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Public Health Wales

WHO Collaborating Centre on Investment for Health and Well-being

How to Make the Case for Sustainable Investment in Well-being and Health Equity:

A Practical Guide

Logic framework

Phase 1.
Project scoping and planning

Phase 2.
Evidence gathering, synthesis and design

Phase 3.
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Foreword

Wales has committed to and gained substantial progress in driving sustainable development and well-being for the present and future generations.

Public Health Wales' report *'Making a Difference: Investing in Sustainable Health and Well-being for the People of Wales'* has offered evidence and expertise in support of preventing ill health and reducing inequities to achieve a sustainable economy, thriving society and healthy people and planet. Building on the successes of this key publication and gathering further evidence and lessons from other countries, our WHO Collaborating Centre has developed this Investment Guide to help inform and support others in building the case for investing in health equity and well-being.

I hope this will be a helpful practical tool for health and equity advocates, driving sustainable, fair, evidence-informed and rights-based investment towards prosperity for all in the WHO European Region and globally.

Dr Tracey Cooper,
Chief Executive,
Public Health Wales

Attention to health equity, gender equality and the right to the highest attainable standard of health for all has never been more important. Health equity is vital to achieving sustainable development and inclusive economies.

Making progress towards healthy prosperous lives for all requires systematic and sustainable action, including scaling up and adapting what works, and generating new solutions, alliances and tools that break down the barriers to progress. We already have good instruments to describe the problem. We urgently need appropriate know-how to develop and implement solutions and to enable a coordinated approach to advocacy and real life application.

This Investment Guide, developed by the WHO Collaborating Centre on Investment for Health and Well-being at Public Health Wales, provides a useful framework and resource to empower decision-makers to take better-informed decisions and transformative action.

Chris Brown,
Head, WHO European Office for Investment for Health and Development, Venice

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Executive Summary

Urgent action is needed to address the growing health, inequity, economic and environmental challenges that threaten the well-being of present and future generations. Current investment policies and practices are unsustainable and result in high human, social, economic and environmental costs. There is already a clear commitment and concerted action, across the WHO European Region and globally, to tackle these pressures and to drive sustainable development and prosperity for all. National and local governments can play a major role in this.

Health inequities are not inevitable. Coordinated policy action on the determinants of health combined with well-designed and implemented governance approaches have a dual effect on reducing the health gap and improving overall population health.

Substantial evidence demonstrates that investing in evidence-informed, cross-sectoral and fair public policies and interventions brings multiple benefits which drive social, economic and environmental sustainability. Making the case and advocating for investment in well-being and health equity is essential to enable evidence-informed sustainable and fair policy and action for the benefit of people, communities, societies, the economy and the planet. This aligns with and supports the *United Nations 2030 Agenda, the WHO General Programme of Work, the WHO European Roadmap to implement sustainable development* and *the WHO European Health Equity Status Report (HESR) Initiative.*

This guide outlines the step-by-step process of how to synthesize, translate and communicate public health and health economics evidence into policy and practice, making the case for sustainable investment in well-being and health equity. It is intended to help key stakeholders, advocates for health and equity, civil servants and other health and non-health professionals who have a role in informing, influencing or shaping national and sub-national policy and practice.

This guide aims to: i) prevent disinvestment in the health; ii) increase investment in prevention (public health); and iii) mainstream cross-sector investment to address the wider determinants of health and equity, driving prosperity for all. It also supports the four drivers of the HESR – participation, empowerment, policy coherence and accountability.

Building on the *knowledge-to-action framework*, four key phases are described in this guide:

- **Phase 1. Project scoping and planning**
- **Phase 2. Evidence gathering, synthesis and design**
- **Phase 3. Dissemination and communication**
- **Phase 4. Monitoring and evaluation.**

They result in the development of evidence-informed, context-tailored advocacy documents and tools, enabling healthy policy- and decision-making across different sectors, levels of government and country settings. Each phase highlights specific steps, key messages, the resulting products and a number of practical tools and tips to facilitate real life application. Each phase also provides options for essential requirements and potential opportunities depending on the available budget and resources.

Essential elements of this Guide are the health economics approaches, methods and tools to build the case for investment, showing the burden and costs of inaction in parallel with available sustainable solutions, which bring health, social, economic and environmental benefits (returns).

This guide is presented as an interactive online tool, easy to navigate and use. A summary outline is also available, which provides a checklist for each phase and highlights the key steps, messages, products and tools.

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Why is this Guide needed?

A call for action

Urgent action is needed to address the growing health, inequity, economic and environmental challenges that threaten the well-being of present and future generations *(1)*. Regardless of improving levels of health globally and nationally, inequities between and within countries remain, reflecting differences in social, economic, political and cultural context and related investment decisions *(2,3)*. Health inequity is the challenge of our time, preventing many people from living a full life and undermining national and local efforts for sustainable growth and prosperity for all *(4)*.

Current investment policies and practices (business as usual) are unsustainable and result in high human, social, economic and environmental costs *(1)*. If no measures are taken, total healthcare costs across Organisation for Economic Cooperation and Development countries will double by 2050 (5). At the same time, only 10% of global gross domestic product (GDP) was spent on health in 2015, and arguably only around 3% of health care expenditure is allocated to public health and preventive action *(6,7)*.

National, regional and local governments can play a major role in protecting, improving and promoting the health and well-being of their populations while achieving sustainable development and health equity.

The case for investing in well-being and health equity

Substantial evidence demonstrates that the economic value of a healthier society is a resource for social and economic development. Reducing inequities in health improves life chances, benefits wider society and enables prosperity for all (Box 1) *(4)*.

Health inequities are not inevitable. Improving well-being and reducing health inequities are important approaches to creating and sustaining prosperous lives and nations. Coordinated policy action on the determinants of health combined with well-designed and implemented governance approaches have a dual effect on: reducing the health gap and improving overall population health *(4)*.

A key route to achieve these aims is by improving the conditions in which people are born, grow up, live, work and age. Investing in evidence-informed, cross-sectoral and fair public policies and interventions, brings multiple benefits that drive social, economic and environmental sustainability (Box 2) *(1)*.

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Box 1. Why invest for better health and reduce health inequities *(4)*

1. **Reducing preventable ill health is a matter of fairness and social justice.**
   Across Europe, many people die prematurely each year as a result of health inequity.

2. **Health is a human right.**
   Health is recognized as a basic human right in many international treaties and conventions and by almost every country and is referred to in 115 constitutions.

3. **Health is a public good and a national asset.**
   Health is a key asset of individuals, communities and nations, contributing directly to well-being in society and indirectly to other public goods, such as increased social cohesion and the potential for human development.

4. **Loss of health and increasing health inequity lead to social conflict and undermine community cohesion.**
   Health inequities deny access to equal life chances, which affect individual and community capacities to meet basic human needs. The health of populations and the determinants of health equity are critical for social coherence and economic growth, and are a vital resource for human development.

5. **Population health is an economic asset and a productive good.**
   The economic consequences of avoidable illness constitute a major burden on individuals and on the capacity for economic development and labour market productivity. Conversely, a high level of population health is an economic asset.

Equity in its many forms and expressions includes:

- Equity in access to basic services (such as healthcare or education), resources (such as water or income) and opportunities (such as industrialization or decision-making);
- Equity as a value of society contributing to other societal benefits (such as sustainable economic growth, peace, justice, stability and security);
- Equity in levels of exposure and vulnerability to risk (for example in health emergencies);
- Equity as an organizational value (such as gender equality).

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Box 2. Health, equity and prosperity are interrelated *(1)*

1. **Socioeconomic disadvantage is associated with ill health and health inequity, just as poor health is associated with lasting socioeconomic disadvantage.**
   For example, the total welfare losses due to avoidable inequities in health in the European Union (EU) are estimated at 9.4% of GDP, or €980 billion. Inequities in health account for 15% of the total cost of social security benefits and 20% of the cost of health care.

2. **Gender-based inequalities undermine inclusive economic growth and sustainability.**
   For example, underrepresentation of women in the EU labour market costs €370 billion per year (2.8% of GDP). On average, women earn 21.8% less than men in Central and Eastern Europe and Central Asia, and 16% less in the EU.

3. **Age-based inequalities are associated with the risk of poverty.**
   The risk of poverty grows with older age and is much higher among women than men.

4. **Vulnerability is linked to socioeconomic disadvantage and higher risk of ill health.**
   Even a short spell of homelessness reduces a person's chances of reintegration into society and can lead to poor physical and mental health.

5. **Environmental health risks are associated with socioeconomic and health inequity.**
   Environmental health risks exacerbate inequalities between and within countries, across the social gradient and across the life-course.

Examples of costs & solutions *(8)*

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Global and European commitment

The *United Nations' 2030 Agenda for Sustainable Development (9)* requires work to be undertaken in a transformative, inclusive and evidence-informed way, across all sectors of government and society, to achieve social, economic and environmental sustainability. Health is a determinant, an enabler and an outcome of the *17 Sustainable Development Goals (SDGs)*, explicitly targeted in *Goal 3: Ensure healthy lives and promote well-being for all at all ages.* All SDGs are equity-oriented and offer a framework for action where no one is left behind. This is explicitly stated in *Goal 10: Reduce inequality within and among countries* and *Goal 5: Achieve gender equality and empower all women and girls.* At the same time, strengthening equity helps to implement all SDGs and create a society where decisions are taken on moral grounds *(10).*

Central to WHO's *Thirteenth General Programme of Work (2019–2023) (11)* all people should be empowered to improve their health, health determinants should be addressed and health challenges responded to. This is supported by WHO's *A healthier humanity. The investment case for 2019–2023*, which highlights that "Investments in health are not just investments in a healthier future; they're a down payment on a fairer, safer and more prosperous world" *(12).*

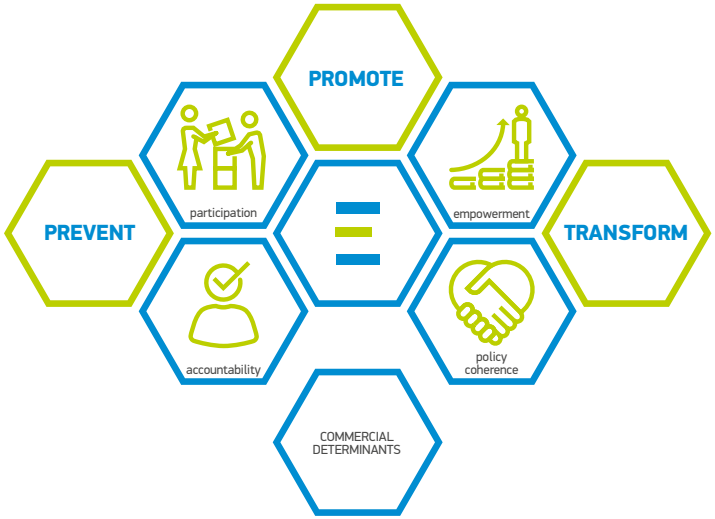
The core principles of *Health 2020, a European strategy and policy framework for health for the 21st century (13)* address the social determinants of health and tackle health inequities in the WHO European Region. For these to be achieved, it is essential to involve and engage people in public policy-making and delivery, through social mobilization, inclusive decision-making and shared accountability *(14).*

The WHO European Roadmap to *implement the 2030 Agenda for Sustainable Development* outlines *'investment for health'* as an enabling measure to achieve sustainable development in the Region. It emphasizes that investing in health and equity is an enabler of prosperity for all, now and in the future; and is addressing social, economic and environmental conditions, it empowers people to achieve the highest attainable standard of health for all *(1,15).*

The Health Equity Status Report (HESR) Initiative (16) identifies priorities and proposes options for increasing health equity and well-being in Europe. It provides a suite of tools to promote and support policy action, addressing key challenges and opportunities to:

- remove the barriers that are holding people back in health and in life; and
- create the conditions for all people to prosper and flourish in health and in life.

