Institutionalization of Evidence-Informed Policies (EIP) in Health Organizations: Evidence Synthesis and Deliberative Dialogue on Critical Factors

São Paulo/SP | 2024

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Contents

List of abbreviations and acronyms

CGEvi - General Coordination of Health Evidence

CIR - Regional Intermanagement Commission

CONASEMS - National Council of Municipal Health Departments

CONASS - National Council of Health Secretaries

CONITEC - National Commission for the Incorporation of Technologies into the SUS

DD - Deliberative Dialogue

DECIT - Department of Science and Technology

EBM - Evidence-Based Medicine

EIDM - Evidence-Informed Decision Making

ENAP - National School of Public Administration

EPI - Evidence-Informed Policies

ESPIE Project - Support for the Institutionalization of Evidence-Informed Policies (EIP) in the SUS

HSL - Hospital Sírio-Libanês

IBAMA - Brazilian Institute of Environment and Renewable Natural Resources

IPEA - Institute of Applied Economic Research

KT - Knowledge Translation

M&E - Monitoring and Evaluation

MEDLINE - Medical Literature Analysis and Retrieval System Online

MS - Ministry of Health

NEv - Evidence Center

OSF - Open Science Framework

PRISMA - Preferred Reporting Items for Systematic Reviews and Meta-Analysis

SECTICS - Department of Science, Technology and Innovation and the Health Economic-Industrial Complex

SUS - Unified Health System

TR - Terms of Reference

VHL - Virtual Health Library

WHO - World Health Organization

1. Policy Brief

1.1. Key messages

The institutionalization of evidence-informed decision making (EIDM) in public health organizations remains an area requiring greater understanding.

Several factors are highlighted in the literature as barriers or facilitators for the institutionalization of EIDM, with monitoring and evaluation being fundamental in the implementation processes of Evidence-Informed Policies (EIP).

1.2. Context

The ESPIE project, 2024-2026, aims to support the institutionalization of EIDM in organizations of the Unified Health System (SUS).

Institutionalization is understood as a process that allows evidence to be seen as a legitimate instrument and become part of decision-making in health policies.

EIDM refers to the process in which evidence from research, local data, user and professional experiences are synthesized, translated, disseminated and applied in health policies and practices.

Among the project activities, the preparation of an implementation guide was planned, based on critical factors and indicators of EIP institutionalization.

A living evidence synthesis was produced from information obtained from global scientific literature, allowing the listing of the main critical factors, that is, barriers and facilitators involved in the institutionalization process, as well as indicators that can be used in monitoring and evaluating the progress achieved and limitations.

A deliberative dialogue was held to gather perceptions and suggestions from participants, both for improving the evidence synthesis and preparing the implementation guide.

1.3. Methods

The living evidence synthesis mapped the critical factors for sustainable processes of institutionalization of EIDM in public health organizations and the monitoring and evaluation indicators related to the implementation of EIP.

A comprehensive literature search was conducted across nine databases, as well as subject-related websites and reference lists of the studies included.

Study selection was performed independently, in duplicate, and disagreements were resolved by consensus. Data extraction was performed by individual reviewers and checked by another reviewer.

The extracted data, both from critical factors and indicators, were grouped into six dimensions:

Governance - which refers to functions related to rulemaking and guidance to achieve the institutionalization of EIPs, including institutionalized platforms that promote interaction and bridge the boundaries between research and policy.

Standardized and routinized processes - which are necessary to ensure high-quality knowledge translation products and processes that policymakers trust and are more likely to use.

Leadership and commitment - which includes legitimate leadership with capacity to influence the lasting adoption of EIP in organizations, through the allocation of resources or encouragement, support and guidance.

Resources - which implies having, in addition to financial resources, a critical mass of people skilled in applying knowledge translation in a routinary and consistent manner.

Partnerships, collective action and support - which are essential for ongoing, multi-stakeholder engagement in the same cause, joint problem-solving, identification of resources for knowledge translation and ongoing technical support.

