

Report prepared for the International Decision Support Initiative (iDSI)

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Supporting evidence-informed priority-setting

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## Abstract

This report highlights some of the key insights about how best to support evidence-informed priority setting, both those derived from the research literature and presented at a workshop and those derived from the discussion at a workshop convened in October 2015.

The report is divided into two parts, with the first part focused on knowing your context. Four questions are proposed to help you get to know your context:

- 1) what types of policy decisions are you trying to inform with research evidence (e.g., paying for a program, service or drug; changing a health-system arrangement)?
- 2) where and how are such policy decisions made (e.g., executive or legislative branch; using a fully systematic and transparent process versus an ad hoc, behind-closed-doors process)?
- 3) who and what influences these policy decisions?
- 4) how would you define evidence-informed policymaking in this context?

Knowing your context is important because different types of policy decisions and different ways of making and influencing policy decisions likely warrant different approaches to supporting evidence-informed priority setting.

The second part of the report is focused on intervening in your context. Three questions are proposed to help here:

- 1) what approaches can you use on the ‘evidence-supply side’ to support evidence-informed policymaking?
- 2) what approaches can you use on the ‘evidence-demand side’ to support evidence-informed policymaking?
- 3) how would you evaluate and learn from the use of these approaches?

Intervening in your context means using the types of proven and promising approaches described in this report, as well as evaluating and learning from the use of these approaches.

## Report

How best to support evidence-informed policymaking is a question commonly asked both by those engaged in conducting policy-relevant research and by those engaged in using research evidence in the policymaking process. Here the question was asked by the International Decision Support Initiative (iDSI), which has a focus on a particular type of health policymaking, namely priority setting. This report highlights some of the key insights about how best to support evidence-informed priority setting, both those derived from the research literature and presented at a workshop and those derived from the discussion at the workshop itself. The workshop was convened at the Bill and Melinda Gates Foundation from 5-7 October 2015.

The report is divided into two parts, with the first part focused on knowing your context and the second part focused on intervening in your context. Knowing your context is important because different types of policy decisions and different ways of making and influencing policy decisions likely warrant different approaches to supporting evidence-informed priority setting. Intervening in your context means using proven and promising approaches from the evidence-supply side (i.e., from outside government), the evidence-demand side (i.e., from within government) or both, as well as evaluating and learning from the use of these approaches.

The workshop involved participants from both the evidence-supply side (staff of Disease Control Priorities 3, Institute for Health Metrics and Evaluation, PATH, and Results for Development), the evidence-demand side (staff of or consultants to the ministries of health of Ethiopia, Indonesia, Tanzania and Thailand), as well as iDSI partners (who come from many types of organizations) and staff of the Bill and Melinda Gates Foundation (which arguably acts at the interface between the evidence-supply side and the evidence-demand side).

### Knowing your context

The first part of this report will help you get to know your context by posing four questions for you to answer:

- 1) what types of policy decisions are you trying to inform with research evidence?
- 2) where and how are such policy decisions made?
- 3) who and what influences these policy decisions?
- 4) how would you define evidence-informed policymaking in this context?

#### **1) What types of policy decisions are you trying to inform with research evidence?**

Many taxonomies of policy decisions exist, but the most salient taxonomy for those interested in supporting evidence-informed policymaking distinguishes:

- a) decisions about the mix of diseases or conditions that need to be addressed;
- b) decisions about paying for or providing a program, service or drug (and here there is a distinction to be made between clinical programs and services and drugs, on the one hand, and public health programs and services, on the other hand);
- c) decisions about strengthening health-system arrangements to get the right mix of covered programs, services and drugs to those who need them (e.g., allowing nurses and

pharmacists to prescribe, changing the approach to deciding what services and drugs are covered by a benefit plan, and developing interprofessional primary-care teams) (Hoffman et al., 2012).

Though all three kinds of decisions may be considered ‘priority setting’ decisions where they involve allocation of finite resources among competing uses, most of those engaged in work described as priority setting are focused on the first two of these three types of decisions, particularly the second type.

There are many reasons for making these distinctions, but I’ll illustrate the importance of making a distinction between informing a decision about a health-system arrangement and informing a decision about a program, service or drug by describing four unique features of the former and contrasting them with the features of the latter. First, advice or decisions about starting/stopping, accelerating/decelerating or consolidating a move towards a new health-system arrangement, like universal health coverage (while juggling a range of interlinked changes) are typically a number of heterogeneous pieces of advice or decisions (small and big, visible and traceable or not, initiated prior to forming a government or not), made over a long period of time, by a broad range of different advisors (or advisory bodies) and decision-making bodies, and with little to no routinization possible. Second, health-system problems and their causes are typically heavily contested. Third, the benefits, harms and costs of particular health-system arrangements are typically seen as context-dependent. Fourth, the optimal source of pre-appraised synthesized research evidence (Health Systems Evidence, <https://www.healthsystemsevidence.org/>) is unique to health-system arrangements (Lavis & Moat, 2015). In contrast, decisions about a program, service or drug are more easily routinized, typically face less contestation about the problem they address and less context specificity in the benefits, harms and costs of alternative ways to address the problem, and can be informed by evidence from many different sources.

