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TOWARDS A CULTURE OF EVIDENCE-INFORMED POLICY

REPORT OF THE SIXTH EVIPNET EUROPE MULTICOUNTRY MEETING

3–5 SEPTEMBER 2019, ISTANBUL, TURKEY

The Evidence-informed Policy Network (EVIPNet) Europe

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Towards a culture of evidence-informed policy: Report of the Sixth EVIPNet Europe Multicountry Meeting

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EVIPNet
EVIDENCE-INFORMED POLICY NETWORK

TOWARDS A CULTURE OF EVIDENCE-INFORMED POLICY

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ABSTRACT

The Evidence-informed Policy Network (EVIPNet) Europe is an initiative of the WHO Regional Office for Europe. It was established to build and institutionalize capacity in knowledge translation (KT) at the country level through the establishment of knowledge translation platforms (KTPs). To date, EVIPNet Europe has brought together multiple country champions in a series of six multicountry meetings, the last of which was held in Istanbul, Turkey in September 2019. This meeting highlighted recent achievements at all stages of the EVIPNet Europe action cycle – situation analyses, evidence briefs for policy and policy dialogues – across the Network, thus allowing members to share experiences and to gain from lessons learnt. To further develop participants' abilities in facilitating evidence-informed policy-making (EIP), participants engaged in a series of sessions hosted by the McMaster Health Forum, which sought to guide and facilitate the production of rapid syntheses. Furthermore, Network members were introduced to the concept of the cultural contexts of health (CCH) as a lens through which to better understand and promote health and well-being. Participants also brainstormed in groups on how best to sustain EIP efforts through the setting up of a national KT infrastructure, and develop country EIP workplans. A tool for rapid case study evaluation was presented, as well as feedback on its pilot implementation by three countries. Future goals include moving towards a more systematic consideration of CCH in EIP efforts and working towards institutionalizing KTPs at the country level. A partnership with Cochrane Nordic is in the offing, with Cochrane Nordic planning to organize training in EVIPNet Europe member countries.

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ABBREVIATIONS

AMR	antimicrobial resistance
AMSTAR	A MeaSurement Tool to Assess systematic Reviews
CCH	cultural contexts of health
DFID	Department for International Development
EIHPM	evidence-informed health policy-making
EIP	evidence-informed policy-making
EBP	evidence-based brief for policy
EHII	European Health Information Initiative
EPPI-Centre	The Evidence for Policy and Practice Information and Co-ordinating Centre
EVIPNet	Evidence-informed Policy Network
GPW	General Programme of Work
GRADE	Grading of Recommendation Assessment, Development and Evaluation
HINARI	Health InterNetwork Access to Research Initiative
IBM	International Business Machines
KT	knowledge translation
KTP	knowledge translation platform
LTCF	long-term care facilities
OECD	Organisation for Economic Co-operation and Development
PD	policy dialogue
SA	situation analysis
UK	United Kingdom
UNESCO	United Nations Educational, Scientific and Cultural Organization
WHO	World Health Organization

EXECUTIVE SUMMARY

In today's information age, policy-makers are confronted with an information and evidence overload, challenging their ability to filter relevant information for decision-making. The usefulness of evidence is, however, contingent upon it being applied in policy and practice. To this end, knowledge translation (KT) has been proposed as a discipline that seeks to strengthen the interface between research and policy.

The Evidence-informed Policy Network (EVIPNet) was established in 2005 as a global initiative with a mandate to build and institutionalize country capacity in KT. At the end of 2012, EVIPNet Europe was launched in the WHO European Region, under the aegis of the WHO European Health Information Initiative (EHII). EVIPNet Europe fosters through its activities the implementation of the European policy framework Health 2020, the United Nations Sustainable Development Goals and the Action Plan to enhance the use of evidence, information and research for policy-making in the WHO European Region. This regional network provides assistance and capacity-building support to its members, inter alia, through multicountry meetings, webinars, technical advice and networking opportunities to share experiences.

The sixth multicountry meeting of EVIPNet Europe took place in Istanbul, Turkey in September 2019. This meeting welcomed two new Member States to the Network. Meeting participants were familiarized with the methods, tools and resources to develop rapid syntheses, bringing together the best available evidence on a specific high-priority health policy issue. Participants were also familiarized with the various methods used in social sciences research and how these complement quantitative methods such as randomized controlled trials. This blending of the quantitative and qualitative is particularly germane with regard to considering the cultural contexts of health (CCH) and how such factors underscore overall health and well-being. In conjunction with these two main foci, participants were encouraged to institute knowledge translation platforms (KTPs) in their home countries, so that the movement towards EIP might become strongly embedded in the working cultures of both researchers and policy-makers.

Key outputs of the meeting included finalizing an evaluation tool, completing drafts of national workplans with a focus on EIP, and learning how to complete a rapid synthesis on a country-specific high-priority topic (per country). Participants left the meeting with a growing appreciation that cultural contexts could act as an enabler in KT activities in their respective countries.

The next steps for implementing EVIPNet Europe's work is expected to expand greatly over the next year due to new partnerships, including with Cochrane Nordic, whose representatives attended the meeting as observers. As a result of Cochrane Nordic's attendance at the event, closer collaboration between EVIPNet Europe member countries and Cochrane is expected to be established. This partnership will greatly widen the scope and depth of EVIPNet Europe's work, strengthen ties and help to deliver meaningful and useful outputs.

1. INTRODUCTION

1.1 BACKGROUND

The establishment of the Evidence-informed Policy Network (EVIPNet) was a direct response to the 2005 World Health Assembly resolution WHA58.34 that urged the Director-General "to assist in the development of more effective mechanisms to bridge the divide between ways in which knowledge is generated and ways in which it is used, including the transformation of health-research findings into policy and practice" **(1)**. Thus, in conjunction with "the global scientific community, international partners, the private sector, civil society, and other relevant stakeholders", EVIPNet was given the mandate "to strengthen or establish the transfer of knowledge in order to communicate, improve access to, and promote use of, reliable, relevant, unbiased, and timely health information"**(1)**.

1.2 WHAT IS EVIPNET EUROPE?

"EVIPNet is something we like to do and we want to continue doing it. It is our opinion that we should be using this type of approach more often to further improve our skills. This is very logical."

Polonca Truden (Slovenia)

Following the establishment of EVIPNet in other WHO regions of the world, EVIPNet Europe was launched in 2012 by the WHO Regional Office for Europe with the specific aim of building country and regional capacity in knowledge translation (KT).

The Action Plan to strengthen the use of evidence, information and research for policy-making in the WHO European Region **(2)** provides EVIPNet Europe with the explicit mandate to strengthen the evidence-informed policy-making (EIP) capacity of the 53 Member States in the WHO European Region. The new WHO General Programme of Work (GPW) 2019–2023 **(3)** renews the need for initiatives such as EVIPNet Europe to provide support at the country level for more effectively formulating and implementing health policies in view of achieving the organizational triple billion goals of 1 billion more people benefiting from universal health coverage; 1 billion more people better protected from health emergencies; and 1 billion more people enjoying better health and well-being.

EVIPNet Europe promotes EIP that is responsive to local contexts, needs and priorities. Its portfolio of EIP activities at the country level include:

- conducting EVIPNet Europe situation analyses (SA) to assess the country context of EIP, the driving factors, barriers and key actors;
- developing evidence briefs for policy (EBP), which synthesize the best available research evidence to answer a specific policy problem in a concise way, written in user-friendly, non-expert language and adapted to various stakeholders. EBPs are based on a systematic search and appraisal of the global, regional and local evidence to understand what is known about that policy issue and which policy options effectively address the issue; and
- organizing policy dialogues (PD), which are deliberative dialogues during which the tacit (experience-based) knowledge of all key stakeholders affecting or being affected by the key priority issue dealt with in the EBP is collected to guide policy development **(4)**.