Culture - which values the use of evidence in decision-making, allowing a collective understanding of what knowledge translation is, of the value it can bring, and what can be expected in terms of activities and benefits.

1.4. Key results

Twenty-four studies were included, of which twenty reported on critical factors, and six on indicators.

The critical factors and indicators are presented in the following elements within each of the dimensions.

Governance - It is important to consider competition in decision-making, the organizational context, communication tools, organizational management of EIPs, monitoring and evaluation, motivation for change and political relevance.

Elements	What is important to consider
Competition in decision making	Several aspects may hinder the implementation of EIDM, including organizational, political and strategic factors; financial and resource constraints; personal experience; common sense; experts' opinion; public and stakeholder pressure; community views and local competition.
Organizational context	The context in which knowledge is produced may differ from the context in which it will be applied, in terms of politics, culture and economy. Therefore, it is necessary to identify the possibilities of adapting evidence in each organization.
Communication tools	It is important to establish mechanisms and channels for effective and sustainable communication, both to build understanding in EIP and to share experiences between researchers and evidence users.
EIPs Organizational management	Implementing a knowledge management system involves the use, transfer and translation of information, and a long-term vision is necessary to ensure continuous learning.
Monitoring and evaluation	Noteworthy is the importance of measuring and improving organizational readiness for change, identifying measurable objectives and ensuring that evaluation measures reflect these objectives.
Motivation for change	It is necessary to invest in building and maintaining trust, motivating and organizing teams to incorporate research into practice.
Political relevance	Attention should be given to the relevance of evidence to policy needs, as well as cultural appropriateness, acceptability or applicability in practice.

Standardized and routinized processes - The following elements were included in this dimension: adequacy, presentation, delivery and information opportunity.

Elements	What is important to consider
Information adequacy	Practical constraints and excessive amounts of information should be considered, adapting the approach to the local context and using participatory formats.
Information presentation	Reach can be facilitated by summaries with key messages tailored to the target audience, in which the relevance of the results and the key factors to contextualize the evidence are clear.
Information delivery	In the information delivery process, active multi-component forms, targeted messages, educational visits and summaries stand out.
Information opportunity	There is a need for providing adequate knowledge at the time of decision-making, through the implementation of knowledge management in health organizations.

Leadership and commitment - Includes the elements of profile and involvement of leaders.

Elements	What is important to consider
Leaders' involvement	It is essential to involve opinion leaders to raise awareness and advocate for integrated solutions.
Leaders' profile	The necessary skills include writing and public speaking skills, as well as the capacity to extract added value from search engines and platforms.

Resources - It is related to the following elements: knowledge, skills and competences, organizational infrastructure, time constraints, training programs, sufficient human and financial resources.

Elements	What is important to consider
Knowledge	One of the barriers pointed out is the lack of knowledge or little familiarity with how to use research results and guideline recommendations.
Skills and competences	These include knowing how to search for, evaluate and interpret evidence. The barriers mentioned include limited digital skills, familiarity with databases and a low level of instruction in research methods.
Organizational infrastructure	It is important to consider political will and a well-established expansion strategy. Attention should be paid to the availability of and access to research, management and political support, and available material resources.
Time constraints	Time constraints, due to inadequate management, staff organization, workload density and labor shortages are factors that hinder the use of evidence.
Training programs	A policy or plan is needed for implementing a range of capacity building activities, including education in research, training in the use of specific technologies that support access to evidence, and understanding of effective KT strategies.
Human resources	The availability of human resources, in addition to the integration of librarians and health information experts in the organization, are factors that facilitate the use of evidence.

Elements	What is important to consider
Financial resources	There is a need to forecast budgets for research-related activities, considering intervention costs and other economic factors.

Partnerships, collective action and support – This refers to elements such as stakeholder engagement, tools and exchange structures, and collaborative processes.