## **2) Where and how are such policy decisions made?**

Policy decisions can be made in many different places, each of which typically has particular ways of making decisions. Decisions can be made by the executive, legislative or judicial branches of government or by organizations outside government (e.g., insurance plans, healthcare organizations). Within the executive branch, decisions can be made by a president or prime minister (who may have been elected or installed through a coup), cabinet (which may be elected or appointed), the minister of health (who may be elected or appointed), the ministry of health (which may be neutral or politicized) or an arms-length body appointed by government (which may too be neutral or politicized). To inform policy decisions in a particular domain, it’s critical to know where and how decisions about that domain are made.

Many of those engaged in priority setting work with or in an arms-length body appointed by government, such as the National Institute for Health and Care Excellence (NICE), which is a neutral, arms-length body, appointed and funded by the United Kingdom government to make policy decisions on behalf of the National Health Service, and which uses a systematic and transparent approach that constrains the political forces at play in the policy decisions it makes (Rid et al. 2015). To inform the workshop, Matthew Hughsam, a fourth-year BHSc student at McMaster University, examined the policy decisions made by NICE. He found that 98% of

guidance documents (1096/1120) addressed programs, services and drugs and only 2% (24/1120) addressed health-system arrangements (Hughsam, personal communication, 2015).

Others engaged in supporting evidence-informed policymaking contend with a more heterogeneous set of venues for decision-making and consequently a more heterogeneous set of decision-making processes. For example, the WHO-sponsored Evidence-Informed Policy Networks (EVIPNet), which focus on policy decisions related to strengthening health-system arrangements to get the right mix of programs, services and drugs to those who need them, are seeking to inform – for any given topic – some or all of the executive and legislative branches of government and key organizations outside government (World Health Organization, 2015) (and unlike NICE, EVIPNet does not itself make any policy decisions). The decision-making processes that EVIPNet is trying to inform are much closer to an ad hoc, behind-closed-doors process than to a systematic and transparent process. EVIPNet members may use both direct routes to politicians, political advisors and public servants in central and line agencies (e.g., to inform election and leadership platforms, budget setting, and policy development) and indirect routes (e.g., to inform stakeholder advocacy, media coverage, international agreements and global guidance).

Note that having highlighted a number of differences between NICE and EVIPNet, this is not to suggest that the two are directly comparable. Rather they are the models most familiar to the workshop organizers, and have been used as illustrative examples here and throughout the workshop to highlight the various issues that need to be considered in ‘knowing your context’.

### **3) Who and what influences these policy decisions?**

Policy decisions can be influenced by many different types of people (who need to be informed by the best available research evidence) and by many different types of forces (which need to be understood in relation to what types of research evidence will be most helpful). Those who influence the policy decisions you’re trying to inform include those in other parts of government than the one making the decision, which can mean the executive branch (e.g., president, cabinet members, minister of health and their advisors; policy, program and technical staff in the ministry of health or in an arms-length body), legislative branch (e.g., legislators and their advisors) and judicial branch. Those who influence policy decisions also include those outside government, which can mean:

- those with a direct material interest (e.g., those working for drug companies and some professional associations);
- those with a narrow or broad public interest (e.g., members of disease groups, members of civil society groups, staff of NGOs);
- those with a more technical interest (e.g., members of external review groups, staff of WHO, researchers in universities, and staff of many of your initiatives); and
- those with a journalistic interest (e.g., reporters).

A key consideration is for which groups are you going to invest the time to inform them with the best available research evidence.

Turning to what influences the policy decisions you’re trying to inform, it’s important to distinguish among: what gets on the governmental agenda (i.e., the list of subjects to which

government is paying attention, which is usually driven by either a problem or politics), what gets on the decision agenda (the short list of subjects that government has decided to do something about, which usually requires a problem, a viable policy to address the problem, and the right politics), what policy choice is made (which is typically influenced by some combination of institutions (structures and processes that determine who can make the decision and how, past policies that shape current dynamics), interests (who wins, who loses and by who much), ideas (values about what should be and beliefs about what is), and external forces such as the state of the economy and WHO guidance), and what approach to policy implementation is selected (which is typically influenced by some combination of the same factors as policy choice) (Kingdon 2012; Hall 1996).