The HESR Initiative *(16)* has identified **four drivers of health equity: policy coherence, empowerment, participation and accountability;** with a cross-sectoral impact of **commercial determinants** of health. These drivers have a **preventive role** (to combat discrimination and drive protection and realization of rights and policy measures for health equity); a **promotional role** (to prioritize action on health equity and determinants in driving forward intersectoral work) and a **transformative role** (to accelerate equity in participation in society's development and in sharing the benefits of development).



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Box 3. The Health Equity Status Report (HESR) Initiative *(16)*

- Sets a baseline for monitoring health equity status and policy progress.
- Sets an agenda for scaling-up and enabling action on health equity.
- Scales up mainstreaming of equity into WHO policies and programmes.

Progress is measured across **five policy categories,** including ensuring the conditions for a healthy and prosperous life and contributing to the SDGs:

HESR policy action areas	Relevant SDGs
1. Health and health services: policies that ensure the availability, accessibility, affordability and quality of prevention, treatment and health care services.	SDG 3 (good health and well-being)
2. Health and living conditions: policies that improve the physical, social and natural environments in which people live and that have an impact on their health.	SDG 1 (no poverty), 2 (zero hunger), 9 (inclusive industrialization), 11 (inclusive cities and human settlements), 15 (sustainable use of ecosystems), 16 (peaceful and inclusive societies)
3. Health, personal and community capabilities: policies that improve the personal and collective knowledge and capabilities of communities and individuals to influence social, economic and environmental changes that promote their health.	SDG 4 (inclusive education), 5 (gender equality)
4. Health, employment and working conditions: policies that improve the availability and accessibility of work in the labour market and the conditions of that work, such as security, flexibility, financial reward, physical and mental demands and risks.	SDG 8 (inclusive economic growth and employment for all)
5. Health, income and social protection: policies that ensure basic income security and reduce vulnerability to risks associated with disability, sickness, maternity/paternity, old age, bereavement, caring, unemployment and housing.	SDG 10 (reduced inequalities - promote income growth of the bottom 40%)

The HESR Initiative contributes to:

- strengthening the equity impact of the health, while preventing disinvestment
- increasing the impact of cross-sectoral policies for health equity, while increasing investment for public health and prevention
- improving governance and target resources to better tackle the roots of exclusion, stigma and discrimination
- building alliances and advocating better investment for healthier lives for all.

Taking forward these global and European commitments requires robust evidence, political drive, cross-sectoral activities, multidisciplinary stakeholder and public engagement and innovative approaches to balance the limited resources and meet the needs of both current and future generations.

Making the case and advocating for investment in well-being and health equity are essential to enable evidence-informed, sustainable and fair policy and action for the benefit of people, communities, societies, the economy and the planet.

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What is the purpose of this guide?

Supporting investment, governance and accountability

This guide supports the *WHO European HESR Initiative (16)* and the *Roadmap to implement the 2030 Agenda for Sustainable Development (15)*, providing a practical tool to improve governance, investment and accountability for health and equity.

This guide is flexible regarding country contexts and priorities. It focuses on building the case for investment through the mobilization, translation and communication of evidence as well as advocacy, wide cross-sector and stakeholder engagement and participation and the monitoring of progress and accountability.

It particularly aims to:

- **Prevent disinvestment in health;**
- **Increase investment in prevention (public health);** and
- **Mainstream cross-sectoral investment to address the wider determinants of health and equity, driving sustainable development and prosperity for all.**

Building a step-by-step case for investment, flexible regarding national contexts and priorities

This Guide outlines the step-by-step process of how to synthesize, translate and communicate public health and health economics evidence into policy and practice, making the case for sustainable investment in well-being and health equity. It helps the development of evidence-informed, context-tailored advocacy reports and other relevant documents and tools, enabling healthy policy- and decision-making across different sectors, levels of government and country settings. It also shows the necessity for and helps to facilitate cross-sectoral and multidisciplinary working, public participation, context tailoring and accountability along the whole process of evidence translation. Finally, this Guide also presents options for the best-case scenario and the required minimum, depending on the skills and resources available within the project team.

Who is this guide for?

This guide is intended to help key stakeholders, advocates for health and equity, civil servants and other health and non-health professionals who have a role in informing, influencing or shaping national and sub-national policy and practice. This includes national, sub-national and local public health agencies, institutes and teams, governments' health or other relevant departments, parliaments' research or evidence review departments, policy and government advisery services, and others.

To use this guide effectively, a basic understanding of health policy, health systems and health economics is desirable.

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Methodology

This Guide has been inspired by the experience of Wales (United Kingdom) where an evidence synthesis report was developed to inform about and advocate for investment in prevention to address the current and future social and economic challenges affecting health in Wales (Box 4) *(17)*.

Building on this experience, this guide has been developed using a mixed methods approach including an evidence review, wide stakeholder engagement and an international multisector expert consultation and peer review.

This guide is based on the theoretical knowledge-to-action framework *(18)*, which describes the process of translating knowledge from research into practice (action) (see Annex 1 for further details). Multiple barriers can hinder the effective translation of evidence into policy and practice. These include: conflicting (political) interests; lack of access to high quality evidence; the complexity of evidence; lack of exchange between researchers and policy-makers; availability of evidence at the right time; mutual mistrust; and lack of time and resources *(19,20,21)*. Overcoming these barriers requires robust planning and process, synthesizing of evidence including health economic data, tailoring to relevant national and local contexts, identifying priority areas for action and the costs of inaction, and showing the benefits and returns of recommended policies and interventions. The resulting product, such as an evidence-informed policy report or brief, needs to be easy to understand, clear and robust and use the language of policy- and decision-makers.

A systematic **evidence review** was conducted to gather tools and resources that guide the synthesis, translation and communication of public health evidence to inform policy and practice.

Stakeholder interviews were conducted with 21 key stakeholders to inform the outline of this guide, identify key resources and tools, and highlight useful elements, challenges, facilitators, enablers and anticipated pitfalls in the knowledge-to-action process. When gaps in knowledge were detected, experts were contacted in order to identify additional resources or experiences that could contribute relevant evidence.

Finally, an **international multi-sectoral expert consultation and peer review** was undertaken on initial and advanced drafts of this guide to ensure its relevance and transferability across sectors, contexts, settings and countries. This included relevant experts from Public Health Wales, the WHO Regional Office for Europe, the WHO European Office for Investment for Health and Development, the Steering Group of the WHO Regions for Health Network, the European Public Health Association, and a number of national and international networks and organizations.

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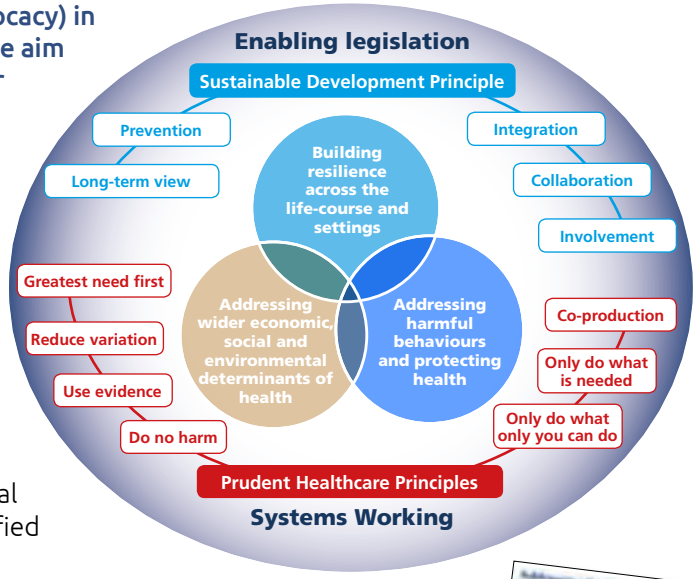
Box 4. The example of Wales *(17)*

Public Health Wales identified the need to develop a report to inform policy (advocacy) in the context of Welsh Government elections and an enabling policy framework. The aim was to show clearly the burden (costs) of ill health and inequity in Wales, together with available sustainable solutions which bring social and economic returns, thus making the case for investing in prevention across the health and other public sectors. Looking back, four distinctive phases were identified along the process:



Phase 1. Project scoping and planning

An initial project outline was developed with the aim and objectives, stakeholders, methodology, management, and expected deliverables. A project group of experts in public health, research, policy, project management and communications undertook scoping work to understand the Welsh strategic, policy and health context. Ten most challenging public health issues were identified and classified into three areas for priority investment. To identify the burden, as well as the available sustainable investment options, an evidence synthesis was planned together with an expert consultation with public health, social policy, health economics and other relevant professionals. The project group identified the target audience and further further steps to be taken.

Phase 2. Evidence gathering, synthesis and design

A search protocol was developed and experts in each subject area were consulted to help find the relevant evidence. The Health Intelligence division within Public Health Wales worked closely with other public health experts to analyse, synthesize and identify key investment options. An important consideration was to translate the evidence in a clear, concise and easy to understand way. Thus, the report was developed and published in three parts: a brief executive summary with key messages and example data; infographics on the key areas to visualise the findings; and a report with the supporting evidence and references.

Phase 3. Dissemination and communication

An advanced stakeholder analysis identified Welsh Government; executive, management and finance departments of the Welsh health service, as well as key decision-makers across the public sector as key stakeholders. Windows of opportunity were identified in a communications and dissemination plan to make best use of the report, such as identifying times of organisational change or financial planning periods.

Phase 4. Monitoring and evaluation

A follow-up meeting was held with the project group and key experts to discuss the challenges, lessons learnt and further opportunities. A three-year follow up with an outcome and impact assessment was done through a stakeholders' survey and interviews, including qualitative and quantitative data on usage and awareness of the report. Future long-term assessment and evaluation is also planned.

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Making the case for investment – a logic framework

This Guide describes four distinctive, though interrelated phases of making the case for investment in health and the relevant steps, as well as how they support the HESR Initiative and its implementation.

Making the case for investment – A logic framework with entry points, key phases, steps and end points

HESR drivers/ entry points	Making the case for investment: key phases	Key steps along the process[1]	Key end points
• Participation • Empowerment • Policy coherence	**Phase 1. Project scoping and planning**	**Step 1.** Development of a project initiation document and management structure **Step 2.** Scoping and priority-setting **Step 3.** Stakeholder mapping and engagement **Step 4.** Planning of the monitoring and evaluation of the final product	**Prevent** Prevent disinvestment **Promote** Increase investment in prevention **Transform** Mainstream cross-sectoral investment
Five health equity policy action areas: 1. Health and health services 2. Health and living conditions 3. Health, personal and community capabilities 4. Health, employment and working conditions 5. Health, income and social protection	**Phase 2. Evidence gathering and synthesis**	**Step 1.** Evidence-gathering and synthesis **Step 2.** Evidence translation and product design	
• Empowerment • Participation	**Phase 3. Dissemination and communication**	**Step 1.** Development of a dissemination plan **Step 2.** Analysis of the target audience for dissemination **Step 3.** Identification of channels for communication and dissemination **Step 4.** Advocacy	
• Accountability • Participation • Policy coherence	**Phase 4. Monitoring and evaluation**	**Step 1.** Finalization of the evaluation plan **Step 2.** Evaluation of the process and monitoring of its use **Step 3.** Evaluation of the outcomes and impact **Step 4.** Communication of the findings of the evaluation	

[1] **Note:** The time, resources and capacity required for each phase will vary depending on national / local context and factors, such as starting point, available evidence and expertise, scope of stakeholders and target audience, length of project and others.