At the regional level, EVIPNet Europe convenes annual multicountry meetings that serve to promote EIP commitment and enhance KT **institutionalization (5)**, inter alia, through peer support and mentoring of newcomers to the Network by more experienced Member States. It is hoped that such combined initiatives will broker enduring horizontal partnerships and networking between EVIPNet Europe member countries, as well as vertical linkages between the WHO Secretariat of EVIPNet Europe and member countries.

Tanja Kuchenmüller,[1] leading the WHO Secretariat of EVIPNet Europe, and Ursu Pavel (WHO Representative, Turkey) welcomed the participants, including two new member countries (Austria and Turkey), to the Sixth EVIPNet Europe multicountry meeting. The opening session provided a general overview of EVIPNet Europe, its mandate, tools and activities as well as its progress. As the WHO Regional Office for Europe was the last to launch EVIPNet activities among other WHO regions, this allowed it the distinctive advantage of being able to capitalize upon the experience gained from its counterpart networks in other regions. While 13 member countries met in Turkey for the inaugural multicountry meeting of EVIPNet Europe in 2013 **(6)**, the Network has since grown to comprise 21 member countries and has hosted four further multicountry meetings, which took place in Slovenia (2014) **(7)**, Lithuania (2015) **(8)**, Moldova (2016) **(9)** and Slovakia (2017) **(10)**.

1 Unit Leader, Knowledge Management, Evidence and Research for Policy-Making, Division of Information, Evidence, Research and Innovation, WHO Regional Office for Europe

"The power of good meetings is the enthusiasm of the chair. Tanja brings out the best in people. The most important part of these meetings is the increased motivation. It's like returning to school with an inspiring teacher."

Sead Zeynel (North Macedonia)

Countries joining the Network can benefit from a community of practice, as well as technical assistance and peer support. EVIPNet has a variety of tools and networks to promote KT in the European Region (see **(4)**). Beyond capacity-building, the explicit goal of EVIPNet Europe is for countries to promote a culture more favourable to KT at national and regional levels. This requires institutionalization of KT via knowledge translation platforms (KTPs), which are formalized networks of key national actors charged with planning and implementing KT activities and interventions **(4)**.

1.3 THE SIXTH MULTICOUNTRY MEETING

MEETING OBJECTIVES

The primary objectives of the meeting were threefold:

1. To build the technical capacity of Network members in conducting rapid syntheses to inform policy-making;
2. To consider the synergies at the interface of CCH and EIP; and
3. To discuss and explore strategies to institutionalize the work of EIP and EVIPNet Europe teams in each member country.

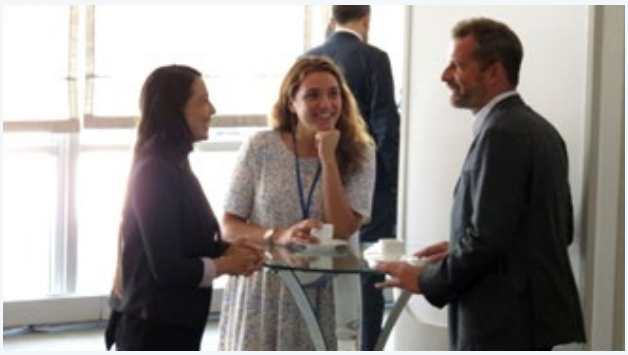
ORGANIZATION OF THE REPORT

In accordance with these objectives, this meeting report (a) introduces the lessons learnt on EIP country activities; (b) presents an overview of the rapid response synthesis sessions via an in-depth series of sessions facilitated by Michael Wilson of the McMaster University Health Forum, as well as a pilot experience in a country in the Americas; (c) documents the exchange of experiences, lessons learnt and good practices, including the successful experiences of countries; and (d) provides an introduction to the synergies at the interface of CCH and EIP through a new collaboration with the CCH initiative at the WHO Regional Office for Europe. These sessions were led by Nils Fietje, head of CCH, and Felicity Thomas, co-director of the WHO Collaborating Centre on Culture and Health[2]; (e) discusses the institutionalization of KT via KTPs; (f) presents a new tool

2 Senior Research Fellow at Exeter University http://cultureandhealth.exeter.ac.uk/

for EBP evaluation; and (g) highlights progress on workplans that will be implemented with the support of EVIPNet Europe.

BOX 1. A CLOSER COLLABORATION BETWEEN EVIPNET EUROPE MEMBER COUNTRIES AND COCHRANE



Forging a partnership © WHO/Mustafa Guzel

"Everybody is entitled to health care that is informed by the best available evidence, no matter where you live in the world. The work of EVIPNet Europe to bring evidence into practice and adapt it to local conditions is therefore a cornerstone of optimal health care and resource use."

Karsten Juhl Jørgensen,
Acting director, Nordic Cochrane Centre

The acting Director of Cochrane Nordic,[3] Karsten Juhl Jørgensen and his communications officer, Dina Muscat Meng, attended the EVIPNet Europe multicountry meeting as observers. One of the outcomes of the meeting is the closer collaboration that Cochrane Nordic will establish with EVIPNet Europe member countries. With the ultimate aim of establishing a Cochrane Baltic, Cochrane Nordic is co-organizing a Cochrane workshop in Estonia that will take place in early 2020.

3 The Nordic Cochrane Centre is a regional centre contributing to evidence-based decision-making in health care by producing high-quality independent research and systematic reviews that are free from commercial sponsorship.
The Centre is hosted by Rigshospitalet in Copenhagen, Denmark. There are associate centres in Finland, Norway, Poland, Russia and Sweden. (https://nordic.cochrane.org/nordic-cochrane-centre-copenhagen)

TECHNICAL SESSIONS

2. LESSONS LEARNT FROM EIP COUNTRY ACTIVITIES

Sharing good practices and lessons learnt among Network member countries is a cornerstone of EVIPNet Europe activities. During this session, three EVIPNet Europe country champions presented their experiences in implementing key EVIPNet Europe KT activities – the conducting of an SA, development of an EBP and organization of a PD **(4)**.

2.1 CASE STUDY I: DEVELOPING AN SA IN ESTONIA

In Estonia, EVIPNet activities started in 2013 with a capacity-building workshop where a number of policy-makers and researchers met to raise awareness on the tools and resources available to health system policy-makers and stakeholders. These would support their use of research evidence, enhance skills in acquiring, assessing, adapting and applying research evidence, and learn how to prepare EBPs. As a result, in 2015–2016, the national team, with the support of the WHO Secretariat of EVIPNet Europe and its partners, prepared its first EBP on the negative health impact of the consumption of sugar-sweetened beverages **(11)**. Since every third child in Estonia is now overweight, this is a significant challenge to health policy-makers in a country that had previously enjoyed one of the lowest incidences of child overweight and obesity in Europe. The experiences from this first EBP showed that there is a lack of relevant structures and experienced specialists that would allow KT and regular preparation of EBPs and thus EBPs could only be carried out case by case.

Understanding the usefulness of EBPs in improving policy-making, work on an SA **(12)** was initiated in January 2018 to identify a suitable mechanism to institutionalize KT work at the country level and to systematize the development of EBPs. Angela Ivask explained that the SA was expected to describe and analyse the local context that potentially enables or hinders

the EIP process, and to deliver sufficient background information with which to guide deliberations on the organizational form, location and strategic direction for a suitable and sustainable KTP.