Research evidence can help to bring a problem to attention or help to establish the appropriateness of a policy to address a problem, and thereby influence agenda setting (Lavis et al. 2012). Research evidence is also one source of ‘ideas’ that influence policy choice and policy implementation, and can include research evidence about a problem and its causes (e.g., indicators related to the problem, comparisons that establish the relative importance of the problem, and ways of framing the problem), about options to address the problem (e.g., benefits, harms, costs / cost-effectiveness, how and why the option works, and stakeholders’ views and experiences with the option), about implementation considerations (e.g., barriers & facilitators, plus the benefits, harms, etc. related to any proposed implementation strategy), and about monitoring and evaluation (Lavis et al., 2012). Research evidence can also inform the interest groups seeking to influence policy choice. Another key consideration is what types of research evidence are needed given the influences on the policy decisions you’re trying to inform.

Taking NICE again as an example, policy choice is most profoundly influenced by ‘institutions,’ namely the structure of an arms-length body and a process that constrains the interests at play (with those facing the most concentrated benefits and costs having a circumscribed role) and gives attention to certain ideas (e.g., principles about good science and citizen voice and research evidence about available options) over others (Littlejohns et al., 2012). In contrast, EVIPNet is dealing with an ever-changing array of people inside and/or outside government trying to influence policy choice and an ever changing array of institutions, interests, ideas and external forces influence policy choice, depending on the issue at hand (World Health Organization, 2015).

#### **4) How would you define evidence-informed policymaking in this context?**

What success looks like for individuals and groups trying to support evidence-informed policymaking likely needs to vary by context. However, most workshop participants could live with the definition I proposed at the workshop: using the best available data and research evidence – systematically and transparently – in the time available in each of: a) prioritizing problems and understanding their causes (agenda setting), b) deciding which option to pursue (policy development), and c) ensuring the chosen option makes an optimal impact at acceptable cost (policy implementation), alongside the institutional constraints, interest-group pressure, values and other types of information (like jurisdictional reviews, consultations, expert review groups, and opinion polls) that influence the policy process. Best available research evidence here means the highest quality, most locally applicable, synthesized research evidence (looking

first for a perfect match to support an instrumental use and then looking more broadly to support a conceptual use)

A very important observation and the biggest departure from this definition in the discussions at the workshop was that many participants working on the evidence-supply side – in whole or in part because of the incentives set by their funders - were focused on supporting the use of their own research evidence, not their evidence in the context of all of the other types of research evidence needed to support evidence-informed policymaking. Less significant differences included the emphasis placed on: 1) data versus research evidence versus tacit knowledge; 2) independence in research versus partnering with those who influence decision-making in the research process; and 3) using citations of their research as a measure of influence versus using measures of evidence use in decision-making (and ultimately impacts on health and other outcomes). Establishing what success looks like means coming to an agreement of what constitutes evidence-informed policymaking and then finding appropriate measures based on this definition.

### **Intervening in your context**

The second part of this report will help you intervene in your context by posing three questions for you to answer (which I have numbered 5-7 to continue from the previous list):

- 5) what approaches can you use on the ‘evidence-supply side’ to support evidence-informed policymaking?
- 6) what approaches can you use on the ‘evidence-demand side’ to support evidence-informed policymaking?
- 7) how would you evaluate and learn from the use of these approaches?

Generally responses to questions 5 and 6 are grounded in part on an understanding of the challenges frequently encountered in supporting evidence-informed policymaking, which I presented at the workshop:

- a) research evidence competes with many other factors, including institutional constraints, interest-group pressure, other types of ideas, and external factors (although politics is a given so many individuals take this as the context in which they work);
- b) research evidence isn’t valued as an information input;
- c) research evidence isn’t relevant;
- d) research evidence isn’t easy to use, which can mean at least four different things:
  - i) research isn’t communicated effectively;
  - ii) research isn’t available when policymakers and stakeholders need it and in a form that they can use;
  - iii) policymakers and stakeholders lack mechanisms to prompt them to use research in decision-making; and
  - iv) policymakers lack forums where health-system challenges can be discussed with key stakeholders who are informed about the best available research evidence.

Responses to questions 1 and 2 are also typically grounded in an understanding of the two factors that emerged with some consistency in a systematic review of 124 studies (case studies,

interview studies, and documentary analyses) of the factors that increased the prospects for research use in policymaking, namely interactions between researchers and policymakers and timing or timeliness (Catallo et al. 2013). The importance of interactions has led those supporting evidence-informed policymaking to explore engaging policymakers in priority-setting, research (including systematic reviews) and deliberative processes. The importance of timing or timeliness has led people to explore one-stop shops for research evidence, rapid-response units and other approaches to making the best available research evidence available when it's needed.

