DRAFT: 2009 06 12

SUPPORT Tools for evidence-informed health Policymaking (STP)

17. Preparing and using policy briefs

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Abstract

Background: This article is number 17 in a series of 21 articles on tools for evidence-informed health policymaking. Policy briefs are a relatively new approach to packaging research evidence for policymakers. In a policy brief, the policy issue is taken as the starting point rather than the research evidence that has been produced or identified. Once an issue is prioritised, the focus then turns to mobilising the full range of research evidence relevant to the various features of the issue. Drawing on available systematic reviews makes the process of evidence mobilisation feasible in a way that would not otherwise be possible if individual relevant studies had to be identified and synthesised for every feature of the issues under consideration.

Objective: In this article we suggest six questions that can be used to guide those preparing and using policy briefs as input in a policymaking process.

Key messages:

- The following questions can be used to guide the preparation and use of policy briefs as inputs to policymaking processes:
  1. Does the policy brief address a high-priority issue and describe the context in which the issue is being (or will be) addressed?
  2. Does the policy brief describe the problem, costs and consequences of options to address the problem, as well as key implementation considerations?
  3. Does the policy brief employ systematic and transparent methods to identify, select, and assess synthesised research evidence?
  4. Does the policy brief take quality, local applicability, and equity considerations into account when discussing the synthesised research evidence?
  5. Does the policy brief employ a graded-entry format?
  6. Was the policy brief reviewed for both scientific quality and system relevance?
- Each of the potential options considered as ways to address the problem would ideally be assessed in terms of:
  1. Its benefits
  2. Its harms
  3. Its costs and, if possible, its cost-effectiveness relative to other options
  4. The degree of uncertainty related to these costs and consequences (so that monitoring and evaluation can be focused on particular areas of uncertainty for any option pursued)
  5. The key elements of the policy option if it has been tried elsewhere and any adaptation considered, and
  6. The views and experiences of stakeholders with regard to each option
- The use of policy briefs is new and continues to evolve through practical experience. Formal evaluations of this approach are needed in order to improve our understanding of which particular design features are well received for particular topics. They are also necessary as a way of improving our understanding of whether, and how, policy briefs influence the policymaking process.

Background

This article is number 17 in a series of 21 articles on tools for evidence-informed health policymaking. It is also the 2nd of 4 articles in this series about making decisions and involving stakeholders in decisions. Its purpose is to suggest questions to guide those involved in preparing and using policy briefs as an input to the policymaking process.

Three major shifts have occurred recently in the focus of many efforts to package research evidence for policymakers. Firstly, there has been a shift from packaging single studies to packaging systematic reviews of studies that address common, policy-relevant questions. A number of research groups, including the SUPPORT collaboration, now produce policymaker-friendly summaries of systematic reviews. These summaries always highlight the key messages from the review but some of them, like SUPPORT summaries, also address considerations related to quality, local applicability, equity and scaling up [1]. This shift in focus has made it easier for policymakers to scan broadly across large bodies of research evidence. And it has also enabled them to extract easily what they need to know from particular systematic reviews that directly address key features of their policy issue of interest.

Secondly, there have been more recent, complementary efforts to package systematic reviews (together with local data and evidence) in the form of a new type of product – the policy brief – which mobilises the best available research evidence on high-priority issues [2]. For policy briefs, the starting point is the issue and *not* the related research evidence that has been produced or identified. Once an issue is prioritised, the focus then turns to mobilising the full range of research evidence addressing the different features of the issues concerned. These include the underlying problem, options for addressing this, and key implementation considerations. Drawing on available systematic reviews makes the process of evidence mobilisation feasible in a way that would not otherwise be possible if single studies had to be identified and synthesised for all the features of the issue. In this paper, we have restricted our use of the term 'policy brief' to products matching this description exactly, but the term could be applied to many other types of products prepared by those supporting policymakers.

Evidence-packaging mechanisms, and policy briefs in particular, have been developed largely as a response to the findings of systematic reviews of factors influencing the use of research evidence in policymaking [3, 4]. Three factors, in particular, have emerged as significant. These are: 1. Timing or timeliness, 2. Accordance between the research evidence and the beliefs, values, interests or political goals, and strategies of policymakers and stakeholders, and 3. Interactions between researchers and policymakers.

