
Developing national institutional capacity for evidence-informed policy-making for health

Executive summary

1. To ensure that health policies are appropriate, effective and cost-effective, they need to be based on sound evidence. Evidence-based policy-making is therefore essential to achieve the Sustainable Development Goals and universal health coverage, and its importance is emphasized repeatedly in WHO's Thirteenth General Programme of Work 2019–2023 (GPW 13). However, it can be challenging for countries to obtain and use high-quality evidence.
2. This paper is the latest step in a long-standing programme of work by WHO to foster evidence-based policy-making in countries of the Eastern Mediterranean Region. It was developed in response to a request by the Regional Committee for the Eastern Mediterranean, and proposes a framework to help countries improve their national institutional capacity for evidence-informed policy-making. The framework provides practical actions that Member States can take to build their national institutional capacity and outlines the support WHO can provide to facilitate this process.
3. Countries' needs, priorities and capacities vary, and the proposed framework is designed to be flexible to accommodate such variations. Furthermore, the paper sets out a five-dimensional analytical approach to help countries assess their needs and capacities and formulate a suitable strategy, and includes real-world examples of different possible actions from countries. The proposed framework is presented for consideration and possible endorsement by the Regional Committee.

Introduction

4. This technical paper was developed in response to a 2017 Regional Committee resolution requesting the Regional Director to "establish regional mechanisms to support the bridging of gaps between relevant research institutions and policy-makers and the translation of research evidence into health policy statements, and support the establishment of national mechanisms (1). The paper focuses on the importance of, and approaches to, establishing and enhancing national institutional capacity for evidence-informed policy-making. It fills an important gap in existing technical recommendations on institutional capacity for improving the use of evidence in policy-making.
5. The paper:
 - clarifies what is meant by "evidence" in the context of policy-making;
 - reviews important challenges to and opportunities for the development of evidence-informed policy-making in countries of WHO's Eastern Mediterranean Region;
 - discusses the generation of evidence in the Region, the resources and capacity available for evidence generation, and the views and perceptions of policy-makers on the use of research evidence in their decision-making;
 - provides an overview of existing recommendations (including WHO resolutions) and decisions on enhancing evidence-informed policy-making;
 - introduces a multiconcept approach to evidence-informed policy-making and ways to increase national institutional capacity; and
 - proposes a regional framework for action to improve national institutional capacity for the use of evidence in health policy-making in the Eastern Mediterranean Region, to be endorsed by the Regional Committee.

6. The paper reflects the priorities of WHO's Thirteenth General Programme of Work 2019–2023 (GPW 13) and the global focus on achieving the Sustainable Development Goals (SDGs) and universal health coverage (2,3).

Sources of evidence for evidence-informed policy-making for health

7. Evidence-informed health policy-making relies on using the best available evidence, bearing in mind national contexts, needs, priorities and resources, to improve population health outcomes (4–7). While the nature of evidence can be debated, evidence originating from quantitative or qualitative research is the main source of knowledge in evidence-informed policy-making (8,9). Research evidence can help in:

- improving policy development processes
- selecting more effective and efficient policy options
- foreseeing the potential effects of policies on different socioeconomic groups (equity considerations)
- recognizing facilitators of and barriers to policy implementation
- assessing the effect of policies on outcomes (7,8,10,11).

8. Research evidence may originate from large studies, interventional studies or systematic reviews of evidence, as well as small studies that focus on national questions, including studies that assess the effectiveness or cost–effectiveness of policy options. As an example, health technology assessments include assessments of safety, effectiveness, cost–effectiveness and the wider implications of including a technology in the health care system. In addition, queries on, for example, the feasibility of implementing a policy in the field, the acceptability of a policy to health professionals or other stakeholders, or the perception of a policy by health care users or the public are best answered by a synthesis of the findings from qualitative research (12).

9. While much attention is given to the role of evidence generated by research in evidence-informed decision-making, policy-makers also seek and use other sources of evidence (e.g. data) for health policies. Policy-makers use nationally representative data to identify priorities, shape the policy agenda and direct their resources and actions to key areas needing attention. National data are also used to complement the evidence obtained from research. Nationally representative health information and data are of paramount importance to understand: 1) the status of health, morbidity and causes of death, and their distribution within different population groups; 2) the distribution of risk factors and behaviours (e.g. obesity and smoking) that affect health outcomes; and 3) the capacity and status of health services, and the use of health care in a country (13). The main sources of data include routine health information systems (including reports on causes of death), national household or health facility surveys, surveillance systems for diseases, risk factors or adverse events, and specific registries (e.g. cancer registries). Such sources of data may have profound impact on service-delivery decisions and policies. For example, a single report received by the national pharmacovigilance surveillance system may affect the availability of a certain pharmaceutical product at the national level. Some countries collate all data-related reports under a national observatory for health or have information dashboards for policy-makers to allow them easy access to key indicators. While national data are frequently used in policy-making, when such data are inadequate, unreliable, out of date or not provided in good time, policy opportunities may be missed or wrong decisions made.

10. Ministries of health also conduct ad hoc or regular research studies and surveys to monitor or assess the implementation of policies, pilot new interventions, evaluate the effects of policies, or assess the satisfaction of health care users with or their perception of health services.¹ Such research studies, although not discussed in detail in the literature on evidence-informed policy-making, are an important source of evidence for policy-makers.