Elements	What is important to consider
Stakeholders' involvement	This includes involving frontline staff and health managers in the design and development of research and mobilizing the civil society.
Tools and exchange structures	Participatory action structures based on the interactive exchange of knowledge and the use of mechanisms and networks for interaction and cooperation between knowledge producers and users, are of excellent value.
Collaborative processes	Initiatives may involve cross-sector and inter-agency learning, collaborative decision-making with other community organizations, multi-stakeholder dialogues, and partnerships of universities and research institutes with local leaders in charge of research.

Culture – This includes credibility of evidence, stakeholders' preferences, organizational difficulty in changing, alignment between research and policy, involvement of decision makers in research, and culture supporting the use of evidence.

Elements	What is important to consider
Alignment between research and policy	Attention should be paid to: research agendas, project selection criteria, possibilities of generalizing findings to other contexts, methodological rigor of research and stakeholders' involvement.
Credibility of evidence	Possible barriers include the lack of credibility of evidence, negative perceptions on the use of research as a bureaucratic and untimely process, the irrelevance of research and the unclear definition of evidence.
Culture of support for the use of evidence	Knowledge translation is enhanced when healthcare professionals have a positive perception of and identification with the organization.
Involvement of decision makers in research	Efforts should be made to involve stakeholders early in the research design and initiation process, and to foster exchange between researchers and health professionals by providing methodological support.
Stakeholders' preferences	It should be considered that preferences in choosing evidence vary according to the professional group, and that evidence can only be used to legitimize decisions already made.
Receptiveness to change	It is necessary to consider the culture of decision-making, motivation and awareness of evidence, and resistance to the introduction of new practices due to capacity restrictions.

2. Evidence synthesis[a]

2.1. Context

The institutionalization of evidence-informed decision making (EIDM) in public health organizations remains an area that requires greater understanding. This includes identifying the critical factors that influence this process and indicators for monitoring and evaluating the outcomes[1].

2.2. Concepts and definitions

Institutionalization - process and result of (re)creating, maintaining and reinforcing rules, regulations and standard practices that, based on collective meanings and values, actions, and resource allocation, allow evidence to become - over time - a legitimate instrument and part of decision-making in health policies[1].

Evidence-informed decision-making - process by which high-quality evidence from research, local data, users' and practitioners' experiences is synthesized, translated, disseminated and applied to decision-making in health policy and practice[2]. Related concepts include: use of evidence, turning evidence into action, evidence implementation, evidence diffusion, evidence-informed policymaking, knowledge uptake, knowledge mobilization, knowledge transfer, knowledge translation (KT), knowledge implementation, knowledge sharing, research use, research dissemination and translational research.

Critical factors for implementation - factors (e.g. barriers and facilitators) of organizational contexts, at distinct levels (micro, mezzo and macro), that influence the implementation of distinct types of institutionalization processes.

Indicators (monitoring and evaluation) - important decision-making tools used for analyzing the information available on corporate processes, and which contribute to knowledge of the organization's performance.

a - This version has been updated following the suggestions from the deliberative dialogue.

2.3. Objectives

i) Map critical factors for sustainable processes of institutionalization of evidence-informed decision-making in public health organizations, from the perspective of health systems and policies; and

ii) Propose a general framework to support the implementation processes of the institutionalization of evidence-informed decision-making, including the monitoring and evaluation of these processes.

2.4. Methods

This living evidence synthesis aims to inform a discussion to develop contextualized implementation guidelines for institutionalizing EIDM in public health organizations. The protocol was made available on the Open Science Framework (OSF) platform prior to the review[b]. The report is based on the Brazilian guideline for Evidence Syntheses for Health Policies[3] and PRISMA, in aspects relevant to this study[4].

