy Tracing Technique

Policy tracing relies on three main sources. Each is presented here.

Media Analysis

- Media analysis aims to capture reports about the development and implementation of the policy over time and to analyze how the intended policy or policy options are perceived. It also aims to obtain an overview of the social, political, and economic conditions and events that might have influenced the policy implementation, and to identify the actors in this policy.
- Media analysis is performed through a chronological examination of the published media (print, audio-visual, and social media) to identify policy actions and trace their progress. Data collection can be performed using Excel spreadsheets.
- Depending on the particular policy and the purpose of the media analysis, data collected can include the following items: author, title, source and date of publication, stakeholders, key topics, stakeholders and their positions (supporting or resisting the policy), implementation barriers, the use of evidence, and a summary of the media article/posting.
- The results should be analyzed both qualitatively and quantitatively.

Key Informant Interviews

- A sampling frame is developed to identify the selection criteria for the key informants (make sure to include stakeholders who took part in the policy dialogue and other KT activities).
- Additional stakeholders are selected based on the findings of the media analysis and from the snowball sampling technique.
- Face-to-face, semi-structured interviews are conducted and then recorded and transcribed.
- The interview tool includes questions addressing the following themes: the role of the policy maker/stakeholder in the policy-making process, the interviewee's position on the policy (supportive or resistant), how the evidence has been used to inform the policy and how the interviewee has used that evidence, factors that influenced the development and implementation of the policy, implementation barriers, and key lessons learned. The questions can be customized based on the policy under study and the specific purposes of the policy tracing. Data should be analyzed qualitatively.

Documentation Review

- Documents are identified from the interviews and the media analysis and are used to further validate the finding of the media analysis and interviews.
- Documents reviewed include legislation, decrees, regulations, meeting minutes, and official letters, among others.
- Data are collected in a data collection sheet that includes the title of the document, the type of document, the date, the actors, whether evidence from the policy brief or other evidence was used or not, and a summary of the contents of the document. Data should be analyzed qualitatively.

Source: Based on WHO/EURO 2020.

Monitoring and Evaluation of KT Platforms

Effective KT initiatives should include a thorough and detailed monitoring and evaluation plan to ensure that the stated objectives are met and to assess the success of uptake activities and dissemination efforts.

Process Evaluation: Process evaluation may help to identify the different elements of the KT initiative that need to be adjusted or further developed to fit the context and to distinguish barriers and facilitators to the uptake of evidence (Danseco et al. 2009). A variety of indicators are identified to ensure the evaluation of the implementation/process and the impact of KT activities. Success indicators are *SMART*—which means that they are Specific, Measurable, Achievable, Relevant, and Time-bound (Cochrane, no date).

Outputs Evaluation: Evaluation of the outputs from KT activities requires examining tangible products that are developed to assess their quality, credibility, relevance, accessibility, and impact. This can be done by examining published research articles, reports, and organization websites. Also useful are targeted evaluations of uptake and use, as well as assessments of the degree to which recommendations are implemented. Uptake logs or targeted interviews can be used to collect evidence about the use of the provided recommendations. Keeping track of the various stakeholders and institutions that utilized the findings and recommendations can help KT platforms measure their influence and assess the impact of their work (Jones 2011).

Outcome Evaluation: Evaluation of outcomes shows the change in a state or condition that results from the KT activities and outputs. Examples of outcomes may include, but are not limited to, changes in awareness, knowledge, attitudes, behaviors, skills, practices, opinions, decision-making, and/or policy development (Graham et al. 2012).

It is important to note that predicting outcomes and establishing causality can be difficult since the policy context is in a constant state of change (Jones 2011). Because of this, the monitoring and evaluation framework needs to account for the fact that policy changes require a long time to document and track; they are not measured using the tools typically used to assess and monitor project implementation (Kusek and Rist 2004).

When planning the evaluation of any KT activity you should consider the following questions:

What is the Intended Impact You Want to Achieve through Your KT Activities?

To clarify the intended impact, consider a concise, clear description of your KT plan and objectives to identify the impact of your KT activities. Then consider how the impact of each individual KT activity is linked to the KT plan and objectives (for example, the research/knowledge level or the policy/systems level). Be sure to consult with relevant stakeholders and decision-makers when needed.

What Indicators Will You Use to Evaluate Your Intended Impact?

Consider how relevant initiatives have been evaluated previously. Consult existing theories and literature to inform the evaluation of your KT activities. You may also seek expert opinion. The type of indicators used throughout the evaluation will depend on different factors, including the purpose of the evaluation, the KT activities used, and the resources available.

To determine what indicators to use, gather baseline information on the current condition, set specific targets to reach and dates for reaching them, regularly collect data to assess whether the targets are being met, and analyze and report the result. Use the findings for improvement.

Indicators for the Monitoring and Evaluation of KT Platforms

Indicators for monitoring and evaluation of KT platforms can be stratified according to the following domains:

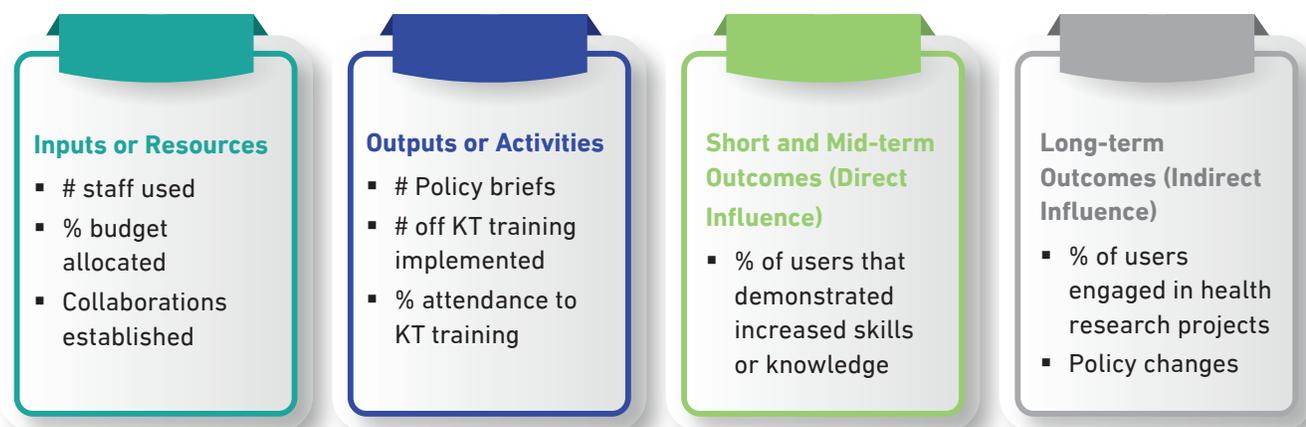
- Process indicators
- Reach and engagement indicators
- Usability indicators
- Use indicators
- Collaboration and partnership indicators.

Note: This is a comprehensive list of indicators. You will need to tailor the list of indicators to fit your specific context. The selection of indicators will depend on different factors, including the purpose of the evaluation, the KT activities used, and the resources available.

Process Indicators

Process indicators refer to how things are being conducted. They may include the detailing the inputs, processes, and methods utilized to establish the KT activities as well as the outputs developed. They may also include the monitoring of timelines and budgets decided upon for the KT activities. Input and output indicators are each listed below (see also figure 8.2).

Figure 8.2: Example of Process Indicators and Short-, Medium-, and Long-Term Indicators



Sources: Based on Cochrane, no date; Graham et al. 2012.

Input Indicators

- Financial resources used or total budget allocated to develop the KT activity/material
- Number of staff/people involved in the development of the KT activity/material
- Staff recruitment and retention plans available
- Number of partnership/collaborative work programs available
- Governance structure, resources put in place (for example, management and leadership)
- Priority-setting exercises completed for health policy topics
- Information management: percentage of the reliability of technology used.

Output Indicators

- Number of KT outputs (for example, translations or number of languages available for the KT material, training or capacity-building courses available)
- Capacity-building sessions/workshops or events on KT for members at the ministry of health or other national stakeholders
- Policy briefs developed on priority health issues
- Rapid response products developed in response to urgent requests
- Policy dialogues organized on priority health issues
- Personalized debriefings conducted with policy makers
- Situation analysis conducted or stakeholder meetings held
- Number/percentage of strategic plans completed as well as milestones met
- Number and type of KT programs, initiatives, or services available (new and old).

Reach and Engagement Indicators

Reach indicators will help you assess whether your KT activities reach your target audiences. They will help you assess who and how many people are accessing and reading the KT outputs and how are your audiences interacting with the outputs provided. Several categories of indicators are available; these include:

How Many People Were Reached?

