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Importance of Process and Impact Evaluation of Public Health Programmes/Policies Overall and Especially in Financially Deprived Settings

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Title

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November 2017

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Place of work: Ukraine

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Introduction: prioritizing public health policies and programmes

WHO Europe's health strategy Health 2020 places public health policies and programmes at the centre of efforts to improve health for all, reduce health inequalities, and strengthen leadership and governance for health. Public health is about action across the whole of government and "... depends as much or more on what happens outside the health sector and ministries of health as within them." (Hunter 2012). The Ukraine National Health Strategy highlights the importance of shifting the focus of public health programmes to an approach that maintains health, promotes healthy lifestyles, strengthens social participation and ensures preparedness against health threats. The key responsibility of central government is establishing and developing policies and strategies for the prevention of disease and promotion of health.

In order to generate sustainable health impact, public health interventions require good policies built on solid stakeholder support and a professional organisation interacting between different sectors and levels. At the international level, there has been growing interest in Health in All and Health Equity in All Policies (H&HEiAP). These initiatives are rooted in the emergence of new approaches to public health arising from key developments:

- the 1986 Ottawa Charter for Health Promotion, which advocated the importance of building healthy public policy
- the 2006 Finnish presidency of the European Union, which prioritised a Health in All Policies (HiAP) approach
- the 2012 publication of Health 2020, the WHO Europe Health Policy Framework and Strategy for Health and Wellbeing, which emphasises the value of HiAP
- the 8th Global Health Promotion Conference on Health Promotion, which produced as key outputs the Helsinki Statement on HiAP and the HiAP Framework for Country Action.

Many of the key public health policies in Ukraine are derived from international commitments to the UN and the WHO programmes and goals such as the 2015 Sustainable Development Goals (United Nations 2016). For example, the mother and child and HIV programmes are based on the UN Millennium Development Goals. Programmes are also driven by funding provided by external agencies such as the UN, the USAID, and the World Bank.

Chapter 1: Evidence for policy and practice

Effective and efficient policies and programmes that make best use of resources to improve health outcomes rely on good research evidence in their design and implementation. The *European Action Plan for Strengthening Public Health Services and Capacity (EAP-PHS)* (WHO 2012a) forms an essential part of the overarching regional policy framework, Health 2020, and is intended to serve as its main implementation pillar. The EAP sets out ten avenues for action which are supported by ten essential public health operations (EPHOs) that countries can self-assess themselves against, adapt and work on (See Box 1).

Box 1. Ten essential public health operations (EPHOs)

1. Surveillance of population health and well-being
2. Monitoring and response to health hazards and emergencies
3. Health protection including environmental, occupational, food safety and others
4. Health promotion including action to address social determinants and health inequity
5. Disease prevention, including early detection of illness
6. Assuring governance for health and well-being
7. Assuring a sufficient and competent public health workforce
8. Assuring sustainable organizational structures and financing
9. Advocacy, communication and social mobilization for health
10. Advancing public health research to inform policy and practice

Advancing public health research is one of these ten EPHOs outlined in the EAP. In particular, the EAP states that:

Research is fundamental to informing policy development and service delivery. Member States will have very different research priorities depending on the public health challenges being faced, on the needs identified, and the resources available to tackle them. Research is required to enlarge the knowledge base that supports evidence-based policy-making at all levels and to develop innovative technologies and approaches to complex public health problems, as well as to ensure that robust methods for implementation, monitoring and evaluation are applied for effective outcomes. This requires partnerships with research centres and academic institutions to conduct timely studies that support decision-making at all levels of public health. (WHO 2012a: 22 para 89)

For many countries, such as Ukraine, this presents an enormous challenge – aspects of which are discussed later in a number of other reports (see for example [Gadsby et al 2017](#)). Public

health interventions are processes that act on individuals, communities, organisations and society. Effective public health policies use a range of methods and aim to be responsive to the needs of the target audience. How the different EPHOs interlink is shown in figure 1. The EPHO 10 is one of a number of enabling actions that support public health intelligence and public health policy and programme development.

