Turning Health Research into Policy:
IDRC International Research Chairs in Evidence-Informed Health Policies and Systems

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Abstract: We undertook a five-year research and capacity-building program focused on supporting evidence-informed health policies and systems in Africa. We conducted the first multi-country study of knowledge translation (KT) platforms globally, with key take-home messages including that policymakers, stakeholders and researchers should: 1) prepare evidence briefs and convene policy dialogues (or demand them), and continue to collect data that will allow us to better match their design features with issues and contexts; 2) prepare rapid syntheses (or demand them), and start to collect data that will allow us to better match their design features with issues and contexts; and 3) think carefully about how to design and where to house KT platforms in light of local contexts and infrastructure, and consider attempting to shift the local context in ways that are more conducive to the work of KT platforms. Using a unique set of training and fieldwork opportunities, we also created a cohort of 11 rising stars from Canada and four African countries (Burkina Faso, Cameroon, Ethiopia and Uganda), as well as Colombia, who are now working in close collaboration with one another on the study and practice of evidence-informed health policies and systems across a broad range of countries.

Keywords: health policy, health system, research evidence, knowledge translation, Africa

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The research problem

Whether the pressure on health-system policymakers and stakeholders to invest healthcare resources wisely derives from a scarcity of resources, in the case of many low- and middle-income countries (LMICs), or from the many and frequently competing demands placed on more plentiful resources, as seen in high-income countries like Canada, the capacity to do so requires a sustained commitment to evidence-informed health policies and systems, which can be defined as the use of the best available research evidence in the time available in each of the agenda-setting, policy development and policy implementation phases of the health policy process. Such commitment was first called for by Ministers of Health in the 2004 "Mexico Statement on Health Research: Knowledge for Better Health" and involves "establish[ing] or strengthen[ing] mechanisms to transfer knowledge in support of evidence-based public health and health-care delivery systems, and evidence-based health-related policies" (Ministerial Summit on Health Research, 2014). Since the Ministerial Summit in Mexico, many units, which we call 'knowledge-translation (KT) platforms,' have been launched, with support from the World Health Organization (WHO), in municipalities, countries, and regions around the world to experiment with efforts to support evidence-informed policymaking about health systems. We knew virtually nothing about the activities, outputs, outcomes and impacts of these KT platforms, eleven of which were active or planned in Africa, at the time we launched our program of research and capacity building. The eight KT platforms that became fully active in Africa were the focus of our evaluation and now constitute the only well-studied such experiments globally.

Objectives

We pursued both research and capacity-building objectives over the life of our research program, which began on 28 June 2009, was set to be completed by 28 June 2014, and (in order to complete an expanded set of objectives) will now conclude on 28 December 2015. This final report addresses the original objectives. An amendment to the final report will be submitted in January 2016, and this amendment will address the expanded set of objectives.

Research objectives

Our research objectives were as follows:

1) to describe annually the activities and outputs of the KT platforms, as well as the (infra)structural and contextual factors that may affect the relationships among activities, outputs and (eventually) outcomes and impacts;
2) to conduct formative evaluations of any priority-setting processes and policy dialogues organized by each KT platform and of any evidence briefs prepared by each KT platform;
3) to conduct outcome evaluations of each KT platform at two to three time periods with a focus on the KT platforms' anticipated outcomes: namely that health research evidence about high-priority policy issues is made available; relationships among policymakers, researchers and KT specialists are developed or strengthened; and

policymakers' capacity to support the use of health research evidence in health systems policymaking is strengthened; and

4) to conduct impact evaluations of the KT platforms with a focus on the platforms' anticipated impact: namely that health systems policymaking processes take into account health research evidence.

These research objectives are only slightly revised from our original research objectives, with the changes primarily being the timing of particular aspects of the evaluation. Of course our trainees introduced additional objectives, such as to examine the discourse related to evidence-informed health policies and systems in Cameroon, Colombia and Uganda, to conduct user testing for the rapid-response programs in Burkina Faso and Uganda and the clearinghouses being used in Uganda and Zambia, and to examine the role of social networks in supporting evidence-informed health policies and systems in Burkina Faso, among others, but we will not address these complementary objectives in this report.

We were able to collect formative evaluations of many more evidence briefs and policy dialogues than anticipated and we were able to conduct more case studies than anticipated. On the other hand, parts of two research objectives were not met, namely the formative evaluations of priority-setting processes (because no KT platforms organized such a process) and the follow-up outcome evaluations for half of the KT platforms (because these KT platforms were so delayed in completing their baseline outcome evaluations). Also, the smaller-than-anticipated number of KT platforms active in other regions, the less continuity in their operations and in the support they received from World Health Organization (WHO) regional offices, and the lack of sustained commitment to data collection, meant that we were not able to pool our data with data from other regions to develop a theoretical framework that identifies how (infra)structural and contextual factors influence whether and how activities and outputs translate into outcomes and impact. The lack of such a framework remains a pressing challenge for the field, albeit one that is fraught with the challenges of studying real-life experiments in ever-changing policy environments, across dozens of countries, and with shifting levels of financial support from funding agencies and technical and other forms of support from WHO regional offices.

Capacity-building objectives

Our capacity-building objectives included:

1) to provide four graduate students from the participating African countries and three graduate students from Canada (who are committed to long-term collaborative research with African partners) with a unique training experience in the area of knowledge translation for policy that includes: exposure to our multi-method approach, joint supervision by us (and others as appropriate), reciprocal training opportunities, a dyad- or triad-arrangement with other graduate students, and the opportunity to pursue for their doctoral thesis an in-depth examination of a KT platform in a single country or a single area of inquiry (such as the formative evaluation of policy dialogues) across countries;

2) to strengthen understanding of key concepts and approaches to knowledge translation for policy for up to 20 more African doctoral students; and
3) to strengthen the capacity of the African teams involved in the multi-country evaluation of the KT platforms, as well as up to 9 more African researchers, in managing, analyzing and interpreting locally collected data and in producing their own local reports that describe their analyses and their interpretations of the meaning and implications of their findings.

Our objective related to graduate students was exceeded (with five instead of four African studies pursuing PhDs at Makerere University and six instead of three Canadian students having completed or pursuing PhDs at McMaster University) and the other two objectives were met.

Our major lessons learned from an objective-setting perspective was that we may never achieve the necessary sample size to develop a theoretical framework about how to match activities and outputs to issues and context on order to achieve desired outcomes and impacts without timing data collection in relation to periods of relative stability in policy environments (e.g., starting at the beginning of a government's tenure in each participating country), securing a financial commitment from a funding agency for the full range of countries needed (not just for the region that has historically had the greatest need for financial support), and finding a stable source of technical and other forms of support (not relying only on WHO regional offices).

Methodology

To address the research objectives:

1) each year we combined a survey of the eight African KT platforms' activities and outputs with a review of any reports and work plans;
2) we collaborated with each local team to survey recipients of its evidence briefs and participants in its policy dialogues;
3) we collaborated with each local team to survey policymakers, stakeholders and researchers about the three outcome domains described above; and
4) we collaborate with select local teams to conduct case studies of health systems policymaking processes (using both interviews and documentary analyses).

We provide the research instruments in an annex.

Our methodology did not change substantively over the life of the research program apart from that, as noted above, we did not survey participants in priority-setting processes (because none were undertaken) and we did not complete follow-up outcome evaluations for half of the KT platforms (because of KT platform delays in completing their baseline outcome evaluations). Also, we conducted media analyses in the context of our impact evaluations (instead of our outcome evaluations, which as noted were delayed) to provide more focus to the media analyses, we conducted focus groups on the meanings and implications of the overall findings and more generally on lessons learned (instead of in direct relation to only the outcome evaluations, which as noted were delayed), and we conducted six case studies in Burkina Faso, five in Uganda, and two each in Cameroon and Zambia, for a total of 15 case studies in the four countries where

our doctoral students were conducting field research (instead of one case study in each of six countries). To complement a point made in the previous section, our trainees introduced many additional methodologies to our program, however, we will not describe them in this report.

Our major lessons learned from a methodological perspective include:

1) we achieved more timely and comprehensive data from our annual activities and outputs survey when we administered the survey face-to-face at annual research meetings and when we embedded the formative evaluation surveys about briefs and dialogues into the KT platforms' regular work processes; and
2) we would likely have achieved more timely and comprehensive data from our outcomes survey had we prioritized this research activity above all others in year 1, simplified the sampling frame (although we would have sacrificed comparability across countries), and shortened the questionnaire (which we did after one country had administered the questionnaire but not before our training session on how to administer it).

Project activities

The IRC budget included funds for personnel at Makerere University (a part-time training coordinator and partial salary replacement for the chairholder), for support and travel for research collaborators, for laptop computers and printers at Makerere University, for four PhD student stipends and fieldwork, and for four PhD students' travel to workshops, to the annual meeting of KTP researchers and to take courses at McMaster University. Twenty workshops (many more than originally budgeted for) were organized jointly with the CRC over the life of the program, five PhD students (instead of the four originally budgeted for) played active roles in the annual meeting (which was held in a range of African countries), and three students completed two semesters of coursework and two students completed one semester of coursework at McMaster University (with their tuition fees waived under the terms of an agreement with McMaster University).

The CRC budget, which was one third the size of the IRC budget, included funds for three PhD student stipends and fieldwork and for their travel to workshops and to the annual meeting of KTP researchers. Six students were supported through stipends, for travel or both, five of them played active roles in the annual meeting (the sixth one joined the group after the last annual meeting), and three PhD students used Makerere University as a base for part of their fieldwork.

Our ability to conduct the evaluation in the first place and to deliver more workshops and support more trainees than originally budgeted for can be attributed to our success in obtaining additional funding related to our research and capacity-building program (Table 1) and to our students' success in obtaining peer-reviewed funding awards (which we return to in the next section given these funds accrued to the students and not to the program per se). Also, our success with the program contributed to the CRC, who began

the program with a Tier 2 Canada Research Chair in Knowledge-Transfer and Exchange, being awarded a Tier 1 Canada Research Chair in Evidence-Informed Health Systems (effective 1 January 2015).