- Number/percentage of users who accessed the KT outputs
- Number/percentage of users who read the KT outputs
- Number/amount of KT outputs distributed
- Number of copies of a specific KT output distributed through a publisher for additional distribution
- Number/amount of KT outputs requested by users or stakeholders
- Number of KT outputs distributed in response to a user or stakeholder's request
- Number of times the KT outputs are clicked on, viewed, or downloaded in a time period
- Number of other articles that have cited the evidence provided by the KT material
- Number of staff at the ministry of health attending KT events or training.

Who Is Being Reached?

- Webpages that have cited the KT evidence
- Number of interviews that have cited the evidence
- Number or percentage of views of the KT evidence coming from selected regions/countries
- Role/position of people attending trainings or events (for example, policy dialogues).

Are People Reached by Interacting with the KT Outputs?

- Media exposure: Number of times the KT outputs are mentioned in blogs, social media, newspapers, and so on
- Number of times the KT outputs have been cited, shared, or commented on

- Number/percentage of users who changed their opinion regarding the topic in response to the KT outputs
- Number of times a KT output is reprinted by a recipient
- Percentage of users or stakeholders who share their copies of a KT output or transmit the evidence provided verbally to colleagues
- Number of times the KT outputs are selected for inclusion in a specific library
- Number of times the KT outputs are archived or indexed in a bibliographic database.

Usability Indicators

Usability indicators can help you understand what people think of your KT activities or outputs, including whether they are easy to access or understand. These indicators include:

- Number/percentage of targeted audiences who have heard of the evidence
- Number/percentage of targeted audiences who reveal being satisfied with the outputs
- Number/percentage of targeted audiences who state that the evidence is easy to understand
- Number/percentage of users who understood the KT outputs
- Number of priority-setting activities engaging audience members
- Percentage of KT outputs or reviews developed with the engagement of the targeted audiences
- Percentage of targeted audiences who state that they trust the evidence
- Number/percentage of users or stakeholders who state that they are satisfied with the KT outputs or that they would recommend it to other people
- Number/Percentage of users or stakeholders who rated the presentation or format of a KT output as usable
- Number/percentage of users or stakeholders who report having gained knowledge from a KT output
- Number/percentage of users or stakeholders who report that a KT output changed their views
- Number of significant awards given to a KT output
- Journal impact factor (that is, the relative importance of the journal that published the article)
- Number/percentage of users or stakeholders who pay for a KT output
- Number/percentage of KT outputs guided by theories of behavior change and communication.

Use Indicators

Use indicators refer to whether users will use the evidence provided by the KT outputs. They may assess increased knowledge or confidence acquired, strengthened institutional capacity for evidence, or whether the evidence is used to inform decision-making and action or has contributed to a change in behavior. These indicators include:

How the KT Output(s) Are Used

- Number/percentage of users or stakeholders who intend to use the KT outputs or evidence
- Number/percentage of users or stakeholders who used the results of the KT outputs to inform their decision or solve a problem

- Number/percentage of users or stakeholders who used the information provided by the KT outputs to support a program or policy
- Number/percentage of users or stakeholders who used the KT outputs for training or capacity building
- Number/percentage of users or stakeholders who stated they used the KT output(s) to improve their own performance or practice.

Institutional, Cultural, and Belief Changes

- Increased funding availability for KT or evidence synthesis
- Increased demand for evidence relevant to the KT outputs from different audiences
- Percentage of audience who state their confidence or knowledge has improved as a result of the KT outputs
- Greater policy-maker capacity to use research evidence
- Presentations done for policy makers, youth, or practitioners that mention the evidence provided by the KT outputs
- Enhanced receptiveness of users' institutions as a whole toward evidence use in decision-making
- Strengthened leadership capacity to serve as change agents and champions for evidence-informed policy making
- Enhanced availability of research evidence about high-priority policy issues for use in policy making
- Enhanced links and collaborations between policy makers and researchers.

Policy and Law Changes

- Qualitative research or testimony from decision-makers who attributed changes in policies or laws to the evidence provided in the KT material
- New measures, bills, laws, and regulations established in response to the evidence
- Number of guidelines of policy that have mentioned the evidence provided
- Number of times evidence provided by the KT outputs is mentioned in policy or government discussions.

Collaboration and Partnerships

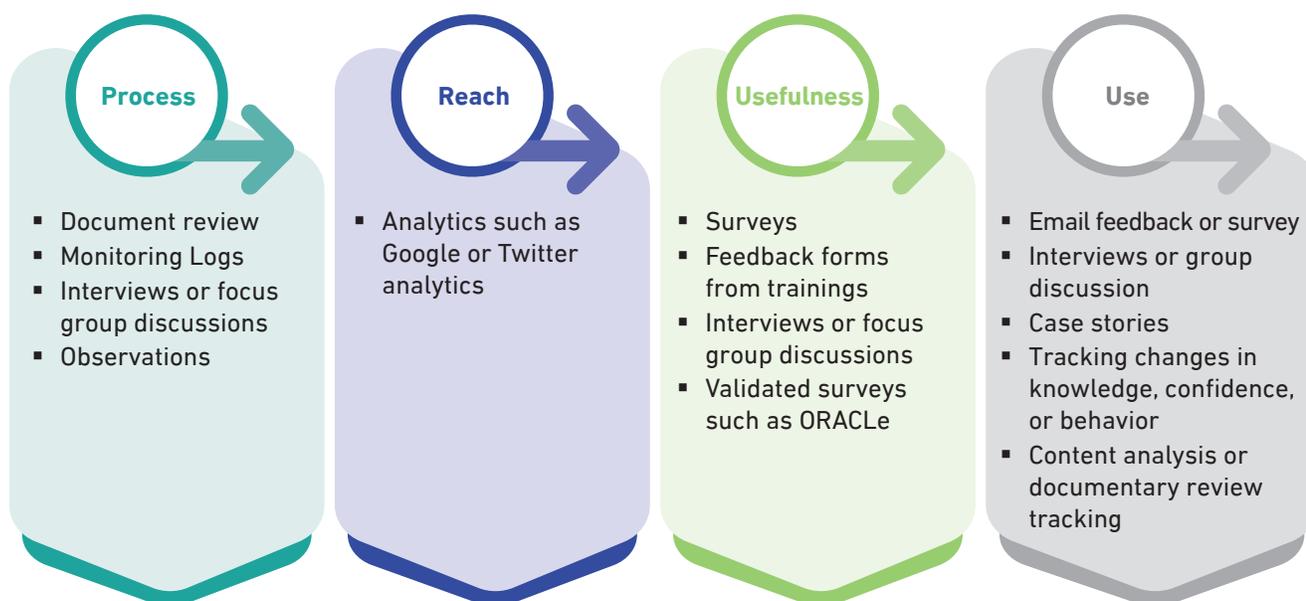
Indicators of *collaboration and partnerships* may help distinguish how often and how well stakeholders work together to share resources and knowledge. These indicators include:

- Number of KT outputs developed or disseminated by social network growth or partners
- Number of times of KT outputs knowledge is shared among individuals or organizations at the local, regional, or global level
- Number of capacity-building efforts implemented
- Type of capacity-building efforts implemented.

Data Collection for Indicators

Different data collection methods can be used to collect data for the various indicators. These may include qualitative, quantitative, or mixed methods. The literature encourages the use of mixed methods with a qualitative component that provides a rich understanding about the KT components (Penny Cooper & Associates 2017). For concepts related to collaborations and engagements that pose a particular methodological concern, the use of interviews and surveys has been proposed as a possible solution for data collection; this would be in addition to network analysis. Moreover, it has been suggested that triangulating quantitative and qualitative data with self-reported data generated by using organizational documents such as KT operational, work, and evaluation plans may be helpful (Penny Cooper & Associates 2017). Examples of data collection methods are elaborated in figure 8.3.

Figure 8.3: Example of Data Collection Methods for Different Indicators



Source: Original figure for this publication.

Note: ORACLE = Organizational Research Access, Culture and Leadership.

There is a lack of consensus about the best approaches when it comes to what to evaluate, how to do the evaluation, and what period of time to consider for the evaluation (Institut National de Sante Publique du Quebec 2013). The next section looks at specific considerations to take into account for data collection and analysis.

Specific Considerations for Data Collection and Analysis

The first consideration is whether the ministry wants to rely on qualitative, quantitative, or mixed methods for data collection. As indicated earlier, triangulation of quantitative and qualitative data with self-reported data generated by using organizational documents such as KT operational, work, and evaluation plans may be helpful (Penny Cooper & Associates 2017).

The next considerations involve answering the following questions:

- What is the validity, reliability, and sensitivity of the data collection method?
- What is the timeline or time frame for data collection?

- Who will perform the data collection (for example, staff at the ministry of public health)?
- What is the analysis plan for collected data?
- What expertise is needed for the evaluation process (for example, staff expertise at the ministry of health, external experts)?
- Who will the decision-makers be and how will they be involved in the evaluation process?
- What are the ethical implications of the method of data collection?