Having access to a stock of the summaries of systematic reviews as well as policy briefs, helps to address the need that policymakers have for timely inputs to policymaking processes [5]. Review summaries and policy briefs can typically be produced in days and weeks, rather than the months or years required to prepare a systematic review from scratch. Conducting primary research studies can be similarly time intensive. Evidence-packaging mechanisms, and policy briefs in particular, can also make it easier for policymakers and other stakeholders to determine whether (and how) the research evidence available accords with their own beliefs, values, interests or political goals and strategies. With a problem clearly defined, the options clearly characterised, and the key implementation considerations clearly flagged, policymakers may be more readily able to identify viable ways forward.

Thirdly, changes have occurred in the purpose for which packaged research evidence has typically been produced. Policy briefs are increasingly an input into a policy dialogue involving individuals drawn from those who will be involved in, or affected by, decisions about a particular issue. These dialogues provide the opportunity for greater interaction between researchers and policymakers. These dialogues, where research evidence is just one input in a policy discussion, are the focus of Article 18 in this series [6].

The formats used for evidence-packaging have often been developed in response to the few available empirical studies of health policymakers' preferences for different mechanisms (and *not* their usage or effects, which typically have not been evaluated) [3, 7]. These studies have revealed a need amongst policymakers to have formats that both provide graded entry to the full details of a review *and* facilitate assessment of decision-relevant information [3]. A graded-entry format of one page of take-home messages, a three-page executive summary that summarises the full report, and a 25-page report (i.e. a 1:3:25 format) has shown to be particularly promising [8]. Presumably, either the one- or three-page summary should follow a structured format [9]. Structured abstracts have been found to have an effect on intermediate outcomes such as searchability, readability, and recall. However, no studies have compared full text to structured abstracts, and no studies have examined the impact of format features on policymakers [10]. Decision-relevant information can include the important effects (both benefits and harms) and costs (i.e. resources used) of policy and programme options, as well as local applicability and equity considerations [3].

Questions to consider

The following questions can be used to guide the preparation and use of policy briefs as inputs to policymaking processes:

1. Does the policy brief address a high-priority issue and describe the context in which the issue is being (or will be) addressed?
2. Does the policy brief describe the problem, costs and consequences of options to address the problem, as well as key implementation considerations?
3. Does the policy brief employ systematic and transparent methods to identify, select, and assess synthesised research evidence?
4. Does the policy brief take quality, local applicability, and equity considerations into account when discussing the research evidence?
5. Does the policy brief employ a graded-entry format?
6. Was the policy brief reviewed for both scientific quality and system relevance?

1. Does the policy brief address a high-priority issue and describe the context in which the issue is being (or will be) addressed?

Policy briefs are distinguished most clearly from other packaged evidence summaries by the fact that they begin with the explicit identification of a high-priority issue. In instances where an issue has been on the agenda of key stakeholders for some time, policy briefs may act as a way to spur progress. This is the case in the example highlighted in Box 1 later in this article, of low coverage rates for artemisinin-based combination therapies (ACT) to treat uncomplicated falciparum malaria in Sub-Saharan Africa countries. Alternatively, if the issue is relatively new, the policy brief may play an agenda-setting role. Either way, it is critical that the issue is deemed a priority by at least some key stakeholders. And, ideally the

prioritisation process should be systematic and transparent, using the processes outlined in Article 2 of this series as a guide [11].

A second key feature of policy briefs is that they are typically *context-specific*. Describing the key features of this context in the policy brief is important in order to create a level playing field among policy brief readers. Box 2 highlights issues related to limited or inequitable access to sustainable, high-quality community-based primary healthcare in Canada. In this instance, a policy brief to explain how the issue should be understood in the context of the particular features of primary healthcare in Canada. Of particular importance was the 'private delivery / public payment bargain' with physicians which has meant historically that most primary healthcare is delivered by physicians working in private practice with first-dollar, public (typically fee-for-service) payment [12]. Improving access in creative ways, including using collaborative practice models, requires an understanding that: 1. Physicians tend to be wary of potential infringements on their professional and commercial autonomy, 2. No other healthcare providers can, at this time, secure the public payment required to function on a viable scale, and 3. Many forms of care (including prescription drugs and homecare services) would still not be covered [13].

2. Does the policy brief describe the problem, costs and consequences of options to address the problem, as well as key implementation considerations?