2.4.1. CONSULTATION WITH INTERESTED PARTIES

Stakeholders were consulted during the development of the protocol. This approach sought to enhance the applicability of the results and facilitate the translation and dissemination of information obtained from the literature. To this end, the following stakeholders were consulted: (i) evidence stakeholders - health policy decision makers, health managers and health practitioners - to facilitate convergence between the research and practical decisions and processes, and to improve understanding of concepts and definitions related to critical factors in the institutionalization of EIDM; (ii) content stakeholders - EIDM experts - to verify the relevance of this synthesis and support the mapping of additional sources of evidence; (iii) methodology stakeholders, to support the planning, conduct and preparation of the study report regarding methodological aspects.

2.4.2. CRITERIA FOR INCLUSION OF STUDIES

The following guiding questions determined this synthesis:

(i) Which factors influence the institutionalization of EIDM in public health organizations, from the perspective of health systems and policies?

b - https://osf.io/rdzps/

(ii) Which dimensions/indicators can be used to monitor and evaluate progress and outcomes related to EIDM, from a health systems and policy perspective, in public health organizations?

Based on these guiding questions, the acronym "PCC" (Problem, Concept and Context) was used for structuring the search strategies for this synthesis (Table 1).

Table 1. *PCC acronym for matters of interest*

Component	Guiding question 1	Guiding question 2
Problem	Institutionalization of EIDM	Institutionalization of EIDM
Concept	Critical factors for institutionalization of EIDM	Dimensions and indicators for monitoring and evaluating the institutionalization of EIDM
Context	Public health management organizations (policy formulation and implementation)	Public health management organizations (formulation and implementation)

The inclusion criteria were: overviews of systematic reviews, systematic reviews, scoping reviews and reviews of qualitative studies that analyzed and/or described any information related to the guiding questions; documents, tools, institutional guidelines.

2.4.3. STUDY SEARCHES

A structured, sensitive and comprehensive literature search was conducted on 04/02/2024 (Appendix 1) in the following databases and research sources: Medical Literature Analysis and Retrieval System Online (MEDLINE, via PubMed); Virtual Health Library (VHL); Web of Science; Health Systems Evidence; Epistemonikos; EMBASE (via Elsevier); Campbell Collaboration; PDQ-Evidence; Google Scholar.

Unstructured searches were conducted in the following sources of evidence-informed policies: Agency for Healthcare Research and Quality - AHRQ/EUA[c]; Centre for Reviews and Dissemination, Service Delivery and Organization[d]; Cochrane Effective Practice and Organization of Care - EPOC[e]; European Observatory on Health Systems and Policies[f];

c - https://eurohealthobservatory.who.int/
d - https://www.york.ac.uk/crd/research/service-delivery/
e - https://epoc.cochrane.org/
f - https://eurohealthobservatory.who.int/

Evidence Informed Policy Network (EVIPNet); International Initiative for Impact Evaluation - 3ie[g]; The Alliance for Health Policy and Systems Research[h]; What Works Centres[i].

Additionally, manual searches were performed in the reference lists of the included studies and through access to gray literature sources.

No restrictions were imposed on date, language and publication status.

As this refers to a living evidence synthesis, searches are expected to be updated annually.

2.4.4. SELECTION OF STUDIES

The selection process was conducted by two groups of reviewers independently, applying a two-stage approach and using the Rayyan[5] platform. In the first stage, the titles and abstracts of the retrieved references were screened and subsequently classified as “potentially eligible” or “eliminated.” In the second stage, the reviewers assessed the full text of the “potentially eligible” references against the eligibility criteria for a final decision. A third group of reviewers resolved inconsistencies in the reviewers’ decisions.

2.4.5. DATA EXTRACTION

One group of reviewers extracted data from each included study, and a second group confirmed the accuracy of the extraction.

The following information was collected for each selected study: General information - author, year of publication, type of publication (article/report, full text/abstract), study design, source of funding and conflicts of interest; proposing institution (governmental, non-governmental, others). Guiding question addressed (1 and/or 2): critical factors for the institutionalization of EIDM, and monitoring and evaluation dimensions and indicators, were addressed.