Tools that may be used to guide your data collection process were identified from the literature and may be explored through the following references:

- Cochrane. No date. Examples of KT Indicators. <https://training.cochrane.org/sites/training.cochrane.org/files/public/uploads/3a.%20KT%20indicators.pdf>.
- Penny Cooper & Associates. 2017. MSFHR Knowledge Translation Evaluation Framework. January. https://www.msfhr.org/wp-content/uploads/2021/05/MSFHR_KT_Evaluation_Framework.pdf.
- Institut National De Sante Publique du Quebec. 2013. *Facilitating a Knowledge Translation Process: Knowledge Review and Facilitation Tool*. <https://www.inspq.qc.ca/en/publications/1628>.

Annex 8A: KT Monitoring and Evaluation Tool

Note: This is a comprehensive knowledge translation (KT) monitoring and evaluation tool. The list of indicators may need to be tailored to your context. The selection of indicators will depend on different factors, including the purpose of the evaluation, the KT activities used, and the resources available. You also need to consider what period of time to consider for the evaluation. The tool may be used to monitor and evaluate the combined outputs and activities carried out by KT platforms (for example, annually, semi-annually, or quarterly), or it may be used to monitor and evaluate specific activities/outputs (case-dependent).

General Information

Purpose of monitoring and evaluation:

.....

.....

Frequency (annual, semi-annual, quarterly):

.....

.....

Monitoring and Evaluation Tool Instructions

Please follow the instructions below to accurately fill in the monitoring and evaluation tool.

Tool Coding

Replace _____ with the appropriate number or text, as required by the context. Enter numerical values directly into the spaces provided.

[To be filled in]: Where text is required, enter relevant information in the designated areas.

Replace with a tick mark (✓) to indicate the applicable option. Place the tick in the designated spaces.

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
What financial resources are used to develop the KT activity and material?				
Input indicators	Total budget allocated to the KT activity/material <i>[to be filled in]</i>	<i>[to be filled in]</i>	<i>[to be filled in]</i>	Document review Monitoring logs
	Number of staff involved in the development of the KT activity/material	<i>[to be filled in]</i>	<i>[to be filled in]</i>	Interviews or focus group discussions Observations
	Number of external people involved in the KT activity/material	<i>[to be filled in]</i>	<i>[to be filled in]</i>	Administrative documents (e.g., budget documents)
	<input type="checkbox"/> Availability of staff recruitment and retention plans <i>[tick if available]</i>	<i>[to be filled in]</i>	<i>[to be filled in]</i>	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number of partnerships or any collaborative work done on KT activities/material available as part of the KT plan	[to be filled in]	[to be filled in]	
	Type of partnerships or any collaboration work done on KT activities/material as part of the KT plan	[to be filled in]	[to be filled in]	
	Types of government structures and resources put in place [tick when applicable] <input type="checkbox"/> Advisory committee put in place <input type="checkbox"/> Data repository available <input type="checkbox"/> Regular meeting established	[to be filled in]	[to be filled in]	
	Did your institution complete any priority setting exercise for health research or policy topics? (Yes/No)	[to be filled in]	[to be filled in]	
	If yes, how many priority-setting exercises were conducted?			
What KT activities are undertaken by the KT platform?				
Output indicators	KT activities directly undertaken [tick all that apply] <input type="checkbox"/> Evidence briefs developed <input type="checkbox"/> Rapid response products <input type="checkbox"/> Training sessions implemented <input type="checkbox"/> Capacity-building courses available <input type="checkbox"/> Policy dialogues <input type="checkbox"/> Personalized debriefings <input type="checkbox"/> Citizen consultations <input type="checkbox"/> Strategic plans completed <input type="checkbox"/> Stakeholder meeting established <input type="checkbox"/> KT video series <input type="checkbox"/> KT webinar series <input type="checkbox"/> KT guideline development sessions	[to be filled in]	[to be filled in]	Document review Monitoring logs Interviews or focus group discussions Observations Administrative documents (e.g., budget documents)
	Number of KT outputs undertaken by the KT platform	[to be filled in]	[to be filled in]	
	Number of evidence briefs developed	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number of rapid response products developed	[to be filled in]	[to be filled in]	
	Number of training sessions implemented	[to be filled in]	[to be filled in]	
	Number of capacity-building courses available	[to be filled in]	[to be filled in]	
	Number of milestones met	[to be filled in]	[to be filled in]	
	Number of stakeholder meetings established	[to be filled in]	[to be filled in]	
	Number of policy dialogues organized on priority health issues	[to be filled in]	[to be filled in]	
	Number of citizen consultation sessions	[to be filled in]	[to be filled in]	
	Number of situation analyses conducted	[to be filled in]	[to be filled in]	
	Number of KT video series provided	[to be filled in]	[to be filled in]	
	Number of KT webinar series provided	[to be filled in]	[to be filled in]	
	Number of KT guideline development sessions	[to be filled in]	[to be filled in]	
	Number of translation languages available for KT material developed.....	[to be filled in]	[to be filled in]	
How many people are reached through the KT platform activities?				
Reach and engagement indicators	Number of people who attended: <ul style="list-style-type: none"> ▪ KT guideline development sessions ▪ KT review training sessions ▪ KT webinar series ▪ KT workshops ▪ KT mentoring/training sessions ▪ KT conferences 	[to be filled in]	[to be filled in]	Analytics, which include but are not limited to: Vimeo analytics, Google Analytics, Facebook analytics, X (formerly Twitter), and YouTube analytics