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Phase 1. Project scoping and planning

Key messages

- A clear question outlining the policy/health area(s) for investment must be identified at the beginning of the project, guided by the five policy action areas and the aims to prevent, promote and transform.
- Initial project scoping and planning are essential, taking account of and aligning with the national or local context to ensure policy coherence.
- Early stakeholder mapping, engagement in participation and accountability are key to the success of the project, empowering various decision-makers and the public.

Outputs

- A multidisciplinary project team and clear project management/governance structure.
- An agreed written project initiation, scoping and management document.
- An initial monitoring and evaluation plan for the final product.

Process outline

Step 1. Development of Project Initiation Document and management structure

Step 2. Scoping and priority-setting

Step 3. Stakeholder mapping and engagement

Step 4. Planning of the monitoring and evaluation of the final product

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Phase 1 Step 1. Development of a Project Initiation Document and management structure

The development of a project initiation document, including a clear management/governance structure, enables transparency throughout the duration of a project *(22).*

Ideally, a project initiation document should include:

- the public health **question or need,** including the rationale, importance and relevance of the topic in the local context;
- clear **aims and objectives** for what the evidence-based product will achieve in relation to investment in health and equity to ensure **relevance and feasibility**;
- an outline of all **stakeholders** with a vested interest in the project and agreed resources available to undertake the project;
- a brief overview of the **methodological approach** to be undertaken, which will inform the evidence synthesis protocol outlined in Phase 2;
- an agreed **output** and **dissemination** plan which may evolve as the project progresses;
- an outline of the desired **impact** and how this will be monitored and evaluated *(22)*;
- an outline of how the **budget, capacity** and **resources** will be split over the stages of the project.

Key tip

The project team should secure permission or a mandate to undertake this work from the relevant internal or external authority.

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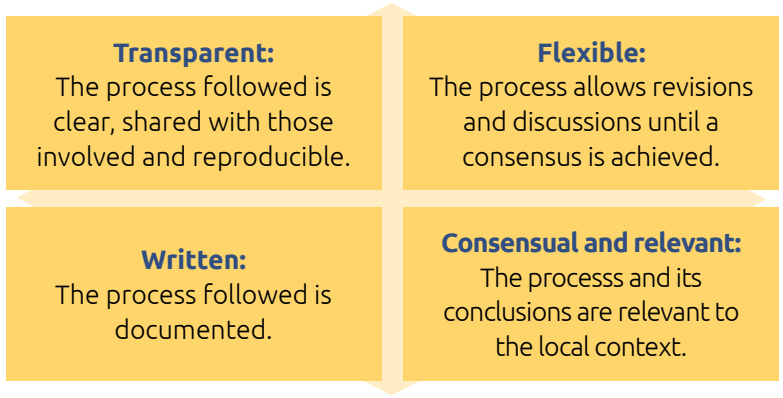
Phase 1 Step 2. Scoping and priority setting

The scoping and priority setting process helps to shape the evidence synthesis agenda and determines the public health topic on which the case for investment will be built *(23)*. At this step, it is also useful to decide whether the case will focus on preventing disinvestment, increasing investment or advocating for cross-sectoral investment to address the wider determinants of health and equity.

Fig. 1. Key principles of a successful priority setting process *(24)*



Key tips

- It is important that all relevant stakeholders are included in the priority setting process.
- Identifying a window of opportunity by setting priorities is essential to successfully advocate for investment in health and equity *(24,29)*.
- Networks and pre-existing relations with relevant experts and stakeholders facilitate engagement and may speed up the scoping process.

The following methods can be used to facilitate this process:

a. **A local context analysis can be undertaken** to understand the size of the public health problem, including the following:
   - a review of current relevant policies and legislation to understand the political climate and context;
   - work to understand the local public health system;
   - a local needs assessment to identify the political, economic, environmental, social and historical contexts, using health information system data, existing public health indicators and wider publicly available datasets *(25,26);*
   - further information on conducting a local context analysis and a situational analysis is outlined in the Regional Office's *Situation Analysis Manual (25).*

b. A **feasibility assessment** can be undertaken, which may include consideration of:
   - the likelihood of relevant economic evidence being available;
   - capacity and resources to carry out the work *(23);*
   - accessibility of data on the cost and health economic analyses of various policy options and interventions *(27,28).*

c. **Consensus building** through: early stakeholder and expert engagement will help to identify the most important public health issues in the local context *(23,28,29).*

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Phase 1 Step 3. Stakeholder mapping and engagement

a. Identification of stakeholders

Relevant stakeholders could include those generating the evidence (such as researchers), those who need to use this evidence (policy-makers, advisers, public health practitioners) and actors involved in the relevant policy and investment changes *(29,30)*. When mapping these stakeholders, it is useful to include information on their expertise, regions or countries, and how they use evidence *(23)*.

Identification of key stakeholders at this stage will also help to identify the suitable target audience for the output of the product. The following questions may help with this process *(29)*.

- Whom does the issue affect?
- Who has the power to make a decision on that issue?
- Who could influence the decision (for example, lobbyists)?
- Who has knowledge or expertise on the topic?

Table 1 includes the key stakeholders recommended as a minimum to undertake this work and potential additional stakeholders if time, budget and availability allow. The stakeholders selected will also depend on the public health challenge to be addressed.

Table 1: Recommended stakeholders

Essential	Optional
Public health professionals	Industry
Academic researchers	Potential research funders
Health service providers/ managers	Media representatives
Policy-makers	The general public
Community organizations and special interest groups	A section of the public such as a patient group
	Financial representatives and budget holders
	Non-governmental organizations

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Phase 1 Step 3. Stakeholder mapping and engagement

b. Prioritization of stakeholders

There are numerous methods for undertaking stakeholder analysis; one being the interest-influence grid (Table 2) which categorizes stakeholders according to their level of influence and their potential interest. Efforts to involve them should focus on those with high levels of influence and interest.

Table 2: Stakeholder mapping: Interest-Influence Grid *(31)*

	Low interest	High Interest
High Influence	**Action: Keep these stakeholders satisfied** Provide sufficient information to these stakeholders to ensure that they are kept up to date but not overwhelmed with data.	**Action: Manage these stakeholders closely** These are the most important stakeholders to engage with.
Low Influence	**Action: Monitor these stakeholders** These stakeholders require minimum communication.	**Action: Keep these stakeholders adequately informed** Talk to these stakeholders to ensure that no major issues arise.

c. Engagement of stakeholders

Early engagement of stakeholders can help both to inform the development of the product and to ensure that stakeholders buy into the process and the final product. The engagement process will rely heavily on the time and resources available to your project team. Be realistic in what can be achieved in the timescales set for this stage of the process. Engagement can involve online and face-to-face consultations, interviews and workshops *(32,33)*. Facilitation mechanisms or the use of external facilitators may be considered *(30)*.

Key tips

- Engaging and negotiating a consensual approach to the topic and the project from the early stages will improve support for the final product as certain stakeholders may be sensitive to investment and policy choices *(34)*.
- The project demands a mix of skills and experience – from research to policy and practice, project management to stakeholder engagement, and topical knowledge to experience with the different methods and processes used *(28)*.

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Phase 1 Step 4. Plan the monitoring and evaluation of the final process

The monitoring and evaluation of the project should ideally be discussed and agreed at the planning stage *(23)*. It is imperative to specify the objectives of the product and what it will be aiming to achieve *(17,35)*; for example, whether it will be:

- **Conceptual:** Informing decisions/providing supporting evidence.
- **Persuasive:** Advocating for policy change or investment.
- **Instrumental:** Implementing evidence-based interventions.
- **All of the above.**

The objectives will also depend on which key thematic area you are planning to pursue through this work. For example, whether the product aims to prevent disinvestment in health, increase investment in prevention or promote cross-sectoral investment to address the wider determinants of health and equity.

Once the objectives have been defined, relevant indicators should be developed. When determining the indicators to use, adherence to 'SMART' indicators is recommended (Fig.2.) *(36)*. Indicators should always be realistic as to what can be achieved in the time period between publication and evaluation *(37)*. In addition, a monitoring and evaluation plan, including measurement moments should be developed. These elements will inform the development of the evaluation plan (see Phase 4).

Fig.2. SMART Indicators *(36)*

Specific: the indicator only measures one element of the outcomes.

Measurable: there are practical ways of measuring the indicator.

Attributable: the indicator should be a valid measure of what it is trying to measure.

Realistic: the indicator should be realistic with regard to resources for data collection.

Time bound: time is a key element in evaluation. The indicator should reflect the period of data collection, and be sensitive to changes over time.

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Phase 1. Tools and Resources

A Model for Evidence-Informed Decision Making in Public Health *(38)*
https://www.nccmt.ca/about/eiph
The National Centre for Methods and Tools (Canada) has developed guidance for the process of collecting, synthesizing and disseminating public health evidence to inform policy and practice. These guides are particularly useful in the planning stages and outline the steps to follow when undertaking evidence-informed public health.

SUPPORT Tools for evidence-informed health Policymaking
- STP 3: Setting priorities for supporting evidence-informed policy-making *(24)*
https://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-7-S1-S3
The SUPporting POlicy Relevant Reviews and Trials (SUPPORT) resource helps guide those setting priorities for finding and using research evidence to support evidence-informed policy-making.

SUPPORT Tools for evidence-informed health Policymaking
- STP 4: Using research evidence to clarify a problem *(39)*
https://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-7-S1-S4
This resource can help in identifying the problem and characterizing its features by outlining questions for consideration in the preliminary stages of the process, such as which indicators can be used to establish the magnitude of the problem and how the problem can be framed in a way that will motivate different groups.

SWOT analysis (Strengths, Weakness, Opportunities and Threats) *(40)*
https://www.nesta.org.uk/toolkit/swot-analysis/
The SWOT analysis template by the National Endowment for Science, Technology and the Arts can be useful at the beginning of a project as a strategic planning model to identify factors that can positively or negatively influence the project.

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Phase 2. Evidence gathering, synthesis and design

Key messages

- A clear evidence search, review and synthesis protocol is a necessary product to develop.
- It is essential to consider the economic and social argument for investment along the five HESR policy action areas, including the commercial determinants of health and equity.
- The evidence should be synthesized and then translated into a concise and easy to understand product, tailored to the target audience and context.
- The use of different formats, including visuals, is key to increasing the impact of the product.
- A multi-disciplinary team of professionals is required to develop a high impact product.

Outputs

- A clear evidence review protocol.
- A narrative synthesis of the evidence identified and selected through the evidence review.
- A target audience analysis that determines the format of the product.
- Products that reflect the needs of the target audience, such as an evidence brief for policy-makers.
- Data/information visualization products, such as infographics.

Process outline

Step 1.
Evidence gathering and synthesis

- Define the question(s) and clarify the purpose
- Identify health economics method/approach
- Choose a review method
- Develop a protocol
- Conducting the review
- Evidence synthesis

Step 2.
Evidence translation and product design

- Analyse the target audience for evidence translation
- Write an evidence-informed policy brief
- Design and visualization

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Phase 2 Step 1. Evidence gathering and synthesis

a. Define the question(s) and clarify the purpose

Policy issues and questions are often too broad to be directly used in an evidence review and need to be transformed into a well-focused review question *(27)*. When the initial question is new or undefined, a scoping review or an evidence mapping exercise may focus the evidence review according to the literature available. A scoping review can help to define the question and understand what relevant health economic evidence is available (Table 3). Evidence mapping is done when the initial question is broad and helps to facilitate the development of more focused questions *(25,27)*.

