

## **Reviewer's report**

**Title:** Evidence-informed health policy: 4. Case descriptions of organizations that support the use of research evidence

**Version:** 1 **Date:** 9 April 2008

**Reviewer:** Martin Eccles

### **Reviewer's report:**

Evidence informed Health Policy.

This review refers to the series of four articles identified below. The articles are drawn from a report to the World Health Organisation. The report was extensively peer reviewed prior to its acceptance by WHO. That review process is documented in the series of reviews below. The four papers below are drawn directly from the report.

In addition one of the reviewers of the report has also provided a review on the series of four papers submitted to Implementation Science.

**Title :** Evidence-informed health policy: 1. Synthesis of findings from a multi-method study of organizations that support the use of research evidence

**Journal:** Implementation Science

**Type :** Research article

**Other subject areas:** International health and human rights, Public health

**Authors:** John N Lavis, Andrew D Oxman, Ray Moynihan and Elizabeth Paulsen

**Title :** Evidence-informed health policy: 2. Survey of organizations that support the use of research evidence

**Journal:** Implementation Science

**Type :** Research article

**Other subject areas:** International health and human rights, Public health

**Authors:** John N Lavis, Elizabeth Paulsen, Andrew D Oxman and Ray Moynihan

**Title :** Evidence-informed health policy: 3. Interviews with the directors of organizations that support the use of research evidence

**Journal:** Implementation Science

**Type :** Research article

**Other subject areas:** International health and human rights, Public health

**Authors:** John N Lavis, Andrew D Oxman, Ray Moynihan and Elizabeth Paulsen

**Title :** Evidence-informed health policy: 4. Case descriptions of organizations that support the use of research evidence

**Journal:** Implementation Science

Type : Research article

Other subject areas: International health and human rights, Public health

Authors: John N Lavis, Ray Moynihan, Andrew D Oxman and Elizabeth Paulsen

In addition I include my editorial comments here.

#### General comments

1] It would be helpful to produce a summary diagram or flowchart that offers readers an overview of the entire study so that they can reliably understand where they are in the process. It would then be helpful if this could appear in each article as a reader may access any one article in isolation.

2] You need to say something about the ethical approval for the study. It isn't clear if this was submitted to any individual ethical review board; this may be an oversight. It is journal policy that if ethical approval or agreed exemption was not gained prospectively then this has to be obtained retrospectively. This needs to be included in each article.

3] Some description of the consent processes that you used needs to be included in each article as appropriate (probably only articles 2-4).

4] Throughout, the manuscripts are cast in the context of the WHO and LMICs; this is unsurprising given the source of the papers. However, you certainly gathered data beyond LMICs (56% of surveys in paper 2 and interviews with NICE in the UK and Australia in paper 4) and you could increase the relevance of your work in two ways. Firstly you could write in terms of national and international policy organisations more generally, rather than always linking back to the WHO (unless you would argue that there is something specific to WHO about what you are saying). Secondly you could consider how far beyond LMICs you think your recommendations could go (given where the data come from). Whilst I would strongly encourage you to do the former I am happy for you to make a judgement about the latter. However, if your conclusions remain drawn around LMICs then this should be reflected in the article titles.

5] Throughout instruments that are referred to should be added as Additional Files so that they are available to readers.

6] Throughout, the articles need to be formatted in the journal style (<http://www.implementationscience.com/info/instructions/>).

7] At the moment certain sections of papers still refer to the report. For example, the acknowledgements section needs to be "allocated" to whichever of the articles it is relevant – comments about transcription and video's currently feature across all articles.

#### Specific comments

Title : Evidence-informed health policy: 2. Survey of organizations that support the use of research evidence.

Page 4, Last sentence on the page; can you give more detail of your survey method. How many reminders did you use, after what time intervals, did you

re-send the instruments or did you just remind recipients?

Page 5, first para, refers to funding from industry – could you be more specific about what sort of industry?

Page 6. Rather than saying both questionnaires are available on request I suggest that you use the Additional File facility so that they will be accessible from the paper. The text should then be adjusted accordingly.

First line of results, 152 (or 86%), delete or.

Page 8, section “Methods used in producing ...” second sentence, I don’t understand the sentence, particularly at the end.

Tables in general.

Remove gray shading.

You sometimes report n’s (lower case please) and sometimes report n(%). You should be consistent across tables; I would prefer you to consistently use n(%)

Table 1. Could you slightly expand the Legend and the sub-headings? Source could be written as Source from which respondent organisation identified – or some such. A reader should be able to read the table in the absence of the text and have a reasonable understanding of the content.

Table 2. Type of organisation section looks like an organisation could endorse more than one response as the column n’s don’t add up to the column total n.

Title : Evidence-informed health policy: 3. Interviews with the directors of organizations that support the use of research evidence.

In general this is the most problematic paper. At 9300 words it is too long to be readily assimilated by a reader; at the moment it is difficult to maintain the thread through the results. You need to find a way to shorten it so that you are still faithfully summarising the data and should aim for an article of 5-6000 words. You should consider if any of the text can be moved into additional files. You could, for instance, put the whole of the current results into an additional file, refer to this early on and then present a much more summarised set of results in the body of the paper. This would allow you to do things like list the seven recommendations (p17) in the results but have the additional detail in the Additional File.

Page 5 Interview guide. Somewhere, perhaps in a table, it would be important to report the 18 core questions so that the reader has some idea what to expect.

Page 6. The results have a series of sub-headings – are these the same as the 18 questions. Wherever they come from it would be helpful to signpost for the reader how the results are to be structured.

Title : Evidence-informed health policy: 4. Case descriptions of organizations that support the use of research evidence

Page 5. Consider adding the data collection protocol as an Additional File.

Page 5. The four core questions could usefully be written out in a more expanded form so that readers are clearer what was asked.

Page 6. Results. You need to characterise the organisations either in the text or the table. At the moment the Table is just a directory for the videos.

Once we have resolved these issues we need to have a discussion about how to best handle the videos.

## Evidence-Informed Health Policy: Using Research to Make Health Systems Healthier

Responses to comments, December 6, 2007

We would like to thank all of the referees for their thoughtful reflections, positive feedback and constructive suggestions. We have responded to specific suggestions below.

Judith Whitworth

Thanks Andy, & congratulations, this is a very useful piece of work & very well done. Thanks to all the team.

1) re success/failure of evidence into policy, I think this is different from evidence into practice. If evidence is not being translated into practice, this is a clear failure. But evidence will never be the only consideration driving policy. Other considerations are politics/equity/financial/cultural etc. The best we can hope for in a pluralist society is that evidence informs policy. So criteria for success & failure may need to be more nuanced.

RESPONSE: We agree and don't see where we have implied anything different from this anywhere in the report.