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number/percentage of users who accessed the KT output(s)	[to be filled in]	[to be filled in]	
	Number/percentage of users who read the KT output(s).....	[to be filled in]	[to be filled in]	
	Number/amount of KT output(s) distributed	[to be filled in]	[to be filled in]	
	Number of copies of a specific KT output distributed through a publisher for additional distribution.....	[to be filled in]	[to be filled in]	
	Number/amount of KT output(s) requested by users or stakeholders..... Number of times the KT output(s) is clicked on (specified by KT platform).....	[to be filled in]	[to be filled in]	
	Number of times the KT output(s) is clicked on (specified by KT platform).....	[to be filled in]	[to be filled in]	
	Number of other articles that have cited the evidence provided by the KT material	[to be filled in]	[to be filled in]	
	Characteristics of target audiences reached through KT activities/material	[to be filled in]	[to be filled in]	
	List the different webpages that have cited the KT evidence provided by the KT platform:	[to be filled in]	[to be filled in]	
	Number of interviews that cited the evidence provided by the KT platform.....	[to be filled in]	[to be filled in]	
	Number/percentage of views of the KT evidence coming from selected regions/countries (identified by the KT platform)	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number of target audiences reached through: <ul style="list-style-type: none"> ▪ KT guideline development sessions ▪ KT reviewer training sessions ▪ KT workshops ▪ KT mentoring/training sessions ▪ KT conferences 	[to be filled in]	[to be filled in]	
Are the people we are reaching interacting with our KT outputs?				
	Number of times the KT output(s) are mentioned in blogs	[to be filled in]	[to be filled in]	Analytics, which include but are not limited to: Vimeo analytics, Google Analytics, Facebook analytics, Twitter and YouTube analytics
	Number of times the KT output(s) are mentioned in social media	[to be filled in]	[to be filled in]	
	Number of times the KT output(s) are mentioned newspapers	[to be filled in]	[to be filled in]	
	Number of times the KT output(s) have been cited	[to be filled in]	[to be filled in]	
	Number of times the KT output(s) are shared	[to be filled in]	[to be filled in]	
	Number of times the KT output(s) have been commented on	[to be filled in]	[to be filled in]	
	Number/percentage of users who changed their opinion because of the KT output(s)	[to be filled in]	[to be filled in]	
	Number of times a KT output is reprinted by a recipient	[to be filled in]	[to be filled in]	
	Percentage of users or stakeholders who share their copies of a KT output(s) or transmit the evidence provided verbally to colleagues	[to be filled in]	[to be filled in]	
	Number of times a KT output(s) is selected for inclusion in a specific library	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number of times the KT output(s) are archived or indexed in a bibliographic database	[to be filled in]	[to be filled in]	
To what extent do the targeted audiences experience the KT activities implemented by the KT platform as useful?				
Usability indicators	Number/percentage of targeted audiences who have heard of the evidence	[to be filled in]	[to be filled in]	Internal to ministry staff: yearly surveys with rating scales Surveys Pre- and post- activity surveys when applicable (immediate survey and follow-up survey) Key informant interviews or focus group discussions Validated tools include but are not limited to Staff Assessment of engagement with Evidence (SAGE); Organizational Research Access, Culture and Leadership (ORACLE); or Seeking, Engaging with, and Evaluating Research (SEER)
	Number/percentage of targeted audiences who reveal being satisfied with the output(s)	[to be filled in]	[to be filled in]	
	Number/percentage of targeted audiences who state that the evidence is easy to understand	[to be filled in]	[to be filled in]	
	Number/percentage of policy makers who understood the content of the KT activity(s)/ material(s) (e.g., the percentage of policy makers who understood the content of the policy brief)	[to be filled in]	[to be filled in]	
	Number/percentage of audiences who state that they trust the evidence	[to be filled in]	[to be filled in]	
	Number of priority-setting activities that engaged audience members	[to be filled in]	[to be filled in]	
	Percentage of KT output(s) or reviews developed with the engagement of the targeted audiences	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who state that they are satisfied with the KT output(s) or that they would recommend it to other people	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who stated that the KT activities have met their expectations	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number/percentage of users or stakeholders who stated that the KT activities are relevant	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who stated that the KT activities have resulted in learning that they can apply	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who stated that the KT activities are of high quality.....	[to be filled in]	[to be filled in]	
	Number/Percentage of users or stakeholders who rated the presentation or format of a KT output(s) as usable	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who report having gained knowledge from a KT output(s).....	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who report that a KT output(s) changed their views.....	[to be filled in]	[to be filled in]	
	Number of awards given to a KT output	[to be filled in]	[to be filled in]	
	Journal impact factor (that is, the relative importance of the journal that published the article).....	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who pay for a KT output(s)	[to be filled in]	[to be filled in]	
	Number/percentage of KT output(s) guided by theories of behavior change and communication	[to be filled in]	[to be filled in]	
How are the KT output(s) used?				
Use indicators	Number/percentage of users who intend to use the KT output(s) or evidence provided	[to be filled in]	[to be filled in]	Email feedback Surveys Key informant interviews or focus group discussions
	Number/percentage of users who adapted the results of the KT output(s) to inform their decision or solve a problem	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number/percentage of users who used the information provided by the KT output(s) to support a program or policy	[to be filled in]	[to be filled in]	Case stories Tracking of changes in confidence, knowledge or behavior over time Content analysis and documentary review
	Number/percentage of users who used the KT output (s) for training or capacity building	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who stated that using the KT output (s) improved their own performance or practice	[to be filled in]	[to be filled in]	
	<input type="checkbox"/> Institutional, cultural, and belief changes [tick if Yes]	[to be filled in]	[to be filled in]	
	<input type="checkbox"/> Increased funding availability for KT or evidence synthesis at the Ministry of Health [tick if Yes]	[to be filled in]	[to be filled in]	
	<input type="checkbox"/> Increased demand for evidence relevant to the KT products (e.g., policy makers advocating for new research regarding the topic to be generated) [tick if Yes]	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who state that their confidence or knowledge has improved on a specific topic because of the KT output(s)	[to be filled in]	[to be filled in]	
	Number of presentations done for policy makers, youth or practitioners that mention the evidence provided	[to be filled in]	[to be filled in]	
	Number/percentage of users or stakeholders who state that their institution as a whole has shown enhanced receptiveness toward evidence use in decision-making as a result of KT outputs	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number/percentage of users or stakeholders who state that KT outputs have strengthened their leadership capacity to serve as change agents and champions for evidence-informed policy making in their institutions	[to be filled in]	[to be filled in]	
	<input type="checkbox"/> There is an increase in the availability of research evidence about high-priority policy issues for use in making policy <i>[tick if Yes]</i>	[to be filled in]	[to be filled in]	
	<input type="checkbox"/> There is an increase in links and collaborations between policy makers and researchers <i>[tick if Yes]</i>	[to be filled in]	[to be filled in]	
	Number of qualitative research or testimony from decision-makers who attributed changes in policies or laws to the evidence provided in the KT material	[to be filled in]	[to be filled in]	
	Number of new measures, bills, laws, or regulations established in response to the evidence	[to be filled in]	[to be filled in]	
	Number of policy guidelines that have mentioned the evidence provided by the KT output(s)	[to be filled in]	[to be filled in]	
	Number of times evidence provided by the KT output(s) is mentioned in policy or government discussions	[to be filled in]	[to be filled in]	
What collaborations and capacity building activities are linked to the KT output(s)?				
Collaboration and capacity-building indicators	Number of KT output(s) developed or disseminated through social networks or partners	[to be filled in]	[to be filled in]	Surveys Network analysis
	Number and breadth of partners supporting KT output (s)	[to be filled in]	[to be filled in]	

Domain	Indicator	Baseline and target	Responsible entity	Data collection method
	Number of times of KT output knowledge is shared among individuals or organizations at the local, regional, or global level	[to be filled in]	[to be filled in]	
	Number of capacity-building efforts implemented that are related or linked to the KT output(s)	[to be filled in]	[to be filled in]	
	Type of capacity-building efforts implemented	[to be filled in]	[to be filled in]	

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CHAPTER 9

THE POLITICAL ECONOMY OF HEALTH

Introduction

Health policy is a complex and multifaceted field, influenced by a myriad of factors, including politics, economics, and social values. The *political economy of health* is a discipline that examines the interplay of these factors and their combined impact on health policy development and implementation.

This chapter provides a comprehensive overview of the political economy of health, with a focus on its relevance to policy makers and policy analysts. It explores the key concepts and frameworks of the political economy of health as well as real-world examples of how it has been used to inform policy decisions—including how collective decision-making occurs and how the political economy of health is relevant for today's health policy making and population health.

This chapter further delves into the crucial role of political economy analysis (PEA) in incorporating political economy perspectives into health policy frameworks. PEA empowers policy makers and other stakeholders to effectively navigate the political and economic landscape, develop actionable strategies, and guarantee that health policies are both politically feasible and socially relevant. By employing PEA, decision-makers can gain valuable insights into the underlying political dynamics and economic factors that shape health outcomes, ensuring that policies are tailored to address the root causes of health challenges and that they can achieve sustainable improvements in population health.

By the end of this chapter, readers will have gained a deeper understanding of the following:

- What the political economy of health is and why it is important
- The rationale for political economy awareness among policy makers and policy analysts
- The importance of PEA as a powerful tool used to understand and integrate political economy insights into health policy frameworks
- An overview of the complex interplay between political and economic determinants and their impact on health policy decisions across different regional and international contexts.

This chapter will provide policy makers and policy analysts with the essential knowledge and tools to navigate the complex landscape of health policy and make informed decisions that lead to better health outcomes for all.

What Is the Political Economy of Health?

The political economy of health, in the context of health policy making, emphasizes the intricate interplay between political, economic, and social forces in shaping policies and health outcomes (box 9.1) (Lynch 2023; McCartney et al. 2019). As evident from the COVID-19 pandemic, health decisions are not

solely driven by scientific findings but also by political perspectives and societal values (Horton 2020; Sparkes et al. 2022). For instance, in some countries, political leaders were hesitant to implement mask mandates because of concerns about individual freedoms (Young et al. 2022). Similarly, the decision to impose lockdowns was often met with resistance from sectors of society that perceived such measures to be an infringement on their liberties and a threat to their livelihoods (Young et al. 2022).

This interplay between scientific evidence, political perspectives, and societal values highlights the complexity of health policy making, especially during complex health emergencies (ECDC 2019). While scientific findings provided crucial guidance, the ultimate decisions regarding public health measures are often shaped by political and economic considerations as well as societal norms (ECDC 2019).

Box 9.1: *The Political Economy of Health Defined*

The political economy of health is the study of how political, economic, and social forces interact to shape health policies and outcomes. It is a complex and dynamic field, but one that is essential for policy makers to understand in order to make informed decisions that will improve the health of their populations (Horton 2020; Lynch 2023; McCartney et al. 2019; Sparkes et al. 2022).

Rationale for Political Economy Awareness

Understanding the political economy of health is vital because it fundamentally shapes health policy development and execution (McCartney et al. 2019). Analyzing political economy provides a way to respond to and take into consideration the political, economic, and social forces that impact health and related policies, whether at the community, subnational, national, regional, or global level (Sparkes et al. 2022).

When policy makers and policy analysts are well versed in the political economy, they are better positioned to devise health policies that are not only technically sound but also socially and politically viable and thus have a better chance for success (Sparkes et al. 2022).

Benefits of Integrating Political Economy into Policy Development and Implementation. There are three main benefits to integrating political economy into the development and implementation of policy. They are:

- **Amplified voice and participation:** An inclusive political economy enables participatory approaches that enhance representation and balance power dynamics, as it considers the complex interplay of political, economic, and social stakeholders involved (Sparkes et al. 2022).
- **Enhanced adoption and feasibility:** An understanding of political economy improves the likelihood of adopting and realizing technically robust policies, as it considers the intricate interplay of political, economic, and social dynamics (Sparkes et al. 2022).
- **Strengthened capacity building:** A comprehensive political economy approach strengthens the ability to identify and address political factors that influence health priorities at various levels (Sparkes et al. 2022).