## **5) What approaches can you use on the 'evidence-supply side' to support evidence-informed policymaking?**

Those working on the 'evidence-supply side' typically include those outside government, such as research institutes, arms-length technical bodies, NGOs, and WHO country offices and their approaches to supporting evidence-informed policymaking typically involve one or more of the following approaches:

- a) cite signals that you're hearing from at least some parts of government that research evidence is valued as a key input to the policy process and 'audit' key decisions by government against the research evidence available at the time of the decision;
- b) organize and act on research priority-setting processes and conduct research in partnership with policymakers and stakeholders to ensure that research is relevant to policymaking (Lomas et al., 2003)
- c) communicate research evidence effectively, both by packaging it better (e.g., prepare a user-friendly summary of a systematic review addressing a key question, or prepare an evidence brief that summarizes all of the relevant data, studies and reviews about a problem and its causes, options for addressing it, and key implementation considerations in a particular context) (Lavis 2009; Moat et al. 2014), and by disseminating it in a more planned way (e.g., ask what's the message, to whom should it be communicated, by whom should it be communicated, how should it be communicated, and with what impact should it be communicated) (Lavis et al. 2003);
- d) make research evidence available when policymakers and stakeholders need it and in a form that they can use, by developing or using one-stop shops for local evidence and using one-stop shops for pre-appraised global evidence (e.g., ACCESSSS for clinical evidence, HealthEvidence for public health evidence, and Health Systems Evidence for health systems evidence), by administering a rapid-response evidence service (Mijumbi et al., 2014) or by building capacity among policymakers and stakeholders so they can find and use research evidence efficiently themselves; and
- e) convene stakeholder dialogues, citizen panels and other deliberative processes that are informed by research evidence but also consider the tacit knowledge and real-world views and experiences of stakeholders (including patients) (Boyko et al., 2012).

EVIPNet Africa teams have particularly emphasized the preparation of evidence briefs and convening of stakeholder dialogues informed by these briefs, and to a lesser extent the use of one-stop shops for pre-appraised global evidence, rapid-response services and one-stop shops for local evidence. The McMaster Health Forum has emphasized the maintenance of a one-stop shop for pre-appraised global evidence (Health Systems Evidence), the preparation of rapid syntheses in 3, 10 & 30 business days, the preparation of both evidence briefs and citizen briefs and

convening of stakeholder dialogues and citizen panels, and building policymakers' capacity to find and use research evidence efficiently.

The strengths of the model used by EVIPNet Africa and the McMaster Health Forum are that it considers the totality of the evidence and the full array of influences on the policy process, involves partnerships among policymakers, stakeholders and researchers, is adaptable to a wide variety of health and political systems, accommodates a wide diversity of infrastructure (governments, NGOs and universities; internet; and journal access), and has been subjected to rigorous monitoring and evaluation from the beginning. The weakness of the model is that it is reliant on good connections in both the policy and research 'worlds' unless it can become fully institutionalized and, in the case of EVIPNet, it has unstable funding and largely volunteer-based supports.

Evaluations of the model have taught us the following:

- a) interviews and focus groups identified that support from policymakers and international funders have facilitated the work, a lack of skilled human resources has sometimes hindered it, and sustainability remains a widely held concern (El-Jardali et al., 2014);
- b) surveys have identified that briefs and dialogues, and their key design features, have been highly valued by policymakers, stakeholders and researchers across all contexts and issues, have led to strong intentions to act on what was learned, and have frequently influenced one or more of the agenda-setting, policy development and policy implementation phases of the policy process (Moat et al. 2014); and
- c) interviews and surveys identified that rapid syntheses have been frequently requested by policymakers, frequently changed policymakers' approach to dealing with an issue, and made policymakers more confident in their decisions (Mijumbi et al. 2014).

## **6) What approaches can you use on the 'evidence-demand side' to support evidence-informed policymaking?**

Those working on the 'evidence-demand side' typically include those within the executive and legislative branches of government, and their approaches to supporting evidence-informed policymaking typically involve one or more of the following approaches:

- a) create an institutional mechanism that privileges the use of research evidence and that constrains other (particularly material interests-based) influences;
- b) signal that research evidence is valued as a key input to the policy process, by giving speeches on the topic, adjusting performance-management systems to reward the use of research evidence, or creating and using evidence-based decisions supports;
- c) participate in research priority-setting processes and allocate funds to and engage in prioritized research being conducted over different time scales (e.g., 1-3 months for evidence briefs, 6-18 months for systematic reviews and three or more years for primary research);
- d) demand the effective communication of research evidence by asking where the dissemination plan is for high-quality, locally relevant and actionable research evidence and by pushing back when presented with single studies or reviews that don't answer the full range of questions needed to inform policy;

- e) ensure that research evidence is available when you need it and in a form that you can use, by using one-stop shops for local and pre-appraised global evidence, by administering an internal rapid-response evidence service or by building capacity among your peers so they can find and use research evidence efficiently themselves; and
- f) create prompts for the use of research evidence in decision-making, by (for example) mandating the completion of an evidence checklist (that documents how evidence was used, where evidence was looked for, and what types of evidence were found) before decisions can be made; and
- g) participate in or use the results of stakeholder dialogues, citizen panels and other deliberative processes.