¹ Examples of routine studies include pharmacovigilance studies, knowledge attitude practice surveys, patient satisfaction surveys, audit reports and quality of care assessments.

Table 1. Sources of evidence and knowledge products that are useful to address policy questions

Main policy question	Usual sources of evidence	Main knowledge products that address the policy question
What are the main priority issues/problems for decision-making?	Household and facility surveys Surveillance studies Routine health information Cause of death and burden of disease studies	Policy briefs Data fact sheets Health information observatories
What can be done (potential policy interventions and their safety and effectiveness)?	Systematic reviews of interventional studies Interventional studies Surveillance studies (for safety)	Clinical or public health guidelines Health technology assessment studies Policy briefs
Are the policy options cost-effective?	Systematic reviews of cost-effectiveness studies Economic modelling and cost analyses	Health technology assessment studies Clinical or public health guidelines Policy briefs
How feasible are the policy options (sustainability, affordability, acceptability and implementation strategies)?	Systematic reviews of qualitative studies Economic modelling and cost analyses Qualitative studies Process evaluations User and provider surveys	Policy briefs Policy dialogue Health technology assessment studies Clinical or public health guidelines

11. In summary, research evidence, especially if it originates from the country (or relates to the needs, resources and priorities of the country), helps identify the issues (e.g. health-related problems and policy concerns), choose policy objectives that are more likely to be achieved, and select policy options that are more effective or cost-effective. Reliable national data and indicators inform the priorities and areas of action for policy-making, and the cost and feasibility of implementing policies in comparison with alternative policy options (4,5,13,14). Table 1 lists different sources of evidence and knowledge products that are best suited to answer different policy questions.

Existing challenges and opportunities in the Region

12. In the Eastern Mediterranean Region, “three parallel streams have shaped, and continue to shape, use of research evidence in health policies” (14). These streams relate to the increasing demand among policy-makers for research evidence and valid information for health policies, the availability, relevance and timeliness of evidence, and the structural and process barriers to the use of evidence in health policy-making. While these challenges are not unique to the Region, tackling them is paramount to the successful implementation of strategies that aim to improve evidence-informed policy-making. The first two streams are discussed in this section, and the third one in later sections.

Policy-makers support of the use of evidence in policy-making

13. Ministers of health of countries of the Region have demonstrated their commitment to use research evidence for decision-making in resolutions of the Regional Committee and other bodies, reflecting the national discourse in many countries and an increased understanding that evidence-informed decision-making is a priority (15–19). These commitments are also a reflection of health becoming more prominent in political debates, national development plans and at election times in several countries. Such level of scrutiny has made it more important for politicians to justify and support their decisions with research evidence, and to use national indicator data and research to evaluate and demonstrate the outcomes of their policies (8,20). In addition, increasing population demand for health services and ageing populations have driven up health care costs, resulting in closer scrutiny of health policies.

Availability, validity, relevance and timeliness of research evidence

14. A major barrier to evidence-informed decision-making in countries of the Eastern Mediterranean Region is the inadequacy of research originating from these countries. Factors that contribute to this inadequacy include: a lack of financial resources and academic capacity to conduct and publish research; insufficient focus

of existing research on policy-oriented questions and national priorities; problems with the quality of research conducted; and difficulties in finding research outputs originating from countries of the Region.

15. Inadequate funding for research is a main barrier in the Region. The Bamako Call to Action on Research for Health in 2008 (21) was an important step to bring this issue to the attention of policy-makers at the global level. In fact, numerous calls had already been made to increase funding for health research. In 1990, the Commission on Health Research for Development (COHRED) announced that “countries should invest at least 2% of national health expenditures to support essential national health research studies” and research capacity strengthening, and “development assistance agencies should ... commit at least 5% of health project aid for essential national health research and research capacity building” (22).² While in general, funding for health research has increased in the Region over the years, it is still very low relative to the overall gross domestic product of the countries of the Region (23).

16. Despite the lack of funding, studies, including those commissioned by WHO, have shown a substantial increase in regional health-related research output (24–28). In a 10-year period (2004–2013), overall health-related research production in the Region increased five-fold; and its share of global output increased from 0.85% to 2.36% of total production – still far below its share of the world population (just under 10%). The Islamic Republic of Iran had the most rapid expansion of research output, followed by Egypt, Saudi Arabia, Tunisia and Pakistan. At the end of the period, per capita production of health-related research output was the highest in Qatar, followed by the Islamic Republic of Iran, Tunisia, Kuwait and Lebanon (24,26,28). This increasing trend in research output is important because a main concern in evidence-informed policy-making is the local relevance of research (29). Therefore, the trend needs to expand to all countries of the Region. The study also showed that a large share of all research publications in the Region originates from just a few academic institutions (Table 2, on next page).

17. In addition, most countries have demonstrated substantial improvement in implementing research ethics standards, in response to a previous Regional Committee resolution (30).