The Imperative for the Political Economy of Health

While health policy makers acknowledge the importance of the political economy of health, there is often ambiguity regarding its application (Reich 2019). Hence, it is imperative for policy stakeholders to:

- Stay abreast of evolving political landscapes and economic fluctuations.
- Regularly evaluate the societal and economic ramifications of health policies.
- Understand health and the socio-cultural, political, and historical phenomena that affect the political economy of health.
- Build collaborations with specialists from economics, political science, and sociology to come to a holistic understanding of the political economy of health.

Navigating the Political Economy in Health Policy Development

Engaging with a political economy perspective, especially during health financing reform, equips policy makers with the tools necessary to surmount political barriers that typically emerge with policy shifts. The World Health Organization (WHO) has devised an approach for dissecting the political economy aspects of health financing reforms, aiding in the formulation of strategies that are aligned with the pursuit of universal health coverage (UHC) (WHO 2022). This approach emphasizes the importance of understanding stakeholders, their power dynamics, and the broader political context to pinpoint both the hurdles and openings within health financing reforms (WHO 2022). By carefully utilizing available tools and approaches, policy makers can form a more comprehensive understanding of the context in which they are working and navigate the political landscape effectively.

The WHO's insights into health financing reforms reveal common strategies that transcend individual country distinctions, providing a blueprint for managing reforms tactically:

- **Embrace technical preparedness:** Harnessing technical evidence and readiness is crucial for capitalizing on opportune moments for political action.
- **Employ strategic reform phasing:** Anticipating resistance is key. By thoughtfully sequencing the steps of reform, policy makers can diminish opposition from influential groups.
- **Master the art of strategic compromise:** To move reforms forward, it is often necessary to make calculated concessions. However, these should not compromise the foundational goals of the policy.
- **Incorporate all elements:** Including these strategic elements in health policy development can lead to more robust and resilient health systems that can navigate the complexities of the political economy effectively.

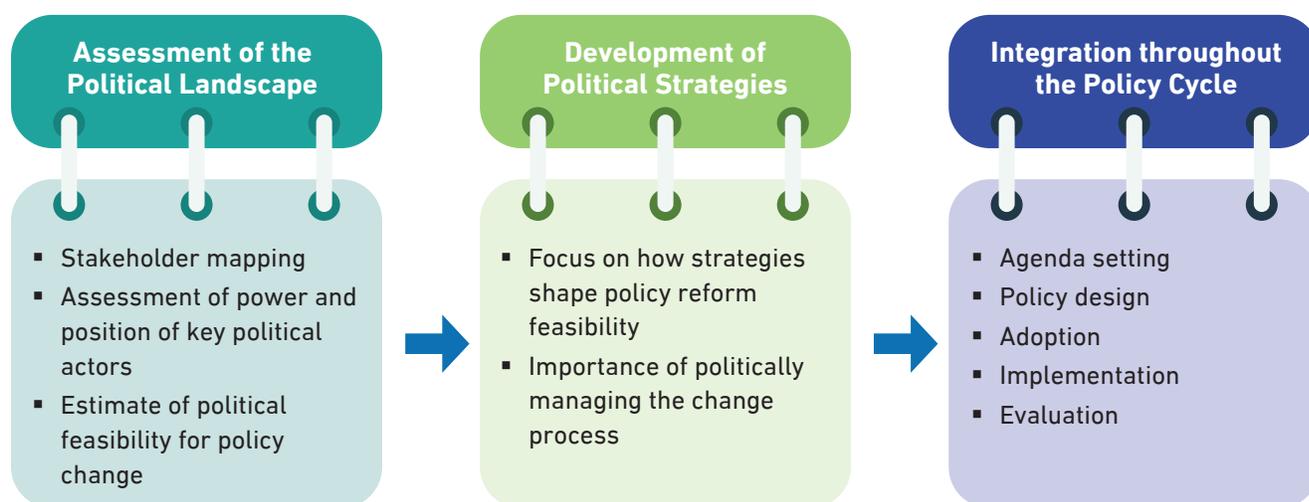
The Significance of Political Economy Analysis in Shaping Health Policy

PEA is a valuable tool for shaping health policy. It helps policy makers to understand the political and economic factors that influence policy decisions and the implementation of those decisions (Reich 2019). Applied PEA can be used to support policy processes in three ways (figure 9.1):

- **Assess the political landscape:** This includes identifying key stakeholders, their interests, and their power. It also involves assessing the political feasibility of policy change (Reich 2019).
- **Identify and develop political strategies:** PEA can help to identify and develop strategies that increase the likelihood of policy success. This may involve building coalitions, managing opposition, and communicating effectively with stakeholders (Reich 2019).

- **Integrate PEA throughout the policy cycle:** PEA can be used at all stages of the policy cycle, from agenda setting to implementation and evaluation. This helps to ensure that policies are designed and implemented in a way that is politically feasible and sustainable (Reich 2019).

Figure 9.1: Supportive Role of Applied Political Economy Analysis in Policy Processes



Source: Original figure for this publication.

One challenge for PEA is to make it accessible and easy to use for policy makers and practitioners (Reich 2019). Several how-to guides have been developed (Booth et al. 2009; Fritz, Kaiser, and Levy 2009; Poole 2011), but there is still a need for more research and assessment on how PEA can be used most effectively in different contexts (Reich 2019).

One example of a software package that can be used for PEA is PolicyMaker 5 (Reich and Cooper 2015). This software combines stakeholder analysis with political strategy development. It has been used in many countries around the world to support the development and implementation of health policies (Reich 2019).

PEA can be a valuable tool for shaping health policy in any country. It can help to ensure that policies are designed and implemented in a way that is politically feasible and sustainable and have the support of key stakeholders. Boxes 9.2, 9.3, and 9.4 provide examples of how PEA has been used to shape health policies in different contexts (Bialous et al. 2014; Loffreda et al. 2021; UNICEF 2017).

Box 9.2: Brazil's Tobacco Control Policy

Tobacco Landscape and Policy Context

Tobacco use remained prevalent in Brazil, despite existing control measures. The powerful tobacco industry wielded considerable influence, while public awareness of tobacco's harms and support for stricter control measures were not yet fully realized. This complex web of economic and political factors posed challenges for implementing effective tobacco control policies.

Issue

To curb tobacco use and improve public health, Brazil sought to develop a new, impactful tobacco control policy. However, navigating the landscape of vested interests and limited public support required a strategic approach that ensured political feasibility and long-term success.

Contd...

Box 9.2: Contd...

Challenges Identified by Political Economy Analysis

- **Powerful tobacco industry lobbying:** The tobacco industry maintained strong political connections and actively lobbied against stricter regulations, posing a significant barrier to policy adoption and implementation.
- **Limited public support:** Public awareness of the full extent of tobacco's harms and support for comprehensive control measures remained insufficient, potentially weakening political will and public compliance with stricter policies.
- **Balancing economic and public health concerns:** Striking a balance between the potential economic implications of stricter regulations on the tobacco industry and prioritizing public health benefits was a crucial challenge for policy makers.

Interplay of Economic and Political Factors

The interplay of these factors significantly impacted policy feasibility. For example, the tobacco industry's lobbying efforts (political) could influence policy decisions, potentially weakening proposed regulations to protect their economic interests. Additionally, limited public support (political) could lead to reduced pressure on policy makers to enact stricter measures, further hindering the effectiveness of tobacco control efforts.

Addressing Challenges and Desired Outcomes

Informed by political economy analysis (PEA), Brazil crafted a targeted tobacco control policy that aimed to overcome these challenges in two ways:

- **Gradual tobacco tax increases:** Implementing incremental tax increases over time allowed for a less disruptive economic impact while steadily raising tobacco prices and discouraging use.
- **Public education campaigns:** Launching targeted public awareness campaigns focused on the health consequences of tobacco use aimed to educate the public, build support for stricter control measures, and increase compliance with policy changes.

Source: Bialous et al. 2014.

Box 9.3: India's National Health Insurance Scheme

Health Care Landscape

India's health care system faced significant challenges prior to the roll out of the country's national health insurance scheme. Access to quality health care was often limited, particularly in rural areas. Out-of-pocket expenses posed a major burden on families, especially those living in poverty or the informal sector. Additionally, a lack of awareness about available health care options and insurance benefits further exacerbated health inequities.

Issue

To address these challenges and improve health care access and equity, the Indian government embarked on the ambitious task of designing a sustainable and equitable national health insurance scheme. However, successfully navigating the complex interplay of economic and political factors was crucial for its success.

Economic Factors

- **Resource constraints:** The vastness of India's population and the country's limited budgetary resources posed a significant challenge to providing comprehensive coverage. Concerns about affordability and sustainability were paramount.
- **Poverty and informal sector employment:** A large portion of the population lives in poverty or works in the informal sector, often lacking stable income and formal employment benefits such as health insurance. This presented difficulties in enrollment and ensuring long-term adherence to the scheme.

Contd...

Box 9.3: Contd...