2) I note the comment re the 1999 hypertension guidelines. There is no doubt that there is a widespread perception that people in the pay of industry got together to urge inappropriate drug use in hypertension. The reality is there has been little or no adverse comment in the (2200) cites in the peer reviewed literature. Conflicts were declared & published. The recommendations re threshold related to lowering pressure, with life style as first line therapy in all, rather than only prescribing drugs. The thresholds have been reinforced by data from a number of studies, albeit not all explicitly, for more aggressive BP lowering. In particular the World Health Report of 2002 pointed out BP is the major risk for CVD, above 115 systolic. In our 2003 statement we did not revise thresholds upward & as you know this was based on a systematic review by SIGN. Thus the statements re inappropriate thresholds in the 1999 guidelines are perception rather than evidence based.

The processes that were used then, nearly a decade ago, would not be used now & a lot of improvements in process have occurred more rapidly than they may have done because of that debate. My view is that it is time to move on

RESPONSE: We have simply quoted what one of the respondents (bottom of page 41) in support of one of the key messages (Be independent and manage conflicts of interest among those involved in the work.

Mike Kelley

I am pleased to provide my review of the above report. The report is well written and presented in a style which a general policy readership would be able to use. It begins with its key messages relating to collaboration, independence, methodological rigour, and implementation. The important points for action for WHO and for others are also made clear.

The main body of the report consists of data generated by a number of methods to tackle the question. Consequently the study is nicely triangulated and the various components form a well rounded whole and a convincing argument. Some of the detail is engrossing managing as it does to get inside the processes of evidence producing and HTA organisations. The relationships with government and researchers are nicely drawn out. The direct and indirect self assessments of success are described, and the barriers and opportunities to the organisations doing this kind of work are outlined.

Overall I identified two places where the authors should check.

Page 28. The last sentence in the 4th paragraph is incomplete.

RESPONSE: Corrected. Now reads: No organisations declined to participate in the telephone interviews.

In the appendix, in the section on NICE, I am quoted several times, but I am not listed as an interviewee.

RESPONSE: We have added Mike Kelley to the list.

Otherwise a first class piece of work.

Jako Burgers

I have read this report with much interest and am impressed by the rigorous approach. It describes a large (maybe the largest) survey of organisations that translate research findings into practice and policy in healthcare, updating previous surveys. Triangulation of data-sources (survey, interviews, practice visits) was used for data collection, which strengthens the confidence in the findings and conclusions. These are consistent with the findings of earlier studies.

The implications of this study seem to fit well in the aims and strategies of international collaborations and networks, such as the WHO. Therefore, one might argue that the social desirability in the responses of the organizations also apply for the investigators of this study. This could explain why Richard's dog Henry only wagged his tail (p. 96). What would have been the impact on the conclusions, if Henry would have outlined a new strategy on health policy ignoring research evidence and only relying on barking authorities?

From this perspective, I have two specific comments:

1. What were the results of the 'independent checks on the credibility of thematic analyses' (p. 11)? Regarding the survey AO and JL reviewed the themes identified by RM (p. 16). No information is provided on the level of agreement

and how discrepancies were solved. Regarding the telephone interviews, AO and RM analyzed the summaries that were prepared by RM (p. 17). RM could not have done this independently. Regarding the case studies, I could not find any information on independent checks. I think it is unlikely that there was full agreement on the analysis of all data. The reliability and credibility of the report could increase, if the authors would provide some information about different perspectives and disparities of opinion and how they dealt with these.

RESPONSE: There were no important disagreements. Any discrepancies were resolved through iterative revisions of the manuscript. For the case studies all three of us reviewed the videos as well as the summaries. As noted in the next comment, the study was largely descriptive and the analysis was limited to extracting the key messages, which are supported by the results reported in the report.

2. Although the study had a descriptive aim, the report could get more flavour, if the authors would discuss in more detail the implications of their findings. They only provide four statements (p. 59), but it would be interested to also know their opinion about how the WHO and other relevant international networks (e.g. INAHTA, G-I-N) could support collaboration, local adaptation, mobilize support and create global public goods. For instance, I am thinking of:

# organizing educational and networking workshops in LMICs bringing together different stakeholders, such as researchers, healthcare professionals and policy makers

# facilitating links between researchers and policy makers through contacts with governments and local authorities

# supporting international research projects with the aim to bridge the gap between research and policy, focussing on LMICs

# supporting capacity building by involving high potentials in LMICs in high impact projects in their own country (to prevent 'brain drains')

I am sure that the authors have more, and probably better, ideas on the next concrete steps for WHO and others that need to be undertaken.

RESPONSE: While we could offer our opinions, these would be outside of the scope of this report and not directly supported by the results.

I would like to wish the authors good luck with finalizing of the report.

Ulysses Panisset

Congratulations for an excellent Report for the ACHR and many thanks for this helpful product that contributes to our work.

Following is just a general comment to a very neat draft, one specific suggestion about the involvement of the general public & media, and a few marginal comments:

1. The document is very useful to organize our current and future work of (and to advocate for) EVIPNet and other WHO strategies for improving

evidence-informed policies. It both adds new light and strengthens some of my understandings of key issues that require a change of the ways WHO works. I prepared bullets of recommendations to WHO and other international organizations to better guide our planning and implementation (a "policy brief." to my own use and to send to Tikki, Tim, and our regional counterparts working with EVIPNet.)

2. NGOs, general public & media: In Page 35, for CPGs and HTAs only one organization identified the informal relationships with the public as important for them as relationships with health professionals and academics. For GSUs, informal relationships with policy makers were more important than with academics and health professionals, and again only one identified the importance of informal relationships with "advocacy organizations, NGOs,..." In page 36, "satisfied clients, the mass media, speciality societies,..." are identified as "strong advocates." In the "Advice to others, 2. Establish strong links with policymakers and involve stakeholders in the work" (p.41) there is no mention of NGOs, media, general public as potential stakeholders. In the questionnaire sent to CPGs/HTAs in FOCUS, question 16. Target users (p.103) option a. is Patients/public. In GSUs, question 17 there is no reference to the public and just an unspecified "d. stakeholders". Is there a "social desirability bias" in responses not taking into account the role of NGOs, public, media as being key stakeholders/users of information and/or advocates for evidence-informed policies? Are GSUs overwhelmed with relationship difficulties between researchers and policymakers and not wanting to complicate even further with other stakeholders? In the conclusions you mention that "Negligible efforts are put into communicating evidence to the wider public, via mass media, and beyond stakeholder constituencies," but it is not clear if the survey and interview would have detected at least a will to do it, if it had "signalled" the interest of the researchers. Additionally, in page 27 (Organization) "we have not communicated very well with the public or clinicians about the methods we use and the rationale for decisions made."

Suggestion: That in page 60: Strengths and weaknesses of all phases combined, I suggest you mention that "there is a need to explore more the role to CPGs, HTAs and GSUs of the general public, NGOs, the mass media, and specialty societies as stakeholders, users and advocates of evidence-informed policies."

RESPONSE: We have added the following sentence to the end of the paragraph listing the strengths and weaknesses of the report on page 60: "In addition, some issues that were not explored in depth by our study warrant further investigation, such as the ways in which organisations that support the use of research evidence involve and communicate with the general public, the mass media and civil society."

3. The issue of WHO responsibility in the contextualization of guidelines and other evidence is crucial (p. 26 "need to adapt existing guidelines) and I suggest you mention it in the conclusions (I want to organize a workshop next year with Sue Hill on the issue).