The core team for Estonia's SA consisted of five members from the departments of Health Systems Development and Analysis and Statistics of the Ministry of Social Affairs, and one member from the WHO country office. Data collection was carried out between November 2018 and February 2019. Various literature sources were searched, and six interviews and fifteen consultations were carried out via written, face-to-face or phone communications. The final draft SA report was presented at a stakeholder consultation in June 2019 to validate and further deliberate on the findings. All stakeholders expressed their support for the SA and agreed with the findings. In the near future, Estonia seeks to hold a broader political discussion on the findings revealed by the SA (see Box 2), and to further develop proposals on the future structure of a KTP.

BOX 2. LESSONS LEARNT FROM CONDUCTING AN SA IN ESTONIA

During the EBP process, a critical lack of relevant structures, experienced specialists and financing were identified as key barriers to systematically integrating EIP into Estonian policy processes. Similar challenges were observed during the conduct of the SA, as well as additional impediments, including the following:

- inadequate national guidance on the nature of the evidence that should be used in the EIP process by policy-makers;
- a lack of time or skills to find and interpret evidence among policy-makers;
- no formal communication platform for researchers and policy-makers;
- insufficient financial resources for analyses and studies;
- no structure or person responsible for EIP due to staff turnover;
- underestimation of the amount of time needed to conduct an SA.

To overcome these challenges, numerous measures to improve the EIP process, in general, were suggested, including the following:

- dedicating a structure or person responsible for EIP;
- conducting training for researchers and policy-makers on EIP and its tools;
- creating networks between researchers and policy-makers.

2.2 CASE STUDY II: DEVELOPING AN EBP IN THE REPUBLIC OF MOLDOVA

As one of the first countries to join the Network, Moldova presents important progress in the implementation of EVIPNet Europe activities. In this session, Marcela Ţîrdea described her country's experience in developing an EBP to reduce children's access to alcohol. Central to the problem of high alcohol consumption by children is a lack of properly implemented regulations, compounded by the consideration of beer as food rather than as alcohol. In support of this topic, the Government of the Republic of Moldova established the Government Programme of Activity to strengthen the control of alcohol regulations **(13)**.

To develop the EBP, a working group comprising policy-makers, researchers and civil society representatives (including youth organizations) was formed under the leadership of the Ministry of Health in 2015. Local evidence was sourced from the grey literature, while international evidence was primarily based on systematic reviews. Support was provided by the WHO Secretariat of EVIPNet Europe, which delivered multicountry and country-specific capacity-building training that significantly increased the working group's ability to access, synthesize and apply evidence. The additional training and technical support on EBP that the team received from the Knowledge to Policy Center, American University, Lebanon, as well as additional assistance provided via two training sessions on Health InterNetwork Access to Research Initiative (HINARI), contributed substantially to the success of the EBP.

In 2015, a first draft of the EBP was presented to key stakeholders at a deliberative consultation, where participants recommended that the focus of the EBP should be redirected towards specifically amending the alcohol control legislation, together with the inclusion of additional local evidence and input from those in the non-health sectors. In consultation with the WHO Secretariat of EVIPNet Europe and the WHO Country Office, it was decided that additional support be provided to the working group in the form of mentoring by Dr Fadi El-Jardali of the Knowledge to Policy Center in Lebanon.[4] The draft EBP was finalized in 2017 and deliberated at a PD with the participation of stakeholders from the sectors of education, agriculture,

4 https://www.aub.edu.lb/k2p/pages/default.aspx

tourism, media, etc. The outcome of this long EBP process (see Box 3) was the revision of Moldova's alcohol control legislation by Parliament.

BOX 3. LESSONS LEARNT FROM CONDUCTING AN EBP IN MOLDOVA

Key challenges identified by Moldova included the following:

- a lack of political stability, e.g. three governments in 2015;
- high specialist turnover;
- weak institutional capacities in EIP and information exchange;
- no financial resources dedicated to EIP and underfinanced research area;
- limited reliability of local evidence.

Countering these challenges was aided by several mechanisms, including the following:

- sharing and using the knowledge, methods and tools acquired in the capacity-building events organized by EVIPNet Europe, as EVIPNet Europe methods and tools provide support in promoting and approving the most difficult public policy;
- collaborating and communicating between national focal points, WHO Country Office and WHO Secretariat of EVIPNet Europe;
- creating formal and informal partnerships with researchers, civil society representatives and colleagues from other public authorities;
- using HINARI to ensure access to international evidence and to overcome the lack of local evidence;
- using any opportunity to promote the use of evidence in policy-making.

2.3 CASE STUDY III: DEVELOPING A PD IN SLOVENIA

Polonca Truden and Maja Šubelj reported on Slovenia's experience in conducting a PD. Previously, her group had completed an EBP on antibiotic prescribing in long-term care facilities (LTCF) for the elderly **(14)**, with the objective of informing antimicrobial stewardship strategies in tackling the growing crisis of antimicrobial resistance (AMR)[5] in LTCF **(15)**. Here, their primary objective was to address the lack of monitoring of antibiotic use, particularly the lack of communication between doctors and nurses working in these facilities.

To organize the PD, two experts from the National Institute of Public Health were nominated by the Ministry of Health. The WHO Secretariat

5 https://www.who.int/antimicrobial-resistance/en/

of EVIPNet Europe provided continuous guidance, capacity-building and technical support to the PD team, while the WHO Country Office assisted the process by professional encouragement, administrative/logistics and financial support; the National Institute of Public Health (NIJZ) provided organizational support. In terms of tools, in particular, the EVIPNet Europe Policy Dialogue Preparation and Facilitation Checklist **(16)** as well as the SUPPORT tools **(17)** and sure Guides **(18)** were drawn upon to organize the PD. PD facilitators were selected based on their long-standing expertise in and championship of AMR, and high-level role/influence and experience in dialogue with decision-makers, while key stakeholders were selected from a range of sectors, including primary care, infectious diseases, nursing and long-term care, with senior/high-level participants.

As a result of the PD (see Box 4), all three policy options are seen as indispensable in Slovenia for improving the prescription of antibiotics in LTCF and are foreseen to be included in the revision of the national AMR strategy. Future recommendations for implementation include: placing AMR even higher on the political agenda while ensuring buy-in from all relevant political decision-makers; promoting strategies to strengthen communication and advocacy, including policy and media tracing, to influence policy formulation to reduce AMR and its implementation in LTCF; building of institutional bridges between ministries and within LTCFs; and encouraging the Ministry of Health to establish a unified approach to long-term care rather than addressing issues pertaining to this area within three separate health directorates.

BOX 4. LESSONS LEARNT FROM CONDUCTING A PD IN SLOVENIA

Challenges during the PD process in Slovenia included the following:

- too few pre-interactions with key stakeholders prior to the PD;
- insufficient clarity on the roles and responsibilities of the coordination team regarding follow-up activities;
- insufficient institutional engagement and management support.

Conducting an effective PD resulted in the following observations:

- Complex issues need a multilevel and multisectoral approach as sociological and cultural factors play a significant role.
- Local evidence should always be integrated to propose the most relevant options.
- Support and communication within the working group catalyses work progress and outcomes.
- Participation of high-level stakeholders throughout the process is necessary to move the process further.
- The early and ongoing involvement of stakeholders is necessary to encourage investment/impact as engagement/liability.