Table 1: Additional funding related to the IRCI research and capacity-building program

Project title	Funding agency	Our role in the project	Start date / end date	Value (currency)
Evaluating knowledge-translation platforms in low- and middle-income countries	Canadian Institutes of Health Research	Principal investigator (CRC) and co-investigator (IRC)	2008-09 2009-14	$100,000 (CAD) $455,934 (CAD)
Supporting the use of research evidence (SURE) for policy in African health systems	European Commission	Co-investigators (CRC and IRC)	2009-14	€3,677,174.42 (euros), of which €67,433.93 went to McMaster University and more to Makerere University
Canada research chair in evidence-based health systems – Tier I	Canada Research Chairs program	Principal investigator (CRC)	2015-21	$1,400,000 (CAD)
Clearing house for health policy and systems research	WHO Department of Research Policy and Cooperation	Principal investigator (IRC)	2012	$40,000 (USD)
Africa centre for systematic reviews and knowledge translation	IDRC	Principal investigator (IRC)	2013-16	$256,000 (CAD)
Working with non-state providers in post-conflict and fragile states in primary healthcare service delivery: A systematic review	Department for International Development (DFID)	Principal investigator (IRC)	2014	£58,000 (GBP)
Using evidence to strengthen health systems in Africa and	IDRC	Supervisor of trainee acting as the	2015-18	$967,000 (CAD)

the Middle East		principal investigator		

Our major lessons learned from our activities include:

1) the power of leveraging other sources of funding in order to successfully complete a large, multi-country study with so many moving parts and to simultaneously build capacity among a large contingent of trainees and research collaborators; and
2) the need to take advantage of annual research meetings that many key people would be attending anyways to administer surveys face-to-face, provide feedback and technical support to country teams, and organize workshops (immediately before or after) as opposed to organizing and paying travel costs for stand-alone meetings and workshops; and
3) the largely untapped potential of agreements between university to enable students to study at another university or to use it as a base for fieldwork, at no cost to the student or the program.

Project outputs

We produced (and continue to produce) a large number of research outputs over the life of the research program (Table 2). The citations for these outputs are provided in the bibliography (see annex). If we had to pick a single journal article as a milestone, it would be the publication in the Bulletin of the World Health Organization of an article about evidence briefs and policy dialogues lead-authored by one of our trainees (Moat et al. 2014). This article demonstrated that the combination of an innovative type of research output (evidence briefs) and an innovative type of social process (policy dialogues) were each highly rated both overall and in terms of their key design features and, taken together, they led to strong intentions among policymakers, stakeholders and researchers to act on what was learned. We can't say this of any other output or process currently being used to support evidence-informed health policies and systems. And the fact that the journal article was lead authored by a trainee makes the milestone all that more potent.

Other specific examples of contributions in the African context included the following:

1. Our work has contributed to the development of the Rapid Response program at the Ministry of Health in Burkina Faso where our PhD Student (Andre Zida) has been leading its development.
2. In addition, this work has influenced and contributed to the development of the knowledge translation platform, "The Center for Development of Best Practices" in Younde, Cameroon where our PhD student Pierre Ongolo-Zogo is the Director.
3. The research chair in Uganda, led the team at the Uganda National Academy of Sciences that advocated for use of evidence to inform policy and practice decisions regarding vaccines and immunisations in the country. The team worked with the Ministry of Health which eventually developed a policy for the establishment of the Uganda National Immunisation and Technical Advisory Group (UNITAG) under his leadership. The NITAG's current mandate is to

provide the best available evidence to Uganda Government, the public and stakeholders on all matters (including future policies) related to vaccines and immunisation in the country.

Furthermore, our work has impacted practice, teaching and research in knowledge translation in major ways at Makerere University in Uganda:

1. An Innovations and Knowledge Translation (IKT) unit has been created at the Makerere University College of Health Sciences to facilitate closer working relationships between university researchers and policy makers and other research users to accelerate use of research evidence produced nationally and internationally.
2. Five years ago there wasn't any large project focussing on research in knowledge translation. Now there are several including "The Supporting Policy Engagement for Evidence –Based Decisions (SPEED) for Universal Health Coverage in Uganda. Knowledge Translation Network Africa (KNET)- Supporting Translation of Health Systems Evidence into policy and action across Africa and the recently concluded SURE.
3. The training in Knowledge Translation (KT) as short courses, at Masters and PhD level is now well established.
4. The policy makers at the Ministry of Health in Uganda are now calling for evidence much more frequently than ever before to inform their deliberations and policy making processes.

Table 2: Number of research outputs, by type

Type	Number
Peer-reviewed publications	
• Journal articles published / accepted	23
• Manuscripts under review at journals	1
• Manuscripts in preparation for journals	18
Presentations*	
• Scientific conferences	35
• Non-academic presentations	6
Other media	4
Theses	2
• BHSc honours theses submitted	1
• PhD theses submitted	3
• PhD theses in preparation	7
Reports	
• Procedures manuals	4
• Country reports**	8
• Workshop evaluation reports***	5

*presentations were made to over 2000 policymakers, stakeholders and researchers
**country reports were updated annually so only the last version of each report has been counted here and included in the bibliography
***detailed workshop evaluation reports were only prepared for the workshops in Kampala, Uganda (2010 and 2011), Addis Ababa, Ethiopia (2012), and Yaoundé, Cameroon (2012 and 2013), however, the list of 15 other workshops is available upon request

Note that we have not counted the many evidence briefs, dialogue summaries, rapid syntheses and other research outputs of the KT platforms that we studied because these outputs were funded through other sources. A list of the evidence briefs and dialogue summaries can be found in the above-mentioned journal article.

We trained (and continue to train) a large number of studies over the life of the capacity-building program, achieved a high degree of disciplinary diversity (bringing together physicians, economists, epidemiologists, political scientists, and interdisciplinary scholars), a high degree of linguistic diversity (English, French and Spanish in addition to local languages) and a reasonable degree of gender equity (with six of fourteen trainees being women), and achieved a significant degree of diversity in terms of country of origin (Table 3). As noted above, a large part of the reason why we were able to do so was that the trainees were very successful at obtaining peer-reviewed funding awards. For example, both Elizabeth Alvarez and Kassu Gurmu were awarded prestigious Vanier Scholarships, and Daniel Patino Lugo was awarded a prestigious doctoral award from Colombia's national funding agency. The BHSc and PhD theses submitted by these trainees are listed in table 2 and cited in the bibliography (see annex).

Table 3: Names of trainees, by supervisor (and with female trainees in bold)

Level of trainee	Trainees (with their nationality) supervised by the CRC	Trainees (with their nationality) co-supervised by the IDRC RC and the CRC
Under-graduate	McMaster BHSc program • **Simone Banh**, Canada (2011-13) • **Natasha Eardley**, Canada (2012-14) • **Ruijun Carolyne Wang**, Canada (2014-15) • Arun Partridge, Canada (2014-15)	• Not applicable
Doctoral	McMaster Health Policy PhD program • Kaelan Moat, Canada (2009-13) • **Jessica Shearer**, Canada (2009-14) • Daniel Patino-Lugo, Colombia (2010-14) • Edward Gariba, Canada / Ghana (2010-15; defense pending)	Makerere PhD program • Pierre Ongolo-Zogo, Cameroon (2010-) • **Rhona Mijumbi**, Uganda (2011-) • André Zida, Burkina Faso (2011-) • Ekwaro Obuku, Uganda (2012-) • Boniface Mutatina, Uganda (2012-)

Level of trainee	Trainees (with their nationality) supervised by the CRC	Trainees (with their nationality) co-supervised by the IDRC RC and the CRC
	• **Elizabeth Alvarez**, Canada (2011-15; defense pending) • Kassu Ketema Gurmu, Ethiopia (2014-)	

Note that the doctoral trainees all received financial support from our research grant, while the undergraduate students were heavily involved in the research program but funded through another source. Note also that one of the undergraduate students produced a thesis as a direct result of their working with our program, which is why the number of undergraduate trainees in table 3 is larger than the number of BHSc theses listed in table 2.

Our trainees benefited to an extraordinary degree from the IRCI, and both we and they rated the IRCI's enhancement of our existing training environments to be highly significant (Table 4). Both the McMaster and Makerere trainees had the unique opportunities to participate actively in a large-scale, multi-country study using a broad range of research methods, to travel to annual meetings and workshops in a diverse array of African countries, and to conduct fieldwork in these same countries. Plus the Makerere trainees had the unique opportunity to take one or two semesters of coursework at McMaster University.

Table 4: IRCI training environment

Chair	Response to the statement: Overall, how has the IRCI enhanced the training environment you could otherwise provide to your students?				
	Not at all	Minimal	Moderate	Significant	Don't know
CRC				X	
IDRC RC				X	

We had originally envisioned the trainees working in dyads and triads, however, they rapidly gelled as a cohort and continue to interact regularly, support one another at key junctures in their research and broader professional endeavours, and collaborate on research projects. We believe we have contributed to creating a cohort of eleven rising research stars in the field of evidence-informed health policies and systems and both African countries' and Canadian provinces' health systems will be the beneficiaries of their future scientific and knowledge-translation contributions. We are already seeing these trainees being successful in applying for research grants (e.g., Pierre Ongolo-Zogo), being called upon to inform policymakers and stakeholders and working in closer partnership with them (e.g., Rhona Mijumi and Kaelan Moat), and being invited to major international scientific, policy and development meetings as recognized experts in their field (e.g., Jessica Shearer and Ekwaro Obuku).

We should also note that the host institutions also benefited significantly from the program. McMaster's then nascent Health Policy PhD program, which was launched just one year before our research and capacity-building program began, was invigorated by having trainees from Makerere involved in the program, and students in the McMaster program recently cited this as one of the program's strongest attributes. Makerere's PhD program has also been invigorated by the large number of trainees with a focus on evidence-informed health policies and systems, which is a new area of study for the university's College of Health Sciences.

Our major lessons learned from the nature and volume of our outputs include:

1) the importance of using the annual meeting with all trainees and using any other meetings where three or more trainees were present to give them a deadline to work towards (they always had to circulate one or more protocols, data-collection instruments or draft papers at least two weeks in advance of the meeting), to give them an opportunity to receive constructive feedback on their written work from us and their peers, and to give them an opportunity to develop their ability to provide constructive feedback to their peers; and
2) the potential of using capacity-building funds to strengthen existing educational programs (not just to develop new ones) and to ensure that both the students directly engaged in the capacity-building program and the students involved in existing programs all benefit from the opportunity.

We continue to struggle with one challenge: knowing when to write up the results from an evaluation when results will continue to come in. We would have had more outputs in the 'published / accepted' row (and fewer in the 'in preparation' row) in Table 2, and this report would have been submitted much sooner, had we simply bitten the bullet and moved to writing up all of our results at defined timelines and regardless of whether more results will continue to come in. On the other hand, our journal articles will be more comprehensive and definitive for the delays.