- **Limited awareness about insurance benefits:** Many communities, particularly in rural areas, had limited knowledge about the benefits of health insurance and how to navigate the enrollment process. This could lead to underutilization of the scheme.

Political Factors

- **Decentralized health care system:** India's federal structure, with health care partially managed by state governments, presented potential challenges to ensuring smooth implementation and consistent quality of care across different regions.
- **Competing interests of stakeholders:** Balancing the interests of various stakeholders—including central and state governments, private and public health care providers, and beneficiary communities—was crucial for successful implementation. Concerns about potential financial losses for private providers and political resistance from vested interests needed to be addressed.
- **Coordination challenges:** Ensuring effective coordination between different levels of government, health care providers, and beneficiary communities was essential for overcoming administrative hurdles and improving efficiency in service delivery.

Interplay of Economic and Political Factors

The success of the national health insurance scheme hinged on successfully navigating the complex interplay of these economic and political factors. For example, limited resources (economic) could restrict the reach of the scheme and potentially lead to dissatisfaction among excluded communities, triggering political resistance (political). Similarly, weak coordination between different government levels (political) could negatively impact scheme efficiency and access to services, despite adequate resources (economic).

Desired Outcome and Potential Challenges

Successful implementation of the national health insurance scheme could significantly improve health care access and equity in India. Reduced out-of-pocket expenses and increased utilization of preventive and curative services could lead to improved health outcomes and reduced financial burden on families. However, challenges such as resource constraints, inadequate awareness, weak coordination, and potential resistance from vested interests require continuous monitoring and targeted interventions to ensure the scheme's long-term effectiveness and inclusivity.

Source: Loffreda et al. 2021.

Box 9.4: South Africa's HIV/AIDS Policy

Context and HIV/AIDS Landscape

South Africa grappled with a significant HIV/AIDS (human immunodeficiency virus/acquired immunodeficiency syndrome) epidemic, with high prevalence rates and unequal access to prevention and treatment services. Fragmented interventions across different government departments hampered a comprehensive response, while social stigma surrounding HIV/AIDS further impeded efforts to reach vulnerable populations.

Issue

To curb the HIV/AIDS epidemic and ensure equitable access to prevention and treatment, South Africa embarked on developing a new national policy. However, navigating complex political dynamics and addressing deeply ingrained social issues were essential for effective implementation.

Political and Social Challenges Identified by Political Economy Analysis

- **Fragmented implementation:** Lack of coordination between various government departments responsible for health care, education, and social welfare hindered a unified and effective response to the epidemic. This resulted in gaps in service delivery and limited reach to at-risk groups.

Contd...

Box 9.4: Contd...

- **Stigma and discrimination:** Persistent social stigma associated with HIV/AIDS discouraged individuals from seeking testing, prevention services, or treatment, impeding early intervention and viral suppression efforts. Discrimination further marginalized vulnerable communities and hampered access to essential support services.
- **Resource scarcity:** Inadequate funding for comprehensive prevention programs and access to antiretroviral therapy (ART) posed a major challenge. Limited resources forced prioritization of certain activities, potentially neglecting other crucial aspects of HIV/AIDS prevention and treatment.

Interplay of Political and Social Factors

The interplay of these political and social factors significantly impacted policy implementation. For example, lack of coordination (political) between health and social welfare departments could lead to gaps in support services for HIV-positive individuals, further reinforcing stigma (social) and discouraging treatment adherence. Similarly, resource constraints (political) could limit the availability of ART in rural areas, exacerbating existing health disparities and reinforcing social inequalities.

Addressing Challenges and Desired Outcome

Informed by political economy analysis (PEA), South Africa devised strategies to tackle these challenges. Establishing a dedicated coordinating body for HIV/AIDS prevention aimed to improve interdepartmental collaboration and streamline service delivery. Public education campaigns and community outreach programs were implemented to combat stigma and discrimination, encourage open dialogue, and promote access to essential services. Addressing resource limitations through increased budgetary allocations and exploring innovative financing mechanisms became crucial for expanding access to ART and prevention programs.

Source: UNICEF 2017.

Examining the Political Economy of Health: Insights from Regional Case Studies

The Middle East and North Africa (MENA) region presents a unique tapestry of health-related political economy scenarios. Diverse in economic wealth, political stability, and health care infrastructure, the countries within the MENA region offer instructive examples of how political economy shapes health outcomes and policy making. This section provides an overview of the complex interplay between political and economic determinants and their impact on health policy decisions across different regional contexts.

By examining case studies from within the MENA region, policy makers can gain insight into the unique political, economic, and social factors that shape health outcomes within their own context. This regional focus allows for a deeper appreciation of the nuances and challenges that are specific to the MENA region, enabling policy makers to tailor their health policy decisions accordingly.

Case Study 1: Saudi Arabia's Public-Private Partnerships and Improved Access to Specialized Health Care

Background

While Saudi Arabia boasts significant advancements in health care infrastructure, access to specialized medical services remained limited in smaller towns and remote areas (Gurajala 2023; Saeed, Bin Saeed, and AlAhmri 2023). Recognizing this gap, the government sought innovative solutions to expand access and expertise.

Political Economic Interaction

Economic drivers: Public-private partnerships (PPPs) offer a way to leverage private sector expertise and resources to augment public health care services. This can lead to improved efficiency, technology adoption, and access to specialized medical care without overburdening public budgets.

Political influences: The government developed a supportive PPP framework with the following components:

- Streamlining regulations and contracts for private investors entering the health care sector
- Providing financial incentives and long-term investment guarantees to attract private partners
- Maintaining quality control and public oversight to ensure equitable access and affordable services.

Outcomes

These combined efforts have led to significant positive outcomes:

- **Increased availability of specialized health care:** PPPs have led to the establishment of specialized medical centers and clinics in underserved regions, offering services such as advanced surgery, cancer treatment, and organ transplantation.
- **Improved health care quality:** Private partners often bring in cutting-edge technology, expertise, and management practices, enhancing the quality of care available to the public.
- **Knowledge transfer and capacity building:** Collaboration between public and private health care professionals fosters knowledge sharing and skill development, benefiting both sectors.
- **Economic benefits:** PPPs create jobs, attract investment, and stimulate economic activity in local communities while also reducing dependency on foreign medical travel.

Implications

This case study showcases how the Saudi government's proactive approach to PPPs in health care, driven by economic considerations and effective policy measures, has expanded access to specialized services and improved overall health care quality. It demonstrates the potential for political and economic factors to work together to achieve positive health outcomes for a wider population (Alasiri and Mohammed 2022).

Case Study 2: Tobacco Control Measures and Reducing Smoking Rates in the United Arab Emirates

Background

Smoking prevalence in the United Arab Emirates remained relatively high compared to some Western countries, leading to an increased risk of cardiovascular diseases and other health problems (Razzak, Harbi, and Ahli 2020). Recognizing the public health implications, the government implemented comprehensive tobacco control measures (Razzak, Harbi, and Ahli 2020).

Political Economic Interaction

Economic drivers: Reducing smoking leads to lower health care costs associated with smoking-related illnesses, promoting long-term economic gains. This economic argument provided the impetus for government action.

Political influences: The United Arab Emirates government adopted a multi-pronged approach (Razzak, Harbi, and Ahli 2020):

- Imposing high taxes on tobacco products, making them less affordable and discouraging purchase
- Banning smoking in public places, including restaurants, cafes, and workplaces; protecting non-smokers; and promoting healthy environments
- Launching public awareness campaigns, highlighting the health risks of smoking and encouraging smoking cessation
- Providing accessible smoking cessation programs and support services to smokers who want to quit.

Outcomes

These combined efforts have yielded the following significant positive outcomes:

- **Decline in smoking rates:** Smoking prevalence has decreased significantly in the United Arab Emirates over the past decade, particularly among younger generations.
- **Improved public health:** Fewer smokers translate to fewer cases of smoking-related illnesses, reducing the burden on the health care system and improving overall public health.
- **Economic benefits:** Lower health care costs and a healthier workforce contribute to economic growth and development.
- **Social progress:** The United Arab Emirates' success in tobacco control serves as a role model for other countries in the region, promoting a healthier future for generations to come.

Implications

This case study demonstrates how the United Arab Emirates' government's strong commitment to tobacco control, combining economic considerations with robust public health policies, has led to significant achievements in reducing smoking rates and improving public health (Monshi and Ibrahim 2021). It exhibits the potential for political and economic factors to work together to achieve positive health outcomes for the entire population.

Case Study 3: Egypt's Pathway to Health Insurance Reform

Background

Egypt's health care system historically comprised a fragmented mix of public, private, and informal sectors, leaving gaps in coverage and accessibility for a significant portion of the population. Recognizing this issue, the government in 2018 enacted the Universal Health Insurance Law (UHI Law), embarking on an ambitious reform journey (Devi 2018).