RESPONSE: This is already in the key messages.

4. (typo detail: p.27, Establishment, 4th line: "For example ONE respondent said" instead of "ON")

RESPONSE: Corrected.

Zulma Ortiz

I wish to thank you again for giving me the opportunity to collaborate with you and your team. I have tried to do a job that helps to distinguish general issues from specific ones. I do not know the exact report target, so just for clarification purposes, let me tell you that I assume that it is a preliminary report from which diverse publications will derive, and also that my function is to identify errors, phrases needing clarification, and also to point out methodological aspects that might not be fully understood, and, eventually, to make any suggestions that could help to improve the report. Accordingly, I would classify my comments in three types: a) General, b) Specific, and c) Suggestions.

General Comments:

- The study is descriptive, with a predominance of qualitative techniques, favoring a better understanding of the issue under study and facilitating not only the identification of institutions using and/or producing scientific evidence to improve the health system, but also helping to define the profiles of such institutions.
- The three phases included in the study not only helped to identify such institutions, but also to further their insight. Using case studies helps to understand their process, limitations, and strengths.
- The inclusion of the appendices attached: list of institutions, instruments used, and references, facilitates the comprehension of the study findings and may play a role if somebody wants to replicate the study or contact any of the institutions.
- I find this report useful, since having a global view of the institutions producing GPC, HTA, and GSU is relevant. This view facilitates the building of alliances, and, at the local level, the referencing to institutions sharing the same objectives.
- I think the information is not presented in a fully friendly manner, not only because of its extension but also because of the way in which it has been structured. Please, see details on this point below. One of the problems is that some paragraphs are repeated in different sections.

RESPONSE: See response below.

- A strong concern regarding case descriptions from page 81 onwards is whether it is appropriate to identify the interviewees by their full names. In some cases, their testimonies and/or verbatim might expose them. Unless informed consents clearly stating that their names would be revealed were signed, I do not consider it convenient to include such data.

RESPONSE: The participants consented to being identified and videotaped.

Specific Comments:

Executive Summary

Although in the method section it is described that sampling for phases 2 and 3 was intentional, it would be convenient to clarify at least that the selection was criteria-based. Otherwise, the reference to the intentional nature only could cause the reader to fail to perceive that the use of criteria existed. It would also be convenient to operationalize the words “successful” and “innovative”, as they represent broad concepts that –in spite of being quite defined with the reading of the whole paper- should be clarified right from the executive summary. In other words, does “innovative” mean “pioneering”?

RESPONSE: This information is provided in the text and in our opinion is not needed in the executive summary.

As regards the results mentioned in this section, from the reading it is derived that the phone interviews were critical for the organization of the information and its presentation in the form of 7 major recommendations. However, each of them describes the other stages in which the recommendation in question was also proposed. I am not sure about the need of reinforcing these aspects in order to make an executive summary more useful, as the reading of the whole document will provide evidence for these issues. The description becomes too long and tedious, and does not add much, especially taking into consideration that it is an executive summary.

An example may help to understand what I am trying to say.

#### 1. Collaborate with other organisations

This advice was reinforced by: 1) the (quantitative) survey finding that more than half of the organisations (and particularly HTA organisations) reported that examples from other countries were helpful in establishing their organisation; 2) the (qualitative) survey finding that many organisations producing CPGs or HTAs conducted a focused review of one particular organisation that they then emulated or a broad review of a variety of organizational models; 3) the (qualitative) survey finding that the advice that was most commonly offered by organizations producing CPGs, HTAs or both was to seek support from similar existing organisations or networks, whether through informal interactions, study tours, mentoring relationships, twinning, partnerships or network memberships; 4) the (qualitative) survey finding that working within national networks....

RESPONSE: We agree that the executive summary is long (1800 words). However, it provides a concise summary of the full report. We prefer to keep the justification for the key messages in the summary. Many people will not read the report beyond this summary, the key messages are already provided without this text at the beginning of the report, and it is easy to scan or skip over this section for anyone who is not interested in the justification.

#### Key messages

The following phrase could be added in the first of the seven implications:  
Collaborate with other organizations in order to learn from each other.

RESPONSE: Although this was the primary reason given for collaborating, it is not the only one. We have not included rationales in any of the key messages

and don't think they are needed.

### Phase 3: Case Studies

Page 18: The next piece of information could be organized in a way that has everything together in the form of a point with a subtitle like, for instance, "Case Study Video".

We decided during the course of the project to make short video documentaries about each site visit (case study), and a cameraperson / editor / technical producer (MB) was hired to work with a member of the study team (RM) on this series. The protocol included the sorts of images to be captured in the video documentaries. One member of the study team (RM) and the cameraperson / editor (MB) conducted all the site visits. A request to host a site visit was sent by email to the director of each selected organisation (or other staff) and the arrangements were made through e-mail or telephone calls. Most interviews were video-taped but only select interview segments were transcribed verbatim. For a small number of interviews with people in the field, only notes were taken. The list of images to be captured included city panoramas, the buildings in which the organisation is located, the reception desk, key interviewees, and other images to help illustrate the narrative of each case study.

RESPONSE: We don't understand the suggestion, although it seems to be that we should dramatically shorten the description of the methods that we used. We do not think this is warranted. Although many people will not be interested in these details, it is important that it is there for those who are interested.

### Results:

Page 19: There is a mention to Table 1, which has a difference in the "Economic Classification" category of 2 institutions in columns 4 and 5, which, in turn, results in a difference of 4 in column 5. In the "Region" category of the same table, 1 is missing in order to complete the total of columns 4 and 5.

RESPONSE: We have corrected the numbers for the regions and added the following footnote to explain the discrepancies for the economic classification of countries: "\*International organisations are not included – 2 organisations producing CPGs and HTAs and 2 GSUs." (WHO EDM, HEN, INCLEN, COHRED)

In Table 2, "Type of Organizations" should have the remark "\*More than one answer was possible for the question", according to the figures, since the distribution exceeds the total.

RESPONSE: Done.

Page 20: Perhaps Focus could be replaced with a clearer title like "Organizations Focus". This also applies to the title of Table 4. The title on page 5 could be "Profile of People Involved in Producing a Product or Delivering a Service".

RESPONSE: We have elected not to change the titles on page 20 and Table 4 or Table 5.

Page 28: A table describing the organizations that participated in Phase 2 could help.

RESPONSE: The organizations are listed in Appendix 5. We have added a reference to the appendix.

Page 55: Having informed consents signed for the interviews could be strength. Not having them could be understood as a weakness. I found no mention regarding this point.

RESPONSE: Although the surveys were not signed, participation was voluntary and returning the completed questionnaires indicates consent for us to use the information that was collected, as described in the introduction to the survey instrument (Appendices 2 and 3). We obtained verbal consent for the interviews, not written consent. We do not agree that this is a weakness.

Page 84: This phrase is not referenced “the triangle that moves the mountain” and may not be understood.