Project outcomes

Promoting scientific collaboration between research chairs

We have converted an existing, somewhat arms-length working relationship between the CRC and IRC into a close and productive collaboration, as evidenced by our five co-authored journal articles and our three planned co-authored journal articles (although the latter is a significant underestimate given that the authorship of a number of manuscripts has not yet been determined), by our co-supervision of five Makerere PhD students and the IRC's hosting of three McMaster PhD students for their field work in Uganda, and by our frequent 'standing in' for one another at international scientific meetings.

We have also learned a great deal from one another and from each other's teams. The most notable example of bi-directional learning is the introduction of a rapid-response program at the McMaster Health Forum on the strength of the Makerere experience and early evaluation results. Another example is the introduction of a clearinghouse for local

studies and policy-relevant documents about the Ugandan health system, which was inspired in part by the Evidence-Informed Healthcare Renewal Portal that is available to Canadian users of Health Systems Evidence (maintained by the McMaster Health Forum).

Providing unique training and fieldwork opportunities for students

We created many unique training and fieldwork opportunities for students and, in so doing, created a cohort of eleven rising stars from Canada and four African countries (Burkina Faso, Cameroon, Ethiopia and Uganda), as well as Colombia, who are now working in close collaboration with one another on the study and practice of evidence-informed health policies and systems across a broad range of African and other countries.

The annual scientific meetings, punctuated by the International Forum on Evidence Informed Health Policymaking, Addis Ababa, Ethiopia, in 2012 (Neves et al. 2014), created extraordinary opportunities for networking, mentorship, collaboration, idea generation, and practice with presenting to policymakers, stakeholders and researchers. The workshops developed trainees' capacity to find and use research evidence to strengthen health systems and get the right mix of programs, services and drugs to those who need them, as well as the capacity to draw on a wide variety of disciplinary perspectives and methodological approaches in their research, to prepare rapid syntheses and evidence briefs and convene stakeholder dialogues, and to undertake a wide variety of other research and knowledge-translation activities. We also used these workshops to train a broader network of PhD students and research collaborators. The exchange agreement between our universities allowed five Makerere students to study for one or two semesters at McMaster, and allowed three McMaster students to use Makerere as a base for their fieldwork.

The fieldwork opportunities were particularly unique, both for the 'natural experiments' in supporting evidence-informed health policies and systems that students were able to study in 'real time' and for the extraordinary access to policymakers, stakeholders and researchers that their participation in our research and policy networks made possible. Examples of the fieldwork include studying:

1) the impacts of evidence briefs in two policy domains in Uganda and Zambia (Moat);
2) the impacts of research evidence in two HIV prevention-related policy domains in Ethiopia (Gurmu);
3) the impacts of research evidence in two policy domains in each of Cameroon and Uganda (Ongolo-Zogo) and in Colombia (Patino Lugo), as well as the discourse around evidence-informed policymaking in these countries;
4) the influence of social networks, both connected to and separate from the KT platforms, on evidence use in four policy domains in Burkina Faso (Shearer);
5) the influence of students' research on policy and program development in Uganda (Obuku);
6) the views about and experiences with a rapid-response service in Uganda (Mijumbi) and Burkina Faso (Zida);

7) the views about and experiences with global evidence clearinghouses among policymakers, stakeholders and researchers in Uganda and Zambia (Gariba) and with a national clearinghouse among the same groups in Uganda (Mutatina); and
8) the views about and experiences with a 'workbook' to contextualize global guidance among policymakers, stakeholders and researchers in Uganda and Peru (Alvarez).

While we have many moving testimonials from the trainees, we provide just one here (from Rhona Mijumbi): "With the requirement that I spend up to a year at McMaster University, this fellowship provided me an invaluable opportunity to attend courses that advanced my knowledge greatly. I was also exposed to people and groups like the Canadian Coalition for Global Health Research and others that I have built partnerships with that will last into the future. I do have confidence in the work that I am doing following the exposure through meetings and other interactions that have been made possible because I am an IRCI scholar. I continue to be called on as an expert of policy and knowledge translation, thanks to the skills, knowledge and exposure I have accumulated. An example of this, is when I was asked to facilitate a policy dialogue on primary eye care in Kenya involving policy makers from Kenya, Tanzania, Malawi and South Africa in February 2014."

Identifying new avenues for knowledge and policy

We conducted the first, large-scale, cross-country study of KT platforms and, in so doing, took a major step towards our ultimate goals of being able to provide guidance to the policymakers, stakeholders and researchers establishing or overseeing KT platforms about how to:

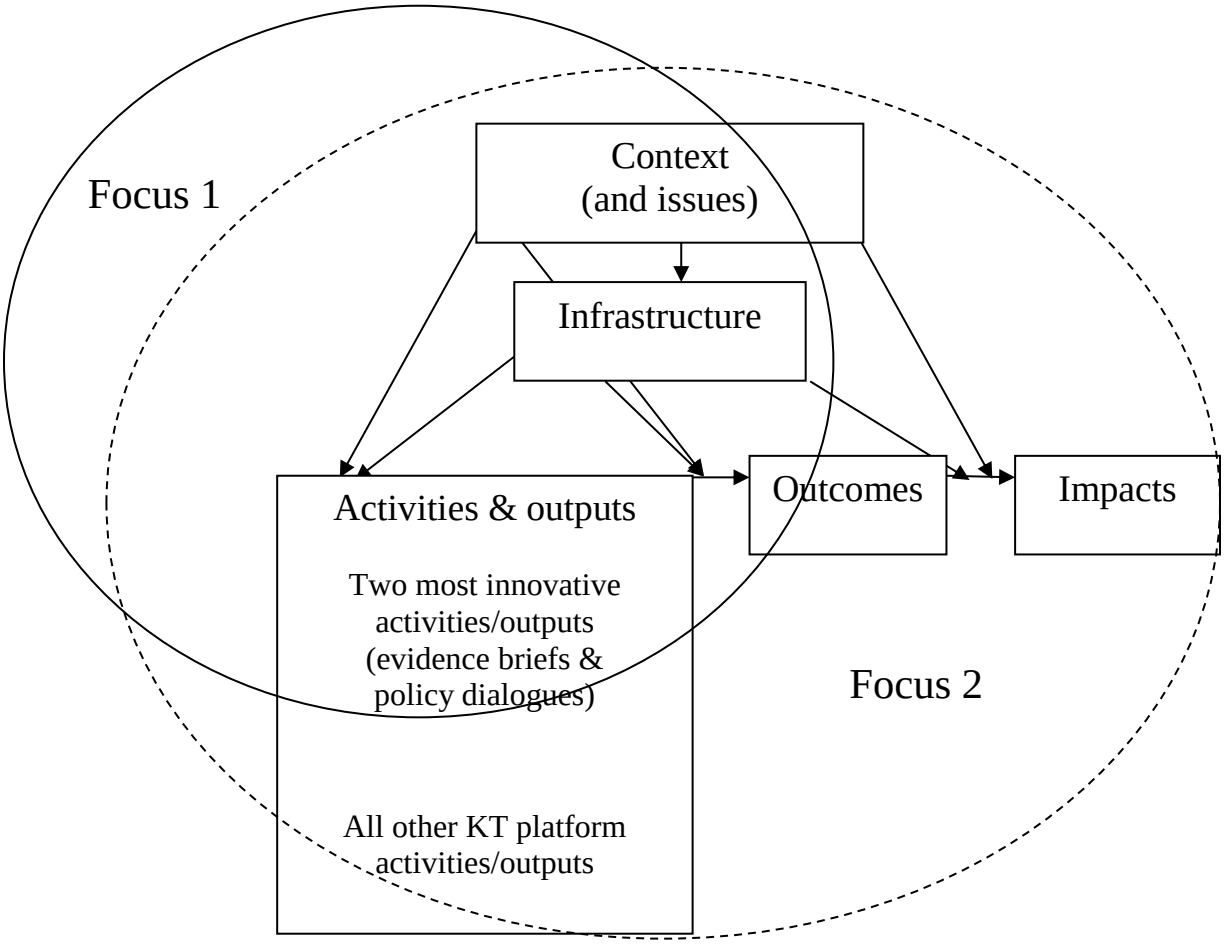
1) match the features of two of the the KT platforms' most innovative activities/outputs – evidence briefs, and policy dialogues – to particular issues and contexts (e.g., should evidence briefs conclude with recommendations for select, non-politicized issues or should policy dialogues aim for consensus in political systems with a tradition of consensus-driven policymaking?); and
2) match combinations of the KT platforms' activities and outputs to contexts and (infra) structure in a way that achieves the great outcomes and impacts (e.g., does the optimal balance among rapid syntheses, briefs and dialogues, and clearinghouses differ according to whether there's a neutral civil service and the KT platform is located outside government)?

The first question is what we call focus 1 and the second question is what we call focus 2 (Figure 1). As we described above, we are not yet able to answer these key questions, but we have made substantial progress.

Figure 1: Visual depiction of key relationships warranting study

Our brief, high-level summary of what we have learned from a descriptive perspective about the contexts in which these KT platforms were operating, the issues they've addressed, the infrastructure they worked with, and their activities and outputs, are as follows:

1) the KT platforms were functioning in very different health and political systems, with highly variable capacity for research synthesis, policy influence, and policy development and with limited media coverage of health policy priorities, research evidence and policy dialogues (context), and with few exceptions (e.g., Centrafrique, which experienced profound political instability over the study period), these features of the <u>context</u> in which KT platforms operated remained fairly constant over time (Lavis et al., manuscript in progress);



2) the KT platforms share few commonalities in their <u>infrastructure</u>, with some located in universities that are home to talented researchers, have strong internet connections and provide access to many relevant journals, and others located in ministries of health that are home to well-connected policy advisors, have weak or no internet connections and limited to no access to relevant journals (Lavis et al., manuscript in progress);

3) the KT platforms prepared evidence briefs and stakeholder dialogues (and select KT platforms prepared rapid syntheses) on a wide variety of high-level issues related to how to strengthen health systems and how to get the right mix of programs, services and drugs to those who need them, and although some KT platforms addressed somewhat sensitive issues (e.g., mental illness in Zambia, which continues to be a source of stigma in parts of society), none of the KT platforms addressed highly politicized issues (e.g., abortion) (Moat et al., 2014); and
4) by far the most common activities undertaken by the KT platforms are convening policy dialogues and the most common outputs are evidence briefs, while only three KT platforms prepared rapid syntheses (of which one produced a large volume of these syntheses) and only two KT platforms were creating national clearinghouses that will contain local studies and policy-relevant documents about the health system (as a complement to global clearinghouses like Health Systems Evidence) (Lavis et al., manuscript in progress).