18. Despite these improvements, important challenges remain. There are concerns that only a small fraction of research publications focus on priority health topics for policy-makers including the needs of vulnerable and disadvantaged groups. In addition, the research methods of published research are often such that they cannot provide evidence that would help inform policy decisions (31). For example, relatively few systematic reviews of interventional studies are from academic institutions in the Region. In the past decade, Cochrane (previously known as the Cochrane Collaboration) has had only two geographical centres in the Region (in Bahrain and the Islamic Republic of Iran), and only one is currently active.³ In addition, the capacity to conduct or oversee the conduct of randomized controlled trials is limited; there are only two WHO-accredited registries for randomized controlled trials hosted in the Region (32,33).⁴ Interventional studies and economic evaluation studies are not frequently conducted in the Region, although these research methods can provide data that can help health decision-making, including the evidence needed to conduct health technology assessment studies and to develop or adapt clinical and public health guidelines (34–37). Qualitative research is also essential as it captures views and perceptions of health care users and providers as well as managers and decision-makers. Qualitative research is often the preferred source of evidence to identify barriers to and facilitators of policy implementation (12) (Table 1). However, qualitative studies are not commonly conducted in the Region. Finding studies with research evidence may be a challenge itself because such studies may be published in national languages and are therefore difficult to retrieve through the usual literature searches. Policy-makers often refer to the difficulty of obtaining relevant and reliable research publications as a barrier to evidence-informed policy-making (29).

² This call was repeated in a WHA resolution on health research in 2005 (6). Another WHA resolution in 2010 proposed the following indicator as a measure of WHO’s performance: “at least 5% of WHO’s combined core and voluntary budgets allocated in support of research at WHO, including dedicated funds for the implementation and evaluation of the research strategy...” (11).

³ Cochrane Bahrain has discontinued its functions.

⁴ In the Islamic Republic of Iran (<https://www.irct.ir>) and Lebanon (<http://lbctr.emro.who.int>). The latter was formally established in August 2019.

Table 2. The 25 institutions in the Eastern Mediterranean Region producing the most biomedical and health research articles indexed on PubMed published between 2004 and 2013 (28)

	Country	Institution	Published articles ^a	% of total (n ~ 141 000)
1	Islamic Republic of Iran	Tehran University of Medical Sciences	8457	6.0
2	Islamic Republic of Iran	Shahid Beheshti University of Medical Sciences	4470	3.2
3	Saudi Arabia	King Saud University	4444	3.2
4	Tunisia	Tunis El Manar University	3579	2.5
5	Egypt	Cairo University	3331	2.4
6	Islamic Republic of Iran	Shiraz University of Medical Sciences	2986	2.1
7	Islamic Republic of Iran	Isfahan University of Medical Sciences	2940	2.1
8	Islamic Republic of Iran	Islamic Azad University	2291	1.6
9	Egypt	Mansoura University	2256	1.6
10	Lebanon	American University of Beirut	2254	1.6
11	Pakistan	Aga Khan University	2214	1.6
12	Islamic Republic of Iran	Tabriz University of Medical Sciences	2095	1.5
13	Tunisia	Sfax University	2033	1.4
14	Islamic Republic of Iran	Mashhad University of Medical Sciences	1971	1.4
15	Egypt	Ain Shams University	1806	1.3
16	Islamic Republic of Iran	University of Tehran	1763	1.2
17	Kuwait	Kuwait University	1744	1.2
18	Islamic Republic of Iran	Tarbiat Modares University	1689	1.2
19	Egypt	Alexandria University	1543	1.1
20	Saudi Arabia	King Faisal Specialist Hospital and Research Centre	1533	1.1
21	Tunisia	Monastir University	1340	1.0
22	Jordan	Jordan University of Science and Technology	1314	0.9
23	Egypt	National Research Centre	1306	0.9
24	United Arab Emirates	United Arab Emirates University	1254	0.9
25	Oman	Sultan Qaboos University	1118	0.8
	Total		61 731	43.8

^aUniversity data include data for affiliated teaching hospitals or research centres. Publications are assigned to the institute according to the affiliation of the lead author.

Initiatives to enhance the availability of evidence for health policy-making

19. WHO and Member States of the Region have endeavoured to improve the availability of research evidence and its use in policy-making. A 2001 resolution of the Regional Committee agreed “to allocate 2% of the JPRM funds in support of regional health research activities” (30). In 2011, the Regional Committee called on “high-income Member States to donate funds in support of regional research on priority public health areas” (38). However, it seems that these resolutions did not make a substantial difference in practice to the limited availability of funds for high-priority research in the Region.

20. The establishment of the Index Medicus for Eastern Mediterranean Region (IMEMR) was an important initiative by the Regional Office in response to a Regional Committee resolution in 1978. IMEMR has been active since 1987 and provides access to research published in national languages or research published in academic journals not listed in the main international databases of academic literature (39). IMEMR currently includes more than 200 000 citations from 668 peer-reviewed health and biomedical science journals published in 20 countries of the Region. Another important initiative was the establishment of WHO collaborating centres. These centres are a commitment of Member States to support WHO’s mission, including the generation of needed evidence for policy-making. Given the expanding capacity of academic institutions in the Region, WHO is aiming to increase the number of collaborating centres in the Region (40).