A policy brief would ideally describe different features of a problem, what is known (and not known) about the costs and consequences of options for addressing the problem, and key implementation considerations. As outlined in Article 3 of this series, a problem can be understood on different levels which include [14]:

1. The nature and burden of the actual common diseases and injuries that the healthcare system must prevent or treat
2. The cost-effective programmes, services and drugs that are needed for prevention and treatment, and
3. The broader health system arrangements that determine access to, and the use of, cost-effective programmes, services and drugs, including how they affect particular groups.

A policy brief would help to diagnose the problem by locating the different features of the problem within one or more of these levels

The number of options described in a brief would ideally conform with local conventions for documents presented to senior policymakers. Many policymakers, for example, are familiar with a three-option model. But regardless of the number of options selected, each option in the policy brief can be characterised in terms of:

- The benefits of each option
- The harms of each option
- The costs of each option or their relative cost-effectiveness (if possible)
- The degree of uncertainty related to these costs and consequences (so that monitoring and evaluation can focus on particular areas of uncertainty if any given option were pursued)
- Key elements of the policy option if it has been tried elsewhere and adaptation is being considered, and
- The views of stakeholders and their experiences related to each option

A policy brief would help to make clear the trade-offs involved in selecting one option over others. If the options are not designed to be mutually exclusive, a policy brief would also help

to make clear the benefits of combing particular elements of the different options, and which *combination* of options might bring about positive synergies. Alternatively, the elements of one or more individual options could be presented first, followed by 'bundles' of options combining different elements in various ways.

Barriers to implementation (outlined in more detail in Article 12 of this series) are located at different levels, ranging from the consumer level, through to healthcare providers, organisations, and broader systems [15]. Policy briefs would help to identify these barriers and describe what can reasonably be expected (again, in terms of benefits, harms, and costs) as a result of pursuing alternative implementation strategies to address these barriers. A policy brief could also identify considerations related to the preparation of a monitoring and evaluation plan. Box 3 provides a possible outline for a policy brief.

3. Does the policy brief employ systematic and transparent methods to identify, select, and assess synthesised research evidence?

Policymakers and a wide range of stakeholders who will be involved in (or affected by) a decision, are the main audience of a policy brief. It is therefore advisable to keep the use of research language to a minimum as most people will be unfamiliar with it. Nevertheless, whether through a 'box' or an appendix, a policy brief should still ideally describe how synthesised research evidence was identified, selected and assessed in ways that are easily understood. The methods, too, should be systematic in nature and reported in a transparent way. For example, users could be provided with a description of how systematic reviews addressing the benefits and harms of particular health system arrangements were identified through a search of continuously updated review databases related to reviews in a particular domain. This could provide significant reassurance to readers that most, if not all, key reviews had been found and that few, if any, key reviews had been missed.

4. Does the policy brief take quality, local applicability, and equity considerations into account when discussing the research evidence?

Systematic reviews may be of high or low quality, highly applicable to a given policymaker's setting or of very limited applicability, and focused on the majority but not prioritized groups. Ideally, a policy brief would flag variations like this for policymakers and other readers. As outlined in Article 7, explicit criteria are available to assist with quality assessments [16]. Importantly, some databases of systematic reviews, such as Rx for Change (www.rxforchange.ca), provide quality ratings for all reviews contained in the database. If possible, a policy brief would provide a quality review for all systematic reviews from which key messages have been extracted. Explicit criteria are also available to assist with local applicability assessments and these are outlined in further detail in Article 8 [17]. Given that policy briefs are typically context-specific, a policy brief would also ideally comment on the local applicability of the key systematic reviews that it cites. Equity considerations can also be addressed using explicit criteria, as outlined in Article 9 of this series [18]. A brief should also note in its introduction whether any groups have been given particular attention in the brief. Group-specific key messages could be added to the overall key messages in each section.

5. Does the policy brief employ a graded-entry format?

Ideally a policy brief would allow busy policymakers and other readers to scan the key messages quickly in order to determine whether these corresponded to their key issue of concern and context sufficiently closely to warrant reading through the entire document. A graded-entry format could take a number of forms. These could include a 1:3:25 format which would include *one* page of take-home messages, a *three*-page executive summary, and a *25*-page report [8] or a 1:12 format, which consists of one page of take-home messages followed by a 12-page report. A policy brief, as a minimum, would contain a list of key messages, a report, and a reference list for those who wish to read more. The key messages would range from the identification of the problem through what is known about the options, and the key considerations for implementation.