Our brief, high-level summary of what we have learned from an evaluative perspective about the KT platforms' infrastructure, activities and outputs, outcomes and impacts, are as follows:

1) support from policymakers and international funders facilitated KT platform activities, while the lack of skilled human resources hindered them, being housed within a university provided protection from political interests while being housed within government helped to secure funding and retain human resources, and sustainability of the KT platform when a key European Commission grant ends was a widely held concern (El-Jardali et al., 2014);
2) evidence briefs and policy dialogues, and their key design features, appear highly valued by policymakers, stakeholders and researchers across all contexts and issues, and led to strong intentions to act on what was learned (Moat et al., 2014);
3) rapid syntheses were frequently requested by policymakers, frequently changed their approach to dealing with an issue, and made them more confident in their decisions (Mijumbi et al., 2014); and
4) evidence briefs (and accompany stakeholder dialogues) frequently influenced one or more of the agenda-setting, policy development and policy implementation phases of the policy process, albeit typically by shaping interest-group responses and the ideas at play in the policy process over time and less commonly by directly influencing the process at the time they are first produced (Moat 2014).

As noted previously, we encountered challenges in being able to evaluate changes in outcomes over time and, had we been successful, we would still not have had a large enough sample size from the African countries alone to examine quantitatively the types of relationships we outline in Figure 1. Our doctoral students' research added significantly to what we've learned but is beyond the scope of this final report.

Our major lessons learned from our experience in achieving these outcomes are the same actionable messages that we routinely share with policymakers, stakeholders and researchers who are interested in supporting evidence-informed health policies and systems and thereby contributing to ensuring that the right mix of cost-effective programs, services and drugs getting to those who need them:

1) prepare evidence briefs and convene policy dialogues (or demand them) to support evidence-informed health policies and systems, and continue to collect (or contribute) data that will allow us to better match their design features with issues and contexts;
2) prepare rapid syntheses (or demand them), and start to collect (or contribute) data that will allow us to better match their design features with issues and contexts; and
3) think carefully about how to design and where to house KT platforms in light of local contexts and infrastructure, and consider attempting to shift the local context in ways that are more conducive to the work of KT platforms (e.g., develop research synthesis, policy influence and policy development capacity; engage journalits in covering research evidence relevant to health policies and systems; and improve internet connections and access to relevant journals).

Another major lesson is for funders like IDRC and its peers to seriously engage with the sustainability concern voiced by African policymakers, stakeholders and researchers involved in these KT platforms. Supporting evidence-informed health policies and systems requires sustained commitment.

Overall assessment and recommendations

Four key design features of the IRCI program were particularly impactful and contributed to what we believe to be extraordinary value for money:

1) pairing a researcher in Canada with a researcher in a low-income country enabled us, as we noted above, to convert an existing, somewhat arms-length working relationship into a close and productive collaboration (and in this instance, the fact that it was a junior-to-mid-career researcher paired with a senior researcher provided opportunities that contributed to the former moving from a Tier 1 Canada Research Chair to a Tier 2 Canada Research Chair) and contributed to bi-directional learning (for example, we have now introduced a rapid-response program at the McMaster Health Forum on the strength of our experience and early evaluation results from Makerere);
2) combining the funds for the IRCI program with funds from other sources enabled us to conduct the first, large-scale, cross-country study of KT platforms and to identify a number of key, actionable findings (including, most importantly, the importance of policymakers, stakeholders and researchers preparing evidence briefs and convening policy dialogues to support evidence-informed health policies and systems, which will in turn contribute to the right mix of cost-effective programs, services and drugs getting to those who need them and, in the long run, to enhanced development);
3) giving such significant emphasis to capacity building enabled us to train in particularly innovative ways a cohort of rising stars from Canada and four African countries (Burkina Faso, Cameroon, Ethiopia and Uganda), as well as Colombia, who are now working in close collaboration on the study and practice of evidence-informed health policies and systems (and also to train a broader network of PhD students and research collaborators who participated in one or more of our 20 workshops); and
4) giving the chairs such high visibility contributed to raising the profile of this key field of study in general but also in our respective institutions (which made it much easier

to negotiate the exchange agreement between the two universities and which contributed to a dramatic increase in demand for undertaking doctoral studies on the topic at McMaster and to a dramatic increase in the engagement of mid-level researchers and practitioners to engage in knowledge translation and knowledge translation research at Makerere).

Indeed, the field is now a priority at both universities, which is perhaps less surprising at McMaster (where evidence-informed health policies and systems so clearly builds on the university's historical strength in evidence-based medicine) than it is at Makerere (where the field was recently rated among the College of Health Science's top five research priorities and where the need to engage in knowledge translation was recently identified as a key component of the College of Health Science's ten-year strategic plan).

Our major lessons learned from the overall program include:

1) invest more time in long-term collaborative relationships with researchers in other countries and across career stages;
2) continue to think big (with large-scale, multi-country studies) even though the challenges in achieving a decent sample size when countries are the unit of study are so much more pronounced than when patients or providers are the unit of study;
3) expose the next generation of research stars to stimulating multi-site research environments, research meetings and workshops and build cohorts of them that work across geographic, discipinary, linguistic and other boundaries; and
4) don't underestimate the impact of high-profile awards on the profile accorded to a nascent field.

We have no specific recommendations to IDRC but are sincerely grateful for the opportunities that this award provided and for its tolerance of our reporting delays.

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Annexes

Annex 1: Bibliography

A. Journal articles published / accepted

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B. Manuscripts under review at journals

1) Mijumbi RM, Rosenbaum S, Sewankambo N. User experiences of evidence briefs from a rapid response knowledge translation strategy in Uganda. Manuscript under review.

C. Manuscripts in preparation for journals

1) Alvarez E, Lavis JN, Brouwers M, Schwarz L. Contextualizing global health systems guidance: Exploring the development of a workbook to support the process. Manuscript in progress.

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Evidence in African health systems (SURE) Annual Meeting, Ouagadougou, Burkina Faso, 14 March 2014.

28) Wilson MG, Lavis JN, Moat KA. The global stock of research evidence relevant to health systems policymaking. Cochrane Canada Symposium, Ottawa, ON, Canada, 24-25 April 2014.

29) Lavis JN. Evidence briefs and stakeholder dialogues (presented as part of a panel about the state-of-the art in policy-focused knowledge translation). Canadian Association for Health Services and Policy Research Annual Conference, Toronto, ON, Canada, 15 May 2014.

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34) Lavis JN. What we're learning about supporting evidence-informed policymaking. American University of Beirut, Beirut, Lebanon, 13 March 2015.

35) Lavis JN. Supporting evidence-informed policymaking / decision-making. Ministry of Health, Muscat, Oman, 16 March 2015.

H. Non-academic presentations

1) Lavis JN. Supporting evidence-informed policymaking in low- and middle-income countries: Preliminary lessons learned from a multi-country study. Alliance for Health Policy and Systems Research. Geneva, Switzerland, 27 October 2011.

2) Alvarez, E. Implementation considerations and small group work. WHO-AFRO Regional Consultation on Optimizing Health Workers' Roles to Improve Access to Key MNH Interventions Through Task-shifting. Addis Ababa, Ethiopia, 21 September 2012.

3) Lavis JN, Moat KA. Informing policy decisions within and about a health system. KT Canada Rounds, Webinar, 9 May 2013.

4) Mijumbi R. Rapid response methodologies for decision making on health services, systems, and policies. Ministry of Health, Brasilia, Brazil, 29 August 2014.

5) Mijumbi R. Panel discussion on uses and limitations of rapid reviews and rapid response methodologies in knowledge translation. Ministry of Health, Brasilia, Brazil, 29 August 2014.

6) Lavis JN. What we're learning about supporting evidence-informed policymaking. Stellenbosch University, Stellenbosch, South Africa, 2 October 2014.

I. BHSc honours theses submitted

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E. PhD theses submitted

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2) Shearer JC (2014). Social networks, research evidence, and innovation in health policymaking in Burkina Faso, Open Access Dissertations and Theses, http://hdl.handle.net/11375/14094

3) Patino Lugo DF (2014). Supporting the use of research evidence in the Colombian health system. Open Access Dissertations and Theses, http://hdl.handle.net/11375/16429

F. PhD theses in preparation

1) Alvarez E. The development, implementation and evaluation of a health systems guidance workbook: Supporting the contextualization of the World Health Organization's (WHO) 'Optimizing the delivery of key interventions to attain Millennium Development Goals 4 and 5' (Optimize4MNH) guidance at the national level. McMaster University.

2) Gariba E. User testing, usage and impact of a one-stop shop targeted at improving policymakers' and stakeholders' use of research evidence in health policymaking processes in African countries. McMaster University.

3) Ongolo-Zogo P. Evaluating initiatives to support evidence-informed health policymaking in Cameroon and Uganda. Makerere University.

4) Mijumbi RM. A rapid response service to meet policymakers' urgent needs for health systems research evidence. Makerere University.

5) Zida A. Institutionalization of a rapid response mechanism providing research evidence for urgent decision making in the Burkina Faso health system. Makerere University.

6) Obuku E. Does students' research support evidence-informed health policies and systems in Uganda? A mixed-methods study of institutions of higher learning. Makerere University.

7) Mutatina B. Evaluating the usability and factors affecting the utilization of the Uganda clearinghouse for health policy and systems. Makerere University.

G. Procedures manuals

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J. Country reports

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2) Clancy SJ, Banh S, Lavis JN, El-Jardali F. Evaluating knowledge-translation platforms in low- and middle-income countries: Kyrgyz Republic deliberative dialogue and outcomes report. Hamilton: McMaster University; 22 March 2012.

3) Clancy SJ, Banh S, Klassen C, Lavis JN. Evaluating knowledge-translation platforms in low- and middle-income countries: Zambia evidence brief, dialogue, and outcomes report. Hamilton: McMaster University, 5 June 2012.

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8) Hammill AC, Eardley N, Lavis JN. Evaluating knowledge translation platforms in low- and middle-income countries: Centrafrique outcomes report. Hamilton: McMaster University, 14 July 2014.

K. Workshop evaluation reports

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Annex 2: Research instruments

2.1 Annual Activities and Outputs Inventory (T1)

Specify the start and end dates for Year 1:

- Start date (e.g., 1 June 2009): _____
- End date (e.g., 31 May 2010): _____

Note: The start date is the date selected as "baseline."