21. The *World report on knowledge for better health: strengthening health systems* was a defining report and a global call for further attention to evidence-informed policy-making, especially in low- and middle-income countries (41). The report resulted in the milestone World Health Assembly resolution WHA58.34 in 2005, which called for knowledge translation as a key strategy and urged Member States to (6):

- establish and implement or strengthen a national health-research policy with appropriate political support and to allocate adequate funding and human resources for health systems research;
- encourage collaboration with other partners in health research so as to facilitate the conduct of such research within their health systems; and
- establish or strengthen mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies.

22. In addition, in 2005 the Evidence-Informed Policy Network (EVIPNet) was established to develop networks of academic investigators and policy-makers and promote the agenda for evidence-informed policy-making at global, regional and national levels (42). EVIPNet seeks processes and strategies that develop reliable policy options (actionable messages) through synthesis of the best available evidence (Fig. 1).

23. The concept of evidence-informed policy-making was further expanded to include: 1) strategies that increase: the demand of policy-makers for research evidence, 2) the production of research that responds to policy needs; and 3) processes that enhance the translation of research evidence to policies and practices (10). Furthermore, the development of policy briefs and the use of policy dialogues have been promoted as tools and platforms that facilitate transparent policy-making for health, and show the benefits and challenges that might be faced if policy-makers adopt one course of action instead of others that have been presented (14,43). While the development of EVIPNet was received with widespread enthusiasm in Latin America, and later in Europe, the adoption of the concept and its use in policy-making in countries of the Eastern Mediterranean Region were limited to few countries, notably Lebanon. EVIPNet approaches tended to focus on policy decisions that were more complex and less suited to standardized processes for synthesizing information for decision-makings, such as health technology assessments (see below).

24. Regional Committee resolutions in 2008 and 2011, respectively, highlighted the commitment of Members States of the Region to “raise awareness among policy-makers about the importance of using research evidence in decision-making and strengthen their capacities in this regard” (44) and to “establish and strengthen different networks at the national level to promote in-country research collaboration and the utilization of research results to inform health policy and planning” (38).



Fig. 1. From theoretical research to decision-making (41)

25. Other approaches to enhance evidence-informed policy-making have been developed under different umbrellas. Health technology assessment has been promoted as an approach to use best available research evidence in combination with local evidence to assess the safety, effectiveness, cost-effectiveness, feasibility and acceptability of technologies (e.g. medicines, devices, procedures) in health care systems (5,35,45). Health technology assessment processes promote systems in which the addition of new technologies to health systems is limited to and based on sound recommendations derived from health technology assessment studies (46,47). Clinical practice guidelines and public health guidelines are also knowledge products developed to improve evidence-informed decision-making at clinical or public health levels. WHO has contributed substantially to the establishment of methods that guide the development of such guidelines. It has also established an agenda to ensure that the recommendations in WHO guidelines are based on sound evidence (34). The WHO guide for guideline development can be adopted at the national level by countries that have the resources to do so. Most recently, WHO collaborated with academic institutions around the world to increase the use of qualitative evidence in policy-making through the development of a new approach to assess how much confidence to place in findings from syntheses of qualitative evidence (12,48) (Table 1).

26. In addition, an extensive programme of work by WHO and the Member States of the Region has aimed to enhance national capacity in the use of routine health information and cause of death data and reporting of core indicators. Following Regional Committee resolutions in 2013, the programme has helped make substantial improvements in national health information systems in all countries of the Region (13,20,49,50).

Programme to enhance national institutional capacity for the use of evidence in health policies

27. Evidence-informed policy-making requires a level of institutional capacity that can support decision-makers in a reliable and timely manner. This capacity may be lacking in many ministries of health. Institutional capacity is the third stream referred to earlier in this paper that affects evidence-informed policy-making in the Region (14). Previous WHO decisions (World Health Assembly or Regional Committee resolutions) on evidence-informed policy-making often do not specify the institutional requirements. A 2007 publication of the WHO Alliance for Health Policy and Systems Research went further in specifying national institutional requirements for evidence-informed policy-making (51), but the focus of the report was on academic institutions and it did not identify the requirements within ministries of health. Further work has also demonstrated the need to expand efforts to build institutional capacity (52). Interestingly, a 2008 Regional Committee resolution requested the establishment of research units within ministries of health (44). This has been implemented by most ministries of health in the Region. On the other hand, a Regional Committee recommendation from 2011 to establish evidence-informed policy networks has not prompted much action in countries (38). The unspecific nature of the 2011 recommendation may be one of the reasons for its limited implementation.

28. In addition, certain policy tools and knowledge products advocated by WHO (Table 1) facilitate the use of evidence in policy-making: policy briefs, health technology assessment studies, and clinical and public health guidelines. Data suggest that most countries of the Region lack national programmes for conducting and/or adapting health technology assessment studies, and for adapting or developing clinical practice and public health guidelines (34,35,53). Similarly, few countries of the Region use or issue regular policy briefs on their main health-related national policies. To change this situation, the different needs of ministries of health should be considered given their context, circumstances and priorities. The different types of questions that policy-makers face for which evidence-informed decision-making is warranted should also be considered (Table 1).