6. Was the policy brief reviewed for both scientific quality and system relevance?

Policy briefs need to meet two standards: scientific quality and system relevance. To ensure that such standards are met, the review process could involve at least one policymaker, at least one other stakeholder, and at least one researcher. This so-called *merit review* process differs from a typical *peer review* process that would typically only involve researchers in the review process, and hence focus primarily on scientific quality. Involving policymakers and other stakeholders can help to ensure the brief's relevance to the health system.

Three additional considerations

Three other considerations warrant mention:

- If possible, the title of a policy brief should be worded in a way that will engage policymakers and other stakeholders (this could be achieved, for example, by using a compelling question as a title)
- The cover and/or the acknowledgements section of a policy brief should provide a list of authors and their affiliations. It should also include a list of those involved in establishing the terms of reference for the policy brief (i.e. the steering committee members) and their affiliations, a list of key informants who were contacted to identify relevant data, and research evidence to inform the preparation of the policy brief and their affiliations. A list of funders (for the organisation producing the policy brief and for the policy brief itself) and a statement about any conflicts of interest among authors and steering committee members should also form part of the policy brief document
- Finally, policy brief series would ideally be the subject of formal evaluations. This will help to improve an understanding of which design features are well received for particular topics and also help to improve our understanding of whether (and how) policy briefs influence the policymaking process

Box 4 provides a description of one approach to the formative evaluation of policy briefs.

Resources

Useful documents and further reading

- Canadian Health Services Research Foundation. Communication Notes: Reader-Friendly Writing - 1:3:25. Ottawa, Canada: Canadian Health Services Research Foundation. – Source of advice about writing for an audience of policymakers and other stakeholders http://www.chsrf.ca/knowledge_transfer/communication_notes/comm_reader_friendly_writing_e.php
- Lavis JN, Boyko JA: *Evidence Brief: Improving Access to Primary Healthcare in Canada*. Hamilton, Canada: McMaster Health Forum; 2009 [13]. – Example of a policy brief for a specific country (Canada)
- Oxman AD, Bjorndal A, Flottorp SA, Lewin S, Lindahl AK: *Integrated Health Care for People with Chronic Conditions*. Oslo, Norway: Norwegian Knowledge Centre for the Health Services; 2008 [19]. – Example of a policy brief that provides an exhaustive review of the potential elements of policy options before bundling them together into three viable options for a specific country (Norway) http://www.kunnskapssenteret.no/Publikasjoner/5114.cms?threepage=1

Links to websites

- Health Evidence Network / European Observatory on Health Systems and Policies – Source of policy briefs targeted at policymakers in the World Health Organization's European Region http://www.euro.who.int/HEN/policybriefs/20070327_1
- Program in Policy Decision-Making (PPD) / Canadian Cochrane Network and Centre (CCNC) database – Source of policy briefs, as well as systematic reviews and overviews of systematic reviews (with links to policymaker-friendly summaries of systematic reviews and overviews of systematic reviews) http://www.researchtopolicy.ca
- SUPPORT Collaboration – Example of a source of policymaker-friendly summaries of systematic reviews relevant to low- and middle-income countries http://www.support-collaboration.org/

Box 1: Supporting the widespread use of a new, highly effective treatment for malaria in Africa

What problem has been identified?

- The overarching problem is one of low coverage rates for artemisinin-based combination therapies (ACT) to treat uncomplicated falciparum malaria in Sub-Saharan Africa. Key features of the problem include:
  - A high incidence of, and death rates from, malaria
  - Existing treatments have much lower cure rates than ACT yet patients often favour existing treatments because of their past experiences and the higher price of ACT
  - The national malaria control policy, treatment guidelines, and drug formulary in many countries do not all support the prescription, dispensing and use of ACT
  - Delivery arrangements for ACT often rely primarily on physicians yet few have regular access to them and many are comfortable receiving care from community health workers. Financial arrangements favour existing treatments over ACT (which is much more expensive) yet some patients are sceptical about heavily subsidised medication. Governance arrangements often do not allow community health workers to prescribe ACT and do not protect against counterfeit or substandard drugs

What information do systematic reviews provide about three viable options to address the problem?