2.4.6. CRITICAL EVALUATION

The methodological quality of the studies was not assessed, but a critical evaluation of the main content of the included studies was carried out by the reviewers, who considered the relevance of the content in light of the guiding questions and with the aim of proposing a

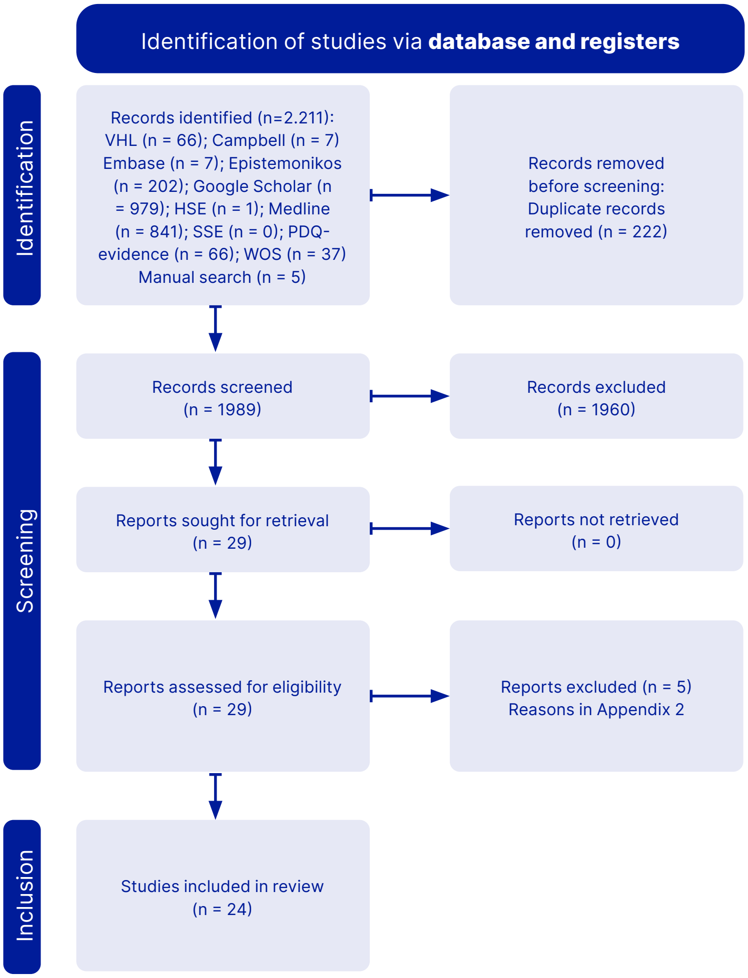
g - https://www.3ieimpact.org/
h - https://ahpsr.who.int/
i - https://www.gov.uk/guidance/what-works-network

conceptual framework for the institutionalization of EIDM, including monitoring and evaluation of the implementation processes.

2.5. Results

Out of the 2,169 records retrieved from the databases, 222 were excluded for being duplicates and 1,923 for reading of titles and abstracts. Of the 24 eligible reports read in full, three were excluded and 21 were included at this stage. Additionally, five systematic reviews were retrieved (four from reference lists and one from the website of the International Initiative for Impact Evaluation - 3ie), of which two were excluded. Thus, 24 articles were selected for data extraction and synthesis (Figure 1). The excluded studies and the reasons for exclusion are presented in Appendix 2.

Figure 1. Flowchart of the selection process, adapted from Page et al. (2021)[4]



2.5.1. GENERAL CHARACTERISTICS OF THE INCLUDED STUDIES

The 24 articles included[6-29] were published from 2011 to 2024. Table 2 presents some characteristics of these studies.

Regarding the design, the studies are referred to as scoping review (n=6), systematic review (n=6), literature or narrative review (n=3), rapid review (n=2), integrative review (n=1), overview (n=1), documentary review (n=1), in addition to qualitative studies (n=2), mixed methods study (n=1) and intervention study (n=1), preceded by literature reviews.