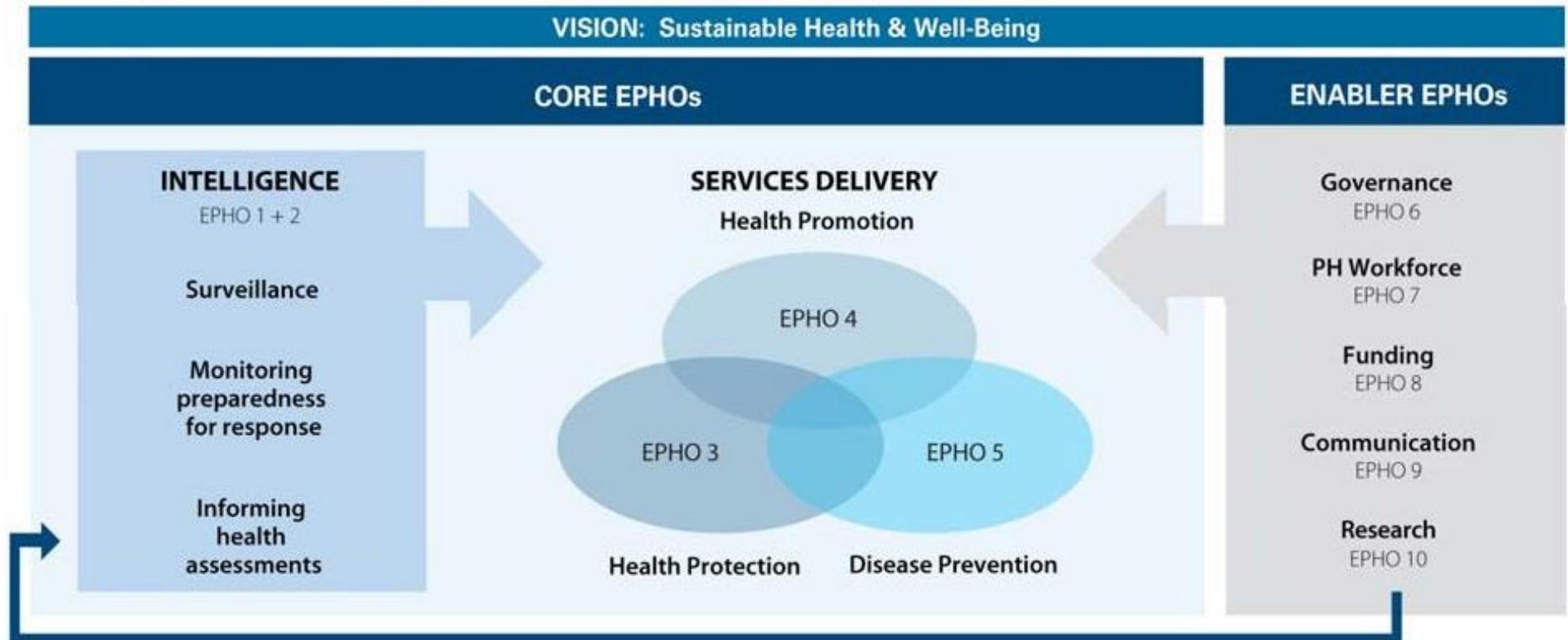
Generally, policies - and the programmes established by policies - are concerned with multiple changes that are likely to occur over a lengthy period of time. This means that outcomes are often problematic to define, measure and attribute to particular interventions. Thus, the evaluation of public health policies and programmes is complex. Thought needs to be given to how policies and programmes are to be assessed at an early stage through agreed intermediate outcomes and what might be termed 'quick wins'. While across Europe research capacity is well established, in Ukraine and some other post-Soviet countries there is a need to strengthen research capacity. This should focus on supporting policy development and programme implementation, evaluating effectiveness, and promoting the practice of evidence-informed decision-making.