- Each of the following three options was assessed in terms of the likely benefits, harms, costs (and cost-effectiveness), key elements of the policy option if it was tried elsewhere, and relevant stakeholders views and experiences:
  - Enlarge the scope of practice for community health workers to include the diagnosis of malaria and prescription of ACT (governance arrangements), introduce target payments for achieving a defined coverage rate for ACT treatment (financial arrangements), and provide them with training and supervision for the use of both rapid diagnostic tests and prescribing (delivery arrangements)
  - Introduce partial subsidies for both rapid diagnostic tests and ACT within the private sector where much care is provided in urban areas (financial arrangements)
  - Restrict the types of anti-malaria drugs that can be imported and introduce penalties for those found dispensing counterfeit or substandard drugs (governance arrangements) and make changes to the national malaria control policy and drug formulary to ensure that ACT is the recommended first-line treatment
- Important uncertainties about each option's benefits and potential harms or risk were flagged in order to give them particular attention as part of any monitoring and evaluation plan put into place

What key implementation considerations need to be borne in mind?

- A number of barriers to implementation were identified, among which were the familiarity of some patients and healthcare providers with existing treatment options and their resistance to change. Systematic reviews, about the effects of mass media campaigns, and the effects of strategies for changing provider behaviour generally, *and* for influencing prescribing and dispensing specifically, proved helpful in deciding how to address these barriers

Notes about the supporting evidence base:

- Six systematic reviews about anti-malarial drugs have been published since the release of the World Health Organization guideline in 2006, all of which lend further support to ACT as the recommended first-line treatment
- Of the systematic reviews identified: two addressed relevant governance arrangements, six addressed financial arrangements, five addressed specific configurations of human resources for health, and fifteen addressed implementation strategies, many of which could be supplemented by local studies

Box 2: Improving access to high quality primary healthcare in Canada

What problem has been identified?

- The problem is limited or inequitable access to sustainable, high-quality community-based primary healthcare in federal, provincial, and territorial publicly-funded health systems in Canada. Key characteristics of the problem include:
  - Chronic diseases represent a significant share of the common conditions that must be prevented or treated by the primary healthcare system
  - Access to cost-effective programmes in Canada for services and drugs is not ideal. This is the case both when Canadians identify their own care needs or (more proactively on the part of healthcare providers) when they have an indication (or need) for prevention or treatment, particularly for chronic disease prevention and treatment
  - Health system arrangements have not always supported the provision of cost-effective programmes, services and drugs. Many Canadians do not:
    1. Have a regular physician or place of care
    2. Receive effective chronic-disease management services, or
    3. Receive care in a primary healthcare practice that uses an electronic health record, faces any financial incentive for quality, or provides nursing services

    What is more difficult to determine is the proportion of physicians who receive effective continuing professional development for chronic disease management and the proportion of primary healthcare practices that:
    1. Are periodically audited for their performance in chronic disease management
    2. Employ physician-led or collaborative practice models, and
    3. Adhere to a holistic primary healthcare model's (the Chronic Care Model's) key features [20]

What information do systematic reviews provide about three viable options to address the problem?

- Each of the following three options was assessed in terms of likely benefits, harms, costs (and cost-effectiveness), key elements of the policy option if it had been tried elsewhere, and stakeholder views and experiences related to these options:
  - Support the expansion of chronic disease management in physician-led care through a combination of electronic health records, target payments, continuing professional development, and auditing of their primary healthcare practices
  - Support the targeted expansion of inter-professional, collaborative practice primary healthcare
  - Support the use of the Chronic Care Model in primary healthcare settings. This model entails the combination of self-management support, decision support, delivery system design, clinical information systems, health system, and community
- Important uncertainties about each option's benefits and potential harms or risk were flagged. This was done in order to give these issues particular attention within any monitoring and evaluation plan put into place

What key implementation considerations need to be borne in mind?