Table 3. Frameworks to define evidence review questions

Framework	Description
The **PICO Framework** (Population, Intervention, Comparison and Outcome) *(41)*	PICO has been designed to focus questions and helps reviewers to conduct a clear and structured search in databases to find the most relevant evidence to the public health topic or problem. **P**opulation: the situation, population or person of interest. **I**ntervention: the thing that could potentially make a difference. **C**omparison: measurement of the comparison against the intervention, for example the control or standard care. **O**utcome: the end point of interest.
The **SPICE Framework** (Setting, Perspective, Intervention, Comparison and Evaluation) *(25)*	The SPICE framework is an instrument designed for global health practitioners to search qualitative research evidence. **S**etting: where and in what context. **P**opulation or perspective: for whom. **I**ntervention: what. **C**omparison: measurement of the comparison against the intervention, for example the control or standard care. **E**valuation: how well the intervention works and what results have come from it.
The **SPIDER Framework** (Sample, Phenomenon of interest, Design, Evaluation and Research type) *(42)*	The SPIDER framework is a search strategy tool for qualitative and mixed method evidence. **S**ample: smaller samples are often used in qualitative research where findings are not intended to be generalizable to the general population. **P**henomenon of **I**nterest: how and why certain experiences, behaviours and decisions are occurring. **D**esign: influences the robustness of the study. **E**valuation: may include more subjective outcomes. **R**esearch type: qualitative, quantitative and mixed-methods research could be searched for.

The involvement of stakeholders and achievement of consensus when the research questions, the scope of the review and key concepts are being defined will ensure the relevance and potential impact of the review *(25,27)*.

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b. Health economics evidence

Health economics is the interplay between the costs of an intervention/service and the outcomes/benefits from it which supports making the case for investing to improve health and equity *(43)*. The effect of investment in health and equity can be measured using a variety of economic methodologies.

Table 4 provides an overview of the traditional health economics evaluation methods and approaches. Further information can be found in Phase 2. Tools and Resources.

Table 4. Traditional health economics evaluation methods

Method	Benefits	Limitations
Return on Investment (ROI) Quantitatively evaluates the potential returns of implementing interventions as well as defining the costs of inaction *(1,25)*.	• ROI models serve as standardized metrics for measuring the financial efficiency of investment opportunities. • Commonly used.	• Focus exclusively on financial measures and exclude other intangible aspects of an opportunity.
Social Return on Investment (SROI) Addresses the challenge of measuring a wider concept of value by capturing aspects across economic, social and environmental factors. The method results in a ratio of benefits to costs, estimating the value created for every monetary unit invested. The concept of SROI strongly emphasizes stakeholder engagement and participation in defining value, so is relevant in the context of advocacy for investment in health and equity *(1,28,44)*.	• Has the capacity to measure broader socio-economic outcomes and compute views of multiple stakeholders into a singular monetary value.	• Cannot be compared across programmes as value is defined by stakeholders. • Can be subjective. External scrutiny needed to check if assumptions made are reasonable.
Cost-minimization Analysis (CMA) Used when an intervention or service and its alternative achieve the same outcomes. CMA aims to identify the least costly option *(45)*.	• There is only the need to collect cost data.	• Difficult to find interventions or services with the same outcome. • Need to consider whether costs should take inflation and discounting into account.

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Table 4. Traditional health economics evaluation methods continued…

Method	Benefits	Limitations
Cost-Effectiveness Analysis (CEA) Compares the costs of alternative interventions or services with a treatment's common therapeutic goal, expressed in one main outcome measured in natural units *(43)*. Also includes the **Incremental Cost-Effectiveness Ratio (ICER)**, which calculates the difference in costs between one intervention and an alternative, divided by the differences in outcomes *(46)*.	• There is only outcome that is measured in natural units.	• Only one outcome will represent the effect of the treatment. However there may be other relevant outcomes that are not measured *(47)*.
Cost-Utility Analysis (CUA) An extension of CEA, CUA measures health benefits in non-monetary units such as Quality Adjusted Life Years (QALYs) or Disability Adjusted Life Years (DALYs). Unlike CEA, CUA is multidimensional and incorporates considerations of quality of life as well as quantity of life gained *(48)*.	• Patient outcomes involving both quality and length of life can be included in the analysis. • In theory, the QALY measure is universal.	• Equity issues associated with QALYs *(43)* • QALY measure can vary by method and respondent, sometimes making comparisons with other studies difficult.
Cost-Benefit Analysis (CBA) Places monetary value on both costs and outcomes. Benefits in this method can be valued using the human capital approach, which values benefits in terms of productivity gains or an individual's preference using willingness to pay or willingness to accept *(43)*.	• By using the same outcome measures, CBA allows comparison of interventions which can be unrelated. • The net benefit is easy to interpret.	• In order to convert non-monetary outcomes into costs, assumptions are required. External scrutiny needed to check if assumptions made are reasonable.
Social Cost-Benefit Analysis (SCBA) As an extension of CBA, SCBA takes into account the full spectrum of costs and benefits (including social and environmental) as a result of a programme or intervention. When undertaking SCBA, it is important to consider elements such as externalities, shadow pricing and multiple types of outcomes, and it often requires complex modelling systems.	• Has the capacity to measure broader socio-economic outcomes and compute views of multiple stakeholders into a singular monetary value.	• Cannot compare across programmes as value is defined by stakeholders.
Cost-Consequence Analysis (CCA) Collects, categorizes and lists the cost components of a chosen intervention without making judgements about each of the components' relative importance.	• Decision-maker can focus on the outcomes most important or salient to them.	• No weighting system to appraise the results.

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c. Choose an evidence review method

When performing a review to inform the investment and/or disinvestment of public resources, it is essential that the review methods are comprehensive (seeking to include all available relevant evidence), objective, transparent and recognize and minimize bias. In addition, the review method chosen should be based on the review question(s) and aim to achieve the health equity theme of this work. Key characteristics of the main review types are outlined by the WHO Regional Office for Europe, for example systematic reviews, mixed method reviews, scoping reviews and rapid reviews (see Phase 2. Tools and Resources) *(25)*. Available budget and capacity will determine what methodology the project will use.

An evidence review can use primary and/or secondary sources of evidence so it is important to clarify which will be included *(49)*. A primary source provides original evidence from a piece of research, whereas secondary sources provide descriptions and interpretations of primary sources. If available resources are limited, a review of primary sources may not be feasible. In this situation, secondary evidence sources (such as systematic reviews) could be used rather than primary research papers, and/or automated methods could be used for screening and selecting evidence for inclusion in the synthesis. Where a full systematic review method is not selected, it is essential to be transparent about the methodological adjustments made and to consider the potential effects on bias. For example, using only one reviewer to assess the quality of the evidence or narrowing the search to a smaller range of databases which may reduce the comprehensiveness of the review. Snowballing or a layered approach (which involves updating or complementing systematic reviews with primary sources) can be considered if it is suitable to the scope of the project and when the review team has relevant expertise and experience, but this could risk the introduction of bias *(27)*.

Key tips

- When choosing a review method, it is important to ensure that the method selected is relevant to the topic and health equity theme, is appropriate to the skills and resources within the team, and can feasibly be undertaken in the available timeframes.
- If limited resources are available, a scoping or rapid review may be the most viable option. However, systematic reviews are the gold standard of review methodology and would limit the bias introduced through other review methodologies.

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d. Develop a protocol

The protocol is a structured plan, developed in coordination and agreement with the stakeholder group, which outlines all the relevant information necessary for conducting the evidence review. It should detail the following *(25,27)*:

- **Background information** based on the local context analysis undertaken in Phase 1;
- **The review question**, which can consist of both primary question and secondary research questions;
- **The search strategy** – where to search, search criteria to help decide which evidence will be eligible for inclusion in the review, key words and limitations, based on the conclusions of the scoping and priority setting processes in Phase 1;
- **How the quality of the evidence will be assured;**
- **A data extraction strategy** to include how data will be extracted from included sources;
- **How the evidence will be synthesized,** for example whether a meta-analysis of quantitative data may be conducted, or a narrative synthesis;
- **The review timeline.**

Key tip

Excellent record keeping will ensure the transparency and reproducibility of this stage, thus helping to secure stakeholder engagement and the legitimacy of the findings *(29)*.

A focused search strategy should include the following:

- **Keywords and subject terms.**
- **Where the evidence search will be undertaken,** for example scientific databases, professional bodies and/or grey literature relevant to the subject matter or the local context *(25,27)*. Where available, local sources or data (as well as disaggregated data from wider studies) should be considered, provided that their quality is assessed *(27)*.
- **Inclusion and exclusion criteria** *(25)*.
  - ✔ Language – which languages will be included?
  - ✔ Publication dates – which period will the search need to focus on?
  - ✔ Which health economic evaluation methods will be concentrated on?
  - ✔ Article and publication type – will the search include academic literature, non-academic/grey literature, expert opinion?
  - ✔ Study design – will the search focus on secondary data sources and/or primary data sources?
  - ✔ Will other sources of information be relevant, such as interviews with stakeholders and the target audience to bring the scientific evidence into the local context?

Further details of where to search for the evidence can be found in Phase 2. Tools and Resources. The use of different software and technology may help speed up or facilitate the evidence review. There may, however, be a cost involved *(27)*. Databases, websites, journals or resource repositories for the review may require a subscription or payment of a fee *(24)*.

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e. Conducting the review

The review team should ideally include two reviewers with relevant evidence review skills, and may also include those with expertise on the subject to advise *(27)*. If time and resources allow, subject experts, librarian specialists, and knowledge translation and policy formulation experts should be involved *(24,25)*. The stakeholder group identified in the stakeholder mapping and prioritization process in Phase 1 could additionally provide some of the skills and knowledge required.

Firstly, it is important to exclude all duplicate records of evidence from the review. After the search and initial screening have been completed, all evidence should be subject to quality appraisal. Assessing the quality of research evidence is essential for a review to be reliable. Critical appraisal is a methodology used for assessing study quality. The concept of quality usually relates to the trustworthiness, value and relevance of research evidence in a particular context. It is specifically concerned with the risk of bias which can arise from the design of the study as well as its conduct. It is important to be explicit about the rationale and process behind the quality assessment of the papers included *(25)*.

Appropriate evidence should then be extracted. If gaps in the evidence are identified, evidence from similar contexts can be adapted where possible *(17)*.

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f. Evidence synthesis

The evidence review will lead to the development of a narrative synthesis – a critical analysis of the evidence in a specific context *(27)*, and/or the results of the meta-analysis, given the focus on quantitative health economics measures, which will form the evidence base for the development of the final product.

When working on investment for health equity, the data extracted from relevant records may include:

- the health, social, economic and environmental burden of the public health issue at stake;
- the cost of the issue if left unaddressed *(24)*;
- the cost, cost-effectiveness and ROI of solutions proven effective to address it *(17)*;
- information on the risks and benefits of different options, their acceptability to stakeholders or the adaptation needed for local implementation *(24)*.

It is important to consider the four principles of evidence synthesis as outlined by Donnelly et al *(50)* (Fig.3.).