Eighteen studies focused only on critical factors, four addressed only indicators, and two reported both critical factors and indicators.

The critical factors analyzed are related to knowledge translation (KT), organizational context, collaboration between researchers and decision-makers, information dissemination tools or evidence dissemination, implementation, use of evidence in management, incorporation of research into practice, scaling of public health interventions and organizational culture.

The proposed or applied indicators refer to implementation, quality of KT, KT networks, KT infrastructure and capacity building, information systems and evaluation of program implementation.

Table 2. *General characteristics of the included studies*

Author, year	Design	Objective	Focus
Abu-Odah et al. (2021)[6]	Overview (5 systematic reviews, 4 narratives, 1 scoping review)	To synthesize existing literature to elucidate barriers and facilitators in translating health research into clinical practice	KT critical factors
Alsaqqa (2020)[7]	Literature review (58 articles)	To present a framework that incorporates diverse types of interconnected points of view, including coordination across various divisions of organizations, based on research in the healthcare context	Critical contextual factors of healthcare

Author, year	Design	Objective	Focus
Armstrong et al. (2013)[8]	Intervention study and implementation plan, based on a theoretical and narrative literature review, a systematic review of the effects of KT strategies, a research of local governments and a qualitative study of decision-making processes in local governments in Victoria, Australia	To describe the design and implementation plan of a knowledge translation intervention for public health decision-making in the local government	Implementation indicators
Becerril-Montekio et al. (2021)[9]	Scoping review (74 articles)	To identify terms, approaches, application and influence of collaboration between researchers and health system decision makers in the process of research on the use of evidence	Critical factors for collaboration between researchers and decision makers
Bhuiya et al. (2024)[10]	Scoping review (253 articles)	Identify quality indicators from existing tools that provide guidance on how to practice knowledge translation and implementation science (KT practice tools) across all KT domains (dissemination, implementation, sustainability and scalability)	Quality indicators on KT
Clar et al. (2011)[11]	Systematic review (54 articles)	To evaluate the effects of interventions to improve the uptake of research into health policies in low- and middle-income countries; to identify barriers and facilitators to the uptake of research evidence	Critical factors for the uptake of research evidence
Da Silva et al. (2022)[12]	Rapid review (2 articles)	To identify strategies to promote the use of tools (dashboards, tabulators, databases etc.) to disseminate information of interest for monitoring and evaluation in health systems and policies	Critical factors and indicators for the use of dissemination tools
Delnord et al. (2019)[13]	Scoping review (79 articles)	To identify key mechanisms and determinants of KT that could help monitor the impact of national health information systems	Critical factors and indicators of national health information systems

Author, year	Design	Objective	Focus
Dodd et al. (2019)[14]	Systematic review (24 articles)	To better understand the critical factors that facilitated the dissemination of scientific evidence across multiple phases of health policy formulation in Bangladesh	Critical factors of evidence dissemination
Doshmangir et al. (2022)[15]	Qualitative study, preceded by a systematic review (18 articles)	To review the interventions used for promoting the knowledge and skills of researchers and knowledge-producing organizations in the production and translation of evidence for policymaking and to explore interventions at the individual and institutional levels in the Iranian health system to strengthen EIDM.	Critical factors of KT
Harlos et al. (2012)[16]	Literature review and narrative synthesis (100 articles)	To synthesize management and healthcare literature to gain insights into implementing evidence-based changes in healthcare, drawn from sector-specific data	Critical factors of implementation
Humphries et al. (2014)[17]	Systematic review (14 articles)	To identify potential barriers and facilitators faced by managers in using evidence in program management in health organizations	Critical factors for using evidence in management
Kuchenmüller et al. (2022)[18]	Mixed methods in four phases: a targeted bibliographic review of KT networks, activities and indicators; two scoping reviews to refine the set of indicators; reviews by international KT experts and an online consultation with experts; piloting	To describe the development of a framework for monitoring and evaluating knowledge translation (KT) networks	KT network Indicators
Li et al. (2018)[19]	Integrative review (36 articles)	To identify the most commonly reported organizational contextual characteristics that influence the implementation of evidence-based practices in healthcare settings and describe how these characteristics affect implementation	Critical factors of organizational context

