Understanding policy briefs

Advanced workshop for policy makers: Using policy briefs in health policy-making

Mehrnaz Kheirandish
Regional Advisor for Evidence and Data to Policy
Division of Science, Information and Dissemination, WHO EMRO

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World Health Organization
REGIONAL OFFICE FOR THE Eastern Mediterranean

Outline

- Policy making processes and policy brief as a tool for policy making
- Identifying key messages in a policy brief; a few examples of policy briefs
- WHO EMRO recommended template for developing of the policy briefs

Access to recordings and all materials: http://www.emro.who.int/evidence-data-to-policy/about.html (under technical products navigation icon)

Defining "*evidence-informed policy-making*" What is a "policy"?

- **A policy is a course of actions by governments or large institutions that affects the society**
- **It may involve decisions on:**
  - Doing new actions/interventions …
  - Not to do an action or intervention …
  - Keep, maintain or continue an action/intervention …
- **A policy may occur at different levels**
  - International, national and sub-national (e.g. provincial) levels
  - Policy briefs are often addressing national policy-making but they can also be used for policies concerning a group of countries

Defining *"evidence-informed policy-making"* What is "evidence"?

Evidence:

"Any form of knowledge -including, but not confined to research- of sufficient quality to inform decisions" (WHO 2011 Glossary)

Best available evidence:

A synthesis of high-quality evidence from global databases (e.g. systematic reviews), which is combined with local evidence to design contexts specific solutions. It can also be complimented with tacit knowledge, especially when explicit knowledge from local contexts is of poor quality or is not available. (WHO 2017 EVIPNet)

Evidence-informed policy-making:

Evidence-informed policy-making for health requires the establishment of programmes and processes to identify the priority health topics and the best available evidence for the selection of effective interventions, and to develop decision-making approaches that take in to account the best available evidence. (WHO EMRO 2019)

Multi-concept approach for evidence-informed policy-making;

http://www.emro.who.int/evidence-data-to-policy/about.html

Source: WHO Regional Committee for the Eastern Mediterranean resolution EM/RC66/R.5 on developing national institutional capacity for evidence-informed policy-making for health. Cairo: WHO Regional Office for the Eastern Mediterranean; 2019

The integrated system for evidence-informed policy-making that all technical programs which are the sources of evidence are linked together to inform policy making.

Evidence-informed policy-making

Using best-available evidence to answer policy questions

Policy-maker questions	What are the main priority issues/problems for decision-making?	What are the potential effective and safe policy options?	Are the policy options cost-effective and affordable?	Are the policy options feasible to implement and sustainable?

Policy-makers are keen in using evidence in their decisions

Usual sources of evidence	Household, facility and user surveys	Household, facility and user surveys	Household, facility and user surveys	Household, facility and user surveys
	Routine information and surveillance	Routine information and surveillance	Routine information and surveillance	
		Interventional and cost-effectiveness studies	Interventional and cost-effectiveness studies	
	Qualitative studies			Qualitative studies
Knowledge products and processes	Policy briefs	Policy briefs	Policy briefs	Policy briefs
	Data fact sheets and observatories	Guidelines and health technology assessments	Guidelines and health technology assessments	Guidelines and health technology assessments

Important challenges in availability of products and processes

Source; Dr Arash Rashidian, Capacity Building workshop for Development of Policy Briefs: General Principles, Oct 2021

What is a policy brief?

- **A useful policy brief needs:**
  - To be brief
  - To include valid and relevant content (best available evidence)
  - To include policy options and key massages addressing the problem
  - To be presented in an appropriate format for policy-makers

- **Unfortunately, many policy briefs do not meet these criteria!**
  - **Are lengthy!**
  - **Do not address** key aspects of the policy
  - **Are not based on** valid and relevant content
  - …

Examples of titles used in some policy briefs

Title	Comments on the title
Gender and tobacco control: a policy brief	Short and focused
Policy brief: Nurse fatigue, sleep, and health, and ensuring patient and public safety	Catchy
Successful ageing and social interaction: A policy brief	Short and focused
ICN policy brief World Health Organization Global Strategy on Human Resources for Health in the era of the post 2015 Sustainable Development Goals: Nursing's Essential Contribution	Not understandable Too long
Actions for improved clinical and prevention services and choices preventing HIV and other sexually transmitted infections among women and girls using contraceptives services in contexts with high HIV incidence	Too long

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Policy brief on improving access to artemisinin-based combination therapies for malaria in Burkina Faso

Bocar Kouyaté, Victor Nana
Ministry of Health, Ouagadougou, Burkina Faso

Keywords: Antimalarials, Care access, Health policy, Burkina Faso

THE PROBLEM

Malaria is a major public health problem in Burkina Faso. Statistics from health facilities in 2006 show that 40.1 percent of medical consultations, 53.4 percent of hospital admissions, and 45.8 percent of deaths are malaria related (2). Malaria among children under 5 years of age accounted for 46 percent of all cases in 2004, 49 percent in 2005 and 48 percent in 2006. In the same age group, malaria was the cause of 66.4 percent of deaths in 2004, 62.0 percent in 2005 and 62.7 percent in 2006.