Research is lacking about the strengths and weaknesses of most models employing these approaches, including their benefits, harms and costs. However, NICE -- an example of an institutional mechanism that privileges the use of research evidence and social values and that constrains other (particularly material interests-based) influences (Littlejohns et al., 2012) – is an exception to this generalization and has been more extensively studied than most demand-side interventions.

A key observation that applies to both questions 5 and 6 is that groups or individuals acting as ‘knowledge brokers’ can push for improvements on both the evidence-supply side (e.g., communicating research evidence effectively, both by packaging it better and by disseminating it in a more planned way) and on the evidence-demand side (e.g., advocating for the creation of institutional mechanisms that privilege the use of research evidence and building capacity to find and use research evidence efficiently). Knowledge brokers could be individuals, existing agencies, or groups of individuals with some formal linkage between the research and decision-making circles, including those who themselves function as a research unit (for example, the technical unit within a ministry of health). HITAP in Thailand is a good example of an institution with a dual function as a generator of primary research in health economics and health policy, and a knowledge broker through HTA processes where they convene stakeholders including policymakers, clinicians, and civil society. While there is a growing trend to formalize the knowledge broker role (i.e., through formal hires), certain individuals or organizations make effective knowledge brokers because of their structural position in their networks. Social network analysis can help to identify these knowledge brokers as well as their contacts among those working on both the evidence-supply side and evidence-demand side (Shearer et al., 2014).

## **7) How would you measure, evaluate and learn from the use of these approaches?**

Efforts to measure, evaluate and learn from the use of these approaches need to consider some of the key insights that emerged during the workshop:

- a) the goal of using (or supporting the use of) the best available data and research evidence in policymaking may conflict with the incentives for those on the evidence-supply side to support the use of only their own research evidence and to attribute policy decisions to only their own efforts;
- b) ‘easy’ measures of influence like citations in policy documents can be easily gamed, while more robust measures of influence like use in policymaking (e.g., through case

studies drawing on interviews, documentary analysis and media analysis) can require significant resources to do well; and

- c) social network analysis offers promise as one way to measure influence, both in how evidence is shared among members of the network and in how the network itself is re-shaped in response to interventions on the evidence-supply side and evidence-demand side (Shearer et al., 2014).

The first two of these insights suggest that funders have a key role to play in creating incentives for the creation of theories of change for the full suite of groups attempting to support evidence-informed policymaking (or at least those that they fund directly). The approaches outlined in Sections 5 and 6 on both the evidence-supply and demand sides could form the basis of process indicators for measuring the success of activities to support evidence-informed policymaking. Given iDSI's focus on mechanisms that cut across groups, it may be uniquely well positioned to pilot such an approach.

## **Conclusion**

Knowing your context is important because different types of policy decisions and different ways of making and influencing policy decisions likely warrant different approaches to supporting evidence-informed priority setting. Intervening in your context means using proven and promising approaches from the evidence-supply side (i.e., from outside government), the evidence-demand side (i.e., from within government) or both, as well as evaluating and learning from the use of these approaches. The seven questions outlined in this report provide a way to think carefully about both the context for and any intervention in supporting evidence-informed policymaking.

As an illustration of how to apply such insights, iDSI's final presentation included ideas for how it -- in its role as a knowledge broker -- could adjust its approach to supporting evidence-informed priority-setting by giving greater attention to:

- a) working with initiatives on the evidence-supply side to maximize their policy impact (e.g., by identifying potential partners in target countries and advising them about how to elicit and respond to demands from government and how to package and disseminate research evidence in ways that support its use in priority-setting);
- b) working with governments on the evidence-demand side to optimize their use of research evidence in policymaking (e.g., by raising awareness of the importance of evidence-informed priority-setting, supporting the creation and sustainability of robust institutional mechanisms for evidence-informed priority-setting, and building technical capacity for evidence-informed priority-setting);
- c) evaluating iDSI's own impact in terms of its country partners' success in evidence-informed priority-setting; and
- d) supporting collaborations across countries and initiatives.

The final presentations by groups on the evidence-demand side often included substantive adjustments to their goals, approaches, monitoring and evaluation plans, and collaborations with other countries and with local and global initiatives. Examples of adapted goals included supporting evidence-informed policy implementation and not just policy development (Thailand)

and using the best available research evidence systematically and transparently (Ethiopia and Tanzania). Examples of adapted approaches included (exploring) developing a health-technology assessment agency and using both one-stop shops for research evidence and stakeholder dialogues for tacit knowledge and real-world views and experiences (Tanzania) and building technical capacity for, and developing a working group to institutionalize, evidence-informed priority specifically and evidence-informed policymaking more generally (Indonesia). Examples of adapted monitoring and evaluation plans included examining the strength of relationships between researchers and policymakers (Tanzania) and the number of universities actively engaged in a network focused on this type of work (Indonesia). Most of the examples of collaborations with other initiatives related to south-south and south-north learning about promising approaches on the evidence-demand side.