3. CONDUCTING RAPID SYNTHESES

A major focus of the sixth EVIPNet Europe multicountry meeting was on strengthening the technical capacity of Network members in conducting rapid syntheses to inform policy-making. Given that system leaders (policy-makers and stakeholders) have to frequently address urgent health or social system questions, the focus has increased on conducting rapid syntheses as one part of larger efforts to support EIP. A rapid synthesis is a synthesis of research evidence that is produced in a time frame that is aligned with policy-makers' needs, ranging from several days to a few weeks. As is the case for other KT mechanisms, a rapid synthesis is developed upon the explicit request of policy-makers about a specific, high-priority, health- or social-system question. It can: (i) clarify a problem and its causes; (ii) frame options for addressing it; (iii) identify implementation considerations; or (iv) inform monitoring and evaluation plans.

Conducting rapid syntheses should be underpinned by a commitment to being systematic and transparent in identifying and synthesizing evidence and insights for health and social system leaders. In order for such analyses to be completed, good real-time project management is of the essence. Moreover, rapid syntheses should be an important component of support for rapid-learning health systems (see Box 7), which aim to be data-driven, patient-centred and constantly evolving. Such evolvability permits them to be responsive to urgent requests through flexibility in terms of timeline and the types of evidence and insights included.

A growing body of literature suggests that rapid syntheses are effective means of increasing the uptake of evidence **(19)**; as such, they have been utilized successfully in several countries, including in the Americas (see Box 5) **(20)**.

BOX 5. PIONEERING A RAPID RESPONSE SERVICE IN THE AMERICAS

A success story in EIP, Evelina Chapman[6] of the WHO Secretariat of EVIPNet Europe was instrumental in implementing a pilot rapid response service programme launched in Buenos Aires, Argentina. Central to the success of the pilot was the development of three types of rapid response reports using methodological shortcuts, which were found to have increased confidence on evidence and communication with all stakeholders and decreased uncertainty in the decision-maker. In particular, the pilot programme demonstrated that rapid response reports are especially valuable and effective when evidence is scarce.

Source: Evelina Chapman. Pilot experience of the Evidence-informed Rapid Response Program to support Health Management (PRRIEG). Ministry of Health, Buenos Aires, Argentina. Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 3 September 2019.

3.1 CONDUCTING A POLICY ANALYSIS IN THREE DAYS: RAPID EVIDENCE SYNTHESIS

At the sixth EVIPNet Europe multicountry meeting, a series of sessions hosted by Michael Wilson (McMaster Health Forum) provided participants with the steps needed to systematically and transparently conduct a rapid synthesis on a pressing health system issue of relevance to their country. To enable participants to work on timelines conducive to the needs of often-rushed policy-makers, the goal of this practical session was for participants to prepare a rigorous synthesis of the best available evidence over three business days. The "hands-on" sessions were supported through real-time individualized feedback from the workshop facilitator. The groups were asked to prepare a presentation based on their rapid synthesis using an approach that could be harnessed to brief senior policy-makers in their respective governments. Research topics selected by country teams included interventions to prevent youth alcohol consumption, the efficacy of individual lifestyle counselling on smoking in the general population and a comparison of approaches to increase the uptake of measles–mumps–rubella vaccinations.

6 Former coordinator of EVIPNet Americas for six years and a former Vice-Minister of Health in Buenos Aires, Argentina

Overall, this session aimed to achieve the following objectives within the constraints of conducting a policy analysis:

- to identify where to search for relevant and high-quality evidence when faced with a pressing health system issue;
- to develop and refine searches for evidence to include in a rapid synthesis, identify relevant systematic reviews to include and begin data extraction.

Some pointers regarding an efficient rapid synthesis process include the following:

- soliciting the advice of at least two experts for insights;
- formulating questions well, possibly requiring a scoping exercise;
- taking into account A MeaSurement Tool to Assess systematic Reviews (AMSTAR) scores (see Box 6), which assess the quality of the review.
- incorporating the grey literature;
- selecting the most recent systematic reviews in order to avoid double counting of studies;
- conducting jurisdictional scans.

BOX 6. AMSTAR AND GRADE

A high AMSTAR **(21)** score means that the systematic review was conducted to a high standard. This does not, however, mean that the evidence summarized in the review is of a high standard. For instance, the review may not contain any eligible studies (i.e. it is an "empty" review). Alternatively, the included studies may be of low quality (i.e. methodologically weak). GRADE, however, rates the quality of the evidence (as opposed to the quality of the systematic review) **(22)**. It is used in some of the user-friendly summaries of systematic reviews (e.g. SUPPORT summaries) that are linked to one-stop shops such as Health Systems Evidence (to see the quality of evidence, look for a link to a SUPPORT summary). Readers of a systematic review will also need to ask themselves whether the review is locally applicable.

Source: Michael G. Wilson, PhD, Associate Professor and Assistant Director, McMaster Health Forum, McMaster University. EVIPNet Rapid Synthesis Workshop – Sessions #11 & 12. "Hands on" sessions about producing a rapid synthesis; Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 4 September 2019.

3.2 LESSONS LEARNT IN CONDUCTING A RAPID SYNTHESIS

Attendees were invited to prepare a brief presentation on their rapid syntheses to obtain feedback on the approaches they had applied and the evidence gathered. This feedback session also focused on the identification of key lessons learnt, which included the need for efficient division of labour, good communication, clear questions and the inclusion of all relevant findings, not just the ones that might be politically expedient at the time. Participants expressed great interest in applying their newly acquired skills in rapid synthesis to working on real-world problems when they returned to their home countries. For some, the advantage of rapid synthesis was that they presented an abbreviated format much more applicable to policy-makers' needs than lengthy reports. Additionally, presenting the rapid synthesis methodology could encourage policy-makers themselves to seek transparency in the briefs that they receive.

As rapid synthesis is being recognized as a useful and important tool in view of strengthening EIP at the country level (see Box 7), the WHO Secretariat of EVIPNet Europe will increasingly focus its activities on supporting its member countries in effectively applying this EIP mechanism. This includes providing assistance in setting up national rapid response units for which some member countries have already officially submitted a request.

RR session facilitated by Michael Wilson © WHO/Mustafa Guzel

BOX 7. RAPID-LEARNING HEALTH SYSTEMS

At the outset, rapid learning health systems were devised as a potential means of filling knowledge gaps through mass analysis of electronic health records **(23)**. Today, however, their use has shifted to rather encompass a data-driven, product-centred, system-supported and culture- and competency-enabled combination of health systems and research systems **(24)**. Here, the term "rapid learning" applies to the fact that policy initiatives require political and social capital for institutionalization and are expected to require small changes throughout the process. In other words, policy initiatives are a constant cycle of small refinements, with the inherent expectation that one is unlikely to get them right the first time, or for the initiative to work well all the time.

Rapid learning health systems require the following three types of analyses (and evidence sources):

- policy analysis (a synthesis of best-available evidence – systematic reviews and primary studies when needed – and insights from key informants about benefits, harms and adaptations needed for policy options);
- system analysis (policy documents, websites, data and insights from key informants about how systems work and how to do things differently);
- political analysis (policy documents, websites and insights from key informants to identify factors that affect government agenda-setting and policy choices).

Sources: **(23,24)** & Michael G. Wilson, PhD, Associate Professor and Assistant Director, McMaster Health Forum, McMaster University. EVIPNet Rapid Synthesis Workshop – Sessions #5 & 6. Importance of conducting rapid syntheses to inform policy and their importance for rapid-learning health systems. Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 3 September 2019.

4. A PARTNERSHIP BETWEEN CCH AND EVIPNET EUROPE

Awareness of cultural contexts is vital for effective KT, as successful uptake of evidence in policy is dependent on good understanding of the cultures of study participants, researchers and policy-makers. Today, there is growing appreciation for the myriad ways in which cultural contexts intersect with health **(25)**. Incorporating cultural contexts requires different types of evidence and research methods. These include the use of non-traditional data sources such as qualitative evidence and narrative studies. While culture has always been central to the work of EVIPNet Europe, no specific tools or approaches have yet been developed by EVIPNet Europe in this area.