Political and Economic Drivers

- **Political will:** The UHI Law reflects a strong political commitment to universal health care access, driven by a desire for social equity and improved public health outcomes. This commitment translated into substantial government investment in infrastructure, personnel, and technology for the new system.
- **Financial sustainability:** Recognizing the long-term financial implications, the UHI Law established a carefully designed financing structure. Graduated contributions, based on income levels, aim to ensure affordability and avoid overburdening low-income groups (Soliman and Hopayian 2019).
- **Stakeholder involvement:** The reform process actively engaged various stakeholders, including public and private health care providers, patient representatives, and civil society organizations. This fostered buy-in and strengthened the system's legitimacy.

Challenges and Opportunities

- **Implementation hurdles:** Operational challenges remain: these include provider network adequacy, service quality variations, and effective management of information systems. Ongoing monitoring and adjustments are crucial.
- **Financial sustainability:** Long-term financial sustainability requires consistent government commitment, efficient resource allocation, and potential adjustments to financing mechanisms as needed.
- **Potential benefits:** Successful implementation can yield significant benefits, including improved health outcomes, reduced inequalities, and increased economic productivity due to a healthier workforce.

Implications

Egypt's UHI Law reform journey exhibits the complex interplay of political economy in health policy. Strong political will, careful financial planning, active stakeholder participation, and a focus on equity are crucial for success. While challenges remain, Egypt's progress provides valuable lessons for other countries aiming to achieve universal health coverage through systemic reforms.

Case Study 4: Jordan's Health Policy Evolution: Navigating Crises and Crafting Resilience

Background

Jordan's health care system has faced unique challenges due to its geographic location and geopolitical context (Rababa 2023). Hosting large refugee populations, coupled with the recent COVID-19 pandemic, has put immense strain on the country's health care infrastructure and resources (Rababa 2023).

Political and Economic Pressures

- **Refugee influx:** The arrival of over 1.3 million Syrian refugees significantly increased health care demand, placing pressure on hospitals, personnel, and medical supplies. This, together with limited international aid, forced the government to balance refugees' needs with those of Jordanian citizens.

- **Economic constraints:** Jordan, a lower-middle-income country, faces ongoing economic challenges. Tight budgets and dwindling resources further amplified the strain on health care financing, pushing for reforms aimed at greater efficiency and cost-sharing.

Policy Responses and Innovations

- **Resilience and resourcefulness:** Despite limitations, Jordan demonstrated remarkable resilience in adapting its health care system. The country expanded primary health care services, established specialized clinics for refugees, and adopted innovative strategies such as telemedicine to increase access.
- **Equity and access:** Maintaining equitable access to health care for both Jordanians and refugees remained a core principle. Social health insurance schemes were expanded, and financial assistance programs were implemented to ensure affordability for vulnerable populations.
- **Reforms for sustainability:** Recognizing the need for long-term financial sustainability, the government introduced co-payment systems for public health care services and encouraged private health insurance enrollment. This aimed to share the financial burden while maintaining quality care.

Challenges and Opportunities

- **Integration and sustainability:** Effectively integrating refugees into the health care system and ensuring long-term funding for expanded services remain ongoing challenges.
- **Quality and affordability:** Balancing cost-sharing measures with affordable access for low-income groups and managing potential inequalities require careful monitoring and adjustments.
- **Lessons for resilience:** Jordan's experience in navigating crises and adapting its health care system offers valuable lessons for other lower-middle-income countries facing similar challenges.

Implications

Jordan's journey demonstrates the crucial role of political will and resourcefulness in adapting health care systems to unforeseen crises (Akik et al. 2022). Its commitment to equity, coupled with innovative strategies for efficient service delivery and financing, offer a valuable model for other developing nations striving to build resilient health systems in the face of adversity.

Examining the Political Economy of Health: Insights from Global Case Studies

This section provides an overview of the complex interplay between political and economic determinants and their impact on both health policy decisions and health outcomes across different international contexts, allowing policy makers to draw parallels and identify transferable lessons from other countries' experiences. By examining how different countries have addressed different health challenges, policy makers can gain valuable insights into effective strategies and approaches that can be adapted to the local context.

Case Study 1: The US Mortality Disadvantage: A Political Economy Perspective

The Issue

The United States faces a significant health disadvantage compared to other wealthy nations. Americans have a lower life expectancy than their counterparts in many high-income countries, with gaps exceeding three years compared to France and Sweden (OECD 2013). This gap has widened noticeably since the 1980s (Navarro 2019).

While some health behaviors play a role, merely addressing individual choices does not fully explain the US disadvantage (Bambra, Smith, and Pearce 2019). A political economy approach reveals deeper structural factors impacting health outcomes. Among these are:

Limited Regulation of Unhealthy Products

- The United States ranks among the least regulated markets globally for harmful products such as tobacco, alcohol, and ultra-processed food (Freudenberg 2014).
- This lack of control allows powerful industries to influence policies and shape consumption patterns, disproportionately impacting low-income and minority communities.

Inadequate Social Welfare

- Compared to other wealthy nations, the United States offers much less social support.
- Modest and stigmatized social insurance benefits leave millions uninsured or underinsured, hindering access to health care and contributing to health inequalities (Bambra, Smith, and Pearce 2016).

Weak Collective Bargaining and Political Incorporation

- Unlike countries with strong unions and robust social safety nets (such as Sweden), the United States has low trade union membership and limited political representation for working-class interests.
- This weakens the influence of groups traditionally at higher health risk, further deepening inequities.

Geographical Context Matters

- Unhealthy products are often readily available in low-income areas, and local disamenities such as poor air quality exacerbate health risks.
- Understanding the local socio-spatial context is crucial for effective policy interventions.

Implications for Policy and Decisions

Beyond individual-level interventions, addressing the US mortality disadvantage requires a macro-level focus on political, economic, and policy drivers. This includes:

- Strengthening regulation of unhealthy products to counter industry influence
- Enhancing social welfare programs to ensure wider health care access and reduce poverty's health impacts

- Empowering working-class communities through stronger unions and political representation
- Creating local initiatives that tackle disamenities and promote health-promoting environments.

By integrating a political economy lens into health policy, the country can move beyond individual behaviors and address the systemic factors that contribute to the US mortality disadvantage (Bambra, Smith, and Pearce 2019).

Case Study 2: Regional Health Divides in the United Kingdom and Germany

While many high-income nations grapple with regional health inequalities, the United Kingdom stands out for its persistent North-South divide. Unlike Germany, which dramatically narrowed its East-West gap within a generation, the United Kingdom's regional disparities remain stark. Examining the German case offers valuable insights into potential interventions for the United Kingdom and other countries facing such challenges (Bambra, Smith, and Pearce 2019).

Key Drivers of Germany's Success

- **Economic transformation:** Reunification brought rapid economic improvements to the German Democratic Republic. The adoption of the Western Deutsche Mark, substantial investments in industries, and transfer payments significantly boosted living standards, particularly for older residents through increased pensions.
- **Improved access to resources:** Increased availability of food, consumer goods, and health care services, including modernized hospitals and equipment, contributed to better diets and health care outcomes.
- **Sustained political commitment:** German reunification was driven by a strong political resolve to close the gap and "grow together." This commitment translated into consistent policy interventions and resource allocation.

Lessons for the United Kingdom and Beyond

- **Addressing economic disparities:** The United Kingdom's North-South divide hinges on economic differences. Targeted investments in the North, alongside policies promoting regional economic development, could narrow the gap.
- **Prioritizing health care investment:** Improving access to quality health care in disadvantaged regions, potentially through targeted funding and resource allocation, can play a crucial role in reducing health inequalities.
- **Strong political leadership:** Ultimately, tackling regional health disparities requires sustained political commitment. The United Kingdom needs policies driven by a clear vision and long-term strategy for equitable health outcomes across regions.

By learning from successful models such as Germany's and implementing a multi-pronged approach encompassing economic, health care, and political strategies, the United Kingdom and other countries facing similar challenges can address their persistent regional health divide and work toward a more equitable future for all citizens.

Case Study 3: Excess Mortality in Glasgow, Scotland

Scotland's health disadvantage manifests significantly in Glasgow's excess mortality. While traditional explanations such as poverty or deindustrialization alone fall short, a deeper look—one that takes a political economy approach—reveals a complex interplay of factors rooted in politics and economics (Bambra, Smith, and Pearce 2019; Walsh et al. 2016).

Beyond Individual Choices

Glasgow's health problems cannot be explained by individual choices alone. While half of under-65 deaths are linked to alcohol and drugs, other health aspects—such as smoking, diet, and physical activity—seem unlikely major contributors. Even educational disparities contribute minimally (Bambra, Smith, and Pearce 2019; Walsh et al. 2016).