RESPONSE: We have added the following reference as a footnote: P Wasi, Triangle that moves the mountain and health systems reform movement in Thailand. Regional Health Forum. <http://w3.whosea.org/rhf/rh4/6h.htm>

Page 94: The inclusion of Henry (Richard’s dog) as an interviewee could be seen as very informal or lacking seriousness.

RESPONSE: We agree.

Page 96: A paragraph is repeated in Case 8.

Interviewees

- Dr Octavio Gomez Dantes, Ministry of Health
- Dr Julio Frenk, Secretary of Health
- Dr Asa Cristina, Secretary of Health, Federal District of Mexico

City

- Dr Mauricio Hernandez and Dr Miguel Gonzales Block, National Institute of Public Health
- Dr Michael Reich, Harvard University, United States

Additional support

- Felicia Knaul, researcher8

RESPONSE: We have corrected this.

Page 123: Organization number 20 should say “Gobierno” instead of “gobierno”.

RESPONSE: We have corrected this.

Suggestions:

Key messages might include mentions to the patients’ and society’s roles in the

work performed by the characterized institutions.

RESPONSE: While we would agree with the message, it is not supported by the results of this study. We have addressed this elsewhere.

It could also be good to mention how the issues under study are prioritized/not prioritized.

RESPONSE: We don't understand this suggestion. We have summarised what we found about approaches to setting priorities in the report.

I wonder whether it is possible to include a mention to the pharmaceutical industry's role.

RESPONSE: We have referred to the pharmaceutical industry several places in the report already and this was a major focus of the Philippine case study. The main message that came out was that organisations consider their independence from the pharmaceutical industry as a strength and that they recognise a need to manage conflicts of interest, as we have reported.

Finally, I think that mentioning something about leadership capacity and emphasizing divulgation could also be indicated as key messages.

RESPONSE: This did not emerge as a key message from our analysis of the results, although we agree that this is likely important.

Finn Børlum Kristensen

Thank you for the opportunity to review the draft.

The draft report is well written, and brings very useful information. Its global perspective is of unique value.

The results reflect what the project set out to do.

The method of identifying the institutions who received the survey is clear, and you got a high response rate.

The survey results are supplemented with interviews – this information underlines the results and carries the messages through in a readable flow of information.

The addenda allow readers to check the instruments used.

The results, and the discussions / conclusions / summaries are useful, not least useful for producers of Guidelines and HTA.

I hope the report will be out soon so that the EUnetHTA work packages – not least WP 6 can make public reference to it and use it.

Please indicate when I can share the report with two or three researchers involved in the editing of the WP 6 book describing policy structures and policy processes related to the production and use of HTA in policy making in selected EU member states to come out next year.

Nelson Sewankambo

Thank you for asking me to review Draft 4 October 2007 of this EIH report which was a review of organizations that support the use of research evidence in developing guidelines, technology assessments and health policy.

This is a very rich and detailed study that was very well conducted and produced detailed results on a topic of major importance. This study went beyond what other studies have tried to cover with similar but different study designs. The authors set out to creatively use a combination of 3 data collection methodologies – questionnaire surveys, telephone interviews and case descriptions that employed both quantitative and qualitative approaches to cover the three types of organizations that support the use of research evidence in development of CGPs, HTAs and health policy with special interest in low and middle income countries of the world.

Below are the specific comments

1. Lay out of the document: I feel that the case descriptions pages 81-96 are part of the results and are simply an extension of phase 3 results presented on page 44-48. Either the two are together in one results section or the detailed descriptions page 81-96 are presented clearly as appendices. Currently these detailed descriptions are neither appendices nor results.

RESPONSE: We do not feel strongly about this, but have left this as is. The case descriptions are listed after the tables. Although both the tables and the case descriptions could be placed in the text, we feel the report flows better as it is. This is due in part to limitations in our ability to format the report. We have added the following reference to the case descriptions in the results section:

#### PHASE 3: CASE DESCRIPTIONS

We conducted site visits between September and November 2005 with eight of the organisations included in the survey. A brief description is provided for each of the cases at the end of the report (following the tables) and the video documentaries that were produced are listed in Appendix 6.

2. Language and sentence construction: There is need to improve the language and sentence constructions especially in the results section so as to make easy reading and flow of ideas. Some places have incomplete sentences.

RESPONSE: We have attempted to do this. It may be possible to have the report copy edited by someone else prior to its release.

3. There seem to be very many quotes. Some could be summarized into boxes.

RESPONSE: We agree the report could benefit from better formatting and would be happy for someone to do this, if it is possible.

Comments on specific sections:

1. Conflict of interest statement for each author is missing

RESPONSE: We have added this following the Acknowledgements.

Conflicts of interest

ADO and EP are employed by the Norwegian Knowledge Centre for the Health

Services, which was included in the survey. ADO is a member of the WHO Advisory Committee on Health Research. JNL is President of the PAHO/WHO Advisory Committee on Health Research and a member of the Scientific and Technical Advisory Committee of the Alliance for Health Policy and Systems Research, which is co-sponsored by and housed within WHO.

2. Acknowledgements page 5: Of the 4 authors only John Lavis is mentioned and how he is salaried. How about others EP, ADM and especially RM?

RESPONSE: John Lavis' salary support is noted as a condition of his funding which supported his work on this report. We have added that ADO and EP are employed by the Norwegian Knowledge Centre for the Health Services under conflicts of interest, as noted above, since the Centre was included in the survey.

3. Key messages page 6: I do APPRECIATE that the key messages should be short BUT at the same time the messages should be clear to the reader e.g message j should incorporate learning i.e. Collaborate with AND LEARN from other organizations message 3 – Be independent of interest groups (including ministry of health) and manage conflict .....; message 7 is not so clear. Implications number 3 for WHO and other organizations could be expanded a bit more by picking up a few ideas in section 3 page 59.

RESPONSE: We feel the key messages are sufficiently clear and that additional explanation is provided in the executive summary and full report.

4. Executive summary page 7

On page 8 again the key result number 1 which I picked up in "Collaborative with and learn from other organizations". The discussion is focused on the methodology of the study and the weaknesses of the study and misses out any discussion of the results. Similarly the summary has no conclusions.

RESPONSE: We have added the following conclusions to the executive summary:

#### CONCLUSIONS

Participants regard an evidence-based approach as the greatest strength in the way these organisations conduct their work. They see the time-consuming nature of an evidence-based approach as the greatest weakness. They view relationships between researchers and policymakers as highly desirable, but there appears to be little awareness of the nature of potential tensions that can arise and how to manage or resolve them. A lack of resources, both financial and human, poses a challenge in many organisations. Conflicts of interest are seen as a critical issue. Multi-disciplinary teams and international networks are seen as highly desirable, and there is a strong perceived need for coordination at an international level to avoid duplication of processes. Little effort is put into dissemination and implementation activities in relationship to the efforts that are focused on producing evidence-based materials. Negligible efforts are put into communicating evidence to the wider public, via the mass media, and beyond stakeholder constituencies.