Hosted at the WHO Regional Office for Europe, the CCH project aims to enhance public health policy-making through a nuanced understanding of how cultural contexts affect health and health care in four key areas: nutrition, migration, environment and mental health **(15,26)**. To date, CCH has hosted five expert group meetings and works in collaboration with bodies such as the United Nations Educational, Scientific and Cultural Organization (UNESCO), the Organisation for Economic Co-operation and Development (OECD), the Wellcome Trust and the Robert Wood Johnson Foundation. Today, CCH aims to scale up the implementation of activities at the country-level in Member States. As per the 2018 CCH expert group meeting **(27)**, this move involves a partnership with EVIPNet Europe that integrates CCH evidence into policy-making while enhancing KT mechanisms.

CCH panel discussion with country champions © WHO/Mustafa Guzel

Thus, the meeting in Istanbul was a unique opportunity to explore the interface between CCH and KT. The CCH session was divided into two parts: (a) a general overview presented by Nils Fietje of how cultural contexts affect health and well-being, combined with a panel discussion in which champions discussed their country-level perspectives on including culture in KT activities, and (b) a detailed presentation on the dynamic nature of culture by Felicity Thomas, followed by hands-on work.

4.1 WHAT IS CULTURE AND WHY DOES IT MATTER?

"While culture is something that is shared across groups of people, it is not a static set of beliefs and practices, but rather an ever- emerging array of collective values, ethics, assumptions and ideals."

Felicity Thomas

The term culture itself has been subject to a multiplicity of definitions (see Table 1). Culture is not a static set of beliefs and practices but is instead dynamic. Culture is all encompassing and does not merely equate with categorizations of ethnicity or race. Studies of culture and health thus necessitate an understanding of cultural beliefs, values and norms over time and across space, and their impact on health behaviours and outcomes. Experiences of health and well-being are inextricably influenced by cultural contexts that, concurrently, inform the beliefs and actions of people, policy-makers and health-care practitioners (see Box 8). As a consequence, improving health outcomes is dependent upon health providers recognizing and understanding the sociocultural conditions that enable people to be healthy.

4.2 A CCH APPROACH IS MULTIDISCIPLINARY

"To inform the implementation of Health 2020 adequately, data collections need to be strengthened and new health monitoring approaches need to be explored. These include the use of non-traditional data sources such as qualitative evidence and narrative studies."

European Health Report, WHO 2015

Understanding cultural contexts requires us to consider a wide range of evidence. Yet even today, health policy and practice continue to often rely on particular forms of evidence at the expense of others, a bias underlain by the predominating view that the humanities and social sciences are less valid than scientific fact due to their focus on opinion and experience. It is necessary to recognize that all forms of knowledge and practice – from the scientific and medical (such as systematic reviews and randomized controlled trials) to qualitative methods (such as narratives) – are duly influenced by culture. Indeed, our understanding of the subjective beliefs

TABLE 1. A DIVERSITY OF DEFINITIONS ON CULTURE

A DIVERSITY OF DEFINITIONS ON CULTURE	
Culture is the set of distinctive spiritual, material, intellectual and emotional features of society or a social group, encompassing art and literature, lifestyles, ways of living together, value systems, traditions and beliefs.	UNESCO Universal Declaration on Cultural Diversity, 2001
Culture is a matrix of infinite possibilities and choice.	Wole Soyinka
Culture is ... conventional understandings, manifest in act and artefact.	Robert Redfield, 1941
[Culture is] the shared, overt and covert understandings that constitute conventions and practices, and the ideas, symbols, and concrete artefacts that sustain conventions and practices, and make them meaningful.	Napier et al., 2014 (28)
Culture ... is that complex whole which includes knowledge, belief, art, morals, law, custom, and any other capabilities and habits acquired by man as a member of society.	Edward Burnett Tylor, 1870

Source: Nils Fietje, PhD, Unit leader, Evidence for Health and Well-being in Context, WHO Regional Office for Europe. Session #4. How cultural contexts of health play a role in EIHPM; Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 3 September 2019.

and experiences of health, illness and well-being has been limited by a focus on the quantitative, which is based on limited sets of variables that elude the compounding of risk factors that typify our daily lives. In other words, quantitative measures are ill-suited to dealing with complexity. Rather, social science researchers use a range of qualitative methods (see Table 2), such as interviews, focus groups and ethnographic approaches, to compare experiences of health and well-being across and within geographical and cultural settings.

Central to the CCH approach is the recognition that all research methods can be useful. Accordingly, the inclusion of different methods and their associated different forms of data serves only to strengthen the evidence base rather than undermine it.

TABLE 2. TYPES OF SOCIAL SCIENCE AND HUMANITIES METHODOLOGIES USED BY CCH

TYPES OF SOCIAL SCIENCE AND HUMANITIES METHODOLOGIES USED BY CCH	
Participatory research	Commonly used in international development as an attempt to rebalance power relations and to inform action, participatory research involves a range of methods, including mapping, diagramming, autophotography, participatory surveying and budgeting. This method can be effective in reaching marginalized groups and for use in sensitive issues.
Engaged research	Engaged research is about researchers and stakeholders such as community members, civil society, policy-makers and health professionals working together throughout the research process, which ensures that stakeholders play a part in shaping and directing the research. As this also ensures that research is done in a language that is inclusive rather than exclusive, it helps give people ownership of the process and any interventions that follow.
Historical studies	A wide range of sources, such as written records, oral history and visual media, can be used to investigate how social, cultural and economic factors have influenced developments in medicine and health care, and shaped subjective experiences of health and disease. These methodologies can help to understand how cultural beliefs and norms have shaped health and well-being over time and across the Region, as well as show how the collection, presentation and interpretation of health and well-being data have been influenced by social and cultural factors.
In-depth qualitative and ethnographic studies	Narratives are the stories that people tell to make sense of their experiences. In comparing experiences of health and well-being across and within settings and population groups, using methods such as interviews, focus groups and ethnography serves to provide in-depth insight into lived experience.
Studies of cultural heritage	The analysis of literature, films, art and sites deemed to be of historical or cultural significance provides insight into societal norms and values that influence daily choices and health behaviour, as well as factors that promote or constrain resilience and belonging. It can also enable an understanding of the factors that promote resilience and a sense of belonging, and the factors that exclude certain groups from this.
Popular media	Popular media, e.g. films, novels, newspapers, can shape and reproduce – as well as contest – cultural norms and values, including those that impact on well-being.

Source: Felicity Thomas, PhD, Senior Research Fellow, Exeter University, United Kingdom. Session #21. EIP and cultural context of health; Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 4 September 2019.

4.3 CULTURE IS AN ENABLER

Culture is wide-ranging, dynamic and ever present, affecting our daily interactions, values, aspirations, working practice, and policy and regulation. As a result, culture influences the way that people understand and respond to health and well-being. Further investing into and strengthening the cultural contexts of EIP can only lead to improved health outcomes and better understanding.

Much of the CCH work has examined the manner in which cultural factors intersect with social, political and economic circumstances to determine patterns of disease and ill-health and to influence the way people experience well-being. In the context of EIP, creating an understanding of the influence of cultural determinants of health is important for two key reasons: (a) identifying the barriers and facilitators that influence the choice and implementation of evidence-informed policy options, and (b) to better understand the overall EIP culture that prevails in a country and the importance that is attributed to evidence as a means of improving health policy, systems and outcomes.