Under each category heading, please list:

(a) the activities the KT platform plans to undertake in its first year (Year 1). Where possible, please list specific activities and outputs, such as presentations, events, directories, databases, policy briefs, or reports, and provide pertinent details such as numbers, titles/topics, or dates. You may also list targets (e.g., 5 presentations to policymakers, 5 presentations to researchers, 3 presentations at conferences to general audience – one at a national conference and two at local conferences) where specific activities have not yet been planned/scheduled.

(b) any activities with a similar goal and which took place in the KT platform's jurisdiction (i.e., in the country, district/province, or municipality on which the KT platform is focused) in the year prior to the KT platform's implementation/start.

A general description of the types of activities that fall under each heading is provided along with a list of prompts that you may use to organize your list. Please list each activity as a separate bullet item.

PLEASE REMEMBER to send copies of any reports for funding agencies or work plans that document your planned activities for the coming year to the McMaster team.

Section 1: Creating a general climate for the use of evidence in policymaking

(a) List the activities the KT platform plans to undertake in Year 1 with respect to creating a general climate to support the use of evidence in policymaking (including awareness of the KT platform's activities). These activities might include presentations, promotional materials, or incentives (awards). Please indicate the topic of the presentation/promotional material/incentive and who the target audience is (i.e., policymakers, stakeholders, researchers).

Presentations

-
-
-

Promotional materials (brochure/pamphlet)

-
-
-

Incentives

-
-
-

Other

-
-
-

(b) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 2: Setting knowledge-translation (KT) priorities

(a) List the activities the KT platform plans to undertake in Year 1 with respect to identifying specific policy challenges/issues that could be informed by research evidence, and setting KT priorities accordingly.

Priority setting events

-
-
-

Training of researchers to undertake priority setting exercises

List training sessions or workshops, training materials, reports on training needs assessments among researchers, and reports on above training course/workshops.

-
-
-

Creating awareness/support for research related to identified priorities

Examples include: funding calls targeted at researchers; presentations to researchers and research funders; meetings or presentations to report on the findings (or the progress) of a specific research project (that is related to a KT priority); reports on desk research or surveys of policy challenges/issues that could be informed by research evidence; as well as general meetings, workshops, or presentations on priorities (or for the purpose of setting priorities) (e.g., Priority Setting Workshop attended by researchers and policymakers; Presentation by researchers to policymakers on upcoming research projects based on national KT priorities)

-
-
-

(b) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 3: Production of research evidence on KT priorities

(a) Describe any activities the KT platform plans to carry out in Year 1 with respect to the production of research evidence on KT priorities – specifically, efforts to facilitate, commission, conduct, or update both policy briefs and new primary research on identified KT priorities.

Policy briefs

List specific policy briefs as well as things like meetings related to the preparation of policy briefs (e.g., meeting to set the terms of reference for a brief, where researchers and policymakers are present) and efforts to engage policymakers and/or stakeholders in merit reviews.

-
-
-

Systematic reviews

List specific systematic reviews as well as things like meetings related to the conduct of systematic reviews (e.g., meeting to set the terms of reference for a review, where researchers and policymakers are present).

-
-
-

New primary research

Include specific journal publications and published research reports, as well as paper presentations of research results. Interim reports can be included for research still being conducted (e.g., 2007: "Provision of care in rural areas." Interim report published and distributed to policymakers; Journal Publication: "Expanded Roles for Nurse Practitioners" Journal of Medicine; Report: "Effectiveness of the Diabetes Program." Project Report, 2007)

-
-
-

Training of researchers to acquire, assess, and adapt systematic reviews, conduct new systematic reviews or to undertake primary research on identified policy priorities

List training sessions or workshops (e.g., September 2-5, 2007: Systematic review training for researchers; July 5-9, 2008: Workshop on Systematic Review Methods for researchers involved in the Malaria research project); training materials; reports on training needs assessments among researchers; and reports on above training courses/workshops.

-
-
-

(a) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 4: Push efforts

(a) List the activities the KT platform plans to undertake in Year 1 with respect to "push" efforts or putting research evidence on particular policy issues/challenges "into the hands of" policymakers and other stakeholders.

Convening policy dialogues at which issues/challenges and related research evidence are discussed by policymakers, stakeholders, and researchers

In addition to policy dialogues per se, list conferences where specific policy issues/challenges are discussed or debated by policymakers, researchers, and stakeholders.

-
-
-

Dissemination of policy briefs (outside of dialogues) and dialogue summaries/reports

-
-
-

Training researchers to understand the policy context in which they will undertake "push" efforts, identify actionable messages arising from research evidence, package research evidence as policy briefs, organize policy dialogues, and support policymaking

List training materials, reports on training needs assessments among policymakers, and reports on above training courses/workshops

-
-
-

Other knowledge-translation activities with the aim of encouraging and supporting the use of research evidence on particular policy issues/ challenges but have not been described in any of the categories above

Examples include: meetings or presentations to policymakers or stakeholders regarding a specific research project (e.g., Meeting with stakeholders to present revised proposals for Hospital Outpatient project; "Health Research Systems Survey" paper presented to policymakers at Ministry of Health; Meeting with stakeholders to update them on progress of a particular research project).

-
-
-

(b) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 5: Efforts to facilitate user pull

(a) List the activities the KT platform plans to undertake in Year 1 with respect to facilitating "user pull" – that is, facilitating policymakers' ability to acquire, assess, adapt, and apply research evidence on policy priorities. Activities may include efforts to: develop and maintain a research resource listing, clearinghouse, database, or website; develop and maintain a "rapid response" service that provides research evidence and related advice to policymakers on an urgent or semi-urgent basis; develop and maintain a directory of researchers and knowledge-translation specialists; training policymakers to acquire, assess, adapt, and apply research evidence ; and supporting them to develop structures and policies to acquire, assess, adapt, and apply research evidence.

Research resource listing/clearinghouse/database/website

-
-
-

Rapid response service

-
-
-

Directory of researchers and KT specialists

-
-
-

Training for policymakers to acquire, assess, adapt, and apply research evidence

List training sessions or workshops, training materials, reports on training needs assessments among policymakers, and reports on these training courses/workshops (e.g., Workshop on Finding and Using Research Evidence for policymakers and other professionals from the Ministry of Health).

-
-
-

Supporting policymakers to develop structures and policies to acquire, assess, adapt, and apply research evidence

-
-
-

(b) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 6: Exchange Efforts

(a) List the activities the KT platform plans to undertake in Year 1 with respect to promoting partnerships between policymakers and researchers. These may be activities aimed at: answering research questions or exchanging information and ideas (that you have not listed yet under any of the above categories).

Face-to-face interactions (not yet listed under any of the above categories)

List presentations or meetings where policymakers are present and where the goal is to determine how to answer research questions on policy priorities. Such meetings will likely occur in the early/planning stages of a research project (e.g., meeting to present research proposals or letters of intent for a policy priority research project to policymakers).

-
-
-

Electronic discussion fora

-
-
-

(b) Describe any activities with a similar goal and which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start.

Section 7: Other Activities

(a) List any other activities the KT platform plans to carry out in Year 1 that are worth documenting and that you have not already recorded above.

-
-
-

(b) Describe any other knowledge-translation activities which took place in the KT platform's jurisdiction in the year prior to the KT platform's implementation/start that have not already been mentioned.

-
-
-

2.2 KT Platform Profile (T1)

Specify the start and end dates for the year for which you are reporting:

- Start date (e.g., 1 June 2009): _____
- End date (e.g., 31 May 2010): _____

Note: The start date is the date selected as "baseline." The start and end dates specified above constitute the current reporting year.

The KT Platform Profile seeks to describe various features of the KT platform's infrastructure (e.g., governance, team size, and composition) and the context in which it operates (e.g., what stage it is at in its implementation, current economic situation in the country/district/municipality). It also seeks to document any anticipated changes over the course of the current reporting year.

With respect to each item in Section 1, please describe the KT platform's infrastructure and context as it exists upon implementation (i.e., at baseline).

Section 1: Infrastructure

1. Describe the composition of the governing body of your KT platform. Sometimes this governing body is known as a "steering group" or advisory committee. Indicate how many members of this body are policymakers, how many are researchers, and how many are stakeholders.

   Does the KT platform anticipate any change in the composition (or nature) of the governing body over the course of the current reporting year? Please specify.

2. Describe the nature of the unit or network in which the KT platform is "housed." This institution(s) may be a government office/department, a research institution, or an intermediary body.

   Does the KT platform anticipate any changes over the course of the current reporting year with respect to the institution(s) in which it is housed? Please specify.

3. Describe the relationship between the KT platform and this unit or network. It may be that "housed" is not the right word to describe the relationship. Please indicate how the relationship should be characterized.

   Was the unit or network newly created for the purpose of establishing the KT platform or did the unit/network exist beforehand?

   If the unit/network already existed was its organization altered to accommodate the new KT platform? How?

   Does the KT platform anticipate any changes in the relationship between itself and the unit or network in which it is "housed" over the course of the current reporting year? Please specify.

4. Describe the size and composition of the KT platform team. That is, describe the members of the KT platform who are directly involved in the platform's activities as well as their roles (e.g., researcher, librarian, "knowledge broker," policymaker). Also indicate the full-time status of each position (where devoted to KT platform activities full-time= 1.0, half-time = 0.5, etc).

   Does the KT platform anticipate any changes in the size and composition of its team over the course of the current reporting year? Please specify.

5. Outline the annual budget for the KT platform. Indicate the sources of funding, amounts, and whether any major evidence-to-policy initiatives are given specific amounts of money.

6. Indicate the proportion of the annual KT platform budget that comes from the Ministry of Health. (Calculate as a proportion of the total annual budget and express as a percentage.)

7. List and describe any written agreements with research and other institutions that support or undertake (some of) the KT platform's activities. These might also take the form of Memorandums of Understanding (MOUs).

   Were there any prior written agreements between these institutions and the KT platform before the KT platform was established? Please explain.

   Does the KT platform anticipate renegotiating any of the current written agreements over the course of the current reporting year? Please specify.

   Does the KT platform anticipate negotiating or signing any new written agreements with research or other institutions over the course of the current reporting year to support or undertake KT platform activities? Please specify.

8. Specify the KT platform's jurisdiction – that is, the geo-political area (e.g., country, district/province, or municipality) on which the KT platform is focused. If the KT platform's focus is a country, please indicate if the country is a unitary state with no sub-national (provincial/district) level of government.