The recent WHO Europe midterm stocktake on strengthening public health capacities and services presents the findings of a survey of member states on the key success factors and barriers that they encountered while attempting to strengthen public health services. Lack of evidence and the need for research and evaluation were significant supportive activities and the absence of these was seen as a significant barrier to strengthening public health (WHO 2016a). Evidence for policy development and evaluation of programme implementation and impact are seen as key elements in ensuring the successful development and implementation of public health programmes. The disconnect between policy research, policy impact monitoring and policy practice is well recognised and evaluation often comes too late to be of use for policy decision-making (WHO 2015). Evaluation of policy – both content and process/ implementation – is essential to ensure that public health programmes are successfully implemented and that policy and decision-makers understand how to support successful implementation. The need for this in countries with less developed public health systems is especially critical and increasingly recognised (WHO 2016b, 2016c).

Evidence-informed public health also presents particular problems relating to the nature of the evidence and how this is applied in practice (Dobrow et al 2004, Petticrew et al 2004). Evidence is often viewed through particular frames and is by its very nature contestable. The question for public health policy makers is, therefore, what evidence to draw on and how to obtain it? Recently the WHO Europe has been seeking to strengthen the use of evidence for

Figure 1:

Clustering of EPHOs to deliver public health services



(Source: WHO 2012a: 39)

policy-making (WHO 2016b, 2016c). The focus for this is not the *What* but rather *How* to implement policies and programmes.

The goal is to consolidate, strengthen, and promote the generation and use of multidisciplinary and inter-sectoral sources of evidence for making health policy in line with the health related sustainable development goals and the Health 2020 policy framework. One of the four agreed areas for action is knowledge translation and increasing capacity in the journey from research to policy (Hunter and Visram 2016:1)

Public health by its very nature is a more political process than medicine as it deals with social processes and what have been described as ‘wicked issues’ (Hunter 2009). For example, the relative priority given to health inequalities is underpinned by ideological positions about the nature of inequality itself. It is unlikely that complex health problems, such as obesity, or environmental problems such as pollution, will be solved through single interventions or a narrow focus on individual behaviour change. Debates about the extent to which the state should intervene in individual lifestyles is not one that is open to a strict evidence-based approach, although evidence is often employed in arguments to sustain particular viewpoints (Holland 2007). Public health policy involves not only decisions about the degree or distribution of *health* harm or benefit, but also how to define those health harms and benefits and balance these against issues such as individual freedom. As Kenny and Giacomini (2005) have argued “*The quintessential ethical problem of the public policy maker is how to define, identify, justify, and distribute inevitable benefits and harms, rather than simply striving to ensure benefit and avoid harm*” (p254). Good evidence is clearly key to enabling such assessments to be made. In 2007 the Nuffield Council of Bioethics produced a report examining ethical issues in public health. The report *Public Health: Ethical Issues* (Nuffield Council of Bioethics 2007) developed an ethics “intervention ladder” which sets out a way of thinking about the acceptability and justification of different public health policy interventions by governments.

Governments are responsible for the health of their citizens and have a critical leadership and stewardship role in the organized effort by society to promote health and well-being. The EAP-PHS provides a framework which sets out how the various elements of the responsibilities for public health contribute to the development of an overall public health policy programme. The key goal is for governments to support sustainable health and wellbeing.

Given this responsibility and the complexity of many contemporary health challenges, governments have a crucial role to play in not only developing public health policies, but also establishing programmes based on good evidence and evaluating their impact to ensure that policy goals are achieved. In Ukraine, the transition from a focus on delivering specific public health programmes and actions to evaluating broad policies and system delivery will need to be supported through the development of a co-ordinated approach to providing research and intelligence. Research is fundamental to informing policy development and service delivery. Research can take a number of forms: descriptive, analytical or experimental and includes:

- research to enlarge the knowledge base that supports evidence-based policy-making at all levels
- development of new research methods, innovative technologies and solutions in public health
- establishment of partnerships with research centres and academic institutions to conduct timely studies that support decision-making at all levels of public health.

The government therefore has an important role in supporting the production of evidence. This involves setting out how it operationalises EPHO 10 (see Box 2):

In strengthening the capacity to produce (and use) good research evidence, the government should actively engage stakeholders within and beyond government to draw in expertise and knowledge and identify research agendas. It should commission research that will enable them to formulate and implement better policies and programmes, and also engage with academic and non-academic research-active funders and organisations in the national and international settings. It should focus on building capacity for evaluating the impact of policies and programmes, for instance by investing in health monitoring and information systems. And it should develop approaches to ensure that research is relevant and usable, for example by investing in knowledge transfer and brokerage.