BOX 8. FROM CULTURAL COMPETENCIES TO CULTURAL HUMILITY

Until recently, the notion of cultural competencies was stressed in multicultural clinical training as achieving mastery of a finite body of knowledge on the cultures of "others"; however, this view opened up possibilities of paternalistic physician–patient dyads, as well as creating power imbalances between clinicians and defined populations. Cultural humility instead moves away from the simple notion of mastery towards a lifelong commitment to self-evaluation and self-critique **(29)**. Central to cultural humility is an appreciation of one's own assumptions and unconscious biases that is cognizant of multiple "truths". In this way, practitioners rather recognize that others have their own culturally mediated ways of knowing, instead of a perception that the way we live our lives is the only or best way. While cultural competencies are goal oriented and view cultures as monolithic entities or stereotypes based on academic knowledge, cultural humility instead reinforces the perception that gaining knowledge of other cultures is a lifelong attempt that requires substantial introspection and personal growth. While KT espouses cultural competencies in EIP work such as rapid-learning health systems **(24)**, thus far cultural humility has not yet been widely adopted in the field. However, as CCH considers cultural humility to be central to their approach, it would be worthwhile for EVIPNet Europe to move towards adoption of cultural humility as a key practice.

Sources: **(24,29)**

As a result of the CCH session, EVIPNet Europe and CCH will jointly work on identifying existing tools and mechanisms that can further advance the systematic incorporation of CCH into EIP (see Box 9).

BOX 9. THE DEVELOPMENT OF A HEALTH EVIDENCE NETWORK SYNTHESIS REPORT ON CCH AND EIP

The Health Evidence Network (HEN), initiated and coordinated by the WHO Regional Office for Europe, is an information service for public health system decision-makers in the WHO European Region. HEN synthesis reports use multidisciplinary and intersectoral sources of evidence to support policy-making. They summarize what is known about a policy issue, gaps in the evidence and areas under debate. Based on the synthesized evidence, HEN proposes policy considerations (as opposed to recommendations) for policy-makers and other stakeholders to consider when formulating their own recommendations. The reports are indexed in the National Centre for Biotechnology Information Bookshelf in the United States of America and are searchable and available via the PubMed archive.

In fact, the role of culture within policy-making has increasingly been recognized.[a] It is now acknowledged that policy-making occurs in value-laden, dynamic ways that vary in different contexts, including how research and evidence are generated and used.[b–e] To better understand these mechanisms of the interplay between CCH and KT, which have not yet been systematically studied we have commissioned a HEN synthesis report on:

What mechanisms exist to integrate cultural contexts into the KT process for health policy-making? Considering the following elements within the scope:

- tools, frameworks and models;
- how CCH influences KT; and
- synonyms for tools.

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a. Oliver K, Boaz A. Transforming evidence for policy and practice: creating space for new conversations. Palgrave Communications. 2019;5(1):1.

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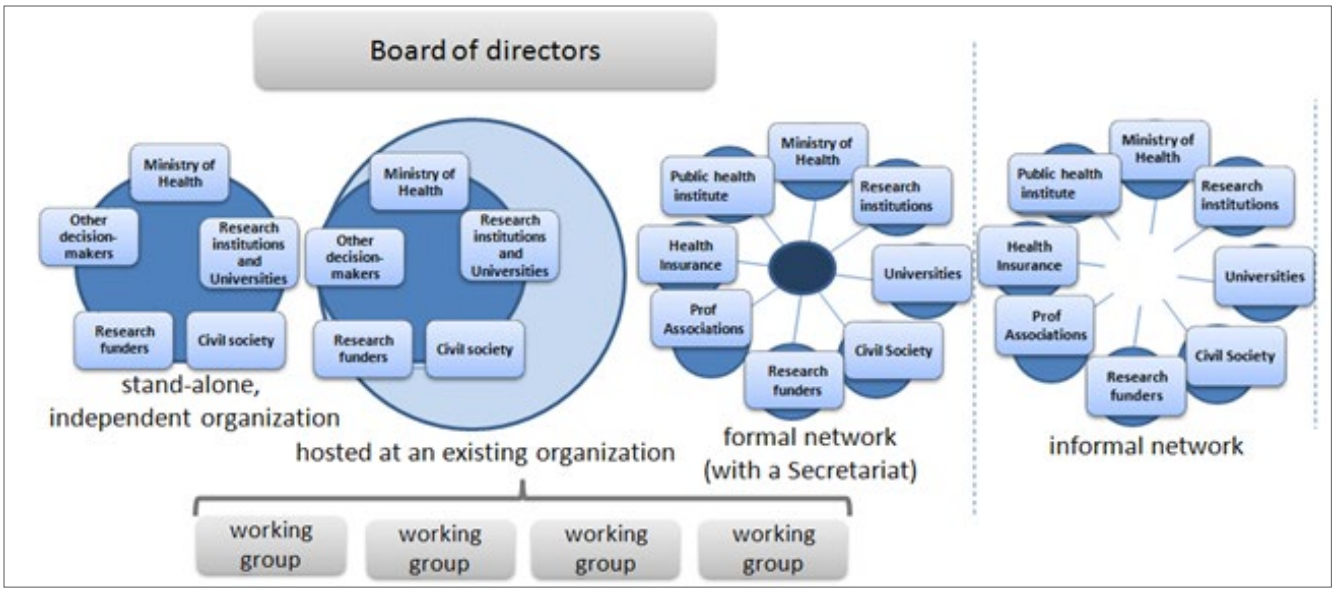
5. INSTITUTIONALIZATION OF A KNOWLEDGE BROKERING ORGANIZATION

5.1 INSTITUTIONALIZATION EVIPNET KTPs AT COUNTRY LEVEL

EVIPNet Europe aims to go beyond individual capacity-building and institutionalize the systematic and transparent use of evidence in policy decision-making through the establishment of national KTPs. KTPs are core to the work of EVIPNet Europe as they lead and coordinate country KT interventions. They implement or delegate KT mechanisms such as EBPs and PD, rapid response services, clearinghouses and priority-setting exercises. Although many EVIPNet Europe member countries have conducted an EIP SA to identify the institutional niche for establishing a KTP, the next steps towards institutionalization are still under negotiation. During this session, the conceptual information on KTPs and institutionalization was presented. The various forms that a KTP can take are: (i) an independent organization, (ii) a part of an existing organization, (iii) a network with a stable secretariat and an informal network (see Fig. 1). Regardless of form, the WHO Secretariat of EVIPNet Europe empowers KTPs in promoting evidence use.

KTP institutionalization session – group work by participants © WHO/Mustafa Guzel

Fig. 1. Types of KTPs



Source: Tanja Kuchenmüller, Unit Leader, Knowledge Management, Evidence and Research for Policy-Making. Session #13. Institutionalization of a KTP (theoretical level). Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 4 September 2019.

Participants worked in four groups (a) to define institutionalization, and (b) to identify the key domains of institutionalization. Participants strove to think not only about the theoretical aspects, but also local applicability and feasibility: how to institutionalize KTPs in their own respective countries. Discussions centred around the different types of KT institutions, the role of the Ministry of Health, the ideal order of steps in the KTP process, the various ways a KTP could be institutionalized, and the pros and cons of tapping into an existing structure versus creating something de novo. These points were reported back in plenary (see results in Table 3) and compared with the preliminary findings of a literature review, which will feed into the framework development of the WHO Secretariat of EVIPNet Europe. More broadly, these efforts will contribute to the wider project that EVIPNet Europe is undertaking with the EVIPnet steering group on creating an institutionalization framework.