Fig. 3. Four principles of evidence synthesis *(50)*

Inclusive
- Involves key stakeholders and is relevant and useful to them
- Considers many types and sources of evidence
- Uses a range of skills and people

Rigorous
- Uses a comprehensible body of evidence
- Recognizes and minimizes bias
- Is independently reviewed through a quality assurance process

Transparent
- Clearly describes question, methods, sources of evidence and quality-assurance process
- Communicates complexities
- Acknowledges limitations
- Declares conflicts of interest

Accessible
- Written in plain language
- Available in a suitable timeframe
- Freely available online

All elements of this step have to be written up into a formal review report, which will consist of what was done, what was found and a write up of the synthesis.

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The evidence synthesis can be shaped into various formats, including written text, narratives and visuals tailored to the target audience *(23)*. The chosen format will depend on available resources and budget.

a. Analyse the target audience for evidence translation

Further to the stakeholder mapping carried out in Phase 1, the evidence gathered should be presented in a user-friendly format and shaped to support the decision-making processes to enable investment in health and equity *(30,50)*. Any recommendations should be made in the context of a country's institutional capacities and political environment.

Key tip

It is useful to share the narrative with colleagues for professional feedback, as well as with members of the target audience, in order to ensure it is suitable for their level of knowledge *(33)*.

b. Write an evidence-informed policy brief

Evidence briefs and policy briefs are prominent tools to present to policy- and decision-makers outlining an investment challenge, its scope and possible solutions or policy options to consider. They can be used as advocacy documents to convince the target audience of the urgency of the current problem and the need to adopt the preferred alternative *(52)*. These products outline the effectiveness, the benefits and disadvantages, and the uncertainties or barriers to implement identified interventions/practices *(23)*. Throughout these products, it is important to focus the main messages on the health equity theme being promoted, for example, prevention of disinvestment in health, increase of investment in prevention and cross-sectoral investment to address the wider determinants of health and equity.

Evidence products tend to follow the one-three-twenty-five (1:3:25) principle, which is reader friendly and an effective way to structure findings for decision–makers (Box 5). This should include a one-page outline of the main messages, a three-page executive summary followed by 25 pages *(22)*. The components target different audiences depending on their understanding of the subject matter, their available time and their part in the decision-making process.

Narratives and stories can also help to support the translation of complex research findings into a language that is easy to comprehend and can aid the process of advocacy (Box 6) *(53)*.

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Box 5. The 1:3:25 principle

One page: key messages

The one-page summary should:

- Include background information on the topic being considered, including the local context to build the case for prevention
- identify gaps in current policies and propose policy options that address the problem (including benefits) and considerations for their implementation; such proposals should be based on the economic evidence identified in the evidence synthesis.

This part of the brief is targeted towards stakeholders (especially policy-makers) with restricted time to comprehend ample research findings *(23,29)*.

Three pages: (executive) summary

The executive summary should be more detailed and elaborate on the public health challenge, relevant policy and investment options and considerations regarding implementation. It consists of an analysis of the context and research evidence gathered, mainly intended for policy and scientific advisers or researchers involved in the decision-making process *(23,29)*.

Twenty-five pages: supporting evidence/findings

The supporting evidence is a comprehensive presentation of the evidence.

Firstly, it should outline the scope and size of the public health issue, the underlying causes and current investment. Conducting interviews with experts, arranging meetings with the target audience and using frameworks are a useful way to support tailoring the product *(23)*.

Secondly, policy options addressing the issue should be presented, including their respective costs and anticipated impact, followed by suggestions for implementation. These should include the advantages, disadvantages and barriers to policy implementation and how they can be addressed. The inclusion of examples and case studies can provide evidence of the effectiveness of the suggested policy options *(29,52)*.

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Box 6. Guide to drafting an effective narrative

Choose a point of view.

✔ A first-person perspective can create more intimacy and help individuals relate to a situation.

✔ A third-person narrative is more suitable when multiple stories and points of view are merged into one narrative.

Establish a 'conflict'.

✔ Involve a character facing a conflict, which is resolved in the end in relation to the public health challenge. The story can be shaped in different ways, for example in chronological order, or starting with an event (such as an investment decision) around which the story is built up.

✔ Incorporate details into the story in order to make it more vivid for the audience. The use of details also helps to evoke emotion in the audience, and makes them identify with the character and the challenge at hand. Use language that sounds natural and familiar to the target audience.

c. Design and visualization

Visualizing the evidence, together with the provision of an outline in a written format, helps to engage the target audience and capture their attention.

Key tip

Be careful not to duplicate or contradict key findings when presenting them in different formats. Ensure key messages are consistent across the full body of work.

Infographics

Infographics are effective tools to communicate complex data and findings quickly and clearly *(54)*. Their purpose is to explain key findings and proposed actions in a visualized format, so as to enable the target audience to understand the key findings without the extensive supporting evidence.

Key tip

It may be beneficial to commission an external designer to produce an infographic if the skills do not exist in-house.

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Table 5. How to create an infographic

1. Define a clear story	When designing the infographic, it is important to consider the following questions. • What are the main points that the reader should take away? • Does the infographic present the question at hand and describe the scope of the public health challenge? • Are investment options for the public health challenge clearly presented? Knowledge about the target audience is needed to design infographics to their needs. Stakeholder and engagement sessions can support this.
2. Identify suitable content for visualization	There are various ways to present the key findings, for example: • compare the different public health investment options according to a common variable or framework • show interrelated factors of the public health challenge and its investment options • represent relationships, connections and processes to simplify more complex findings.
3. Optimize the structure and organization of the infographics	Be aware of the following aspects when creating infographics: • contextualize them for the audience and bringing in a human interaction to personalize or individualize them • remember their complexity normally depends on the platform where the findings are presented (Twitter, for example, operates with short messages). Decide between leading the audience through a story or letting them explore for themselves.
4. Capture the information in a visualization brief for design	This brief should include: ✔ a one-sentence story (the take away message) ✔ the original source material to be visualized ✔ where the visual will be published and possible other uses for it ✔ format (such as a website) ✔ a sketch of the visualized version of the key findings ✔ reference material for design.
5. Apply design tools effectively	The infographics should have various colours, imagery and a consistent layout but these choices must be justifiable. • The distinction between key elements and supporting elements must be clear and reflected in the size, font and colour. • Infographics should have a look and feel that ensures a good experience for the target audience, guiding readers by, for example, using arrows. This may need to be consistent with the organizational branding.
6. Finalise	Before being integrated, the infographics should be pre-tested by an external reviewer who does not see the written research findings. Feedback should be incorporated into the final design, where applicable.

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Infographic: Example from Wales *(17)*

1 See "Increasing Physical Activity Levels in Wales"
2 "Best buys" recommended by WHO for nutrition with compelling evidence of cost-effectiveness, feasibility, low-cost and appropriate to implement within the constraints of the local health system.

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Evidence gathering

Public Health Wales Observatory Evidence Service Evidence Guides 1-6 *(49)*
(To access contact: publichealthwalesobservatory@wales.nhs.uk)

This series of guides provides an overview of the steps to undertake an evidence review from how to use evidence to how to implement the evidence.

Health economics methodology

A Guide to Health Economics for those working in Public Health *(43)*
http://cheme.bangor.ac.uk/documents/guide-handbook-en.pdf
This guide introduces key economics terms in order to better understand and assess economic evidence. This will be useful for the selection of types of economic evidence to focus on in the evidence search and to improve understanding of the evidence selected for synthesis.

Health Economics: An Introduction to Economic Evaluation *(55)*
https://www.ohe.org/publications/health-economics-introduction-economic-evaluation
This publication offers an overview of approaches to health economic evaluation methods, illustrated with examples and guidance about which methods are appropriate in which situations. This again is a useful resource when selecting which economics methods to focus on in your evidence search.

Social Return on Investment – Accounting for value in the context of implementing Health 2020 and the 2030 Agenda for Sustainable Development *(44)*
http://www.euro.who.int/en/countries/italy/publications/social-return-on-investment-accounting-for-value-in-the-context-of-implementing-health-2020-and-the-2030-agenda-for-sustainable-development-2017
This paper aims to expand the understanding of the concept of SROI and its importance for implementing the 2030 Agenda for Sustainable Development and the European Health 2020 strategy. This will be a useful resource to those interested in including SROI data in their evidence search and synthesis.

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A guide to Social Return on Investment (SROI) *(56)*
http://www.socialvalueuk.org/resources/sroi-guide/
This Guide provides a clear framework for managing and accounting for social value or social impact using the SROI method.

Economic evaluation and impact assessment *(57)*
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/
NEF Consulting provides contemporary economics methods and approaches to assess the value and impact of programmes and interventions, focusing especially on capturing their social, economic and environmental value (benefits, returns). These include the following economic tools:
- Social Return on Investment (SROI), captures economic, social and environmental returns
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/sroi-centre-of-excellence/
- Social and Environmental Cost-Benefit Analysis (SCBA), introduces the concepts of social value and/or environmental sustainability into the balance sheets of cost-benefit models;
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/social-environmental-cost-benefit-analysis-scba/
- Local Multiplier 3 (LM3), which is a simple and understandable way of measuring local economic impact
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/local-multiplier-3/ .

Evidence synthesis

A resource for developing an evidence synthesis report for policy-making. Health Evidence Network (HEN) synthesis report 50 *(28)*
http://www.euro.who.int/en/publications/abstracts/resource-for-developing-an-evidence-synthesis-report-for-policy-making-a-2017
This resource has been developed to outline key approaches, methods and considerations for the synthesis of evidence to support the systematic and routine use of the best available evidence for decision-making relevant to the needs of public health decision-makers.

Rapid reviews to strengthen health policy and systems: a practical guide *(27)*
https://www.who.int/alliance-hpsr/resources/publications/rapid-review-guide/en/
This manual provides practical guidance on how to undertake rapid reviews to support the use of rapid reviews to inform health policy and systems decisions.

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Phase 2. Tools and resources

MSTAR 2: a critical appraisal tool for systematic reviews that include randomised or nonrandomised studies of healthcare interventions, or both *(58)*
https://amstar.ca/Amstar-2.php
This tool provides a checklist and relevant resources for assessing the quality of systematic reviews.

Evidence translation and product design

SUPPORT Tools for evidence-informed health Policymaking: STP 13: Preparing and using policy briefs to support evidence-informed policymaking *(59)*
https://health-policy-systems.biomedcentral.com/articles/10.1186/1478-4505-7-S1-S13
This resource has been designed to guide those preparing and using policy briefs to support evidence-informed policymaking by answering questions such as whether the policy brief addresses the relevant context of the issue and whether it employs systematic and transparent methods to identify, select and assess synthesized research evidence.

SURE Guides for Preparing and Using Evidence-Based Policy Briefs *(29)*
https://www.who.int/evidence/sure/guides/en/
The Supporting the Use of Research Evidence (SURE) Guides were developed to support individuals responsible for preparing policy briefs informed by research evidence and provide guidance on how to prioritize topics for policy briefs and inform and engage stakeholders.

The 7 G.R.A.P.H.I.C principles of public health infographics design *(60)*
https://visualisinghealth.files.wordpress.com/2014/12/guidelines.pdf
Published by the University of Leeds, these guidelines contain useful tips on how to design health infographics and convey health messages to the target audience.

The Functional Art: An introduction to information graphics and visualization *(61)*
This resource provides an introduction to understanding and using information graphics, including how to use colour and other graphic tools, and best practices for creating interactive information graphics.