Box 2: EPHO 10: Advancing public health research to inform policy and practice

- 10.1 Country's capacity to develop PH research
- 10.2 Adequacy of available resources (e.g. databases, information technology, human resources) to implement research
- 10.3 Planning for the dissemination of research findings to public health colleagues (e.g. publication in journals, websites)
- 10.4 Country's evaluation of the development, implementation, and impact of public health (and public health service) research efforts
- 10.5 Fostering innovation among staff
- 10.6 Ministry of health's research into and monitoring of best practices
- 10.7 Active use of research evidence in designing and supporting policy in the field of public health
- 10.8 Capacity for the collection, analysis and dissemination of health information
- 10.9 Capacity to carry out research on the social determinants of health (and their influence on health) in order to shape and target policy
- 10.10 Mechanisms for ensuring that policies, priorities and decision-making are consistent with evidence of the effectiveness of their implementation.

The EAP-PHS places a particular emphasis on knowledge brokering or knowledge translation:

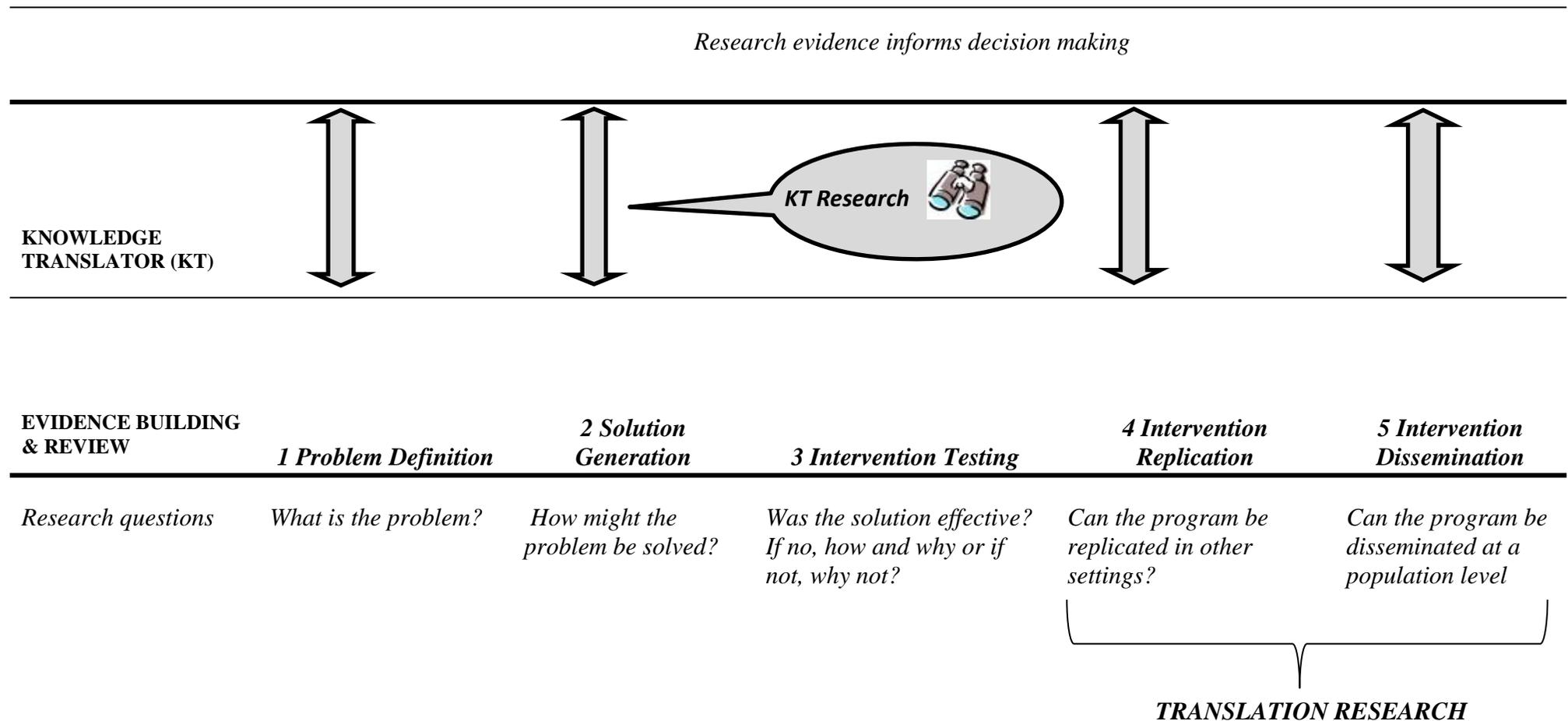
There is, however, increasing recognition of the importance of understanding how research and knowledge are produced and used (or not used) in practice. New approaches are being pioneered in an effort to strengthen the evidence base for public health interventions and its take-up in practice, employing methods appropriate for complex public health problems and which can provide practical guidance to policy-makers on interventions most likely to work in the long term and be most cost-effective. In such circumstances, knowledge exchange occurs through building relationships and networks created in local contexts.

