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Editorial

John N Lavis,[1] Mehrnaz Kheirandish,[2] Lubna Al-Ansary,[3] Huda Basaleem,4 Rana Hajjeh,[5] Ahmed Al-Mandhari[6] and Arash Rashidian[7]

[1] Director, McMaster Health Forum, and Professor, Department of Health Research Methods, Evidence and Impact, McMaster University, Ontario, Canada. [2]Regional Adviser, Evidence to Policy, Department of Science, Information and Dissemination, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt.

[3] Professor, Department of Family and Community Medicine, College of Medicine, King Saud University, Riyadh, Saudi Arabia.

[4] Assistant Vice president for Academic Affairs, University of AdenUniversity of Aden Faculty of Medicine and Health Science, Aden, Yemen.

[5] Director of Programme Management, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt. 6Regional Director, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt.

[7] Director of Science, Information and Dissemination, World Health Organization Regional Office for the Eastern Mediterranean, Cairo, Egypt. (Correspondence to Arash Rashidian: rashidiana@who.int).

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Evidence-informed policy-making benefitted from much-needed attention and resources during the COVID-19 pandemic (1). As a result, 3 key movements and innovations are now making it possible to provide better evidence support (higher quality and more aligned to the speed of advisory and decision-making) for policy-making than ever:

1. The expansion and streamlining of “living evidence” and “living guidance” approaches. These were used by WHO and other multicountry or national agencies, and included rapid evidence-to-recommendation processes (i.e. living guidelines) (2-4), and rapid evidence provision and synthesis for decision-making (5).
2. Enhanced use of digital technologies for rapid contextualized evidence syntheses. These approaches include upgraded evidence portals and artificial intelligence (AI)-powered evidence syntheses (6). Such innovations were also used in combination with other traditional approaches used for “living evidence”.
3. Expanded use of a ‘general contractor’ model of evidence support that leverages the use of existing expertise through agreements that enable the provision of the relevant evidence from research and data needed in response to urgent needs. While such approaches are not new (7), their use was amplified and extended beyond the existing centres of excellence.

Now is the time to examine further and expand these innovative approaches in countries and settings where they have not been used before, and to formalize and institutionalize the national evidence support system (8). Before COVID-19, ‘rapid’ evidence syntheses were often prepared in weeks and months, however, during the pandemic “policy support” teams began to respond to policymakers’ questions within 2–3 business days. As an example, evidence portals like the COVID-END Inventory, which was tagged the ‘best’ evidence syntheses for any given question based on three criteria: (1) quality of the evidence synthesis; (2) up-to-dateness of the search; and (3) availability of a GRADE evidence profile. It also provided an inventory of decision-relevant evidence syntheses. These enhanced features are now being added to existing evidence portals such as Health Systems Evidence and Social Systems Evidence, to facilitate the identification of the evidence syntheses from which context-appropriate insights can be drawn.

AI-powered living evidence syntheses have begun to emerge across a range of sectors,

including in challenging and fast-moving policy areas like climate and health, in which AI is used to automate the processes and reduce the timeline for the development of updated evidence syntheses (9). Being able to download single studies using existing tags aligned to the local context meant that a new synthesis can be prepared remarkably quickly. AI-powered software can dramatically reduce the labour involved in assessing studies for possible inclusion in an evidence synthesis and in keeping these syntheses 'living,' which means regularly updated as the context, issue and/or evidence evolve.

Before COVID-19, evidence support for policymakers was often provided in a chaotic way. Data analysts and experts conducted evaluations or evidence syntheses and provided 'their' evidence separately. The burden then fell on policymakers to make sense of the disparate inputs.

The WHO Regional Office for the Eastern Mediterranean (WHO/EMRO) and its counterpart, WHO Regional Office for the Americas (PAHO), were unique in calling for a more joint approach that matched the right form of evidence with the right question. WHO/EMRO proposed the "integrated multi-concept" approach (Figure 1) aimed at enhancing evidence-informed policy-making via establishing structural and programmatic linkages between different streams of evidence support mechanisms while avoiding inefficiencies and inconsistencies (10). The approach was used as a critical lens in documenting the experiences of countries assessing the use of evidence for COVID-19 response (5) and now being implemented in 3 pioneering countries of the region, which will provide prototypes for adaptation to other countries (11). Several countries in the region are affected by acute or protracted emergencies, hence the lessons learnt are of immediate value for implementation.

During the pandemic we began to see the expansion of the 'general contractor' model, like what happens with home renovations. Rather than having to hire an electrician, plumber, tiler, and other trades, homeowners (in our case policymakers) can turn to a general contractor who can bring in the right collection of evidence at the right time. The contractor may draw on multiple forms of domestic (national or sub-national) evidence, global evidence syntheses, and other types of information (Figure 2).

Rapid contextualized evidence syntheses and the general contractor model can be piloted by members of WHO/EMRO's Network of Institutions for Evidence and Data to Policy (NEDtP), and such pilots should be seen as part of a broader effort to strengthen national evidence support systems (12). This means enhancements in at least 4 areas:

1. Working with policymakers (on the evidence-demand side) to (a) incorporate evidence use into routine advisory and decision-making processes (which we call ‘enablers’); (b) build and sustain an evidence culture; and (c) strengthen capacity for evidence use.
2. National commitment towards the integrated multiconcept approach for evidence-informed policy-making through linking the main technical programmes and sources of evidence and data at national level.
3. Establishment of rapid evidence for policy agreements with NEDtP member institutions, to elicit and prioritize questions from policymakers and coordinate responses to the questions.

4. Identification and working with timely, demand-driven evidence-support units that can provide different forms of domestic evidence, and leverage living evidence syntheses and other parts of the global evidence architecture.

Noting the attention given to the WHO programme for enhancing evidence-informed policy-making in the region in recent years, and its inclusion in the WHO/EMRO’s Vision 2023, the Eastern Mediterranean Region is uniquely positioned to be at the vanguard of such efforts globally (10,13,14).

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