The final presentations by groups on the evidence-supply side also sometimes included substantive adjustments in these four areas, although at times the status quo was perceived to be working well (e.g., producing a global public good). Examples of adapted goals included a greater focus on responding to demands from policymakers at particular moments in time and recognizing the need to respond with a group's own research evidence but also to point policymakers to sources of the other types of research evidence they need. Examples of adapted approaches included co-producing relevant and understandable products and strengthening local engagement efforts (both for co-production and to support the use of the resulting products). Examples of adapted monitoring and evaluation plans in part paralleled the adapted approaches, and included measures of access to needed products and of local engagement, but also included a shift in focus from specific attributions of the impact of an initiative to collective contributions to impact at the country level (and hence to the alignment of theories of change and of monitoring and evaluation plans across initiatives where possible). Most of the examples of collaborations with other initiatives included a prominent role for organizations like the Bill and Melinda Gates Foundation that have the broader view on the entire 'eco-system' or 'steps in the chain' of evidence-informed priority setting (especially on the evidence-supply side but also on the evidence-demand side), that can identify opportunities for avoiding duplication and capitalizing on potential synergies (e.g., offering workshops that address the full spectrum of data analysis, evidence synthesis, and supports for the effective communication and use of data and research evidence), that can share theories of change and monitoring and evaluation plans and push for alignments where possible, and that can provide the types of long-term financial support required to create and sustain the institutional and technical capacity needed for evidence-informed priority-setting.

As I often say at the beginning of a stakeholder dialogue, everyone is probably 'part of the problem' but everyone that participated in the workshop should be a big part of any solution.

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## Appendix 1. List of workshop participants

First Name	Last Name	Company	E-MailID
<b>Workshop facilitators</b>			
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## Appendix 2. Final workshop agenda



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### Workshop on Supporting Evidence-Informed Policymaking

#### Curriculum

**Monday 5 October to Wednesday 7 October 2015**  
**Lead Faculty: John N. Lavis and Jessica Shearer**

#### OVERVIEW OF THE WORKSHOP

This workshop is designed to spur reflection about how initiatives and governments can support evidence-informed policymaking, particularly in the field of priority setting.

#### OBJECTIVES OF THE WORKSHOP

The objectives of the workshop are:

- To become familiar with the topic of evidence-informed policymaking, the challenges to achieving it, the approaches that can be used to support it, and what success looks like
- To appreciate how the nature of these approaches varies by the types of policy decisions being considered and the political and health system contexts in which they're being used
- To identify ways that your initiative or government can better support evidence-informed policymaking in the future and monitor and evaluate its efforts, including coordination between different initiatives and policymakers working in a given country

#### PRE-WORKSHOP TASKS

Please work with other participants from your initiative or government to complete these two tasks by **Thursday 1<sup>st</sup> October**. Send your responses (#1) and PowerPoint (#2) to John Lavis ([lavisj@mcmaster.ca](mailto:lavisj@mcmaster.ca)) and Jessica Shearer ([jshearer@path.org](mailto:jshearer@path.org)):

1. Bullet-point responses to the following questions:
  - o Describe how you'd define 'evidence-informed policymaking' (i.e., how you'd know it if you saw it)
  - o Describe three challenges you've experienced in supporting evidence-informed policymaking

2. Please work with other participants from your organization (or initiative) to prepare a 5-minute slide presentation about your initiative's or government's approaches to supporting evidence-informed policymaking using the PowerPoint template provided.

## **WORKSHOP READINGS**

You will receive a link to a DropBox of relevant resources and readings. You will note in this agenda, below, where those readings will be referred to during presentations and group activities.

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## **Day 1 – Monday 5 October 2015**

### **1:00 - 3:00 Day 1, Session 1**

Title: Welcome, introductions and overview of the workshop

Faculty: John Lavis and Jessica Shearer

Format: Welcome by BMGF (5 minutes)  
Workshop introduction (10 minutes)

Introductions to and brief presentations by 4 teams (20 minutes)

Discussion (25 minutes)

Introductions to and brief presentations by 6 teams (30 minutes)

Discussion (25 minutes)

Objectives:

- To be welcomed by and introduced to the workshop faculty
- To become familiar with the objectives, structure and mix of pedagogical approaches used in the workshop
- To meet fellow workshop participants and hear about the approaches they use to support evidence-informed policymaking

### **3:00-3:15 Health break**

### **3:15 – 4:10 Day 1, Session 2**

Title: What types of policy decisions are you trying to inform with research evidence?