(WHO 2012a: 22 para 90)

The process of knowledge brokering or translation refers to three related fields – bringing together information and evidence gained through research; knowledge production through contextualisation and transfer; and knowledge uptake and use. Rychetnik et al (2012) set out a useful framework for different elements of knowledge brokerage (fig 2).

It needs to be recognised, however, that unlike the delivery of healthcare – which tends to have a more clearly defined focus - public health involves a wide range of national and local government policies and programmes and attention has to be given to wider contextual issues. There is a recognition that not only does a complex web of factors exist that impacts on health but that addressing health problems and improving population health is multi-factorial and requires a multi-sectoral and organisation approach (Rychetnik et al 2012). HiAP approaches focus attention on the wider determinants of health and also the role of governments, the private sector and communities in improving health and preventing ill-health. Thus attention needs to be paid to the needs of different evidence users including national and local governments, private organisations, local communities and third sector organisations. More attention needs to be paid, therefore, to how research is designed and undertaken to appropriately inform and support more effective public health policies, programmes and interventions. Some groups who will need evidence may have had little contact with health services – for example transport planners – and yet are critical in terms of supporting public health (reducing accidents, reducing vehicle emissions etc). Working in partnerships and in a co-production mode between researchers and research users is one approach, with attention being paid to the engagement of research users in the design, execution and dissemination of research.

Figure 2: Translation processes to support evidence based policy and practice



(Source: Rychetnik et al 2012: 39)

Chapter 2: Supporting evidence for public health policy: the UK experience

Despite a long history of public health services in the UK, a significant investment in public health research has only slowly developed. The main focus of research remains on underpinning science research and areas such as prevention, disease treatment, detection and diagnosis although there is a growing investment in aetiology which includes environmental and social factors that impact on health. Investment in health services and service and policy evaluation makes up a much smaller element of funding although there has been an increasing emphasis on these areas in the last 5-10 years. The major funders of prevention research in the UK are the NIHR, Department of Health, MRC and Wellcome Trust, which together support almost 70% of the prevention research portfolio. During the last ten years, all funders have increased the amount that they spend on prevention research. The NIHR and the MRC have dedicated research programmes:

- NIHR Public Health Research Programme
(<http://www.nets.nihr.ac.uk/programmes/phr>)
- NIHR School for Public Health Research
- MRC Population and Public Health
(<https://www.mrc.ac.uk/research/initiatives/population-health-sciences>)

Recent assessments of public health research in the UK have, however, called for a stronger emphasis on population health research and, in particular, research that focuses more on areas such as behaviour change, complex systems approaches to tackling health problems and an emphasis on the structures and processes for implementation of public health policies and programmes (Rutter et al 2017). This includes research on:

- programme delivery (evaluations of interventions)
- the role and capacity of the workforce
- working with local communities
- developing effective public health programmes
- prioritising resource allocation for public health

As in other countries, the delivery of public health services in the UK is fragmented – split between national and local government organisations, NHS services including primary care services, voluntary groups and private institutions. To accommodate these differences there are different approaches to supporting research. Different funding programmes in the UK support these various research activities (see box 3).