## 5. Background:

a) Justification: Whereas it is clear that there were recommendations from the Mexico Summit and from the 2005 World Health Assembly it is NOT clear why a new study (this study) was necessary given the fact that there were recent reviews (referred to this report) that had taken place regarding CPGs, HTAs. The reader needs to be convinced whether or not a review of those recent reports would not have been adequate to serve the objectives of this study. One possibility is that previous surveys have not focused on GSUs or LMIC or combined surveys, telephone interviews and case descriptions. The front page indicates that this report is prepared for WHO ACHR. Did WHO request for this study or what?

RESPONSE: We believe the background provides adequate justification and explanation. We address what this report adds to previous studies in the discussion. WHO did not request this study. We have added the following paragraph to the background to explain its relationship to the ACHR and WHO:

Related to these resolutions, WHO asked the Advisory Committee on Health Research (ACHR) for advice on ways in which WHO can improve the use of research evidence in the development of recommendations, guidelines and policies. The ACHR established a subcommittee to collect background documentation and consult widely among WHO staff, international experts and end users of WHO recommendations to inform this advice. This report was prepared as part of the background documentation to inform ACHR's advice to WHO.

b) Paragraph 2 of page 14 is a combination of objectives of some methods. I would prefer to have a separate section on objective and also transfer what appears to be methods to the methods section which follows. It would be a nice way of introducing and summarizing the methodology which is expanded with the rest of the current methods section.

RESPONSE: We prefer to leave the introduction to the methods as it is, at the end of the background section.

## 6. Methods page 14

a) See comments above

b) Please state when this study was carried out so that there is a time reference point in case of future similar studies.

RESPONSE: We have added this information to the results as follows.

### PHASE 1: SURVEY – QUANTITATIVE RESULTS

We sent 176 questionnaires, and 152 (or 86%) completed questionnaires were returned between April and October 2005.

### PHASE 2: TELEPHONE INTERVIEWS

We conducted the telephone interviews between June and October 2005 with 25 of the organisations included in the survey (Appendix 5).

### PHASE 3: CASE DESCRIPTIONS

We conducted site visits between September and November 2005 with eight of the organisations included in the survey (see case descriptions).

c) I suspect there was a weakness in the composition of the project reference group and partly that is why you did not have more organizations from LMICS. Of course there may be fewer organizations of (interest) in LMICS than in high income countries. I, however, think you should have had in the group a bigger representation from LMICS and thus increasing the chance of more members identifying relevant organizations which are not properly documented through membership to GIN or INAHTA etc.

In the REACH video the Director KEMRI said that they (KEMRI) had a unit which had been doing research to policy work for a long time. May be this unit should have featured and more for example East, West, Central, South and North Africa.

Did question 49 of appendix 2 yield any additional organizations which should have been included in this study?

RESPONSE: Identification of organisations was not limited to contacting people in the reference group, GIN and INAHTA. As noted in the methods section: "We drew on members of both formal and informal international networks to identify particularly innovative or successful CPG-producing organisations and HTA agencies and to identify GSUs. The formal networks included the Appraisal of Guidelines for Research and Evaluation (AGREE) collaboration, the Cochrane Collaboration, GIN, GRADE Working Group, International Clinical Epidemiology Network (INCLIN) Knowledge Management Program, and INAHTA. The informal networks included our project reference group, staff at WHO headquarters and regional offices, and personal networks." While it is unlikely that we identified all relevant organisations in LMIC, we were quite liberal in our inclusion of organisations from LMIC and used multiple methods to identify these organisations, including snowballing (asking people we contacted for additional contacts, particularly in LMIC). Question 49 did not yield any additional organizations that were not included.

d) Phase I survey page 15

Study population: Paragraph 2 sentence 1 states "while we included all eligible organizations from LMICS" I doubt that the list was exhaustive and that you included all eligible organizations. See comments above.

RESPONSE: See response above. We have modified this sentence as follows to clarify what we did: "While we included all eligible organisations from LMICs that were identified by any of the people we contacted".

It is not clear how or what criteria (if any) were used to classify organizations from high income countries as particularly innovative or successful in their work.

RESPONSE: We have added the following two sentences on page 15 to clarify this: "We included organisations that were considered to be particularly innovative or successful based on recommendations of those we contacted and

our own knowledge. No specific criteria were used in making these judgements.”

#### Survey development administration

Is the questionnaire developed by AGREE collaboration hitherto widely recognized as the best or most comprehensive? Why was it selected as the best starting point? You also included a final group of additional questions – why and what was the basis? In short the rationale for changes in questionnaire should be explained (transparency).

RESPONSE: This is addressed in the discussion and the questionnaires are attached as appendices. In fact, relatively few prior surveys have been undertaken. The reasons for adding additional questions seems obvious to us: to collect relevant information given our objectives, which were not identical to those of the AGREE survey.

On page 16 first paragraph indicates that questionnaires were piloted with 3 organizations. Did the pilots lead to any change in questionnaires?

RESPONSE: We have added the following at the end of the paragraph to answer this question: “We piloted the questionnaire with three organisations in each category (and received responses from five organisations) in April 2005. No changes were made in the questionnaires following based on the pilot.”

“We want 3 reminders if we did not receive a response” In what period of time?

RESPONSE: We have indicated this as follows: “We sent three reminders if we did not receive a response up until October 2005.”

#### Phase 3: Case studies

REACH stands out as an exception because the investigators deviated from the laid down selection criteria which were applied to other sites. It was not explained as to why this was necessary and why.

REACH in particular was picked up when there may have been others that the investigators knew of.

RESPONSE: If we had been aware of other organisations that met our inclusion criteria we would have included them in the survey. REACH was included based on the same criteria as the other organisations, which are described in the same paragraph. REACH was not included in the survey because it was not yet established, as indicated in the sentence explaining the inclusion of REACH: “the Regional East African Community Health (REACH) Policy Initiative, which is currently in the resource-mobilization phase in its development.”

P18 first paragraph states that “We decided during the course of the project to make short video documentaries ...” why did you do this?

RESPONSE: We have added the following explanation:

Advantages of the video documentaries are that:

- They let people describe in their own words what they are doing and the audience can hear this and see them and the context in which they work;

- They are entertaining and people enjoy them, thus enhancing their impact.
- They can include conflicting viewpoints that can be a good starting point for discussion and debate.
- They can highlight different issues that are of broad relevance, such as explicit versus implicit rationing, tensions between researchers and policy makers working together, and conflicts of interest.
- They provide people an opportunity and stimulus to reflect about how they are doing things.
- They can be helpful in one-on-one meetings with decision makers to get across concepts and generate enthusiasm.

On page 1 (the front page) indicates that this is Final Report and Video documentary series. However, I do not seem to see any reference in the text to appendix 6 either in results or discussion.

RESPONSE: We have added a reference to the appendix describing the videos on page 18 in the methods, where we have added the above rationale for them, and we have added the following to the results section on page 55:

### PHASE 3: CASE DESCRIPTIONS

We conducted site visits between September and November 2005 with eight of the organisations included in the survey. A brief description is provided for each of the cases at the end of the report (following the tables) and the video documentaries that were produced are briefly described in Appendix 6.

### Ethical issues

Consent process and institutional approvals: Since this study involved human subjects it may be necessary to address how you handled ethical issues (if any) including obtaining institutional ethical approvals and informed consent.