In addition, data on the therapeutic efficacy of antimalarials at six sentinel sites in 2003 indicated treatment failure rates varying between 26.9 percent and 63.3 percent for chloroquine and 10 percent for sulfadoxine-pyrimethamine, thereby prompting Burkina Faso to adopt a new malaria treatment policy in February 2005 (3). The first-line drugs now recommended for the treatment of uncomplicated malaria are the artemisinin-based combination therapies (ACTs) artemether + lumefantrine and amodiaquine + artesunate (4–6;15;16).

A core strategy for malaria control is *early and appropriate management of malaria cases* at all levels of the health pyramid (3;5;6). The home-management strategy for treatment of uncomplicated malaria was adopted by the National Malaria Control Programme (PNLP) in 1997 and has been implemented in all health districts in partnership with community groups and associations (9;11;14). Thus, in addition to fulfilling their traditional role in the referral process, community intermediaries will also be supplied with ACTs to enhance the home management of uncomplicated malaria (3;5;6). However, it should be noted that the majority of community health workers are no longer practicing because there is little or no financial incentive for them to do so (10;13). The strength of their commitment to providing community-based services is undermined by the absence of a continuous and effective motivational strategy on the part of communities, the Ministry of Health, and other partners.

ACTs are available at subsidized rates in public health facilities only, despite the fact that private facilities are important dispensers of medication, particularly in urban areas. This leads to deficiencies in early treatment of uncomplicated malaria, given that private facilities dispense ACTs at prices in excess of CFAF 4,000 (US$9) (i.e., forty times more expensive than ACTs for children under 5 years of age and four times more expensive than ACTs intended for adults).

With the introduction of ACTs and the scaling up of their use in treating uncomplicated malaria, single-drug therapy, especially chloroquine, should be removed from the list of essential drugs. Single-drug therapy should be strictly reserved for specific pathologies.

The following key points emerge from analysis of the malaria control situation: (i) Motivating community intermediaries to ensure the long-term future of community-based interventions remains a challenge; (ii) It has been decided to subsidize ACTs dispensed by public health services but not private facilities because of concerns that the latter might not respect pricing guidelines; and (iii) Single-drug therapy

POLICY OPTIONS

Universal and equitable access to ACTs for treating uncomplicated malaria is needed urgently. Three policy options that could improve access are changes in *Delivery arrangements*: motivate community health workers responsible for home management of uncomplicated malaria; *Financial arrangements*: ensure that private-sector stakeholders (pharmacies, clinics, nursing practices) comply with national guidelines on subsidized pricing of ACTs; and *Governance arrangements*: ban antimalarial drugs used in single-drug therapy for uncomplicated malaria and remove these drugs from the national list of essential drugs. These three options are described in Table 1.

IMPLEMENTATION OF THE POLICY OPTIONS

Obstacles to implementing the three policy options and strategies for addressing these are described in Table 2.