Research capacity is key to this and over the years a number of specialist areas of research have developed and expanded in universities, including:

- Epidemiology and public health
- Primary care and public health
- Health promotion
- International public health

In addition, central funding has been used to support a national Public Health Research Consortium which brings together the skills and expertise in 11 Universities and, more recently, the NIHR has renewed funding for the School for Public Health Research for a second five year term, consisting of a consortium of universities working on a research programme agreed with the Department of Health.

Box 3: Research funding in the UK	
Research area	Funder
Basic knowledge and intelligence	Academic research funded by governments, research funding boards and large charities
Transnational funding	Academic research or collaborations between academics and practitioners funded by EU
Evaluations of national policies and programmes	Government funding
Effectiveness of public health interventions	Academic research funded by governments and research funding boards, charitable funding
Providing evidence to support effective interventions	National public health agencies as part of core functions, public health observatories (locally based), academic institutions
Local service evaluations	Undertaken by services or academic institutions usually funded locally

Universities also offer postgraduate courses in public health and doctoral research student training. This funding is agreed for a period of five years with research programmes negotiated between the researchers, the NIHR and the Department of Health. Five years give the opportunity to both build a programme of research and to develop a researcher/policy maker relationship. The UK Clinical Research Collaboration – a partnership between the main UK research funding bodies; academia; the NHS; regulatory bodies; the bioscience, healthcare and pharmaceutical industries; and patients – has also established six collaborative public health research groups. These have an emphasis on building research

capacity. Some also include a rapid response facility designed to respond quickly to requests for rapid reviews, evaluation studies, etc. from policy makers and practitioners. The six centres have been funded over a period of 10 years (2008 to 2018). The expectation is that the respective universities involved in the initiative will assume responsibility for funding the academic posts created by the UKCRC initiative.

The NIHR and the system of postgraduate professional training provide opportunities for academic study and training in research. The aim here is to prepare practitioners who understand research - both as evidence users but also in terms of generating research activity. Much of this activity is integrated into existing academic research groups and also the national clinical post qualification training programmes designed to support students to gain specialist professional qualifications. The partnership between training and education, research, practice and funding organisations has been critical for developing a stronger public health research and evidence environment in the UK.

In addition to these more academic research structures there are a number of local authority based public health observatories undertaking monitoring and surveillance and data analysis to inform public health and health services programmes at the local level. Public Health England, through its national, regional and local area structure, also has a substantial knowledge and information role providing intelligence and evidence analysis to support public health action, analysis for national programmes and advice to national and local policy makers (for more information see <https://www.gov.uk/government/organisations/public-health-england/about/statistics>). , It would be useful to make the range of data available in Ukraine useful for analysis and to support policy- in the way this has been achieved in the UK. There are systematic approaches for collecting this data nationally and producing information in usable formats, including reports with national and local data (<https://www.gov.uk/government/organisations/public-health-england/about/statistics>) and local health profiles, such as the following one for Canterbury, which are updated annually.

Health Summary for Canterbury

The chart below shows how the health of people in this area compares with the rest of England. This area's result for each indicator is shown as a circle. The average rate for England is shown by the black line, which is always at the centre of the chart. The range of results for all local areas in England is shown as a grey bar. A red circle means that this area is significantly worse than England for that indicator; however, a green circle may still indicate an important public health problem.