29. Since 2015, WHO has expanded its programme of work in the Region with a focus on institutional capacity and policy processes that enhance evidence-informed health policy-making. In response to ad hoc requests from ministries of health, WHO has supported countries in developing policy briefs, using qualitative evidence in decision-making, and research priority setting. Some key Region-wide activities include:

- development of a map of the capacity for health research of regional research institutes (54,55)
- bibliometric studies of health-related research production in the Region (24, 28)

- expert consultations on the development and adaptation of evidence-based guideline (2015)
- regional capacity-building (training of trainers) on the development of policy briefs (2015 and 2016)

30. The outcomes of the above-mentioned activities, together with countries' experiences in enhancing evidence-informed policy-making, were presented in an event prior to the 2017 Regional Committee in Islamabad in 2017. In response to that presentation, the Regional Committee requested WHO to "establish regional mechanisms to support the bridging of gaps between relevant research institutions and policy-makers and the translation of research evidence into health policy statements, and support the establishment of national mechanisms", while committing themselves to building "national capacity to use evidence from health research in national policy-making for health" (1). The following activities followed the Regional Committee recommendations.

- Expert consultation on approaches to improve institutional capacity for evidence-informed decision-making (2017)
- Expert consultation on developing national plans for conducting household surveys (2017)
- Publication of a position paper in the *Eastern Mediterranean Health Journal* highlighting the WHO commitment and approach (2017) (14)
- Conceptual review of existing methods to enhance institutional capacity for translating evidence into policy (2018) (Elsayed O, Rashidian A, Elfeky S, Mandil A. Unpublished paper, 2019).
- Sharing of regional activities at a WHO global consultative meeting on evidence to policy (2018)
- Assessment of the status of institutional capacity for evidence to policy in countries of the Region (2018–2019) (see Table 3 for the key findings)
- Regional meeting of WHO collaborating centres to re-evaluate their roles and functions (2019)
- Regional consultation on strengthening country health information systems and capacities to monitor universal health coverage and health-related SDGs (2019)
- High-level meeting on evidence to policy (2019). This meeting, for the first time, discussed the different strategies for evidence to policy: knowledge translation processes, health technology assessment studies, guideline development and adaptation, routine data and surveys, and ad hoc studies used to support policy-making.

Table 3. Status of evidence-informed policy-making in countries of the WHO Eastern Mediterranean Region

a) Main finding 1: Evidence-informed policy-making is **understood** and viewed **favourably** in the Region

- 90% believed that their organizations support the use of research evidence in decision-making
- 69% believed that their organizations support professional development of policy analysts
- 74% reported regular attendance in meetings on policy development

b) Main finding 2: Availability of resources and capacity for evidence-informed policy-making are important challenges

- 51% believed that their organizations provide adequate support for evidence-informed policy-making enforce
- Only 13% reported any existing policy to require the use of research evidence in policy-making
- Only 21% of organizations conducted more than five research projects that addressed national needs to support health policy-making
- About 10% of the organizations had more than five policy analysts

c) Respondents' views on how WHO can help countries in evidence-informed policy development**In improving national capacity:^a**

- Provide capacity-building for researchers, policy-makers and policy analysts (83%)
- Recommend institutional settings and working guides for the use of evidence in policy-making (73%)
- Provide mentorship programmes and technical advice including experts and tools (72%)

In establishing regional mechanisms:^a

- Develop policy briefs based on region/country-specific context (75%)
- Facilitate communication between researchers and policy-makers (73%)
- Increase accessibility of evidence sources (60%)
- Provide an accessible platform for best practices (58%)
- Develop public health/clinical practice guidelines (57%)
- Develop fast response team(s) for review and synthesis of context-sensitive evidence for emergency situations (48%)

^aPercentages in brackets are the percentage of respondents who supported the action.

Source: Survey of 68 senior policy-makers (including a few former ministers of health) and senior policy developers (within health ministries and academia) from all 22 countries of the Region (2018–2019) (Elsayed O, Rashidian A, Elfeky S, Mandil A. Unpublished paper, 2019).

Selecting the appropriate approach to improve national institutional capacity for using evidence in policy-making

31. Countries of the Region vary in their national capacities as well as their needs and priorities, and a framework for action to improve their institutional capacity for evidence to policy should reflect these different circumstances and national expectations (Box 1). Such a framework should also draw on international experience and the success or not of previous recommendations. At the same time, a country may find different methods or approaches that fit its specific needs.

Box 1. Factors affecting the selection of the appropriate approach to improve national institutional capacity for evidence-informed policy-making

The required national institutional capacity is context-specific and varies by country. The appropriate solution for a country requires consideration of the following factors.

- National population and priority needs
- Capacity of academic institutions to conduct valid and reliable health research or synthesis of research
- Capacity of academic institutions to provide training on key disciplines and methods needed for evidence-informed decision-making, e.g. systematic reviews, cost-effectiveness and economic modelling, development of policy briefs; development and adaptation of guidelines, policy analyses, qualitative studies and synthesis of qualitative research, and statistical analyses
- Presence of institutions of technical excellence linked to the health ministry (e.g. national public health institutes; national health research institutes)
- Availability of financial resources for health research and research synthesis
- Presence of relevant units within the health ministry, or the opportunity to develop such units (e.g. health policy units, planning departments, research and development units, and health technology assessment units)

32. In addition, a set of dimensions is needed to guide the choice of method for establishing or enhancing national institutional capacity for evidence to policy (Box 2). These dimensions are not fixed choices: countries can select from a range of options in a dimension, and it is important to carefully consider which options to select. It is also possible to choose alternatives within some dimensions for different policy questions. For example, the country might decide to have extensive dialogue and stakeholder involvement for some policies (politically sensitive or high-impact policies) and have more selective stakeholder involvement in other policies.