RESPONSE: We have added the following paragraph at the end of the methods section:

No sensitive data were collected and none of the participants requested confidentiality. The purpose of the survey was explained in the survey instrument (Appendices 2 and 3), participation was voluntary, and return of a completed survey indicated consent to our use of the collected information in this study. Verbal consent was obtained for the telephone interviews and face-to-face interviews as well as recording of these.

### Results p19

#### Survey – Quantitative results

Regarding the first paragraph of this section you may want to add to last sentence "... 14 identified through INCLEN, one from other source" and ... from question 49 appendix 2.

RESPONSE: We have edited the paragraph as follows:

Twenty-nine organisations were identified through the Guidelines International

Network (GIN) membership list, 26 through the International Network of Agencies for Health Technology Assessment (INAHTA), 14 through INCLIN and 82 through personal contacts (including responses to the last question in the questionnaire that asked about other organisations) (Table 1). Forty-nine of the 57 units supporting government policymaking were identified through personal contacts.

P 25 Role of WHO and other international organizations.

Whereas this question has 2 components i.e. WHO and other international organizations the responses reflect only WHO. This is the trend wherever reference is made to WHO and other international organizations. This is carried through the discussion of findings p. 56 etc.

RESPONSE: We have noted references to other international organisations wherever this is relevant. For example, on page 26: "A question gauging views about WHO's and other international organizations' current role in developing guidelines and HTAs and helping policymakers to access and use research evidence did not reap a rich set of responses. Many organisations in high-income countries focused on the importance of international networks such as Guidelines International Network (GIN), Health Technology Assessment International (HTAi), and International Network of Agencies for Health Technology Assessment (INAHTA), whereas many organisations in low- and middle-income countries focused on WHO's role more generally and not specifically in the domain of CPGs and HTAs."

Advice to others p40

This section from p40-44 is very similar to the section on principal findings from all 3 phases p56-59. It is very clear why the two sections are very similar. The challenge is presenting them in such way that does not make them monotonous and repetitive.

RESPONSE: While we agree this may be repetitive, it provides a clear description of the findings from each phase and allows readers to judge for themselves the extent to which the different phases provide complementary support for the key findings. It is easy for readers who are only interested in the key findings to skim or hop over these sections.

Does this also mean that telephone interviews were the most useful approach to collecting information since they produced the structure for recommendations?

RESPONSE: No. The different approaches were complementary.

Discussion p48

Phase 1: Survey pages 48-49 sounds like results and not discussion of results.

RESPONSE: We have simply summarised the principle findings at the beginning of the discussion, as suggested by guidelines for discussion sections.

Under strengths and weaknesses on page 49 it may be necessary to explain the study weaknesses:

a) Despite your best efforts to focus on LMICS why were there not more organizations from LMICS in study phases I and II? Is it a reflection of what is on the ground i.e. not many innovative or very progressive/productive (successful) organizations, or is the methodology you used to identify them? If it is more of the former than the latter that calls for heightened efforts to develop innovative and successful organizations in LMICS.

RESPONSE: This is answered in the first part of the sentence: “despite significant efforts to identify organizations in low- and middle-income countries”

b) Is there any data in the results to suggest or back up the supposition that there may be social desirability biases in the responses received?

RESPONSE: No.

#### Phase II: Telephone interviews

On page 52 first paragraph is the statement that all types of organizations tended to focus largely on weaknesses in implementation, rather than strengths. I suggest that this be indicated as a third study weakness because we need to learn not only from weaknesses but from strengths and successes as well.

RESPONSE: We believe this is an accurate description, not a weakness, and we have reported the main findings based on what was reported about the strengths that were identified.

Most examples of success among CPGs and HTA producing units were where there was a perception that clinicians adhered to the organizations recommendations or policy makers based their decisions on the work of the organizations. Can the authors suggest on what else the organizations would have given as examples of success. This is useful in educating study respondents, readers and those starting or planning to start similar organizations to view success more broadly. Similarly failures would also be viewed more broadly.

RESPONSE: We have added the following in response to this comment: “However, the examples of success varied and included efficiently building on work undertaken by other organisations, production of good quality guidelines, providing a basis for political decisions or actions, timeliness, documenting support for current practice, providing support for not using new costly interventions with potential adverse effects or more expensive interventions without documented benefits, increasing delivery of effective interventions, supporting the delivery of effective interventions to disadvantaged or vulnerable populations, linking CPGs to an audits, improving assessments of the quality of care, undertaking assessments of the quality of care, and improved health outcomes.”

How do the seven recommendations offered as advice to those trying to establish similar organization compare with those from previous studies (even though they had different designs, did not include GSUs and did not focus on LMICS).

RESPONSE: We have compared the findings of our study under the heading “What this study adds to previous studies” for each of the three phases.

What the study add to previous studies p 53

“A key question that was being asked by policy makers in McDavid’s studies (2003) was value for money from HTA organizations.

Clearly this information is not available for the present study and that question will not go away but become increasingly more prominent over time. Through a fairly complex question it may be useful for the authors to recommend that organizations pay specific attention to this question in their future operations and attempt to generate answers. They would be useful in advocating for resources.

RESPONSE: While this may be a reasonable recommendation based on McDaid’s study, it does not flow from the findings of our study and is not supported from our findings. We have suggested recommendations that emerged from our study that are consistent with his conclusions: “These findings and the conclusions he draws support the advice that emerged from this study “to collaborate with other organisations and, indirectly, the importance of establishing strong links with policymakers and stakeholders, and to be attentive to implementation considerations even if implementation is not a remit.”

P54 bottom paragraph discusses WHO without mention of other international organizations as to what they are doing or should do e.g. COHRED, INCLEN etc. Same comment applies to paragraph 4 on page 56.

RESPONSE: We focused specifically on WHO because this report was prepared as a basis for giving advice to WHO. We mention other international organisations where these were identified by participants and where relevant.

Since case studies and documentaries were costly and extremely cumbersome to conduct there is need to be very clear as to the value added by each to this study.

How about the special inclusion of REACH: What was value added in terms of results or experience for learning?

RESPONSE: We believe these speak for themselves, particularly the video documentaries, including the REACH case study, and we have not added any additional text justifying our methods or the selection of cases.

P59 presents the 4 main implications of the findings for WHO and other international organizations. The writing style in sections 1-4 that follows addresses WHO only and not the other organizations.

RESPONSE: This reflects the purpose of the report.

Item 4: Creation of global public goods has occurred several times but remains unclear to me regarding its form which could be at least one or both of the following:

a) WHO should play a role or undertake the activities similar to those of a CPG, HTA, GSU leading to products which are global public health goods.

b) WHO should play a role to produce global health public goods like guidelines (possibly evidence based) to facilitate good practice in development and managing GSUs and units engaged or planning to engage in CPG or HTAs.

c) WHO should play a coordinating role

There is need to clarify content of this recommendation.

RESPONSE: We have added the following explanation: "WHO should play a role in creating knowledge-related global public goods, including the development of methods, evidence syntheses and policy instruments."

Conclusion p 60-61

Need to include in conclusion a clearer statement about WHO and other international organizations (even though WHO might be the most important for now).