Domain	Indicator	Local No Per Year	Local value	Regional average ^a		England Average		England Range	England Best
				Eng value	Eng worst	25th Percentile	75th Percentile		
Our communities	1 Deprivation	12,190	7.9	20.4	63.8			0.0	
	2 Children in poverty (under 16s)	4,200	17.7	20.6	43.6			6.4	
	3 Statutory homelessness	82	1.3	2.4	11.4			0.0	
	4 GCSE achieved (5A*-C Inc. Eng & Maths)	988	59.0	60.8	38.1			81.9	
	5 Violent crime (violence offences)	1,494	9.9	10.6	27.1			3.3	
	6 Long term unemployment	430	4.4	9.9	32.6			1.3	
Children's and young people's health	7 Smoking status at time of delivery	234	17.6	12.7	30.8			2.3	
	8 Breastfeeding initiation	950	71.4	73.9	40.8			94.7	
	9 Obese children (Year 6)	183	15.0	18.9	27.3			10.1	
	10 Alcohol-specific hospital stays (under 18)	17	57.8	44.9	126.7			11.9	
	11 Under 18 conceptions	54	20.6	27.7	52.0			8.8	
Adults' health and life-style	12 Smoking prevalence	n/a	21.4	19.5	30.1			8.4	
	13 Percentage of physically active adults	n/a	60.1	56.0	43.8			68.5	
	14 Obese adults	n/a	16.0	23.0	35.2			11.2	
	15 Excess weight in adults	209	54.2	63.8	75.9			45.9	
Disease and poor health	16 Incidence of malignant melanoma	22	14.9	14.8	31.8			3.6	
	17 Hospital stays for self-harm	401	253.2	188.0	596.0			50.4	
	18 Hospital stays for alcohol related harm	1,023	679	637	1,121			365	
	19 Drug misuse	520	5.3	8.6	26.3			0.8	
	20 Recorded diabetes	7,518	5.6	6.0	8.7			3.5	
	21 Incidence of TB	13	8.6	15.1	112.3			0.0	
	22 Acute sexually transmitted infections	1,195	793	804	3,210			162	
	23 Hip fractures in people aged 65 and over	190	547	568	828			403	
Life expectancy and causes of death	24 Excess winter deaths (three year)	69	14.5	16.5	32.1			-3.0	
	25 Life expectancy at birth (Male)	n/a	80.2	79.2	74.0			82.9	
	26 Life expectancy at birth (Female)	n/a	83.4	83.0	79.5			86.6	
	27 Infant mortality	6	4.1	4.1	7.5			0.7	
	28 Smoking related deaths	248	266	292	480			172	
	29 Suicide rate	10	7.4	8.5					
	30 Under 75 mortality rate: cardiovascular	89	70.2	81.1	144.7			37.4	
	31 Under 75 mortality rate: cancer	165	130	146	213			106	
	32 Killed and seriously injured on roads	55	36.5	40.5	116.3			11.3	

Chapter 3: Developing public health policy research and evaluation

As discussed in Gadsby et al. (2017) and Nizalova et al. (2017), despite Ukraine being one of the five countries in the WHO European region with the lowest life expectancy (11 years less than in the EU) and more than 10 years' life expectancy gap between males and females (European Health Report 2012), there has been little investment in the public health infrastructure or development of public health programmes. This is despite the development of the WHO health strategy, Health 2020 - an overarching plan for delivering population health improvement and for reducing health inequalities. This strategy has yet to be implemented in Ukraine. In addition, while there is compulsory routine collection of data by a wide range of organisations, it is very fragmented and therefore of limited use as a source of public health intelligence.

It is clear from the EAP that governments are key to the development and support of public health research programmes. However, the recent WHO Europe midterm review of Member State-led assessments of Essential Public Health Operations (EPHOs) identifies a need for more evidence, and more support in using evidence to inform policy (WHO 2016a, 2016b, 2016c). The majority of survey responses came from eastern European countries, and while Ukraine was not one of these, the same issues are relevant. A number of these issues are discussed in other discussion papers. Understanding the impact of programmes and policies is also essential in developing successful approaches to improving health. The need for research capacity is not just in identifying health problems and developing programmes to address these but also in building capacity and knowledge to understand the most effective ways to implement these programmes and to measure what impact they have. Evaluation needs to address both processes of implementation as well as outcomes. Programme evaluation is perhaps more essential where resources are scarce. In an analysis of public health programme evaluation in countries with limited health resources by RAND, a key conclusion was that:

Rigorous program evaluation of interventions in various resource-limited settings is needed to determine which interventions will work most effectively and to spend scarce resources wisely. (Wynn et al 2006:xiii)

The authors go on to argue that:

When supported by strong process evaluations, an impact evaluation provides information that can be used to design interventions in new sites that take advantage of the knowledge, experience, and "lessons learned" in similar cultural environments. To inform decisions on future program design, an evaluation model should provide for wide dissemination of findings from rigorous impact evaluation. (Wynn et al 2006:xiv)

Their report clearly argues that ensuring best use of resources requires evidence on both the programme's impact and how it was implemented. It also highlights the importance of the relationship between those implementing policies and programmes and the evaluators. Good policy and programme development needs to be informed by the knowledge gained from evaluations.