s in health policy-making

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Table 1. Policy Options

Policy option	Motivate the community health workers (CHWs) responsible for home management of uncomplicated malaria	Ensure private-sector stakeholders comply with national guidelines on subsidized pricing of artemisinin-based combination therapies (ACTs)	Recall antimalarial drugs used in single-drug therapy for uncomplicated malaria
Description	• Train CHWs • Supervise and provide guidance to CHWs • Cover CHW training costs and expenses	• End pricing structure applicable to malaria treatment • Introduce subsidies for treatment of uncomplicated malaria • Contracting arrangements for provision of subsidized ACTs by private health facilities	• Draft and promulgate regulations to discontinue single-drug therapies (Ministerial order retracting the marketing authorization for single-drug therapies, inter-ministerial order to halt imports, etc.) • Organize recall of current stocks • Destroy stocks in approved manner • Reimburse owners for recalled and destroyed stocks • Inform/raise awareness among the general public
Advantages	• Involving community health workers in maternal and child health programs (compared to usual care) can reduce mortality in children under 5 years and morbidity from common childhood illnesses (10) • Training workshops, alone or combined with other activities, can improve professional practice and treatment outcomes for patients (7) • Fewer severe malaria cases in the community • By bringing treatment closer to the home, mothers will change their health-seeking behavior (1;8;9) • Reduction in health workers' workload, enabling them to devote their freed-up time to other health tasks	Evidence indicates that: • The private sector is an important health provider for the poor in low- and middle-income countries • Many measures involving the private sector can be successfully implemented in poor communities (12) • Increases in health-care costs tend to reduce the demand for treatment	• Effective treatment of uncomplicated malaria (if treatment with single-drug therapy is replaced with ACTs) • Fewer severe malaria cases • Fewer malaria-related deaths
Disadvantages	Overuse leading to possibility of rapid emergence of resistance to ACTs (6)	There is growing evidence that the private sector fails to provide high-quality care (2)	Resurgence of single-drug therapy through black market in contraband medication, corruption
Cost	CFAF 10 billion[a] (based on the malaria incidence rate, the number of uncomplicated malaria cases treated with ACTs dispensed by private facilities, the cost of ACTs and the level of subsidy according to age group)	CFAF 5 billion[b] (based on the malaria incidence rate, the number of uncomplicated malaria cases treated with ACTs dispensed by private facilities, the cost of ACTs and the level of subsidy according to age group)	CFAF 50 million[c] (based on estimated stocks of chloroquine and other artemisinin-based single-drug therapies as per import and consumption data)
Acceptability	• Decision makers at the Ministry of Health (favorable) • Technical and financial partners (mixed) • Procurement office (CAMEG) (favorable) • Pharmacy managers (unfavorable) • Associations and NGOs (very favorable) • Patients (mixed)	• Decision makers at the Ministry of Health (favorable) • Technical and financial partners (favorable) • Procurement office (CAMEG) (favorable) • Private pharmacists (mixed) • Patients (very favorable)	• Decision makers at the Ministry of Health (favorable) • Procurement office (CAMEG) (favorable) • Pharmacy managers (mixed) • Street vendors of medicines (unfavorable) • Patients (neutral)

Table 2. Implementation of the Policy Options

Policy option	Ensure private-sector stakeholders comply with national guidelines on subsidized pricing of artemisinin-based combination therapies (ACTs)	Motivate the community health workers (CHWs) responsible for home management of uncomplicated malaria	Recall antimalarial drugs used in single-drug therapy for uncomplicated malaria
Obstacles to implementation	• No procedure for contracting with private facilities in the strategic plan for malaria control (5) • Essential Generic Medicines Procurement Office (CAMEG) stock inaccessible to private pharmacists • Lower profit margin on ACTs for private sector • Insufficient community input	• No national strategy for community-based intervention • Opposition from parents/patients if not informed of CHW role • Opposition from CHWs due to increased workload if motivation is insufficient	• Opposition from pharmacists and other vendors due to loss of profit margin • Lack of public enthusiasm, preference for tried and trusted medications
Strategies for implementation	• Lobby pharmacists, clinics and private practices to enter into a formal contract • Lobby CAMEG • Mobilize additional resources to finance ACT subsidies • Information campaign in the media targeting communities	• Fine-tune the national strategy for community-based services (6) • Introduce financial incentive scheme for community intermediaries based on profits from sale of ACTs • Tailor training of community intermediaries to their role and tasks • Referral centers for health and social welfare (CSPS) to guide and supervise community intermediaries	• Issue an interministerial order prohibiting the import and use of single-drug therapies • Public relations campaign to modify attitudes to single-drug therapy • Organize recall of single-drug therapies and document their destruction (3) • Reimburse recalled and destroyed stock • Launch information campaign in the media targeting communities

10 May 2014

An Evidence Brief for Policy

Executive summary

Improving Patient Safety for better Quality of Care

This evidence brief was prepared to inform dialog about multiple policy options. ***It does not include recommendations.***

Who is this evidence brief for?

Policymakers, their support staff, and other stakeholders with an interest in the problem addressed by this evidence brief

Why was it prepared?

To **inform deliberations** about health policies and programmes by **summarizing the best available evidence** about the problem and viable solutions

What is an evidence brief for policy?

Evidence briefs for policy bring together **global research evidence** (from systematic reviews*) and **local evidence** to inform deliberations about health policies and programmes

***Systematic Review:** A summary of studies addressing a clearly formulated question that uses systematic and explicit methods to identify, select, and critically appraise the relevant research, and to collect and analyse data from this research

Full Report

The evidence summarised in this Executive Summary is described in more detail in the Full Report

Share evidence

Send this policy brief to people in your network who might find it relevant

The problem:

Adverse events in national healthcare

Adverse events can occur from nearly any patient interaction with the healthcare system. Estimates for adverse drug events (ADEs) stand at 5% to 20% for hospitalized patients while 3% to 14% of hospital admissions are related to ADEs. Errors involving medical devices such as hypodermic needles, syringes, unsafe blood and blood products are significantly associated infections including, HIV, Hepatitis B and malaria. Hospital acquired infections affect 28% of admitted patients. The organisational safety culture in health facilities and hospitals is rather weak with predominantly punitive responses to medical incidents.