   Does the KT platform anticipate any change in its jurisdiction over the course of the current reporting year? Please specify.

9. If there are any knowledge-translation priorities that the KT platform is focusing on, describe them here. Indicate if the focus is longer- or medium-term.

   Are there any new knowledge-translation priorities that the KT platform plans to focus on in the current reporting year? Please specify.

Section 2: Contextual Factors

10. When was the KT platform implemented/ set up?

How would the KT platform describe the stage of implementation it is currently at (e.g., planning phrase, or whether it is has begun implementation on a small, moderate, or full scale)?

11. (If applicable), describe any anticipated support or engagement with the EVIPNet resource support group or any of its members over the course of the current reporting year. This can include training sessions or workshops.

12. Describe any anticipated collaboration with KT platforms in other countries/places over the course of the current reporting year. This can include shared attendance at workshops or training sessions, or any collaboration on relevant evidence-to-policy initiatives.

13. Describe any knowledge translation initiatives led by others that are being implemented or currently in place in the KT platform's country/province/municipality.

14. Describe the present government in the country/province/municipality on which the KT platform is focused.

    Are any changes in government anticipated over the next year?

15. Describe the present economic and political situation in the country/province/municipality on which the KT platform is focused.

    Are any changes in the present economic or political situation anticipated over the next year that may influence the link between the KT platform's activities/outputs

and its outcomes/impact (e.g., coalition government that could fall at any time, cabinet shuffle anticipated, recession)?

2.3 Policy Brief Questionnaire

[Insert name of KT platform] Evaluation – Policy Brief

Please circle the number that corresponds to your answer and (if you wish) offer any suggestions about how the policy brief can be improved.

Several questions make reference to "stakeholders." The term "stakeholders" includes: staff or members of civil society groups; staff or members of health professional associations or groups; staff of donor agencies (e.g., European Community, Swedish International Development Agency) or international organizations (e.g., World Health Organization); and staff of pharmaceutical or other biotechnology companies.

<u>Section A</u> – Views about how the policy brief was produced and designed

1. The policy brief described the context for the issue being addressed. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

2. The policy brief described different features of the problem, including (where possible) how it affects particular groups. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

3. The policy brief described three options for addressing the problem. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

4. The policy brief described what is known, based on synthesized research evidence (i.e., systematic reviews), about each of the three options and where there are gaps in what is known. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

5. The policy brief described key implementation considerations. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

6. The policy brief employed systematic and transparent methods to identify, select, and assess the synthesized research evidence. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

7. The policy brief took quality considerations into account when discussing the findings from the synthesized research evidence. How useful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

8. The policy brief took local applicability considerations into account when discussing the findings from the synthesized research evidence. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

9. The policy brief took equity considerations into account when discussing the findings from the synthesized research evidence. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

10. The policy brief did not conclude with particular recommendations. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

11. The policy brief employed a graded-entry format (e.g., a list of key messages and a full report). How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

12. The policy brief included a reference list for those who wanted to read more about a particular systematic review or research study. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

13. The policy brief was subjected to a review by at least one policymaker, at least one stakeholder, and at least one researcher (called a "merit" review process to distinguish it from "peer" review, which would typically only involve researchers in the review). How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy brief be improved in this regard?

_____
_____
_____

<u>Section B</u> – Overall assessment of the policy brief

14. The purpose of the policy brief was to present the available research evidence on a high-priority policy issue in order to inform a policy dialogue where research evidence would be just one input to the discussion. How well did the policy brief achieve its purpose?

Failed	Moderately failed	Slightly failed	Neutral	Slightly achieved	Moderately achieved	Achieved
1	2	3	4	5	6	7

Comments:

_____

Section C – Views about what can be done better or differently

15. Reflecting on your reading of the policy brief, please list **at least one** element of how the policy brief was produced and designed that should be retained in future policy briefs.

16. Reflecting on your reading of the policy brief, please list any element(s) of how the policy brief was produced and designed that should be changed in future policy briefs.

17. Reflecting on what you learned from reading the policy brief, please list **at least one** important action that policymakers, stakeholders, and/or researchers can do better or differently to address the featured policy issue.

18. Reflecting on what you learned from reading the policy brief, please list **at least one** important action that you personally can do better or differently to address the featured policy issue.

Section D – Role and background

19. I am a (please tick (√) single most appropriate role category):

Broad role category	Specific role category	Tick (√) single most appro-priate
Policymaker	Public policymaker (i.e., elected official, political staff, or civil servant) in the national government	
	Public policymaker (i.e., elected official, political staff, or civil servant) in a sub-national government (e.g., province/state or a district if the latter has independent policymaking authority)	
	Manager in a district/region (if it does not have independent policymaking authority)	
	Manager in a healthcare institution (e.g., hospital)	
	Manager in a non-governmental organization (NGO)	
Stakeholder	Staff/member of a civil society group/community-based NGO	
	Staff/member of a health professional association or group	
	Staff of a donor agency (e.g., European Community, Swedish International Development Agency) or international organization (e.g., World Health Organization)	
	Staff of a pharmaceutical or other biotechnology company	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

20. I have been working in my current position for _____ years.

21. If you identified yourself as a policymaker, stakeholder, or "other," please indicate if you have training and/or extensive experience as a researcher (circle one):

Yes / No

22. If you identified yourself as a researcher, stakeholder, or "other," please indicate if you have experience as a policymaker (circle one):

Yes / No

Thank you!

ID #: _____ (Your responses will be kept confidential and data will not be reported in ways that could potentially identify you or your organization.)

2.4 Policy Dialogue Questionnaire

[Insert name of KT platform] Evaluation – Policy Dialogue

Please circle the number that corresponds to your answer and (if you wish) offer any suggestions about how the policy dialogue can be improved.

Several questions make reference to "stakeholders." The term "stakeholders" includes: staff or members of civil society groups; staff or members of health professional associations or groups; staff of donor agencies (e.g., European Community, Swedish International Development Agency) or international organizations (e.g., World Health Organization); and staff of pharmaceutical or other biotechnology companies.

<u>Section A</u> – Views about how the policy dialogue was designed

1. The policy dialogue addressed a high priority policy issue. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

2. The policy dialogue provided an opportunity to discuss different features of the problem, including (where possible) how it affects particular groups. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

3. The policy dialogue provided an opportunity to discuss three options for addressing the problem. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

4. The policy dialogue provided an opportunity to discuss key implementation considerations. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

5. The policy dialogue provided an opportunity to discuss who might do what differently. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

6. The policy dialogue was informed by a pre-circulated policy brief. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

7. The policy dialogue was informed by discussion about the full range of factors that can inform how to approach a problem, possible options for addressing it, and key implementation considerations. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

8. The policy dialogue brought together many parties who could be involved in or affected by future decisions related to the issue. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

9. The policy dialogue aimed for fair representation among policymakers, stakeholders, and researchers. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

10. The policy dialogue engaged a facilitator to assist with the deliberations. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

11. The policy dialogue allowed for frank, off-the-record deliberations by following the Chatham House rule: "Participants are free to use the information received during the meeting, but neither the identity nor the affiliation of the speaker(s), nor that of any other participant, may be revealed." How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____
_____

12. The policy dialogue did not aim for consensus. How helpful did you find this approach?

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

How could the policy dialogue be improved in this regard?

_____
_____
_____

<u>Section B</u> – Overall assessment of the policy dialogue

13. The purpose of the policy dialogue was to support a full discussion of relevant considerations (including research evidence) about a high-priority policy issue in order to inform action. How well did the policy dialogue achieve its purpose?

Failed	Moderately failed	Slightly failed	Neutral	Slightly achieved	Moderately achieved	Achieved
1	2	3	4	5	6	7

Comments:

_____
_____
_____

<u>Section C</u> – Views about what can be done better or differently

14. Reflecting on your participation in the policy dialogue, please list **at least one** element of how the policy dialogue was designed that should be <u>retained</u> at future policy dialogues.

_____
_____
_____
_____
_____
_____

15. Reflecting on your participation in the policy dialogue, please list any element(s) of how the policy dialogue was designed that should be changed at future policy dialogues.

_____
_____
_____
_____
_____
_____

16. Reflecting on what you learned from participating in the policy dialogue, please list **at least one** important action that policymakers, stakeholders, and/or researchers can do better or differently to address the featured policy issue.

_____
_____
_____
_____
_____
_____

17. Reflecting on what you learned from participating in the policy dialogue, please list **at least one** important action that you personally can do better or differently to address the featured policy issue.

_____
_____
_____
_____
_____
_____

Section D – Views about using research evidence more generally

Each question in this section refers to a scenario where you have been asked to brief or provide advice to policymakers or when you are personally involved in a policy debate or decision making. Please answer each question as though you are engaged in a typical briefing, advocacy, or decision-making process.

18. I expect to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

19. I want to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

20. I intend to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

21. Using research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide is…

Very harmful	Moderately harmful	Slightly harmful	Neutral	Slightly beneficial	Moderately beneficial	Very beneficial
1	2	3	4	5	6	7

Very bad	Moderately bad	Slightly bad	Neutral	Slightly good	Moderately good	Very good
1	2	3	4	5	6	7

Very unpleasant (for me)	Moderately unpleasant (for me)	Slightly unpleasant (for me)	Neutral	Slightly pleasant (for me)	Moderately pleasant (for me)	Very pleasant (for me)
1	2	3	4	5	6	7

Very unhelpful	Moderately unhelpful	Slightly unhelpful	Neutral	Slightly helpful	Moderately helpful	Very helpful
1	2	3	4	5	6	7

22. Most people who are important to me in my professional life think that…

I should definitely not	I should almost certainly not	I should probably not	Neutral	I should probably	I should almost certainly	I should definitely
1	2	3	4	5	6	7

… use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

23. It is expected of me that I use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

24. I feel under social pressure to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

25. People who are important to me in my professional life want me to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

26. I am confident that I could use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

27. For me to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide is…

Very difficult	Moderately difficult	Slightly difficult	Neutral	Slightly easy	Moderately easy	Very easy
1	2	3	4	5	6	7

28. The decision to use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide is beyond my control.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

29. Whether or not I use research evidence of the type that was discussed at the policy dialogue to help work through what I will say in a briefing, advocate for, or decide is entirely up to me.