TABLE 3. SUMMARY OF BRAINSTORMING SESSION ON INSTITUTIONALIZING KTPS

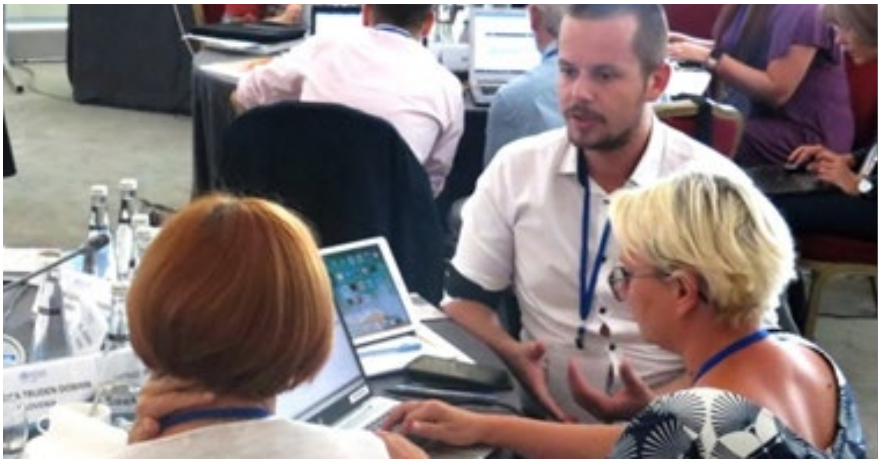
SUMMARY OF BRAINSTORMING SESSION ON INSTITUTIONALIZING KTPs	
Group 1	This team envisioned institutionalizing a KTP as building a sustainable and stable structure, as well as building long-term commitments to overcome personal interests and formalize cooperation with key EIP actors. This requires (i) willingness by decision-makers, e.g. in the form of commitment letters or laws supporting the work of the KTPs, (ii) sustainable resources (financial resources, trained staff and good lobbying), and (iii) continued support by WHO.
Group 2	Institutionalization requires being hosted in an institution, thus it is not informal. For this, it would require personnel in a team with appropriate training in EIP and KT who can form a network of partners. It requires KT responsibilities and partnerships to be established by a regulation or legislation. To establish the KTP, the process must be planned in advance, with timelines and resources, a legal framework, dedicated personnel, appropriate training, good access to databases, sustainable funding, and commitment by policy- and decision-makers to use evidence in policy formulation and implementation.
Group 3	This team expressed the idea that a KTP, with the mandate to bridge the research-to-policy gap, should be situated "in the middle of society", executing the following functions: to produce policy-relevant knowledge; link agencies and EIP actors; build KT capacity and implement core KT activities such as conducting a situation analysis, developing EBPs, communicating and advocating for its KT activities; as well as monitoring and evaluating its KT activities. A KTP needs to have its own budget, from a combination of project income and donor revenue; have trained human resources, and be recognized by decision-makers for its KT work; rely on a network of supporting actors, including universities; and obtain continued support from WHO.
Group 4	Institutionalization requires that the KTP is hosted in a suitable institution, receive its mandate through special regulation protecting its work, human resources and budget, government support, and knowledge that is channelled or sifted down to state institutions. Institutionalization was viewed as a linear process, proceeding from stakeholder debates on KTP establishment and functioning, to the drafting of a note by the Ministry of Health, which needs to be passed to the government where it is amended and approved by Parliament.

5.2 KT AND ITS INSTITUTIONALIZATION THROUGH WORKPLAN DEVELOPMENT

Developing a workplan is an important means of identifying the way forward and having a roadmap to strategically and efficiently collaborate with others in achieving joint goals.

The purpose of this session was to bring EVIPNet Europe national champions – both experienced and new members – together to reflect on future KT activities and possibilities for institutionalization, and to develop their new country workplans for the 2020–2021 biennium. Prior to the workshop, a workplan template had been sent to the participants to allow them to brainstorm on and draft initial future KT activities at country level with both WHO country offices and relevant government agencies.

At the multicountry meeting, participants were exposed to step-by-step explanations on how to fill in the provided workplan template, using examples of the draft workplans submitted by a few countries as a pre-workshop task. Participants learnt to tailor their workplans to the work of EVIPNet Europe, ensuring that the lead persons, timelines and the resources required were identified, as well as how the workplan would contribute to the United Nations Sustainable Development Goals.[7] Post-meeting, participants were required to finalize their workplans, to meet with the respective WHO Country Office if necessary, and to send their documents back to the WHO Secretariat of EVIPNet Europe for review and consolidation.



An animated brainstorming session © WHO/Mustafa Guzel

7 Access to all goals at https://sustainabledevelopment.un.org/sdgs

5.3 A KNOWLEDGE-BROKERING SUCCESS STORY: THE EVIDENCE FOR POLICY AND PRACTICE INFORMATION AND CO-ORDINATING CENTRE (EPPI-CENTRE)

As a practical example of the KT institutionalization process, the EPPI-Centre, part of the Department of Social Science within the University College of London (UCL) Institute of Education, is an internationally recognized research centre that excels in the design and conduct of systematic reviews and research on evidence ecosystem and research use **(30)**. As discussed by Mukdarut Bangpan, the successful institutionalization of the EPPI-Centre **(31)** owes much to the development of research expertise and staff commitment over the past 25 years. The Centre started as a small group of researchers in the field who sought to organize, collect and synthesize data in a reliable way, with a focus on systematic reviews. At the time, its stated goal was to be the first to develop a database of well-designed evaluations of interventions in education and social welfare. In 1995, it received funding for work on methods of research synthesis. Central to the continued success of the EPPI-Centre is its co-location with academic institutions, which permits easy access to resources such as publications, and an incentive system that recognizes systematic reviews as academic output. Its continued success is also due to sustainable funding and a network of partnerships. In short, two key driving factors of institutionalization could be identified: developing a portfolio of tools and a portfolio of partnerships (Box 10).

Sharing experience of EPPI-Centre KT institutionalization facilitated by Mukdarut Bangpan
© WHO/Mustafa Guzel

BOX 10. A DEVELOPING TOOLBOX

In conducting systematic reviews, the EPPI-Centre works with several partners, including the Campbell Collaboration[8] and Cochrane Reviews.[9] The EPPI-Centre has emerged as a key leader not only in the conduct of systematic reviews, but also in its study of **research use**. In line with this, its information technology staff developed in-house software for use by internal and external teams on conducting systematic reviews. This is complemented by published books on policy-relevant systematic review and evidence synthesis,[10] as well as short courses on a variety of topics. Regarding a focus on evidence use, the EPPI-Centre has developed an Evidence Library, which is a service for users on when and how to use evidence for policy-making, as well as a Research Advisory Service. Their overarching aim as an organizational knowledge broker is to not only collect evidence, but to also develop methods and a framework to work with different types of evidence in the field. One recent tool that emerged from the EPPI-Centre's systematic review programme of work was the evidence gap map, first described in 1996.

The EPPI-Centre has been at the forefront in developing and utilising technology for research and evidence synthesis. EPPI-Reviewer, for instance, is an end-to-end software solution for conducting systematic reviews, producing evidence gap maps and managing data from citation screening through synthesis. In addition to a long-standing (20-year) collaboration with the UK Department of Health, the KTP also has a focus on international development through partnerships with UNICEF and the World Bank. EPPI-Centre collaborates with the UK Department for International Development (DFID) to build capacity of international research teams to conduct systematic reviews in different policy areas.