Box 2. Dimensions that guide the choice of method for establishing or enhancing national institutional capacity for evidence to policy

- Dimension 1: Integrated multiconcept approach or single-concept approaches
- Dimension 2: Adaptation or new development
- Dimension 3: Role of academic institutions
- Dimension 4: Level of stakeholder involvement
- Dimension 5: Level of standardization of methods and formality of policy development

Dimension 1: Integrated multiconcept approach or single-concept approaches

33. Evidence-informed policy-making for health requires the establishment of programmes and processes to identify the priority health topics and the best available evidence for the selection of effective interventions, and to develop decision-making approaches that take into account the best available evidence. As described earlier, different knowledge products (Table 1) are available to enhance evidence-informed policy-making. However, often the programmes are implemented independently of each other and they compete for the same resources (financial and human expertise), which are very limited in most countries of the Region.

34. There is an important overlap in the technical expertise required for the development of different knowledge products and reports on the synthesis of evidence. For example, the development or adaptation of clinical practice or public health guidelines and health technology assessments both require technical understanding of systematic reviews and economic modelling. While health technology assessments evaluate technologies and clinical practice or public health guidelines cover diseases or health issues of concern, the development of such guidelines can benefit from the findings of health technology assessments. The results and recommendations of health technology assessments and guidelines also form the basis of many policy briefs. In addition, a health technology assessment or a national guideline may benefit from public dialogue. All of these approaches require explicit conflict of interest management to ensure that the process is not affected by undue personal or financial biases (34). Furthermore, understanding and use of national data are a requirement for the development or adaptation of all of the above knowledge products. While different products are needed for different policy questions (Table 1), bringing the approaches closer together has benefits; it can streamline national policy-making and allow better use of the limited expertise and resources available within most ministries of health or their associated agencies.

35. A call has been made to join or integrate the different approaches to evidence to policy (46), but this has not been widely discussed or adopted. This integrated multiconcept approach (Fig. 2) to national institutional capacity for evidence-informed policy-making was discussed at a meeting on institutional capacity for the use of evidence in health policy-making in February 2019 in Lebanon. The deliberations of this meeting were used to further develop and refine the framework for action for evidence-informed policy-making in countries of the Region.

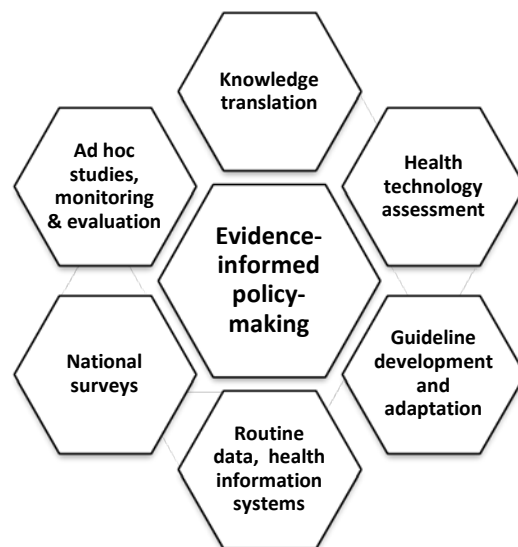


Fig. 2. Integrated multiconcept approach to evidence to policy for health (Rashidian A, unpublished report, 2019)

36. Many countries have adopted parallel approaches to evidence-informed policy-making in which, for example, guideline programmes are not linked with health technology assessments or with policy dialogue initiatives. These initiatives may also sit within competing sectors of health ministries. While such non-integrated approaches are understandable, it is recommended that they be brought together under one umbrella.⁵ In other words, as regards this dimension of analysis, we recommend that all countries aim to move towards the multiconcept approach; this contrasts with the four other dimensions of analysis in this paper, where each country should choose the approach that best suits it. While it may be difficult to establish an integrated multiconcept approach because of different interests and priorities, it should pay dividends in the long term.

Dimension 2: Adaptation or new development

37. Countries need to decide if they intend to develop the required guidelines, health technology assessment reports or policy briefs from the beginning, or whether it is better to adapt existing documents from reliable sources (e.g. WHO guidelines, WHO regional policy briefs and health technology assessment reports from countries with established programmes). For most countries of the Region and for most of the priority issues, adaptation of existing knowledge products (if they are relevant to a country's needs and priorities) is preferable (Box 3). Nevertheless, adapting economic analyses or feasibility assessments from one context to another is a challenge.

Box 3. National capacity for the development of evidence synthesis for health policy-making: Islamic Republic of Iran

In the Islamic Republic of Iran, the co-existence of health with medical education under one ministry is an example of an integrated health system, where policy-makers benefit from close collaboration with academic institutions. National efforts to build capacity within the country to strengthen the use of research in policy-making have been important in generating better evidence-informed policies. These efforts have also resulted in enhanced national capacity to conduct systematic reviews, economic evaluation studies and qualitative research.