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Phase 3. Dissemination and communication

Key messages

- The dissemination plan should be tailored to the needs and preferences of the target audience.
- An advocacy plan is required to engage with the target audience, aid their understanding, 'buy-in' and use of the product, and to enable empowerment of the relevant stakeholders.
- Analysis of and adaptation to the political context is essential to maximize uptake and application.

Outputs

A dissemination plan, which includes:

- A list of relevant stakeholders.
- The aim pursued when targeting each stakeholder.
- The preferences and characteristics of each audience.
- A list of channels or means for dissemination, targeted to the audience.

Process outline

Step 1. Development of a dissemination plan

Step 2. Analysis of the target audience

Step 3. Identification of channels for communication and dissemination

Step 4. Advocacy

Logic framework

Phase 1. Project scoping and planning

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Phase 3 Step 1. Development of a dissemination plan

A tailored plan for dissemination supports the project team with the active distribution and communication of information to the target audience. Depending on the available resources and budget, the Health Evidence Network *(25)* recommends considering the following questions to structure the dissemination plan.

Immediate use.

- for which policy document or action (such as national strategy, regional action plan) is the synthesis report to be used?
- for which policy events (for example, ministerial meetings, technical conferences, regional committee meetings) is the report requested?
- are there any conferences or meetings on a related technical area or health topic at which the synthesis reports should be presented?

Communication.

- should supplementary communication tools such as infographics be developed?
- would authors, peer reviewers or commissioners speak about the synthesis report on camera?
- which communication media can be used to announce and disseminate the report (for example, websites, social media, clearinghouses, newsletters, email updates)?

Distribution.

- to whom should the published reports be distributed?
- where should the synthesis reports be made available (for example, national libraries, documentation centres, knowledge-brokering organizations, universities)?

Key tips

- Planning an effective dissemination strategy takes time and should be initiated as early as possible.
- As research evidence can change quickly, evidence products are often most powerful immediately after publication.

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Phase 3 Step 2. Analysis of the target audience

A broad target group (such as policy-makers) should have been identified in Phases 1 and 2. The target audience will have to be clustered further in order to determine individuals to contact within organizations, with descriptions of their area of work, interest or role in the defined public health topic and an estimate of the target audience's level of influence and power to act *(22,29).* **For example, the objectives could be simply to inform the audience about the topic, receive input or feedback from them, or persuade them to make a decision on the topic. It is important to target stakeholders from multiple sectors due to the crosscutting nature of the product** *(62).*

The Regional Office suggests that the following factors play a key role in policy decision-making *(28)***:**

- Experience and expertise; political context; public opinion; values and judgements; culture and traditions; available resources (human and physical); budgetary constraints; policy narratives; and non-health stakeholders (for example, pressure groups, lobbyists, industry, and civil society).
- Characteristics of the target audience (for example, age, gender, ideology and role) and whether it is in the public or private sector or is a political party/affiliation, must be taken into consideration in deciding the communication approach and data to be used so that the message conveyed is appropriate to both the context and the audience.

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Phase 3 Step 3. Analysis of the target audience

The dissemination plan should be adapted to the target audience and their preferred channels of communication, using market segmentation approaches *(22, 30, 63)*.

What might be their preferred channel of communication?

- ✔ Different people prefer different formats. For example, would the audience prefer to receive information verbally, written, electronically or printed? Would they prefer face-to-face interaction or would virtual communication be more feasible for them?

What would be the best way to gain their interest?

- ✔ Generally, the chances of gaining interest of the target audience increase when there is mutual benefit for all the involved stakeholders. Try to create hooks and target issues affecting their agenda.

At what time would the information best be presented?

- ✔ Choose an appropriate point in time, when the information is highly relevant and likely to gain a lot of attention. Be aware that some public health topics are sensitive in nature.

Should different stakeholders be contacted in a specific order?

- ✔ It may be beneficial to contact some stakeholders before others especially the key stakeholders from the top-right quadrant of the interest-influence grid (see Table 2).

Who would be the most suitable and credible messenger to communicate to the respective audience?

- ✔ The project team should think of whether there is someone who might already have a close relationship with the target audience, such as a policy adviser. This can increase the likelihood that decision-makers will consider changes. The use of intermediaries or knowledge brokers to bridge between researchers and stakeholders should also be considered.

Key tips

Make use of existing links to the key stakeholders. If there are no links yet, try to find a way to approach them directly.

Bear in mind that addressing investment decisions in public health might contradict the existing political agenda.

It is important to consider that different target groups adopt new proposed changes and ideas at various times. times *(64)*.

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Phase 3 Step 3. Identification of channels for communication and dissemination

How findings are communicated is crucial in influencing evidence-informed decision-making *(65)*. A wide range of potential strategies for dissemination can be used, depending heavily on the budget and capacity available within your project team (Table 6). They usually involve a medium (print or web-based) or an event where the information is presented.

When choosing among strategies for dissemination, the project team should also consider whether these strategies require the involvement of additional people with specific skills, such as developing films or videos, and whether they suit the needs of the target audience. Again, a budget and resources will need to be accounted for.

The Regional Office suggests the following formats for different individual within the target group *(28)*:

- **politicians:** two minute elevator pitches; public opinion polls; briefing notes; small-area data; constituency-relevant maps;
- **health-system decision-makers:** detailed health-status reports; infographics; health equity audits and gauges; a proposal to integrate an issue through quality improvement and performance monitoring; a draft position statement;
- **the public:** educational media campaigns on, for example, the effects of poverty on health; policy changes that work; the potential cost of maintaining the status quo; calls for action.

The most commonly used media vary between countries and contexts. It can be useful to do an internet search beforehand to search for reliable statistics or surveys that identify the most frequently used media.

For all types of dissemination, it is important to ensure that the language used in the product is targeted towards the audiences. A key element to successful advocacy is to make readers feel they can comfortably understand the outputs and consume them within the time they have for examining information on the topic.

Table 6. Channels of Communication *(22, 23, 29, 30, 63, 66, 67)*
(Recommended essential channels of communication are in bold).

Internet	Print	Verbal/Audio/Film
Websites **Newsletters** Online journals **Social media** (Facebook, Twitter, LinkedIn, YouTube) Knowledge exchange portals Wikis Blogs Forums Online training Video modules	Printed journal **News release** **Paper handout**	Radio Film/Video **Conferences** Symposia Workshops **Meetings, either face-to-face or virtual** Policy dialogues Podcasts

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Phase 3 Step 4. Advocacy

An effective advocacy plan enables decision-makers to apply evidence in policy and practice, and to implement and act upon the proposed changes with ease *(28)*. Proposing policy change demands analysis of the current policy environment by mapping the current political landscape and identifying favourable legislation or policies that may strengthen the need to act urgently on the proposed changes.

The following steps will help with the analysis of political processes *(69)*:

- **Who decides:** including administrators, managers, managing directors, chief nursing or medical officers, legislators, heads of state, appointed officials, policy-makers, judges, ministers, boards of advisers.
- **What is decided:** including work plans, laws, policies, priorities, regulations, services, programmes, institutions, budgets, statements, party platforms, appointments.
- **How decisions are made:** including accessibility of citizens to information and the decision-making process, extent and mechanisms of consultation with various stakeholders, accountability and responsiveness of decision-makers to citizens and other stakeholders.
- **How decisions are enforced, implemented and evaluated:** ensuring accountability so that decisions are put into action, laws enforced equitably, etc.

It is important to lay-out a well-defined advocacy path. This includes clear aims and objectives, specific proposed health equity outcomes (to prevent disinvestment in health and increase investment in prevention or cross-sectoral investment to address the wider determinants of health and equity), and a breakdown of any long-term objectives into achievable and management short-term targets *(70)*.

Key tips

- Keep in mind that policy decisions are influenced by legislation, political party agendas, policy resources (referred to as formal politics) as well as circumstances in civil society, communities and organizations (referred to as informal politics) *(69)*.
- Remember that policy decisions are a continuous process of negotiations between different interests (groups).

Key tips

- A risk assessment could determine the barriers to the proposed changes being advocated. Such barriers could include: (i) counter arguments to the proposed changes; (ii) alternative viewpoints and belief systems, and (iii) who is influencing policy-makers' agendas *(68)*.
- Bear in mind that when promoting or proposing changes to the target audience, it is important to recognize previous relationships.

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Phase 3 Step 4. Advocacy

Timing is another important element to consider, for example:

- Engage in lobbying well before elections.
- To impact on budget development, stakeholders should be made aware of the product well in advance.
- Identify windows of opportunity.
- Know the important deadlines for the media and journalists *(70)*.

Advocacy experts also recommend identifying champions to recognize and showcase when dealing with a specific issue *(24,70)*. **They can inspire and motivate others and are examples of how public health can be applied to the real world.**

Key tip

Advocacy is opportunistic so it is important to be prepared to act promptly and appropriately.

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Implementation research toolkit. Module 5. Disseminating the research findings *(71)*
http://www.who.int/tdr/publications/year/2014/participant-workbook5_030414.pdf
This toolkit aims to strengthen implementation research through the utilization of research findings, provision of practical tips on developing a dissemination strategy and use of various dissemination tools.

Communications in health care improvement – a toolkit *(72)*
https://www.health.org.uk/collection/communications-health-care-improvement-toolkit
This toolkit has been designed for health professionals who want to understand and use communications to better plan, implement and spread their work. The toolkit consists of four sections: planning for success, getting started, sustaining interest and spreading the work.

WHO Strategic Communications Framework for effective communications *(73)*
http://www.who.int/mediacentre/communication-framework.pdf
This framework outlines a strategic approach for effectively communicating information across a broad range of health issues, including advocating findings to selected target audiences.

Public health advocacy toolkit *(70)*
https://www.phaiwa.org.au/the-advocacy-toolkit/
This toolkit provides an introduction to public health advocacy, examples of key advocacy strategies and samples of practical advocacy tools.

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Phase 4. Monitoring and Evaluation

Key messages

- A detailed evaluation plan with indicators of success is essential and should be developed at the outset of the project to facilitate and ensure accountability.
- Monitoring of the outputs and outcomes of the plan is a continuous process, which should start shortly after publication of the product.
- Targeted stakeholder involvement and feedback are key in the evaluation process to ensure wide participation and policy relevance.

Outputs

- An evaluation plan, including indicators of success.
- A transparent monitoring plan, which is acted upon shortly after publication of the product.
- An evaluation report.

Process outline

Step 1. Development of an evaluation plan

Step 2. Evaluation of the process and monitoring of the use of the plan

Step 3. Evaluation of the outcomes and impacts

Step 4. Communication of the findings of the evaluation

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Phase 4 Step 1. Development of an evaluation plan

The evaluation plan should describe how the process, outcomes and impact of the product will be monitored and evaluated and outline how the evaluation results will be used *(74)*. **Ideally, the evaluation plan should be started at the project initiation Phase 1. The earlier it is developed and implemented, the greater the outcomes will be.**

There are several main steps in the development of an evaluation plan:

- **clarify the objectives and goals of the product** with regard to the desired impact on driving investment in health and equity;
- **clarify the objectives and goals of the evaluation,** in collaboration with key stakeholders;
- **define the type of evaluation to be undertaken,** including outcome measures;
- **develop evaluation methods and key indicators;**
- **set a timeline for evaluation activities** *(75,76)*.

The following key points should be considered when planning an evaluation.