Policy options:

1) Nurse staffing models for health facilities
2) Empowerment of health consumers
3) Medication review in health facilities

1. Some nurse staffing models probably reduce death in hospitalized patients, reduce length of stay in hospital, but could slightly increase readmission rates.
2. There is low to moderate quality evidence supporting benefits for consumer involvement in developing healthcare policy and research, clinical practice guidelines and patient information material.
3. Medication reviews can minimize on inappropriate prescribing, associated with adverse drug events, drug interactions and poor drug adherence which may decrease hospital emergencies, and slightly decrease mortality.

- Given the limitations of the currently available evidence, rigorous evaluation and monitoring of resource use and activities is needed for all the options.

WHO EMRO is producing a template for the development of a policy brief

- A policy brief should be a standalone document, focused on a single topic
- 2-8 pages, 1000-3000 words

DRAFT FOR GOOD PRACTICE FOR POLICY BRIEF DEVELOPMENT EDP SID WHO EMRO OCTOBER2021

Draft for

"Good Practice for Development of a Policy Brief"

Evidence and Data to Policy, Science, Information and Dissemination

WHO Regional office for Eastern Mediterranean

2021

Template for a policy brief (WHO EMRO, 2021)

1. Title
2. Justification for the brief and policy objectives (introduction/background/purpose)
3. Key messages and policy options (summary presentation of the main messages)
4. Description of policy options and their advantages and disadvantages (details of the main findings)
5. A description of how the policy brief was developed (methods)
6. Further important considerations
7. Acknowledgements
8. Conflicts of interests
9. Sources of evidence and key references

1. “Title” is important!

Keep it short and focused on the topic
Avoid using abbreviations in the title

The number of words should be limited, otherwise divide it into *title* and *subtitle*

Grab the attention of busy readers

- Quickly communicate to stick in mind
- Question mode
- Unusual phrasing

2. Justification for the brief and policy objectives (introduction/ background/purpose)

Briefly describe the purpose of the policy brief

Answer to the questions below:

- What problem does the policy brief address?
- Why the problem is important
- Clarify key relevant issues that are not the focus of the policy brief.

3. Key messages and main policy options

- Summary presentation of the main messages
- List the policy options

Use:

➢clear language;
➢bullet points, if needed;
➢using actionable messages (with clear "dos and don'ts), where relevant

4. Description of policy options and their advantages and disadvantages (details of the main findings)

Include all important “policy options”

For each policy option

- ➢Description
- ➢Main advantages
- ➢Potential disadvantages
- ➢Costs and/or feasibility of implementation
- ➢Responsible stakeholders for implementation (where applicable)

Suggested Table

Policy options	Policy option 1	Policy option 2	Policy option 3
Description	Description of policy option 1	Description of policy option 2	Description of policy option 3
Main advantages	Main advantages of policy option 1	Main advantages of policy option 2	Main advantages of policy option 3
Main disadvantages	Main disadvantages of policy option 1	Main disadvantages of policy option 2	Main disadvantages of policy option 3
Cost and feasibility of implementation	Cost and feasibility of implementation of policy option 1	Cost and feasibility of implementation of policy option 2	Cost and feasibility of implementation of policy option 3
Stakeholders' responsibilities	Stakeholders' responsibilities of policy option 1	Stakeholders' responsibilities of policy option 2	Stakeholders' responsibilities of policy option 3

- Keep the table concise.
- For advantage and disadvantage: consider effectiveness, cost-effectiveness, acceptability, equity implications including evidence and certainty of evidence.

5. A description of how the policy brief was developed (methods)

- Describe methods used in the development of the brief
  - ➢systematic review
  - ➢cost analyses,
  - ➢expert and stakeholder consultation

- Details of the methods as an annex to the policy brief

6. Further important considerations

- You may add recommendations (e.g. indicators and targets) for monitoring of policy implementation
  - ➢ Also consider further highlights that helps the implementation of the policy options
- Discuss key next steps
  - ➢ If further assessment is needed
  - ➢ Note the update time if applicable

Also make sure to include

7. Acknowledgements

8. Conflict of interests (of the brief developers); financial or otherwise

9. Sources of evidence and key references

    use annexes for long list of references.

Thank you

Moderated discussion with the participants on two key questions

- What are the key priority policy questions in (one or more) countries of the region that may benefit from policy briefs?

- What are the key actions for countries to enable them to request and use policy briefs and policy dialogues in policy making for health?