Source: Mukdarut Bangpan, Associate Professor, EPPI-Centre, UCL. Session #14. The EPPI-Centre (practical level). Sixth EVIPNet Europe Multicountry Meeting. Istanbul, Turkey, 4 September 2019.

The sessions on institutionalization demonstrated that challenges remain to systematically bringing the two worlds – decision-making and research production – together. While good practice models of organizational knowledge brokers exist, such as the EPPI-Centre, the evidence ecosystems in the middle of these two communities need to be better understood and guidance identified on how countries can proceed in view of institutionalizing their EIP work. The institutionalization framework that the WHO Secretariat of EVIPNet Europe is currently developing with the EVIPNET steering group will soon provide such guidance to Network member countries.

8 Access at https://campbellcollaboration.org/
9 Access at https://www.cochrane.org/
10 Link to full list of publications (with access) at https://eppi.ioe.ac.uk/cms/Default.aspx?tabid=56

6. DEVELOPING AN EVALUATION TOOL

Evaluation of the EBP development process presents an opportunity for new countries to learn from experienced members. Their valuable lessons should be shared with EVIPNet Europe and the broader community of EIP researchers and practitioners. At the behest of countries at the 2017 multicountry meeting, it was felt to be necessary to develop a tool with which EVIPNet Europe countries could evaluate their EBP process.

In this session, Adrianna Murphy (Assistant Professor, London School of Hygiene and Tropical Medicine) presented a pilot tool for rapid case study evaluation that she had designed while on secondment at the WHO Regional Office for Europe. With the aim of developing a tool that would permit a rigorous evaluation and become a standard tool to compare across countries, her specific objectives were to design an approach that would capture the complexity of the EBP process and be scientifically valid, and to pilot this in three EVIPNet Europe countries. It was imperative that the tool be practical, meaning that it could be implemented in a relatively short time period by someone new to monitoring and evaluation.

"It is important for everyone to feel that their opinion matters and is channelled back to the organizers. This tool is a great opportunity to reflect on what we have done."

Balazs Barbarczy (Hungary)

To design the tool, a scoping review was conducted to identify frameworks and data collection approaches to process evaluation; this identified an approach that combined the Medical Research Council Process Evaluation Framework **(32)** with rapid appraisal methods as being the most appropriate. Invoking the principle of triangulation, rapid appraisal methods provide an understanding of a situation in a more timely and cost-effective manner than standard social research methods and involve collecting data from multiple sources, qualitative interviews with stakeholders and document review. Participants for stakeholder interviews were selected purposively in order to capture the perspectives of as many people as possible who are or were involved, directly or indirectly, in the EBP process. For implementation on the ground, key questions are detailed in the topic guide. Regarding relevant documents, potential avenues of inquiry included terms of reference, workplans, published and in-progress EBPs, situation analyses, lessons learnt reports and other notes from EBP teams.

As tool implementation is itself best improved through an evaluative process, the newly designed tool was recently piloted in three countries that had completed an EBP. In this session, the three pilot countries shared and discussed their lessons learnt. Overall, tool implementation was found to be a clear and straightforward process, although best implemented during or just after the EBP process. More specific suggestions surrounded trimming overly descriptive elements in the topic guide, refining the document review and improving objectivity in the process, perhaps by involving someone external to the EBP process to conduct the interviews. Together, these results from the piloting demonstrated that the evaluation approach can provide useful lessons on key factors that might affect the EBP process, such as access to resources, team leadership and a volatile political context.

Country teams at work © WHO/Mustafa Guzel

7. CONCLUSIONS AND NEXT STEPS

The 2019 multicountry meeting was very well received by EVIPNet Europe's members, covering such topics as (a) institutionalizing KT; (b) conducting rapid syntheses; and (c) considering cultural contexts as intrinsic components of health and well-being.

Overall, key outputs and outcomes of the meeting included the following:

- improved knowledge and skills of participants to develop rapid syntheses;
- a rapid synthesis on country-specific high-priority topics (per country);
- increased understanding and commitment of participants to consider CCH in their KT work;
- draft of national EVIPNet Europe workplans providing the roadmap for each country for the next 2 years;
- input to the EVIPNet Europe KT institutionalization framework that is currently being developed as a new tool for the Network;
- input to the finalization of the EBP evaluation tool, with findings to be published in a peer-reviewed journal;
- increased Network-wide cohesion, exchange of experiences and identification of good practices.

With a growing awareness of the importance of institutionalization, participants are tasked with moving further towards KTP institutionalization. The institutionalization findings from the meeting will feed into the overall institutionalization work.

Participants went back from the meeting taking with them an increasing awareness and knowledge of developing KTPs. Following on the success of the focused sessions on rapid response and CCH at this meeting, these sessions will be replicated next year for the Central Asian and other Russian-speaking countries. Implementing EVIPNet Europe's work is expected to expand greatly over the next year due to an exciting partnership with Cochrane Nordic.

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MEETING PROGRAMME

DAY 1: TUESDAY, 3 SEPTEMBER 2019

Registration

Session 1: Welcome and opening
Ministry of Health, WHO Country Office, WHO Secretariat

Session 2: Introduction to EVIPNet Europe and updates
Tanja Kuchenmüller / Akbar Suvanbekov

Session 3: Successful experiences on Evidence-Informed Health Policy-making (EIHPM) in the Region
3 EVIPNet Europe member countries

Coffee/tea break

Session 4: How cultural contexts of health play a role in EIHPM
Nils Fietje / Andrea Scheel

Group photo and lunch break

Session 5: Importance of conducting rapid syntheses from a policy-maker's perspective
Michael Wilson / Evelina Chapman

Session 6: Rapid evidence syntheses in the context of rapid-learning health systems
Michael Wilson

Session 7: Practical session on searching, finding and appraising systematic reviews
Michael Wilson

Coffee/tea break to be served in the conference room

Session 8: Practical session on producing a rapid synthesis
Michael Wilson

Session 9: Wrap-up
WHO secretariat

Intensive skill building session on evidence syntheses (voluntary)
Michael Wilson

MEETING PROGRAMME (CONTD)

DAY 2: WEDNESDAY, 4 SEPTEMBER 2019

Session 10: Outlook on Day 2
WHO Secretariat

Session 11: Practical session on producing rapid syntheses
Michael Wilson

Coffee/tea break

Session 12: Practical session on producing rapid syntheses
Michael Wilson

Lunch break

Session 13: Institutionalization of a Knowledge Translation Platform (Theoretical level)
Tanja Kuchenmüller

Session 14: The EPPI-Centre (Practical level)
Mukdarut Bangpan

Coffee/tea break

Session 15: Developing of a new workplan
Akbar Suvanbekov / Tanja Kuchenmüller

Session 16: Wrap-up
WHO Secretariat

Pick-up at the hotel

Bosphorus cruise dinner

DAY 3: THURSDAY, 5 SEPTEMBER 2019

Session 17: Outlook on Day 3
WHO Secretariat

Session 18: Presentation and feedback on rapid syntheses
Michael Wilson

Coffee/tea break

Session 19: EVIPNet Europe M&E and rapid case study evaluation tool
Tanja Kuchenmüller /Adrianna Murphy

Lunch break

Session 20: Session: EIP and cultural context of health
WHO Secretariat (EHC)

Coffee/tea break to be served in the conference room

Session 21: EIP and cultural context of health continued
WHO Secretariat (EHC)

Session 22: Wrap-up and closing

The WHO Regional Office for Europe

The World Health Organization (WHO) is a specialized agency of the United Nations created in 1948 with the primary responsibility for international health matters and public health. The WHO Regional Office for Europe is one of six regional offices throughout the world, each with its own programme geared to the particular health conditions of the countries it serves.

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