- Evaluation takes **time,** regardless of the methodological approach adopted *(37,76)*.
- Both **quantitative and qualitative** skills will be required to undertake a rigorous evaluation using multiple methods.
- The research and evaluation designs should be **appropriate** to the specific evaluation questions being asked *(77)*.
- A designated **monitoring and evaluation** team is essential to ensure the evaluation maintains momentum during the development of the product and after it has been disseminated.
- Access to necessary analysis **software** for the selected methods should be considered in the planning stages of the evaluation.

Box 7. Development of measureable indicators to enhance public health evidence-informed policy-making *(78)*

This study presents a set of measurable indicators for Evidence-Informed Policy-Making (EIPM) intended to infer to what extent health-related policies are evidence-informed for the purpose of policy planning, as well as formative and summative evaluations.

The indicators cover the following four areas which can be adapted for use with the product created in this Guide.

1. Human resources – for example, analysing key stakeholders working on the policy and their research experience.
2. Documentation – for example, reflecting on the scientific process undertaken in Phase 2 and the evidence briefs created for stakeholders.
3. Communication and participation – for example, analysing communication, engagement and consultation undertaken with key stakeholders and initiatives for fostering knowledge-sharing.
4. Monitoring and evaluation – for example, analysing how the research evidence has been used in the development of the policy.

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Phase 4 Step 2. Evaluation of the process and monitoring of the use of the product

Process evaluation allows analysis of how the product was developed, disseminated and communicated. It helps to identify what can be learnt from the overall process, and what elements could be improved upon if the process was to be undertaken again. Preferably, process evaluation is started as soon as the product is communicated, with the potential for on-going assessment.

Monitoring the knowledge and use of the product gives an indication of the extent to which it is used by stakeholders, and helps to understand whether it has reached the target audience in an optimal format *(35)*.

There are several methods to monitor the use of the product.

- Involvement of the target audience can provide insight into the frequency and user patterns of the product *(35)*. The method of data collection depends on the size of the target audience and time available *(79)*. Interviews can provide more information, but are more time consuming in terms of data collection and analysis. Alternatively, a questionnaire is less time-consuming and is more suitable for a larger sample size and restricted time availability.
- Tracking the number of times the product is 'mentioned' by the target audience shows the frequency and context in which it is used. Mentions can be systematically collected through web searches and lists of mentions can be complemented by official references of the report.

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Phase 4 Step 3. Evaluation of the outcomes and impact

The two types of evaluation covered in this guide are outcome evaluation and impact evaluation. The type of evaluation carried out will depend heavily on the time and resources available.

Outcome evaluation measures the short- and long-term results that follows the dissemination of the product, for example action in policy action areas as a result of the evidence presented.

Impact evaluation assesses whether the product has brought about any solid changes in the local context. In addition, impact can be determined based on the number of interventions that are implemented following publication of the product.

Key tips

- The outcome and impact measurements as well as the presentation of the findings of any evaluation should be tailored to the interest of the key stakeholders *(75)*.
- Policy development and investment decision-making is a complex process, thus, it might be difficult to identify an impact that is fully attributable to the evidence synthesis report *(80, 81)*. It is important to recognize this when undertaking an evaluation.

Methods

The data collection method to be used for the evaluation should be chosen because they fit the evaluation questions, not because they are a favoured method *(74)*. A misfit between the evaluation question and data collection methods can lead to incomplete or even inaccurate information being collected, with little relevance to the aims of the evaluation.

Similarly to monitoring of the knowledge and use of the product, involvement of the target audience can be useful in outcome and impact evaluation through stakeholder interviews or questionnaires. The target audience should be included in the process as early as possible, and should be informed about possible points at which evaluation is done to increase participation rates *(30)*.

A questionnaire to involve the target audience should include both closed and open-ended questions. This allows for respondents to elaborate on certain elements, for example by naming policy changes that have been inspired by the product *(76)*.

Key tips

- Early stakeholder engagement can lead to higher response rates to questionnaires or interviews.
- The use of personal communication and personalized invitations encourages stakeholders to be involved in the evaluation process and increases response rates *(82)*.

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Phase 4 Step 4. Communication of the findings of the evaluation

When communicating the findings of the evaluation, there is a need to understand at whom they are targeted. The format, context, detail and content of the evaluation briefing should reflect the needs and interest of the target audience *(76)*.

In addition, an assessment of how the results of the evaluation have been used to influence decisions and what the consequences of the evaluation were is recommended *(77)*.

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Phase 4. Tools and resources

Impact Evaluation in Practice *(83)*
https://siteresources.worldbank.org/EXTHDOFFICE/Resources/5485726-1295455628620/Impact_Evaluation_in_Practice.pdf
This interactive textbook introduces impact evaluation aimed at practitioners and policymakers to help them strengthen the evidence base for developing programmes and policies.

Developing an Effective Evaluation Plan. Setting the course for an effective evaluation plan *(84)*
https://www.cdc.gov/obesity/downloads/CDC-Evaluation-Workbook-508.pdf
This workbook can help develop a joint understanding of what constitutes an evaluation plan, why it is important, and how to develop an effective evaluation plan in the context of the planning process.

Evaluation and impact assessment *(57)*
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/
NEF Consulting provides contemporary methods, approaches and tools to assess the value and impact of programmes, projects or organizations, on a national, local and organisational level.
These include: social return on investment, outcomes evaluation, social cost-benefit analysis, multicriteria appraisal, local multiplier 3 (lm3) and prove and improve tools.

- **Outcomes evaluation,** measuring the actual change from a specific activity, based on the principle of measuring what matters to stakeholders
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/outcomes-evaluation/

- **Multi-Criteria Appraisal (MCA),** accounts for the role of economic, social and environmental factors in decision-making
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/multi-criteria-appraisal-mca-2/

- **Prove and Improve Tools** to prove and improve the impact of enterprises, projects and others
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/prove-and-improve-toolkits/

- **Social Return on Investment (SROI)**, capturing economic, social and environmental returns
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/sroi-centre-of-excellence/

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• **Social and Environmental Cost-Benefit Analysis (SCBA)**, introduces the concepts of social value and/or environmental sustainability into the balance sheets of cost-benefit models
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/social-environmental-cost-benefit-analysis-scba/

• **Local Multiplier 3 (LM3),** a simple and understandable way of measuring local economic impact
https://www.nefconsulting.com/our-services/evaluation-impact-assessment/local-multiplier-3/

Communicating Development Evaluation Results *(85)*
http://www.oecd.org/dac/evaluation/communicatingevaluationresults.htm
This website gives tips on how to communicate and share evaluation findings to the target audience.

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Checklist

Phase 1. Project scoping and planning

- ☐ Have a multi-disciplinary project team and management structure been established?
- ☐ Have key stakeholders been identified and prioritized to inform a stakeholder map?
- ☐ Has a project initiation document been written and agreed with relevant stakeholders?
- ☐ Have the scoping and priority-setting processes been thoroughly documented?

Phase 2. Evidence gathering, synthesis and design

- ☐ Has a question been defined and a clear protocol written?
- ☐ Have the review methods been defined, including which health economics methods are to be focused on?
- ☐ Has the evidence brief been developed following the 1:3:25 format and tailored to the target audience?
- ☐ Have visualizations been used to make the brief more engaging and easier to understand?

Phase 3. Dissemination and communication

- ☐ Has a clear dissemination plan been developed?
- ☐ Have the needs of the target audience been outlined in the dissemination plan?
- ☐ Has an understanding of the current political landscape been considered?
- ☐ Have the appropriate channels of communication been identified?
- ☐ Has an advocacy plan been developed to encourage the target audience to put the evidence and proposed changes into practice?

Phase 4. Monitoring and evaluation

- ☐ Has a clear evaluation plan been developed?
- ☐ Has a process evaluation been undertaken?
- ☐ Has any monitoring of use of the product been undertaken?
- ☐ Has a final outcome and impact evaluation report been written and disseminated among key stakeholders?

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Abbreviations and Glossary

Abbreviations

CBA	Cost-Benefit Analysis
CCA	Cost-Consequence Analysis
CEA	Cost-Effectiveness Analysis
CMA	Cost-Minimization Analysis
CUA	Cost-Utility Analysis
GDP	Gross Domestic Product
HEN	Health Evidence Network
HESR	Health Equity Status Report
KTA	Knowledge-To-Action
NHS	National Health Service
PICO/S	Population, Intervention, Comparisons, Outcomes/Study design
PRISMA-P	Preferred Reporting Items for Systematic Reviews and Meta-analyses for Protocols
QALY	Quality-Adjusted Life Year
ROI	Return On Investment
SDGs	Sustainable Development Goals
SMART	Specific, Measurable, Achievable, Relevant, Time bound
SPICE	Setting, Perspective, Intervention, Comparison, Evaluation
SPIDER	Sample, Phenomenon of interest, Design, Evaluation, Research type
SROI	Social Return On Investment
SUPPORT	SUPporting POlicy Relevant Reviews and Trials
SURE	Supporting the Use of Research Evidence

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Glossary

Health in All Policies. Health in All Policies is an approach to public policies across sectors that systematically takes into account the health implications of decisions, seeks synergies and avoids harmful health impacts in order to improve population health and health equity. As a concept, it reflects the principles of: legitimacy, accountability, transparency and access to information, participation, sustainability, and collaboration across sectors and levels of government *(86)*.

Health inequalities/inequities. Health inequalities are defined as differences in health status or in the distribution of health determinants between different population groups, whereas health inequities are avoidable inequalities in health between groups of people within or between countries (for example from social or economic conditions). While some health inequalities are attributable to biological variations or free choice, others are attributable to the external environment and conditions mainly outside the control of the individual and may be unnecessary and avoidable, as well as unjust and unfair, thus leading to inequity in health *(87)*.

Knowledge synthesis. Knowledge synthesis is the contextualization and integration of research findings of individual research studies within the larger body of knowledge on the topic *(22)*.

Knowledge to Action (KTA) Framework. The KTA describes the process of moving knowledge from research evidence into action and consist of two separate yet connected components, the knowledge creation funnel and the action cycle *(88)*.

Knowledge translation. Knowledge translation is the synthesis, exchange, and application of knowledge by relevant stakeholders to accelerate the benefits of global and local innovation in strengthening health systems and improving people's health *(89)*.

Sustainable development. Sustainable development is development that meets the needs of the present without compromising the ability of future generations to meet their own needs *(90)*.

Sustainable Development Goals (SDGs). The SDGs aim to help drive the implementation of sustainable development. They build upon the Millennium Development Goals and will converge with the United Nations 2030 Agenda (the post-2015 development agenda) *(91)*.