The increased focus on knowledge translation requires developing approaches that underpins the development and evaluation of knowledge exchange interventions. One approach is the SPIRIT Action Framework (Redman et al 2015). This framework is based upon a number of properties that have been shown in the research literature to underpin successful knowledge exchange. These include:

- Having a clearly articulated purpose and identifying the foci for change – in the individual, the organisation and more widely (Rycroft-Malone and Bucknall, 2010).
- Being informed by existing understanding of what influences the use of research in health policy, including descriptive models and empirical findings (Eccles et al., 2005 and Rycroft-Malone and Bucknall, 2010), drawing on the widest possible range of social science.
- Being capable of guiding the development and testing of specific and targeted interventions, including the generation of program logic models and the identification of proximal and distal outcomes and associated measures (Eccles et al., 2005 and Gregor, 2002).
- Providing an organising structure to build knowledge (Eccles et al., 2005, Gregor, 2002 and Rycroft-Malone and Bucknall, 2010). It will generate testable hypotheses about the drivers of research use and assemble these into causal pathways that have predictive value and are capable of explaining why a particular strategy might or might not work, and under what circumstances.

One approach that draws on this framework which is useful to exploring the main features of new programmes, policies or interventions is to undertake evaluability assessments (Ogilvie et al 2011). Evaluability assessments are a cost-effective strategy to assure that limited evaluation resources can be used in the most appropriate ways. Using this method, it is possible to assess whether the programme (or elements of the programme) in question is/are ready to be evaluated for outcomes, what changes are needed to do so, and whether the evaluation would contribute to improved programme performance. Evaluability assessment is an iterative process that builds understanding of the programme design, the underlying programme model or theory of change, opportunities for useful evaluation, and potential

programme improvement. We have drawn on this approach in this project and it frames the method of data collection and analysis presented in other reports of this project (Gadsby et al. 2017, Nizalova et al. 2017). Essentially it provides both an initial assessment allowing knowledge about the policy or programme to be methodologically examined but also provides valuable insights in terms of the internal validity of a particular public health approach and whether there is potential for more in-depth evaluation.

Conclusions

If there is to be significant improvement in population health and wellbeing in Ukraine, then there needs to be greater commitment to, and investment in, research infrastructure of a kind that will help achieve this goal.

Complex public health programmes need careful thought in their design and implementation so that anticipated outcomes in the short, medium and long-term can be realised, and so that any potential harmful effects (for instance on inequalities) can be mitigated against. This requires thinking systemically, and using a wide range of research evidence to examine the quality of both the programme purpose and the expected outputs. This research evidence should be multi-disciplinary, with a strong focus on health policy and systems research that is concerned with “the system-level factors and forces that cut across actions dedicated to tackling particular health problems, as well as those that underpin and shape the performance of health programmes that target specific health conditions” (Gilson 2012: 32).

A recent analysis of public health programme and policy documents in Ukraine found that existing plans and documents contained little discussion of the evidence that might support the theories and assumptions underpinning the programmes (see Gadsby et al 2017). On the basis of information available, the achievability of many of the programmes’ objectives was questionable, given the activities and resources available, and given the complexity of some of the issues being dealt with. Furthermore, the analysis pointed to a number of limitations related to the data available for the tracking of process and outcomes. There were clear opportunities identified for evidence-informed improvements to both programme design and implementation, which would in turn help to ensure positive outcomes.

However, it is not just a case of generating more research for the sake of it. Research is required which will not only better inform policy and its implementation but will also proceed through adopting a co-production approach whereby researchers, and those at whom the research is directed, work closely together at all stages of the research process from the questions to be asked through to its dissemination and, hopefully, uptake. Knowledge transfer and brokerage are important components of attempts to get evidence into policy and practice. WHO, among others, is promoting the notion of evidence-informed policy among Member States and there are lessons and approaches from other countries which can assist in realising its potential.

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