Strongly disagree	Disagree	Somewhat disagree	Neither agree nor disagree	Somewhat agree	Agree	Strongly agree
1	2	3	4	5	6	7

Section E – Role and background

30. I am a (please tick (√) single most appropriate role category):

Broad role category	Specific role category	Tick (√) single most appro-priate
Policymaker	Public policymaker (i.e., elected official, political staff, or civil servant) in the national government	
	Public policymaker (i.e., elected official, political staff, or civil servant) in a sub-national government (e.g., province/state or a district if the latter has independent policymaking authority)	
	Manager in a district/region (if it does not have independent policy-making authority)	
	Manager in a healthcare institution (e.g., hospital)	
	Manager in a non-governmental organization (NGO)	
Stakeholder	Staff/member of a civil society group/community-based NGO	
	Staff/member of a health professional association or group	
	Staff of a donor agency (e.g., European Community, Swedish International Development Agency) or international organization (e.g., World Health Organization)	
	Staff of a pharmaceutical or other biotechnology company	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

31. I have been working in my current position for _____ years.

32. If you identified yourself as a policymaker, stakeholder, or "other," please indicate if you have training and/or extensive experience as a researcher (circle one):

Yes / No

33. If you identified yourself as a researcher, stakeholder, or "other," please indicate if you have experience as a policymaker (circle one):

Yes / No

Thank you!

ID #: _____ (Your responses will be kept confidential and data will not be reported in ways that could potentially identify you or your organization.)

2.5 Sample Identification Tool

At T1, and again at T2 and T3, the sample identification tool will be used to identify a sample comprised of 25 policymakers, 15 stakeholders, and 10 researchers. Each time the survey is administered, the sample identification tool must be completed. This tool consists of three lists of positions, one for each category of survey participant. A designated member of the local team will use publicly available directories, such as government phone books, and NGO and university websites, to identify the person who provides the best possible match for each position.

As the sample identification tool seeks to identify policymakers at various levels of government within the KT platform's jurisdiction (5 policymakers from the national level, 5 from the sub-national level, plus 15 from the largest city or district within the selected sub-national jurisdiction), the local team needs to determine the single largest sub-national (i.e., state or provincial) jurisdiction if one exists.

If your KT platform is located in a unitary state (i.e., there is no sub-national level at which a separate tier of elected officials govern the jurisdiction), you will select twice as many of each type of official in the national government.

If your KT platform is focused on a particular sub-national area (i.e., state or province) that is not the largest in the country, retain this focus, and throughout the sample identification tool, please read "KT platform's jurisdiction" for "largest sub-national jurisdiction" or "sub-national jurisdiction."

The completed sample identification table will be sent to the McMaster team in advance of Telephone Meeting #2 with the local team, and again for final approval before survey administration. For the McMaster team's reference, please specify:
The jurisdiction of your KT platform: _____
The single largest sub-national (i.e., state or province) jurisdiction within the country: _____
Is the country a unitary state? Yes / No
The single largest city/district located within either (i) the single largest sub-national jurisdiction, or (ii) the KT platform's jurisdiction if this jurisdiction is not the country and does not correspond to, or fall within, the single largest sub-national jurisdiction: _____

The second column of the Sample Identification Tool lists descriptive, or non-specific, titles of positions within each participant category, such as "Head of strategic health policy (i.e., not only policy related to specific programs)," "Head of an infectious disease program," "Most senior manager (in a health care institution in the largest city/district) in charge of planning." In completing the sample identification tool at T1, you will first need to associate a specific title with each of these. For example, in Canada a specific position title associated with the descriptive title, "Head of an infectious disease program," would be "Director, HIV/AIDS Policy, Coordination & Programs Division, Infectious Disease & Emergency Preparedness Branch, Public Health Agency of Canada." In large organizations like governments and hospitals, try to identify positions as close to the fourth level from the top (i.e., the fourth level below the Minister of Health or President and Chief Executive Officer). For Canada, we would select government participants from the Director level whenever possible because the top tier of the government looks like this:

1. Minister
2. Deputy Minister
3. Assistant Deputy Minister (Director-General in some countries, such as Malaysia)
4. Director
5. Manager

The second step is to identify the specific individuals who occupy these positions and obtain their contact information. Steps 1 and 2 are likely to be iterative and will involve consultation among the local team.

At T2 and T3, the task of completing the sample identification tool involves reviewing the list of specific titles you identified when completing the tool at T1 and verifying whether (i) the position still exists or has undergone other changes (e.g., merged with another position or been split into two new positions), and (ii) the same individual continues to hold the position originally identified. Where changes have occurred in either (i) or (ii), you will need to identify the new individual now holding a position, or a new position and the person who holds it.

To assist you in completing the tool we have provided examples from the Canadian context of specific position titles associated with each of the descriptive titles. These are listed in Column 6. Equivalents for your KT platform's jurisdiction can be entered in Column 3; while the names of individuals who hold these positions and their contact information can be entered in Column 4. Column 5 allows you to record comments. Column 7 contains comments about the examples from the Canadian context.

Table 1: Sample identification

Specific Role Category	Descriptive Position Titles	Specific Position Titles (Your KT platform)	Name of Individual who Holds the Position and Contact Information	Comments	Specific Position Titles (Examples from Canadian Context)	Comments
Policymakers (25)						
Public policymakers in the national government (5)	Civil servants in the national government:					
	• Head of strategic health policy (i.e., not only policy related to specific programs)				Canada: Director, Policy Coordinating and Planning Directorate (within Health Policy Branch)	
	• Head of primary healthcare (or a healthcare oriented "horizontal") program				Canada: Director, Policy Coordination & Planning, Primary Care Coordination Division, Health Canada	
	• Head of public health (or a public health oriented "horizontal") program, such as maternal and child health program)				Canada: Director, Office of Public Health Practice, Public Health Agency of Canada (PHAC)	
	• Head of an infectious disease program (e.g., HIV/AIDS)				Canada: Director, HIV/AIDS Policy, Coordination & Programs Division, Infectious Disease & Emergency Preparedness Branch, PHAC	
	• Head of a chronic disease program (e.g., diabetes)				Canada: Manager, Diabetes Coordination, Centre for Chronic Disease Prevention and Control, PHAC	Chronic diseases are headed by Managers in Canada, so this is a case where it is appropriate to survey a Manager (i.e., the fifth level)
Public policymakers in the single largest sub-national (e.g., provincial/state) jurisdiction (or sub-national jurisdiction of focus for the KT platform)(5)	Civil servants in the government of the single largest sub-national jurisdiction (if no such level of government exists, the numbers from the national level can be doubled):					
	• Head of strategic health policy (i.e., not only policy related to specific programs)				Ontario: Director, Health System Strategy Branch, Health System Strategy Division	
	• Head of primary healthcare (or a healthcare oriented "horizontal") program				Ontario: Director, Primary Health Care and Family Health Teams, Health System Accountability and Performance Division	
	• Head of public health (or a public health oriented "horizontal") program, such as maternal and child health program)				Ontario: Director, Public Health System Policy and Planning, Public Health Division	

	• Head of an infectious disease program (e.g., HIV/AIDS)				Ontario: AIDS Coordinator, AIDS Bureau, Provincial Programs Branch, Health System Accountability and Performance Division	Infectious diseases are headed by Coordinators in the provincial government, so this is a case where it is appropriate to survey a Coordinator
	• Head of a chronic disease program (e.g., diabetes)				Manager, Chronic Disease Unit, Health System Policy and Relations Branch, Health System Strategy Division	Chronic diseases are headed by Managers in Canada, so this is a case where it is appropriate to survey a Manager
Manager in the largest city/district within the sub-national jurisdiction (or within the country if a unitary state) (i.e., at the sub-provincial/state level) (5)	• Head of health planning (i.e., not only policy related to specific programs)				Toronto Central LHIN: Senior Director, Performance Contracts and Allocations	Local Health Integration Networks (LHIN's) are district level health organizations responsible for coordinating care within the district/city.
	• Head of primary healthcare (or a healthcare oriented "horizontal") program				Toronto Central LHIN: Critical Care Lead, Toronto Local Health Integration Network	
	• Head of public health (or a public health oriented "horizontal") program, such as maternal and child health program)				Toronto Public Health: Acting Director, Planning and Policy	
	• Head of an infectious disease program (e.g., HIV/AIDS)				Toronto Public Health: Associate Director, TB Prevention & Control, Communicable Diseases Control	
	• Head of a chronic disease program (e.g., diabetes)				Toronto Central LHIN: Team Lead, Performance & Integration (who is also in charge of Chronic Disease Prevention & Management)	
Manager in a (public and/or not-for-profit) healthcare institution in the largest city/district (within province) (e.g., hospital) (5)	Most senior manager in charge of planning (e.g., Director, Vice-President) in:					
	• Large acute care hospital #1 in largest city				Canada (Toronto): St. Joseph's Health Centre (i.e., St. Joseph's Hospital): Executive Vice President Clinical & Professional Programs and Services and Chief Nurse Executive	
	• Large acute care hospital #2 in largest city				Canada (Toronto): Trillium Health Centre (i.e. Trillium Hospital): Associate Vice-President, Strategic Planning & Business Transformation	