Context Matters, but Not Enough

Environmental factors such as Glasgow's climate or housing quality, while potentially impactful, lack sufficient explanatory power. Studies exploring derelict land and housing quality raise further questions about underlying structural and political drivers (Bambra, Smith, and Pearce 2019; Walsh et al. 2016).

Scaling Up to Political Determinants

Glasgow's excess mortality demands a political economy approach, which recognizes the influence of political decisions on health outcomes. A review of key issues pinpoints specific political factors:

- **Different policies in the 1980s:** Unlike other cities such as Manchester and Liverpool, Glasgow focused on redeveloping its city center, which could have made things worse for people already struggling.
- **Moving people out of slums:** After World War II, many people were relocated from overcrowded slums to new housing estates on the outskirts of the city. These new homes, often high-rise and poorly maintained, were not great places to live.
- **Building new towns elsewhere:** Jobs and skilled workers were encouraged to move to new towns built away from “declining” cities such as Glasgow, leaving those who remained with fewer opportunities.
- **Feeling unheard:** People in Glasgow felt they did not have enough say in decisions affecting their lives during the 1980s, which could have added to their health problems.

These factors, combined with neoliberal policies perceived as unfairly targeting Glasgow, created a perfect storm for excess mortality. This rise coincided with an epidemiological shift toward poverty- and despair-related deaths such as drug overdoses and suicides.

Case Study 4: Health Financing Reforms in Georgia

Georgia embarked on extensive health sector reforms, achieving significant progress toward the Millennium Development Goals by 2010 (Witter et al. 2019). Notably, some reforms mirrored international best practices while others were uniquely implemented, such as hospital privatization (for example, the hospital reforms in 2006–12 resulted in the privatization of over 70 percent of public hospitals in a poorly governed environment, with subsequent implications for costs and quality of services) (Witter et al. 2019).

Political and Economic Drivers

- **International influence:** Some reforms followed best practices, suggesting adherence to global trends and potential pressure from international partners.
- **Domestic priorities:** However, radical hospital privatization highlights the way that political agendas can get prioritized over evidence. This could reflect a desire for faster economic growth through market-driven health care, even with potential costs and quality concerns.

Outcomes and Implications

- **Progress achieved:** The reforms contributed to positive health outcomes, aligning with the overall goals.
- **Mixed results:** Privatization, while delivering economic benefits, raised concerns about affordability and quality of care. This underscores the need for careful implementation and monitoring of such reforms.
- **Lesson learned:** This case demonstrates the potential interplay between evidence-based practices and political agendas in shaping health policy. Governments have the flexibility to prioritize political goals, even if they deviate from established norms.

Case Study 5: Sectorwide Approach in Bangladesh

Bangladesh implemented a sectorwide approach, pooling donor funds and shifting family planning services from door-to-door services to clinic-based services (Witter et al. 2019).

Political and Economic Drivers

- **Limited evidence:** Even though evidence of the effectiveness for the clinic-based model might have been incomplete, strong political backing pushed the reform forward. This suggests prioritizing policy changes based on political will and perceived benefits, even with limited data.
- **Donor collaboration:** The pooling of funds through the sectorwide approach highlights the role of external funding and collaboration in supporting health reforms in developing countries.

Outcomes and Implications

- **Successful implementation:** The reforms were successfully implemented, demonstrating the effectiveness of coordinated efforts and political commitment.
- **Potential risks:** Reliance on limited evidence could lead to unforeseen consequences. Continuous monitoring and evaluation are crucial to ensure sustained positive outcomes.
- **Lesson learned:** This case shows that political will can drive reforms even with limited evidence, but cautious implementation and ongoing evaluation are essential.

Case Study 6: Health Financing Reforms in Burkina Faso

Burkina Faso has a long-standing community-based health insurance system—*mutuelles de santé*—which influenced broader health policy initiatives, including plans for universal health insurance (Witter et al. 2019).

Political and Economic Drivers

- **Grassroots movement:** The community-based system arose from a local movement, demonstrating the potential for bottom-up approaches to influence national policy.
- **Sustainability:** The long-standing history of mutuelles de santé suggests its effectiveness and potential for financial sustainability compared to other health financing models.

Outcomes and Implications

- **Policy influence:** The success of mutuelles de santé contributed to shaping national health policy, demonstrating the possibility that local innovations can inform broader reforms.
- **Financial viability:** This case provides insight into alternative health financing models that might be suitable for low-income countries, particularly those with strong community engagement.
- **Lesson learned:** The case highlights the importance of considering bottom-up approaches and alternative financing models in health policy development.

Case Study 7: Ethiopia Health Extension Program

Ethiopia's flagship Health Extension Program (HEP) in 2003 trained female community health workers to improve access to primary health care in rural areas, contributing to Millennium Development Goal achievements by 2015 (Witter et al. 2019).

Political and Economic Drivers

- **Historical and ideological context:** Ethiopia's socialist past and its focus on community health influenced the HEP design.
- **Pragmatic approach:** Limited resources necessitated a cost-effective solution such as HEP, demonstrating the importance of adapting policies to specific contexts.

Outcomes and Implications

- **Improved access:** HEP demonstrably expanded access to primary care in rural areas, highlighting the effectiveness of community-based health care models.
- **Gender empowerment:** Training female health workers contributed to women's empowerment and improved community health outcomes.
- **Lesson learned:** This case underscores the value of considering historical and local contexts, adopting pragmatic approaches, and leveraging community resources in health policy development.

Mechanisms for Learning: Lessons from the Case Studies

Learning from international experience involves interactions with and insights from other countries (figure 9.2). Many countries turn to international study tours, especially during the initial stages of policy development. These tours enable a diverse range of stakeholders, from technical experts to parliamentary members, to gain a firsthand understanding of best practices elsewhere. Crucial to this mechanism are development partners such as the WHO and the World Bank, which not only facilitate these tours but also provide specialized expertise and advice on a variety of policy matters. International meetings, which

often tackle specific topics or regional issues, further function as catalysts, fostering collaboration and knowledge sharing across borders. For instance, meetings in Georgia and Burkina Faso homed in on specific regional issues, while technical assistance programs in countries such as Georgia, Bangladesh, and Burkina Faso were instrumental in understanding and implementing reforms. Ethiopia, too, has exhibited a proactive approach, establishing groups to review and incorporate insights from international studies to refine their health packages.

Capacity building shifts the focus inward, aiming at enhancing a country's inherent skills and expertise to generate evidence, innovate, and expand the capacity to manage implementation well and use the evidence generated. Rather than always relying on international expertise, there is an emphasis on nurturing and developing local talent and institutional know-how. Initially, many countries may send their personnel abroad for training. However, as they recognize the importance of retaining skilled talent and ensuring their skills are tailored to local contexts, there is a marked trend toward strengthening domestic institutions and training programs. While foreign training was initially common, a trend toward nurturing local capacities and institutions emerged in an attempt to retain skilled personnel. In other words, countries might start by training personnel abroad but later emphasize developing local educational institutions to build and maintain a pool of skilled local professionals (figure 9.2).

Regional networks and domestic initiatives bridge the gap between the international and the local, harnessing insights from both dimensions (figure 9.2). Regionally, networks—often influenced by consultants or communities of practice—serve as conduits for sharing knowledge across neighboring countries. Domestic initiatives, on the other hand, focus on intra-country learning. Pilot projects, supported by international nongovernmental organizations (NGOs) or domestic study tours and meetings, for instance, facilitate knowledge exchange across different regions or states within a country. This mechanism also underscores the role of civil society, as seen in Burkina Faso, where advocacy groups, in collaboration with international partners, have significantly influenced policy uptake.

Figure 9.2: Mechanisms for Learning



Source: Original figure for this publication.

Note: NGOs = nongovernmental organizations.

Conclusions

The political economy of health is a complex and multifaceted field, but it is essential for understanding and shaping health policy. This chapter has explored the key concepts and frameworks of the political economy of health, as well as real-world examples of how it has been used to inform policy decisions.

One of the central insights of the political economy of health is that health decisions are not made in a vacuum. They are influenced by a wide range of factors, including political interests, economic considerations, and social values. This is evident in the decisions made during the early part of the COVID-19 pandemic, which has highlighted the complex interplay of these factors in shaping health policy responses.

PEA is a valuable tool for understanding and integrating political economy insights into health policy frameworks. PEA can help policy makers and other stakeholders better understand the intersection between politics and health, assess the political and economic landscape, formulate actionable strategies, and ensure that policies are politically feasible and socially relevant.

Another important insight is that the political and economic fabric of each country shapes the development, implementation, and sustainability of health policies. This is why it is important to take a context-specific approach to the political economy of health.

The journey of integrating political economy into health policy is complex but indispensable. Policy makers, analysts, and health professionals need to regard the political economy as a lens through which the holistic picture of health policy emerges. By understanding and embracing the intricate relationship between politics, economics, and health, nations can chart a course toward sustainable health outcomes that resonate with their unique socio-political and economic fabric.

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