The Iranian National Institute of Health Research (jointly affiliated with Tehran University of Medical Sciences and the Ministry of Health and Medical Education) produces and uses evidence and policy briefs, conducts policy dialogues, and operates as a health observatory and a rapid response unit. The institute has worked on developing health technology assessments on more than 80 new technologies. It commissions health technology assessment studies from academic institutions on behalf of the Ministry of Health and Medical Education. The institute has also developed a national plan for conducting national health-related household surveys. In addition, health technology assessment studies are conducted by the Iranian Food and Drug Administration for their decisions on medicine market entry. Furthermore, results from health technology assessments are used to inform the development or adaptation of national clinical care protocols for expensive medicines.

38. The decision whether to adapt or develop a knowledge product needed for a policy question in low-income or emergency settings may be counterintuitive. For example, countries affected by emergencies have many policy questions, but few knowledge products that address these questions have been developed before. Hence, they need to develop such products but at the same time they lack resources to do this because of the emergency context. In addition, many questions that low-income countries may have are not adequately covered by existing knowledge products. In such circumstances, the country may not have the capacity to establish strong processes for the development of knowledge products, and the support of WHO and other international agencies becomes crucial.

Dimension 3: Role of academic institutions

39. This dimension concerns the level of involvement of academic institutions in evidence-to-policy processes. At one end of the spectrum, academic centres of excellence can be entrusted to develop the required evidence syntheses and knowledge products that policy-makers need for decision-making (e.g. through contractual agreements or memoranda of understanding). For example, Lebanon has a close collaboration between the health ministry and an independent academic institution (Box 4). At the other end of the spectrum, technical units within the health ministry can be strengthened so that evidence summaries

⁵ Countries may adopt non-integrated approaches by having parallel health technology assessment programmes (e.g. separating medicines from medical devices) or national guideline programmes (e.g. separating clinical practice from public health guidelines). Such non-integrated approaches are not advisable as they result in a waste of valuable resources and potential non-alignment of important policy-making processes.

and policy options are developed in-house. Options in between, for example, may rely on a national institute of public health (affiliated with or closely linked to the health ministry)⁶ to conduct such work on behalf of the ministry. While such an institute has a role in national health policy-making in the Islamic Republic of Iran (Box 3), there are other examples of such collaboration in the Region, e.g. in Afghanistan, Morocco, Palestine, Pakistan, Sudan and Tunisia, with varying resources and involvement in national policy-making for health. Most recently in 2019, the Ministry of Health of Morocco tasked the National School of Public Health to develop a knowledge management programme to enhance evidence-informed policy-making in the country.

Box 4. Support from an independent academic institution for evidence-informed policy-making: Lebanon

Lebanon has implemented an expanded programme to use research evidence to inform the policy-making process through collaboration with an independent academic institution. Various policy-makers and decision-makers are involved at all stages of the knowledge translation process. The Lebanese parliament has requested academic units to help them with food and safety legislation.

The Knowledge to Policy (K2P) Center at the American University of Beirut synthesizes evidence, puts knowledge in context and engages stakeholders to impact health policy and action. The Global Evidence Synthesis Initiative was established to build and strengthen cross-sectoral capacity in the production and use of evidence to support policy and practice in low- and middle-income countries. The Secretariat of this initiative is based at the Center for Systematic Reviews of Health Policy and Systems Research at the American University of Beirut. The GRADE (Grading of Recommendations Assessment, Development and Evaluation) Center at the University focuses on producing systematic reviews and developing guidelines to enhance evidence-based health care.

Dimension 4: Level of stakeholder involvement

40. The level of stakeholder involvement could be limited or extensive. It can range from a few consultations with experts or professional groups in the process of developing policy documents to full involvement of stakeholders in policy development and online or face-to-face public dialogues at different stages of policy development.⁷ For this dimension, it is sensible for the country to establish a minimum level of stakeholder engagement, then further involvement can be invited when needed. Again, the country context will be a main factor in the level of stakeholder involvement. For example, policy decisions in response to a national disaster or an emergency, although highly sensitive, may require rapid processes for decision-making, and therefore stakeholder involvement should be adjusted to ensure national policies are made in a timely manner.

Dimension 5: Level of standardization and formality of policy development

41. The development of certain evidence-to-policy products (e.g. evidence-based guidelines and health technology assessments) requires the use of explicit methods that are noted at the start (usually as part of the national policy). Other products may need adjustments in the methods according to the topic. In particular, inclusion of other sources of evidence, e.g. national data, costs and feasibility considerations may vary from policy to policy according to the context.

42. In addition, a country can decide how the policy recommendations from the different sources of evidence and knowledge products (Table 1 and Fig. 2) will affect the decision-making: will the decision-making be bound by the policy recommendations or will the recommendations mainly be advisory? However, two conditions should always be met: 1) management of conflicts of interest (at different levels of the evidence-to-policy process), and 2) the policy recommendations should at least be considered by the policy-makers, even if they decide against the recommended options. Without the first condition, the evidence-to-policy process may allow harmful or conflicted advice in policy-making. Without the second, the evidence-to-policy process is incomplete.