	• Primary healthcare clinic/community healthcare centre #1 in largest city				Canada (Toronto): Practice Manager, Summerville Family Health Team	
	• Primary healthcare clinic/community healthcare centre #2 in largest city				Canada (Toronto): Practice Manager, Southeast Toronto Family Health Team	
	• Large long-term care hospital in largest city				Canada (Toronto): Bridgepoint Health (Chronic disease and long-term care hospital): Vice-President, Strategy & Network Development	
Manager in a non-governmental organization in the largest city/district (5)	Most senior manager in charge of strategy or planning or policy (e.g., Director, Vice-President) for:					
	• International NGO #1 with an office in the largest city				Canada (Toronto): Vice-President, Operations, Canadian Red Cross	
	• International NGO #2 with an office in the largest city				Canada (Toronto): Director of Operations, Stephen Lewis Foundation	
	• National NGO #1 based in largest city				Canada (Toronto): Director of Operations, Ronald McDonald's Children's Charities of Canada	
	• National NGO #2 based in largest city				Canada (Toronto): National Director, Development, Easter Seals Canada	
	• Local NGO based in largest city				Canada (Toronto): Chief Operating Officer, St. Elizabeth's Health Care	Chief Operating Officer is closest position to Chief of Strategy
Stakeholders (15)						
Staff/member of a civil society group (3)	Most senior manager/representative in charge of strategy or planning or policy of:					
	• National civil society group with a general health interest and an office in the largest city				Canada (Toronto): Director, Development, Council of Canadians Congress	
	• National civil society group with a specific disease interest and an office in the largest city				Canada (Toronto): Vice-President, Strategy, Heart & Stroke Foundation	
	• Local civil society group with a public health interest and an office in the largest city				Canada (Toronto): Senior Vice-President, Strategic Alignment, YMCA Toronto	
Staff/member of a health professional	Most senior Manager/Director (i.e., non-elected representative)					

association or group (3)	in charge of strategy or planning or policy for the:					
	• (Sub-national or national) medical association				Canada: Chief Strategy Officer, Canadian Medical Association	
	• (Sub-national or national) nursing association				Canada: Chief Strategy Officer, Canadian Nurses' Association	
	• (Sub-national or national) pharmacists' association				Canada: Chief Operation Officer, Canadian Pharmacists' Association	
Staff of a donor agency (e.g., European Community, Swedish International Development Agency) or international organization (e.g., World Health Organization) (3)	Most senior manager within the country office for:					
	• A US-based donor agency				USAID doesn't have offices in Canada	
	• A Europe-based donor agency				No offices in Canada	
	• World Health Organization				Pan-American Health Organization (PAHO) is the WHO affiliate for Canada: Director, International Health Policy & Communication Strategy	The Director at Health Canada is the PAHO representative for Canada
Staff of a pharmaceutical or other biotechnology company (3)	Most senior manager in charge of government relations within:					
	• An office/subsidiary of an international pharmaceutical company				Canada: Manager, Government Relations, Pfizer Canada	Government relations is a position typically held by a Manager in Canada
	• A domestic pharmaceutical company				Canada: Director, Government Relations, Apotex Generic Drug Company	
	• An office/subsidiary of an international biotechnology company (e.g., diagnostics)				Canada: Manager, Government Relations, Amgen Canada, Inc	Amgen is an American biotechnology firm
Representative of another stakeholder group (3)	Most senior manager within three stakeholder groups not mentioned above:					
	•					
	•					
	•					
Researchers (10)						
Researcher in a national research institution (3)	Most senior researcher in a national research institution and who is a:					
	• Leading researcher about health systems					Canada does not have national research institutions, so twice as many participants would be sampled from the next category
	• Leading researcher about primary health care					

	• Leading researcher about public health					
Researcher in a university in the largest city within the sub-national jurisdiction (or within the country if a unitary state) (3)	Most senior researcher in a university in the largest city who is a:					
	• Leading researcher about health systems				Canada (Toronto): Professor of Health Policy, Management & Evaluation, Faculty of Medicine, University of Toronto Canada (Hamilton): Associate Professor, McMaster University & Director of the Centre for Health Economics and Policy Analysis	
	• Leading researcher about primary health care				Canada (Toronto): Associate Professor, Family & Community Medicine, Dalla Lana School of Public Health, University of Toronto Canada (Toronto): Primary Care Researcher, St. Michael's Hospital	
	• Leading researcher about public health				Canada (Toronto): Associate Professor, Department of Public Health Sciences, University of Toronto Canada: Scientific Director, Centre for Health Promotion, University of Toronto	
Researcher in another institution (3)	Most senior researcher in another institution who is a:					
	• Leading health researcher within the national government but who is not part of a national research institution				Canada: Assistant Chief Statistician, Analysis and Development, Statistics Canada	
	• Leading researcher #1 within a NGO in the largest city within the sub-national jurisdiction (or within the country if a unitary state)				Scientific Director, Ontario HIV Treatment Network	
	• Leading researcher #2 within a NGO in the largest city within the sub-national jurisdiction (or within the country if a unitary state)				Director, Research & Evaluation, World Vision Canada	

Researcher located outside the country (1)	• Senior health researcher investigating health policy and systems issues related to the country, but who lives outside the country				United States: Professor of Public Policy, Management, and Political Science, Yale University	

2.6 T1 Outcomes Questionnaire

[Insert name of KT platform] Evaluation – Outcomes Questionnaire

Please circle the number that corresponds to your answer and (if you wish) offer specific comments on any issues raised in particular questions by identifying the question by number and adding your comments in the space provided on the final page of the questionnaire.

In this questionnaire we refer to "the KT platform's jurisdiction." In your case this is [insert description of jurisdiction – e.g., country name, the state/province of…, the municipality/city of….].

Several questions make reference to "stakeholders." The term "stakeholders" includes: staff or members of civil society groups; staff or members of health professional associations or groups; staff of donor agencies (e.g., European Community) or international organizations (e.g., World Health Organization); and staff of pharmaceutical or other biotechnology companies.

A number of questions offer "Don't know" as a response option. "Don't know" should be selected **only** if you feel that you do not have sufficient information or knowledge to form a view.

Section 1: Views about evidence availability, interactions among policymakers and researchers, and policymakers' capacity to find and use research evidence

Please indicate how often, in your view, the following situations occurred in the KT platform's jurisdiction over the last two years. Please consider each question in light of how often it was feasible for each situation to occur.

1) How often was relevant research evidence about high-priority policy issues easily available to policymakers?

	Never 1	**Very rarely 2**	**Rarely 3**	**Occasionally 4**	**Frequently 5**	**Very frequently 6**	**Always 7**	
a.	Copies of articles or reports about primary research on high-priority policy issues were widely disseminated to policymakers working on these issues.	1	2	3	4	5	6	7	Don't know
b.	Systematic reviews of the research literature on high-priority policy issues were widely disseminated to policymakers working on these issues.	1	2	3	4	5	6	7	Don't know
c.	Policy briefs that described research evidence about a high-priority problem, options for addressing the problem, and key implementation considerations were widely disseminated to policymakers working on these issues.	1	2	3	4	5	6	7	Don't know

d.	Policymakers had access to a personal computer with a functional internet connection.	1	2	3	4	5	6	7	Don't know
e.	Policymakers had access to research evidence on high-priority policy issues through a searchable database focused on these issues.	1	2	3	4	5	6	7	Don't know
f.	Policymakers had access to research evidence on high-priority policy issues through a service operated by researchers and designed to respond in a timely way to questions about these issues.	1	2	3	4	5	6	7	Don't know
g.	Research evidence concerning high-priority policy issues was available to policymakers.	1	2	3	4	5	6	7	Don't know
h.	The research evidence available to policymakers yielded information that could help them address high-priority policy issues.	1	2	3	4	5	6	7	Don't know

2) How often did policymakers and researchers interact in the following ways?

	Never 1	**Very rarely** 2	**Rarely** 3	**Occasionally** 4	**Frequently** 5	**Very frequently** 6	**Always** 7							
a.	Policymakers interacted with researchers as part of a priority-setting process to identify high-priority policy issues for which primary research and systematic reviews were needed.							1	2	3	4	5	6	7	Don't know
b.	Policymakers interacted with researchers as part of the process of conducting primary research or systematic reviews about high-priority policy issues.							1	2	3	4	5	6	7	Don't know
c.	Policymakers interacted with researchers to obtain assistance with finding and using research evidence about high-priority policy issues.							1	2	3	4	5	6	7	Don't know
d.	Policymakers interacted with researchers through targeted efforts to support research use in policymaking (i.e., a rapid-response service or policy dialogues).							1	2	3	4	5	6	7	Don't know
e.	Policymakers interacted with researchers on an informal basis (i.e., through membership on committees, attendance at meetings, personal conversations).							1	2	3	4	5	6	7	Don't know

3) How often did policymakers develop and demonstrate their capacity to find and use health research evidence in health systems policymaking?

Never 1	**Very rarely** 2	**Rarely** 3	**Occasionally** 4	**Frequently** 5	**Very frequently** 6	**Always** 7

a.	Policymakers participated in training to develop their capacity to find and use research evidence about high-priority policy issues.	1	2	3	4	5	6	7	Don't know
b.	Policymakers acquired research evidence on high-priority policy issues.	1	2	3	4	5	6	7	Don't know
c.	Policymakers assessed the quality and local applicability of research evidence on high-priority policy issues.	1	2	3	4	5	6	7	Don't know
d.	Policymakers conveyed research evidence on high-priority policy issues to stakeholders in a useful way.	1	2	3	4	5	6	7	Don't know
e.	Policymakers identified or created places for research evidence in decision-making processes.	1	2	3	4	5	6	7	Don't know

Section 2: KT platform's contributions

4) To what extent do you agree or disagree with these statements about the KT platform's contributions over the last two years.

Strongly disagree 1	**Disagree 2**	**Somewhat disagree 3**	**Neither agree nor disagree 4**	**Somewhat agree 5**	**Agree 6**	**Strongly agree 7**

a.	The KT platform has contributed to enhancing the availability of relevant research evidence on high priority issues.	1	2	3	4	5	6	7	Don't know
b.	The KT platform has contributed to strengthening relationships among policymakers and researchers.	1	2	3	4	5	6	7	Don't know
c.	The KT platform has contributed to strengthening policymakers' capacity to find and use research evidence in health systems policymaking.	1	2	3	4	5	6	7	Don't know

Section 3: Role and background

5) I am a ….(tick (√) single most appropriate role category):

Broad role category	**Specific role category**	**Tick (√) single most appropriate**
Policymaker	Public policymaker (i.e., elected official, political staff, or civil servant) in the national government	
	Public policymaker (i.e., elected official, political staff, or civil servant) in a sub-national government (e.g., province/state or a district if the latter has independent public policymaking authority)	
	Manager in a district/region (if it does not have independent public policymaking authority)	
	Manager in a healthcare institution (e.g., hospital)	

	Manager in a non-governmental organization (NGO)	
Stakeholder	Staff/member of a civil society group/community-based NGO	
	Staff/member of a health professional association or group	
	Staff of a donor agency (e.g., European Community) or international organization (e.g., World Health Organization)	
	Staff of a pharmaceutical or other biotechnology company	
	Representative of another stakeholder group	
Researcher	Researcher in a national research institution	
	Researcher in a university	
	Researcher in another institution	
Other		

6) I have been working in my current position for _____ years.

7) If you identified yourself as a policymaker, stakeholder, or "other," please indicate if you have training and/or extensive experience as a researcher (circle one):
Yes / No

8) If you identified yourself as a researcher, stakeholder, or "other," please indicate if you have experience as a policymaker (circle one):
Yes / No

Thank you!

ID #: _____ (Your responses will be kept confidential and data will not be reported in ways that could potentially identify you or your organization.)

Additional thoughts (Optional)

Do you have any comments regarding issues raised in particular questions?

_____

_____

_____

_____

_____

_____

_____