- Little empirical research evidence could be identified about implementation barriers and strategies. Four of the implementation barriers identified were:
  1. Initial wariness amongst some patients of potential disruptions in their relationship with their primary healthcare physician
  2. Wariness on the part of physicians (particularly older physicians) of potential infringements on their professional and commercial autonomy

3. Organisational scale required for some of the options is not viable in many rural and remote communities, and
4. Willingness on the part of governments to broaden the breadth and depth of public payment for primary healthcare, particularly during a recession

Notes about the supporting evidence base:

- Dozens of relevant systematic reviews were identified, some of which addressed the option directly and others of which addressed elements of one or more options [13]

Box 3: Possible outline of a policy brief

Title (possibly in the form of a compelling question)

Key messages (possibly as bullet points)
- What is the problem?
- What do we know (and not know) about viable options to address the problem?
- What implementation considerations need to be borne in mind?

Report
- Introduction that describes the issue and the context in which it will be addressed
- Definition of the problem in such a way that its features can be understood at one or more of the following levels:
  1. The nature and burden of common diseases and injuries that the healthcare system must prevent or treat
  2. The cost-effective programmes, services and drugs that are needed for prevention and treatment, and
  3. The health system arrangements that determine access to and use of cost-effective programmes, services and drugs, including how they affect particular groups
- Options for addressing the problem, with each one assessed in a table (an example is shown below)

Category of finding	**Nature of findings from systematic reviews and other available research evidence**
Benefits	
Potential harms	
Costs and cost-effectiveness	
Uncertainty regarding benefits and potential harms	
Key elements of the option (how and why it works)	
Stakeholders' views and experiences	

- Implementation considerations, with potential barriers to implementing the options assessed in a table (please see example below), each viable implementation strategy also assessed in table (please see example above), and suggestions for a monitoring and evaluation plan

Levels	**Option 1**	**Option 2**	**Option 3**
Consumer			
Healthcare provider			
Organisation			
System			

Additional content that could appear on a cover page or in an appendix:
- A list of authors and their affiliations

- A list of those involved in establishing the terms of reference for the policy brief (i.e. steering committee members) and their affiliations
- A list of key informants who were contacted to identify relevant data and research evidence to inform the preparation of the policy brief, and their affiliations
- A list of funders (for the organisation producing the policy brief and for the policy brief itself)
- A statement about conflicts of interest among authors and steering committee members

Additional content that could appear in boxes or in an appendix

- Methods used to identify, select, and assess synthesised research evidence (including assessments of quality, local applicability and equity considerations)
- Review process used to ensure the scientific quality and system relevance of the policy brief

Box 4: An example of an approach to the formative evaluation of a policy briefs series

- The McMaster Health Forum surveys those to whom it sends a policy brief, with the long-term goal of identifying which design features work best for particular types of issues, and in which particular health system contexts. Participation is voluntary, confidentiality assured, and anonymity safe-guarded
- Twelve features of the policy briefs series are the focus of questions in the formative evaluation survey:
  - Describes the context of the issue being addressed
  - Describes different features of the problem, including (where possible) how it affects particular groups
  - Describes three options for addressing the problem
  - Describes key implementation considerations
  - Employs systematic and transparent methods to identify, select, and assess synthesised research evidence
  - Takes quality considerations into account when discussing the research evidence
  - Takes local applicability considerations into account when discussing the research evidence
  - Takes equity considerations into account when discussing the research evidence
  - Does not conclude with particular recommendations
  - Employs a graded-entry format (i.e. a list of key messages and a full report)
  - Includes a reference list for those who want to read more about a particular systematic review or research study, and
  - Is subject to a review by at least one policymaker, at least one stakeholder, and at least one researcher. This process is termed a *merit* review to distinguish it from standard *peer* review which would typically only involve researchers in the review process
- For each design feature, the survey asks:
  - How useful did they find this approach (on a scale from 1 = Worthless to 7 = Useful)?
  - Are there any additional comments or suggestions for improvement?
- The survey also asks:
  - How well did the policy brief achieve its purpose, namely to present the available research evidence on a high-priority issue in order to inform a policy dialogue where research evidence would be just one input to the discussion (on a scale from 1 = Failed to 7 = Achieved)?
  - What features of the policy brief should be retained in future?
  - What features of the policy brief should be changed in future?
  - What key stakeholders can do better or differently to address the high-priority issue and what they personally can do better or differently?
  - Their role and background (so that the McMaster Health Forum can determine if different groups have different views and experiences related to policy briefs)
- The Evidence-Informed Policy Networks (EVIPNet) operating in Africa, Asia and the Americas plan to use a similar approach in the formative evaluation of their policy briefs

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