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Annex 1. Conceptual Framework and Evidence Gathering

Conceptual Framework

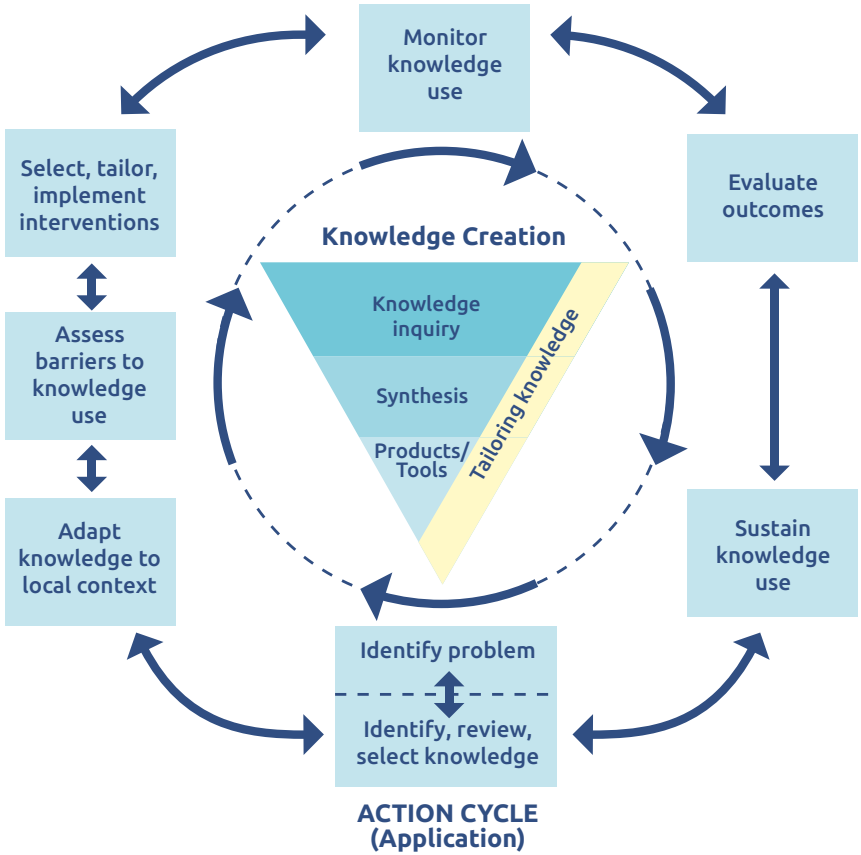
This guide is based on the Knowledge-to-Action framework (KTA) *(18)*. In total, 21 national and international experts and stakeholders were questioned either personally or via e-mail about frameworks which they would recommend for use as a basis for the development of this guide. Experts came from a broad range of organizations within and outside the United Kingdom, including knowledge translation experts, mobilization and management specialists, academics, senior government officials and civil servants, the National Health Service (NHS) and public health staff, think tanks and evidence services. The project team analysed resources recommended by experts and identified the KTA as most appropriate to build the basic structure of this guide.

The KTA describes the process of moving knowledge from research evidence into action, and consists of two separate yet connected components, the knowledge creation funnel and the action cycle (Figure 4). The knowledge creation funnel describes how knowledge becomes increasingly tailored and refined, making it most relevant for the target audience and the context. It consists of three phases:

- knowledge inquiry, when existing evidence is mobilized and collected;
- knowledge synthesis, when collated evidence is merged, contextualized and presented in a clear and brief format that is appropriate and relevant for the target audience;
- products and tools; when the final evidence-informed product is refined, tailored to end-users' information needs, and is communicated and disseminated to relevant stakeholders.

In addition, the action cycle also describes several processes for implementation of the knowledge and/or evidence *(18,88)*.

Fig. 4. Knowledge-to-Action framework *(18)*



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Evidence Gathering

Experts and stakeholders who were involved in developing and informing the *Making a difference: investing in sustainable health and well-being for the people of Wales report (17)* were asked about their experiences and lessons learnt when producing an evidence report as an advocacy product. This feedback then fed into the development of this guide.

Stakeholder engagement

Stakeholder engagement was also valuable to identify key resources and tools to highlight in this guide, as well as in identifying useful elements, challenges, enablers and potential anticipated pitfalls. When gaps in knowledge were identified, the authors contacted relevant experts in order to identify additional resources. Topic areas discussed during the engagement process included:

- knowledge terminology;
- public health evidence/ knowledge translation processes and resources;
- public health policy development and priority setting;
- public health advocacy and communication;
- methodology used and experiences made during the development of evidence based products (such as the 'Making a Difference' report *(17)*);
- evaluation of evidence-informed public health products.

Evidence review

In addition, an evidence review was conducted with the objective to search for applied and evaluated frameworks (including guidelines, tools and models) which could guide the translation of public health evidence into policy and practice.

The following search terms were used to find eligible resources: Public health AND guide* OR tool* OR instruct* OR procedure AND knowledge OR evidence OR research N2 mobili* OR translat* OR synthesi* OR communicat* AND polic* OR practice OR decision OR action NOT clinical. The main databases used to search for relevant literature included: PubMed, MEDLine, EMCare and GoogleScholar. The stakeholder engagement also revealed further resources, mainly grey literature and several websites to be screened such as; WHO, WHO Regional Office for Europe, National Institute for Health and Care Excellence, Knowledge Translation Canada, United Nations University - Institute for Water, Environment and Health, The Health Foundation, the Campaign for Social Science, The Alliance for Useful Evidence, Canadian Institutes for Health Research and the United Nations.

The following eligibility criteria were applied to guide the search:

1. Frameworks/models which purpose is to guide the knowledge translation, mobilisation and synthesis process
2. Reports of evaluations/reviews of such frameworks
3. Reviews of evaluations/applications of such frameworks

Two public health professionals searched relevant databases and a total of 1976 records were identified. After removing duplicates and excluding records based on screening titles and abstracts aligned with eligibility criteria, 35 records were fully screened and an additional 26 were excluded. Nine records appeared to be eligible and after adding another seven records identified through other sources, 16 records where included in the qualitative analysis (Fig. 5. Preferred Reporting Items for Systematic Reviews and Meta-analyses for Protocols (PRISMA) chart). The records were fully screened and relevant information was extracted to inform the content of this guide.

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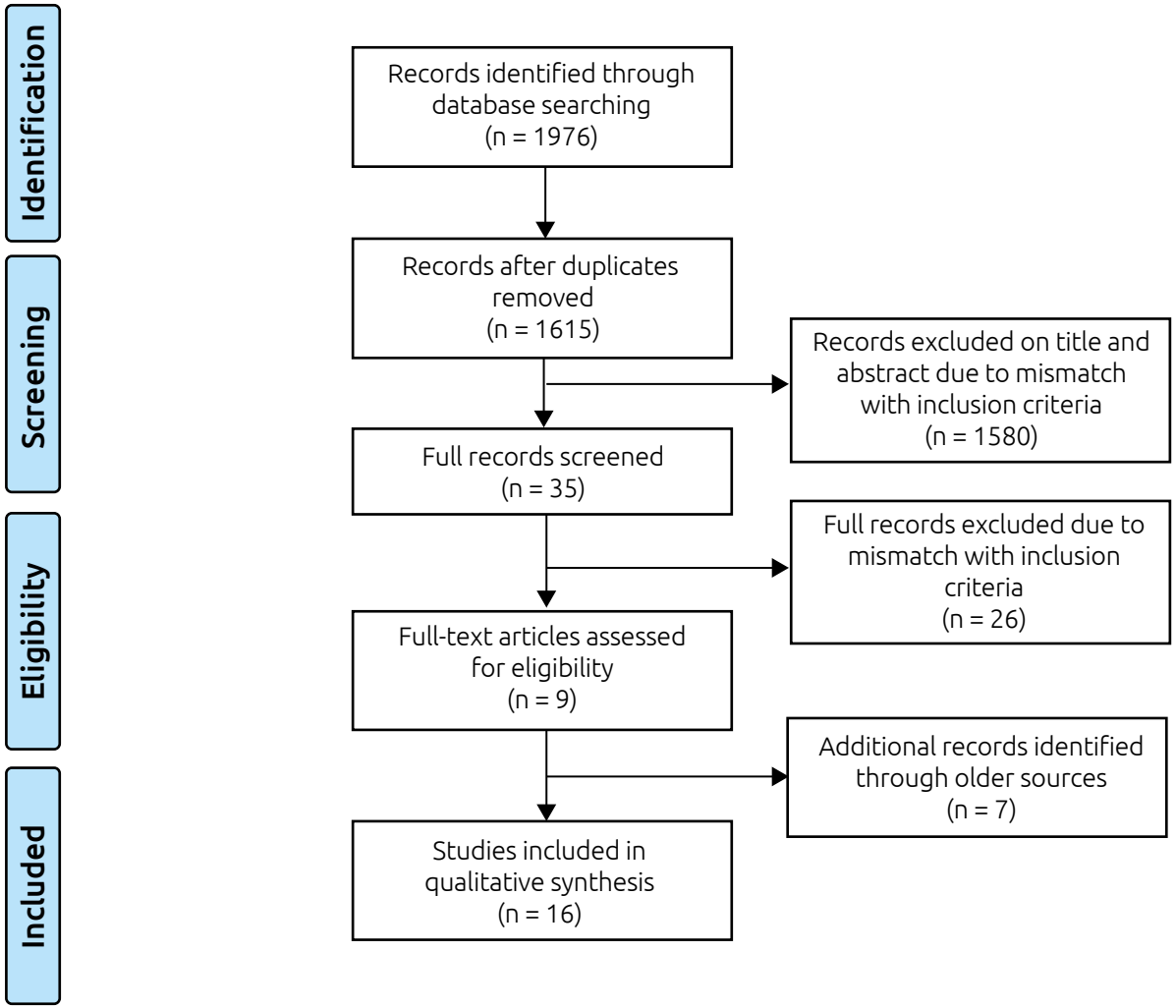
Fig. 5. Preferred Reporting Items for Systematic Reviews and Meta-analyses for Protocols (PRISMA) flow chart of the process of searching and selecting records which cover tools and guidelines for knowledge translation *(92)*



Source: adapted from Moher et al, 2009 (92).

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Authors and Acknowledgments

Authors

Mariana Dyakova
Specialist in Public Health, International Health Lead, Policy and International Health, a World Health Organization Collaborating Centre on Investment for Health and Well-being, Public Health Wales, Wales, United Kingdom

Kathryn Ashton
Senior International Evidence Development Officer, Policy and International Health a World Health Organization Collaborating Centre on Investment for Health and Well-being, Public Health Wales, Wales, United Kingdom

Anna Stielke
Programme Support Officer, Policy and International Health, World Health Organization Collaborating Centre on Investment for Health and Well-being, Public Health Wales, Wales, United Kingdom

Mark Bellis
Director, Policy and International Health, World Health Organization Collaborating Centre on Investment for Health and Well-being, Wales, United Kingdom

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Tammy Boyce, Consultant, WHO European Office for Investment for Health and Development, Venice, Italy

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Henk Hilderink, Top Expert Population Health Foresight, National Institute for Public Health and the Environment, Netherlands

Sascha Marschang, Deputy Director, European Public Health Alliance, Belgium

G.J. Melendez-Torres, Senior Lecturer in Social Sciences and Health, Cardiff University, United Kingdom

Natasha Azzopardi-Muscat, President, European Public Health Association and Senior Lecturer, University of Malta

Irfon Rees, Chief of Staff, Swansea Bay University Health Board, United Kingdom

Alison Parken, Honorary Senior Research Fellow, Cardiff Business School, Cardiff University, United Kingdom

Nicole Rosenkötter, President of the Section on Public Health Monitoring and Reporting, European Public Health Association, and North Rhine Westphalia Centre for Health, Germany

Chris Roberts, Deputy Chief Social Research Officer, Welsh Government, United Kingdom

Duane Schulthess, Managing Director of Vital Transformation, Belgium

Paul Worthington, Research Associate, Wales Centre for Public Policy, United Kingdom

Emma Taylor-Collins, Senior Research Officer, Alliance for Useful Evidence and Wales Centre for Public Policy, United Kingdom

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GIG CYMRU NHS WALES
Iechyd Cyhoeddus Cymru
Public Health Wales

WHO Collaborating Centre on Investment for Health and Well-being

www.publichealthwales.org

Email: generalenquiries@wales.nhs.uk

@PublichealthW

/PublicHealthWales

Public Health Wales
Number 2 Capital Quarter
Tyndall Street
Cardiff CF10 4BZ

Tel: 02920 227744

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