RESPONSE: We have included the following and do not feel it is necessary to repeat the implications for WHO in the discussion, which immediately precede the conclusions: "international networks are seen as highly desirable, and there is a strong perceived need for coordination at an international level to avoid duplication of processes."

Mention is made in the conclusion of a perceived need for coordination at international level to avoid duplication of processes. This message has not been that clear and explicit so far in the results and discussion.

RESPONSE: Coordination and avoiding duplication is mentioned in the results on the bottom of page 26, the bottom of page 30 and at the top of page 32, and in the discussion at the top of page 50 and the bottom of page 60.

As conclusion what has been the value added by this study.

RESPONSE: We have addressed this in the discussion.

Don't the authors want to make a conclusion/recommendation based on their methodology on how future studies in this field should be conducted e.g. inclusion of GSU and focus on LMICS.

RESPONSE: No.

References page 62-67

There are some references appearing in the text but do not appear in the listing e.g. Hailey 2006 is referred to on page 50, WHO 2005 is mentioned on page 51 but not listed.

RESPONSE: We have added the references for Hailey 2006 and corrected WHO 2005a to WHO 2004a.

Table 1 p68

The sub headings: source, economic, classification, region should stand out prominently.

RESPONSE: Done.

## Table 5 and 6

These tables have lots of data which has not been used in the report. To simplify presentation in the tables unused data may be left out without losing quality and richness of the report.

RESPONSE: We prefer to keep these data in this report so that they are easily accessible, if anyone should want them.

## Case presentations p81-89

As discussed above these may be presented as appendix. It is confusing when the listing of case descriptions on page 81 is by region e.g. East Africa, by country e.g. Thailand, by state, by countries, (Australia and South Africa) why not first state the name of the organization or scheme for by country, region or state etc. The same should go for the titles of each case description in the subsequent pages and in appendix 6.

RESPONSE: We prefer to leave these as they are. The same labels have been used in the videos. There are obvious reasons for East Africa being a region and the Free State being a province.

Appendix 6: Same comment as for case presentations above regarding the name in the column for case studies other than for REACH were the other case study sites involved in the survey and telephone interview. If so then why not use the names that appear in appendix 5. The data that appears in the last column "length" is not clear as to what it is referring to and its units.

RESPONSE: See response above. We have changed the heading of the last column to "Length of the video (minutes)".

## Mary Ann Lansang

First of all, congrats on this huge piece of global/globe-trotting research on evidence-informed health policy. There is no other piece of work quite like it--both qualitative and quantitative research from a large number of key informants on EIHP.

The conclusions are sound, and I agree with them. But I was looking for some conclusions in relation to health systems, since your subtitle/tagline is "Using research to make health systems healthier". I'd have to say that most HTAs and CPG developers (and even GSUs) do not directly address "health systems" as such (e.g., aspects of financing, governance, regulations, service delivery)... so it was quite a stretch for me to see that tagline in the title, without a corresponding recommendation/conclusion on this.

RESPONSE: We acknowledge that the title may imply something more than what the report addresses. However, because we have referenced the draft report using the current title, others have not indicated the same confusion, and the content of the report is clearly specified in the subtitle on the front page, we prefer to keep the current title.

Talking about health systems--I also thought that it was strange not to see any

mention of the Alliance on Health Policy and Systems Research and its role within WHO, esp. since you've made a strong point about collaboration and linkages. Although your questionnaire did not single out the Alliance in WHO, I do think that you as the investigators could make your own recommendations/conclusions on the Alliance-WHO role, and not just quote from your interviewees.

RESPONSE: We agree that AHPSR has an important role to play. However, this did not emerge from the findings of this study and the role of AHPSR has changed substantially since 2005, when the interviews were conducted, and is still evolving.

I liked the attempt at disaggregating findings from GSUs vs. those from HTAs and CPG developers. Although content of health policy was not a main focus in your work, I am assuming that GSUs worked additionally on macro-issues related to health systems, for which target clients/policymakers are slightly different from those in the clinical/HTA field or even in health program management.

I of course like the fact that you tried hard to for organizations/groups in LMICs. But I would have wanted to see some disaggregation and analysis of findings from LMICs, as the challenges facing EIHP in these countries are not only in terms of magnitude (inadequacies in human and financial resources, access to studies, etc.) but also in terms of factors affecting EIHP (e.g., corruption--not just in terms of big pharma, research and policy environments, underdeveloped consumer sector).

RESPONSE: We agree, but we did not have sufficient data to explore issues such as these.

The title of your report could broadly be assumed to mean that in addition to the usual HTA/CPG orgs and GSUs, funding and donor agencies that support the use of evidence are also orgs whose views should be looked at... and weren't. As you repeatedly pointed out that HTA/CPG orgs and GSUs complained about the lack of funding, it would have been useful to get the points of views of funding agencies (including their views about WHO's role). I would state this as a limitation upfront.

RESPONSE: We agree this would be a good study to do, but it is not a limitation of what we did.

I didn't have time to go through each of the case studies (which, laudably, are mostly from LMICs). I did read the Philippine example, which was interesting of course. I wonder if you really want to retain the "nicknames" of Tony and Inday Dans, rather than their full names: Antonio and Leonila Dans? And, is the report for general circulation--if yes, did people like Eugene Reyes and Tomas Realiza agree to be quoted with their names or did they wish to be anonymized? [I guess if you have a video, which I haven't seen, then maybe this is not an issue].

RESPONSE: We have identified added Tony and Inday's full names to the list of interviewees as follows: "Dr Antonio (Tony) Dans and Dr Leonila (Inday) Dans, University of the Philippines". All of the participants who agreed to be interviewed

agreed to being interviewed on the record.

Re your quote from Inday Dans stating that "INCLLEN has helped train over 100 clinical epidemiologists who are applying the principles of the evidence-based approach in their work"--this is not clear to me. INCLLEN has trained over 800 at last count... does this quote mean that only 100 of the 800 apply the principles of EBM, or does Inday mean that the Dept. of Clin. Epidemiology at the University of the Philippines (or the Philippine Clinical Epidemiology Network) has trained over 100 clinical epidemiologists... etc. etc. This needs clarification.

RESPONSE: We have corrected this to 800.

And yes... I missed seeing you in Manila when you were there. The INCLLEN Office (which funded this piece of work, together with the Knowledge Plus Program) was headquartered in Manila at that time.

The Mexico case study--I wonder if you should make reference to the Lancet series (2007) on this outstanding example of evidence-to policy.

RESPONSE: We have elected not to add those references since they are not directly relevant to the case description or the focus of this report.

I guess that's it... from my quick read (very sorry again!) of the document. I hope that the ACHR and WHO will take this forward and produce important policy changes in WHO out of your important body of evidence.

Maimunah A Hamid

First and foremost, it is an excellent draft report, very well written and the methodology is well described. The analysis is good and I had no difficulty in understanding the various sections. I particularly like the case descriptions (in the appendix section). They add a thirst for wanting more information about those organisations. It would be excellent if the authors could add their own conclusion as what is/are the key success factors, to summarise each case description. I had listed what I thought could be a success factor for each description.