Faculty: John Lavis

Format: Presentation (10 minutes)  
Discussion (45 minutes)

Objectives:

- To discuss examples of the policy decisions that workshop participants are trying to inform with research evidence (e.g., identifying the mix of diseases or conditions that need to be addressed, including a service or drug in a benefit plan, changing the approach to deciding what services and drugs are covered by a benefit plan, strengthening health-system arrangements to get the right mix of covered services and drugs to those who need them)
- To discuss where and how such policy decisions are currently made in the particular countries in which workshop participants currently work (e.g., by a cabinet comprised of elected politicians, the minister of health, the ministry of health, an arms-length body appointed by government, insurance plans or individual healthcare organizations; using a fully systematic and transparent process or something else)

**4:10-5:05 Day 1, Session 3**

- Title: Who and what influences the policy decisions you are trying to inform with research evidence?
- Faculty: John Lavis and Jessica Shearer
- Format: Presentation (10 minutes)  
Small group work at tables and reporting back (45 minutes)
- Objectives:
- To discuss examples of who influences the policy decisions that workshop participants are trying to inform by research evidence (e.g., elected legislators, minister of health, minister's advisors, technical staff in the ministry, professional associations, civil society groups, NGO staff, WHO staff, external review groups, independent researchers, media)
  - To discuss examples of frameworks that assist with identifying the factors that influence whether a topic makes it onto the government's decision agenda and, once there, why a particular policy decision is made (e.g., go versus 'no go', a policy that imposes concentrated benefits but diffuse costs, a policy with no accompanying implementation plan)
  - To practice applying one of these frameworks to a policy topic or policy option your initiative or country is engaged in

**5:05-6:00 Day 1, Session 4**

- Title: How would you define evidence-informed policymaking and what approaches are you using to supporting it?
- Faculty: John Lavis
- Format: Presentation (10 minutes)  
Discussion (45 minutes)
- Objective:
- To compare the definitions of evidence-informed policymaking submitted prior to the workshop and to develop a workable definition for the remaining of the workshop
  - To compare the the goals, activities, indicators and evaluation results submitted prior to the workshop and to elicit preliminary reactions to shared ground and key differences
- Resources
- Lavis JN. Finding and using research evidence. Hamilton, Canada: McMaster Health Forum; 2014
  - Lavis JN. List of SUPPORT Tools for evidence-informed health Policymaking (STP). Hamilton, Canada: McMaster Health Forum; 2014
  - Oliver, K., Innvar, S., Lorenc, T., Woodman, J., & Thomas, J. A systematic review of barriers to and facilitators of the use of evidence by policymakers. BMC health services research, 2014: 14(1), 2

**Day 2 — Tuesday 6 October 2015**

*\*Note that table groupings will change today. Please look for your new table assignment*

**8:30-9:15 Day 2, Session 1**

- Title: Working on the 'supply' side to support evidence-informed policymaking (part 1)
- Faculty: John Lavis
- Format: Presentation (10 minutes)  
Discussion (35 minutes)
- Objectives: – To become familiar with the types of approaches that can be used by those outside government (e.g., arms-length technical bodies, WHO country offices, research institutes, NGOs) to support evidence-informed policymaking within government, and how these approaches relate to the challenges discussed yesterday
- Resources: – Lavis JN, Lomas J, Hamid M, Sewankambo N. Assessing country-level efforts to link research to action. Bulletin of the World Health Organization 2006; 84(8):620-628.

**9:15-10:00 Day 2, Session 2**

- Title: Working on the 'supply' side to support-evidence-informed policymaking (part 2)
- Faculty: John Lavis and Jessica Shearer
- Format: Small group work (30 minutes)  
Reporting back (15 minutes)
- Objectives: – To identify two approaches that the initiative you know best should either continue using or add to its current complement of approaches to supporting evidence-informed policymaking, the reasons why you have prioritized them, and what indicators can be used to measure their success

**10:00-10:15 Health break**

**10:15-11:00 Day 2, Session 3**

- Title: Working on the 'demand' side to support evidence-informed policymaking (part 1)
- Faculty: John Lavis
- Format: Presentation (10 minutes)  
Discussion (35 minutes)

Objectives: - To become familiar with the types of approaches that can be used by those within government (e.g., cabinet, minister's office, legislative committees) to support evidence-informed policymaking within government, and how these approaches relate to the challenges discussed yesterday

**11:00-11:45 Day 2, Session 4**

Title: Working on the 'demand' side to support evidence-informed policymaking (part 2)

Faculty: John Lavis and Jessica Shearer

Format: Small group work (30 minutes)  
Reporting back (15 minutes)

Objectives: - To identify two approaches that the government you know best should either continue using or add to its current complement of approaches to supporting evidence-informed policymaking, the reasons why you have prioritized them, and what indicators can be used to measure their success

**11:45-12:30 Day 2, Session 5**

Title: Working on the interfaces within and between the supply and demand sides to support-evidence-informed policymaking

Faculty: Jessica Shearer

Format: Presentation (10 minutes)

Small group work and reporting back (35 minutes)

Objective: - To become familiar with how social network thinking and stakeholder analysis can be used to understand how research evidence and other types of information are shared among policymakers, and how this influences policy decisions  
- To discuss ways that network thinking can be used to support evidence-informed policymaking in the countries where you work

Resources: - Network 2-pager  
- Shearer, JC, Dion, M, & Lavis, JN. Exchanging and using research evidence in health policy networks: a statistical network analysis. Implementation Science, 2014: 9(1), 126.