⁶ Such institutes have different names in different countries; for example: National Institute of Public Health, National School of Public Health, National Institute of Health Research, or National Institute of Health.

⁷ Examples of stakeholders include: professional societies or associations, unions for care providers, patient groups, nongovernmental organizations, members of parliament and elected offices, consumer protection societies and the general public.

Framework for action to improve national institutional capacity for the use of evidence in policy-making

43. The framework for action to improve national institutional capacity for the use of evidence in health policy-making in the Eastern Mediterranean Region has been developed through continuous collaboration between WHO and Member States since 2015. As described in this paper, such activities have focused on improving regional and national capacity for the development and adaptation of policy briefs (or guidelines), evidence generation and synthesis, policy-making processes and the identification of effective approaches to institutionalize national capacity for evidence-informed policy-making. This paper provides the technical background to the framework and justification for the practical recommendations given in the framework.

44. The framework should be followed up with a strategy for action to guide WHO support for countries in selecting and adopting the institutional settings that are most suited to their national needs. WHO should continue capacity-building for researchers, policy-makers and policy analysts on evidence to policy (e.g. development of policy briefs, policy dialogue processes and guideline adaptation). WHO should also develop regional capacity and processes for priority setting and the development of key policy briefs based on regional and country contexts. Adapting global WHO guidelines to the regional situation (supported by WHO) and developing guidelines for regional priority issues (where no WHO guideline exists) should be considered. WHO should continue to facilitate communication between researchers and policy-makers, and increase the accessibility of evidence resources through the regional platforms. In particular, WHO should consider training fast-response teams to assess and synthesize evidence for context-sensitive issues in emergency situations where evidence for decision-making is lacking or unclear.

45. The framework also highlights a set of actions for countries to undertake in their efforts to enhance national institutional capacity for evidence-informed decision-making. Certain capacities are essential for every ministry of health regardless of national needs and contexts. This level of institutional capacity ensures that policy support teams can locate, appraise and potentially adapt knowledge products that may be relevant to the priority policy questions. Further actions can be then considered for countries according to their needs and capacity (e.g. emergency or conflict status, national population, academic resources and financial resources), including the establishment or strengthening of associated agencies that can support national evidence-informed policy-making for health.

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Framework for action to improve national institutional capacity for the use of evidence in health policy-making in the Eastern Mediterranean Region

Country categories	Country action	Support from WHO and other development partners
A All countries	<ul style="list-style-type: none"> Establish mechanisms to regulate and manage conflicts of interests in policy-making Enhance the capacity of the ministry of health planning department for critical appraisal of knowledge products and evidence synthesis reports (i.e. policy briefs, health technology assessments, guidelines and systematic reviews) Ensure access of the ministry of health to sources of research evidence for health (e.g. through the WHO HINARI programme) Improve cause of death reports and national observatory for national health indicators including surveillance reports 	<ul style="list-style-type: none"> Provide technical support for selection of appropriate national institutional methods for evidence-informed policy-making Provide technical support for key national capacity-building for evidence-informed policy-making Support the development of policy briefs of regional importance Support the adaptation of global WHO guidelines to the regional context for high priority topics Support the development of multicountry or regional guidelines for high priority topics Establish a regional network of institutions that actively supports evidence-informed policy-making at the national level
B Countries with limited academic resources	<p>In addition to A:</p> <ul style="list-style-type: none"> Ensure a minimum capacity (epidemiology and cost analysis) for development of policy reports Focus on adaptation of high priority evidence synthesis reports to the national setting Include resource funds for evidence-to-policy activities in donor requests to enhance national capacity 	<p>In addition to A:</p> <ul style="list-style-type: none"> Support the development of policy briefs and adaptation of WHO guidelines for national priorities
C Countries affected by protracted or acute emergencies	<p>In addition to A:</p> <ul style="list-style-type: none"> Ensure a minimum capacity (epidemiology and cost analysis) for development of policy reports Include resource funds for evidence-to-policy activities in donor requests to enhance national capacity 	<p>In addition to A and B:</p> <ul style="list-style-type: none"> Support rapid processes for adaptation or development of policy synthesis products for the country's needs
D Countries with large academic capacity/resources and small populations	<p>In addition to A:</p> <ul style="list-style-type: none"> Establish programmes for national health technology assessments and guideline adaptation/development in collaboration with academic institutions Establish formalized evidence-to-policy processes, including for developing policy briefs and conducting policy dialogues Establish an evidence-to-policy team within the ministry of health including all key areas of expertise Develop plans for mid-term (e.g. 10-year) national household surveys Establish an effective cancer registry and pharmacovigilance programme 	As in A
E Countries with large academic capacity/resources and large populations	<p>In addition to A and D:</p> <ul style="list-style-type: none"> Establish institutes affiliated with the ministry of health (e.g. NIPH; NIHR; NICE) tasked with commissioning, developing, appraising or adapting national guidelines, health technology assessments and policy briefs Enhance the capacity of academic institutions to cover all areas needed for evidence-to-policy processes 	As in A

NIPH: National Institute for Public Health; NIHR: National Institute for Health Research; NICE: National Institute of Health and Clinical Excellence