RESPONSE: We appreciate this analysis, are delighted that it was possible based on the case descriptions. We have, however, undertaken a similar analysis and reached somewhat different conclusions than these, based on the questions that we asked in the interviews, as well as considering the results of the case studies in the context of the survey and telephone interviews. In relationship to your conclusions, summarised below, timing and timeliness, conflict management and credibility ("use of an evidence-based approach") also emerged as key factors from our analysis and are addressed in the report. The importance of political commitment is reflected in the advice to WHO to mobilize support. Local champions and leadership did not emerge as key success factors or messages, although we agree that these can explain success.

REACH – local champions

Thailand – timing & timeliness of evidence to policy makers

Free State – ? conflict management

Australia – establishing credibility

Philippines - ? conflict management

Chile – political commitment

UK – clear national mandate

Mexico – leadership and political commitment

There are some other minor suggestions and comments that I had marked in the report through “tracking changes”. Some specific comments are given below:

RESPONSE: We have gone through those and made the minor changes with which we agreed. Our responses to specific suggestions are summarised here.

Page 6. The study’s seven main implications for those establishing or administering organisations to produce clinical practice guidelines or health technology assessments or organisations to support the use of research evidence in developing health policy include:

One key issue is “timing and timeliness of evidence”.

RESPONSE: We agree that timing and timeliness is a key issue. Although it did not emerge as a key message, it is addressed in the first sentence of the conclusions, which we have added to the executive summary.

Page 6. Build human and institutional capacity among those working in the organisation and also capacity among policy makers

RESPONSE: We have elected not to add the suggested text.

Page 9. The study’s four main implications for the World Health Organisation and other international organisations include:

One aspect that came quite prominently in the suggestions was for the WHO to facilitate government support at country level.

RESPONSE: This is covered by the third key message to WHO.

Page 9.

1. Collaborate and nurture collaboration with other organisations

The findings not only pointing that collaboration is important, more so to sustain and gain benefits from such collaboration.

RESPONSE: We prefer to keep the more succinct message.

Page 9.

2. Be independent and manage conflicts of interest among those involved in the work

This advice was reinforced by: 1) the (qualitative) survey finding that independence is by far the most commonly cited strength in how organisations producing CPGs and HTAs are organized; and 2) the case descriptions finding that the presence of conflicts of interest was repeatedly cited as one of two key organizational weaknesses.

It would be facilitating to busy readers if the word “independence” is being qualified here.

RESPONSE: We don't understand the suggestion.

Page 9.

3. Build and retain human and institutional capacity among those working in the organisation and among policy makers

This is an important message to LMIC to ensure a system is created and not person-dependant

RESPONSE: We agree and might add that this presents a challenge in relationship to flagging the likely importance of leadership and local champions as a success factor, as was suggested above.

Page 9. This advice was reinforced by: 1) the (quantitative) survey finding that most organisations have a small number of full-time equivalent (FTE) staff; 2) and the case descriptions finding that developing capacity among and retaining skilled staff and collaborators was one of their two frequently offered types of advice.

Multi-disciplinary skills was also frequently mentioned

RESPONSE: We have addressed this elsewhere in the report.

Page 10.

Be attentive to implementation considerations even if implementation is not a remit

Perhaps to also include evaluation as to capture the importance of “accountability” - value for money – which is most relevant for LMIC.

RESPONSE: We agree that evaluation is important and this comes out in the text below this key message, but we do not think it should be added to the key message.

Page 22. . Relationships with industry or consumer groups are rarely cited as particularly important or valuable.

Perhaps the design of the study contributed to this since most of the organisations with industry influences was excluded

RESPONSE: We agree, but our study was not focused on those other organisations and this finding accurately reflects our findings for the organisations on which we did focus.

Page 27. .” No themes emerged in response to the question about what background documents or resources were helpful in establishing the unit or the question about what other information would have been helpful in establishing the unit.

Could this be contributed by problem in the question itself?

RESPONSE: Possibly, but this does not seem likely to us and we are not sure

how we might have asked this question differently.

1. Is this report part of a series of documentation on Evidence-Informed Health Policy demonstrating how research could contribute to better health systems? If it is not, I would like to suggest the authors to reconsider the current sub-title “Using research to make health systems Healthier” as the report does not emphasise much on how research evidence have been used, rather describing the existing organizations (models).

RESPONSE: See response above.

2. While reading this report I kept thinking of its utility to the readers, particularly those from LMIC. The following were two questions I kept at the back of my mind:

a. What is it out there that I could learn from and emulate if my country has one or more of such organizations, and what would be the scenario if my country has nothing?

The report provides two valuable information:

- A list of favorable characteristics (e.g. evidence approach, sensitive to timing and timeliness of evidence, focus, multidisciplinary teams, evidence in approach, relationship with policy makers, independence, accountability, etc); and

-A list of useful functions/roles of such organizations (e.g. provide evidence, possible involvement in implementation, network and contact, build capacity, work with advocates, disseminate, evaluate impact, etc).

The section on “key messages” is very useful. However, it would be excellent if at the end of the “discussion section” or at the “conclusion” to suggest what possible models could consider if a country (especially LMIC) has HTA, CPG or GSU (or in combination); and what models could they create if the country has nothing.

RESPONSE: This is a good suggestion, but we did not design the study or analysis with this in mind. The report provides some information that could help people to consider some key characteristics of different models and it could be used by someone, together with other sources of information, to address that question. It is, however, beyond the scope of this report.

b. Does this report uncover some other questions that could be taken up as future work to help me further understand the complexity of the matters?

For examples:

- What would be a suitable structure for communicating/disseminating research evidence from such organizations (formal vs. informal; structural vs. a loose link, etc)? Personal contact has been mentioned in several sections. How do we build the strength of “personal contact” to ensure sustainability/continuity of communication (i.e. creating a system vs. person dependant)?

- Why it is that only very few respondents recognized the role of media in supporting dissemination and promoting use of their evidence? What were the experiences and lessons learned among organizations that used media to

disseminate evidence?

- How important is “timing and timeliness” is getting research evidence to policy decision? How do they identify the “opportunity window” and what processes they use to be timely?

RESPONSE: All of these are good questions. However, we do not have specific suggestions for future research that we would like to add to this report and this is to some extent outside of the purpose of this report.

Thank you for giving me the opportunities to review the draft report and providing some comments. I hope they are useful. Please do not make any payment to the little service I could contribute towards this effort. I have enjoyed reading it and benefited from the knowledge gained. Do keep up the good work.

Atle Fretheim

Andy, I have read through now and have just a few minor errors to point out (spelling mistake, missing space - that type of thing?).

RESPONSE: We have made all of the minor corrections marked in the draft report.

In light of Burger's comments I think that it is appropriate to put in something about the "investigators' perspective".

RESPONSE: See response to Jako Burger above.

**Level of interest:** An article of importance in its field

**Quality of written English:** Acceptable

**Statistical review:** No, the manuscript does not need to be seen by a statistician.

**Declaration of competing interests:**

I declare that I have no competing interests.