**12:30-1:30 Lunch**

**1:30-2:30 Day 2, Session 6**

- Title: Case study of supporting evidence-informed policymaking when individual services and drugs are a focus
- Faculty: Peter Littlejohns
- Format: Presentation (15 minutes)  
Discussion (45 minutes)
- Objective:
- To understand how the NICE model and its variants in other countries (e.g., CADTH, HITAP, PBAC, PHARMAC) responds to the challenges in supporting a particular type of evidence-informed policymaking
  - To identify the strengths and weaknesses of the model, what evaluations of it have taught us, and whether and how it became institutionalized
  - To discuss the broader applicability of the model and potential alternatives that would be more broadly applicable for this particular type of evidence-informed policymaking
- Resources:
- The Alliance for Useful Evidence, Nesta and NICE. The NICE Way: Lessons for social policy and practice from the National Institute for Health and Care Excellence. London, UK: NICE, October 2013.

**2:30-2:45 Health break**

**2:45-4:15 Day 2, Session 7**

- Title: Case study of supporting evidence-informed policymaking when strengthening health-system arrangements is the focus
- Faculty: Somsak Chunharas and John Lavis
- Format: Presentation 1 (15 minutes)  
Presentation 2 (15 minutes)  
Discussion (60 minutes)
- Objective:
- To understand how the Thai model and its variants in other countries (e.g., Vietnam) responds to the challenges in supporting a particular type of evidence-informed policymaking
  - To identify the strengths and weaknesses of the model, what evaluations of it have taught us, and whether and how it became institutionalized
  - To discuss the broader applicability of the model and potential alternatives that would be more broadly applicable for this particular type of evidence-informed policymaking
  - To understand how the EVIPNet model (e.g., EVIPNet Chile, REACH Uganda, K2P Center, McMaster Health Forum) responds to the challenges in supporting a particular type of evidence-informed policymaking
  - To identify the strengths and weaknesses of the model, what evaluations of it have taught us, and whether and how it became institutionalized
  - To discuss the broader applicability of the model and potential alternatives that would be more broadly applicable for this particular type of evidence-informed policymaking

- Resources:
- Lavis JN. Evidence-Informed Policy Networks (EVIPNet) Ten Years On. Hamilton, Canada: McMaster Health Forum, 2015.
  - Moat KA, Lavis JN, Clancy SJ, El-Jardali F, Pantoja T, Knowledge Translation Platform Evaluation study team. Assessing views about and intentions to act on evidence briefs and deliberative dialogues across a range of countries, issues and groups. Bulletin of the World Health Organization 2014; 92:20–28.

**4:15-5:00** Group work to prepare for 5-minute presentation on Wednesday

**6:30** Group dinner off-site

### **Day 3 – Wednesday 7 October 2015**

#### **8:30-9:30 Day 3, Session 1**

Title: Plans for supporting evidence-informed policymaking (part 1)

Faculty: John Lavis and Jessica Shearer

Format: Presentation by five teams (5 minutes each)  
Discussion (30 minutes)

Objectives: – To hear from and provide constructive feedback to participating organizations about how they plan to incorporate what they've learned from the workshop in their future efforts to support evidence-informed policymaking (in terms of both approaches and monitoring & evaluation)

#### **9:30-10:30 Day 3, Session 2**

Title: Plans for supporting evidence-informed policymaking (part 2)

Faculty: John Lavis and Jessica Shearer

Format: Presentation by five teams (5 minutes each)  
Discussion (30 minutes)

Objectives: – To hear from and provide constructive feedback to participating organizations about how they plan to incorporate what they've learned from the workshop in their future efforts to support evidence-informed policymaking (in terms of both approaches and monitoring & evaluation)

#### **10:30-10:45 Health break**

**10:45-11:30 Day 3, Session 3**

Title: Plans for supporting evidence-informed policymaking (part 3)

Moderator: Damian Walker

Format: Facilitated discussion (30 minutes)

Objectives: – To identify areas of synergy and complementarity in the proposed future efforts to support evidence-informed policymaking

**11:30-12:00 Day 3, Session 4**

Title: Reflections on measuring, evaluating, and learning from supporting evidence-informed policymaking

Faculty: John Lavis and Jessica Shearer

Format: Presentation by Sujata Mishra (DCP-3/DESH) (5 minutes)

Presentation by Sam McPherson and Martin Belcher (Itad) (10 minutes)

Discussion (15 minutes)

Objectives: – To discuss possible next steps for supporting evidence-informed policymaking in the field of priority setting and for monitoring and evaluating these efforts

**12:00-1:00 Lunch**