Author, year	Design	Objective	Focus
Milat et al. (2015)[20]	Narrative review (24 articles)	To synthesize evidence on scaling public health interventions into policies and practices for the entire population, with a focus on defining and describing frameworks, processes and methods for scaling public health initiatives	Critical factors for scaling interventions in public health
Oliver et al. (2014)[21]	Systematic review (145 articles)	To identify new barriers and facilitators regarding the use of evidence by policymakers and evaluate the state of research in this area	Critical factors in the use of evidence by policymakers
Ongolo-Zogo et al. (2014)[22]	Structured review of government documents (54 documents)	To evaluate whether and how the climate for evidence-based health system policymaking has changed before and after the establishment of two government-based Knowledge Translation Platforms in Cameroon and Uganda since 2006	Critical factors for change in organizational culture
Orton et al. (2011)[23]	Systematic review (18 articles)	To synthesize empirical evidence on the use of research evidence by public health decision-makers in settings with universal health systems	Critical factors in the use of evidence in universal health systems
Scarlett et al. (2020)[24]	Scoping review (32 articles)	To identify, synthesize and evaluate indicators used for evaluating KT infrastructure and capacity building activities in a health policy context in order to inform organizational knowledge intermediaries	KT infrastructure evaluation indicators and capacity building activities
Shafaghat et al. (2022)[25]	Systematic review (17 articles)	To develop a comprehensive framework for evidence-based decision making (EBDM)	Critical factors of evidence-based decision making
Shafaghat et al. (2021)[26]	Scoping review (49 articles)	To map potential facilitators and barriers to evidence-based management (EBM) in health systems to help health managers better implement EBM in their organizations	Critical factors of evidence-based management
Slade et al. (2018)[27]	Rapid review (16 articles)	To evaluate frameworks for incorporating research into routine healthcare practices as a basis for high-quality, safe, efficient, and consumer-focused care	Critical factors for incorporating research into routine practices in health services
Turner et al. (2017)[28]	Scoping review (31 articles)	To review the health literature on innovations in intensive and primary care, and to map processes at the professional, organizational and local system levels that influence how evidence informs decision-making about innovation	Critical factors of decision-making processes at the professional, organizational and local system levels

Author, year	Design	Objective	Focus
Witter et al. (2017)[29]	Qualitative study preceded by analysis of more than 170 different documents and literature review on 3DE	To evaluate if Demand-Driven Evaluations for Decisions (3DE) program model has been successful in supporting and increasing evidence-based policymaking, building capacity, and changing the behavior of Ministry staff.	Critical factors and indicators of the 3DE Program in Uganda and Zambia

Source: Own preparation.

2.5.2. CRITICAL FACTORS FOR THE INSTITUTIONALIZATION OF EIDM

Figure 2 presents the groupings of data extracted from the twenty articles in the following dimensions of the framework of Kuchenmüller et al. (2022)[1]: Governance; Standardized and routinized processes; Leadership and commitment; Resources; Partnerships, collective action and support; Culture.

Figure 2. Aggregated list of critical factors for the institutionalization of EIDM, according to six dimensions adapted from Kuchenmüller et al. (2022)[1].

Governance

- Competition in decision making
- Organizational context
- Communication tools
- Organizational management of EIPs
- Monitoring and evaluation
- Motivation for change
- Political relevance

Standardized and routinized processes

- Information adequacy
- Information presentation
- Information delivery
- Information opportunity

Leadership and commitment

- Involvement of leaders
- Leaders' profile

Resources

- Knowledge
- Skills and competences
- Organizational infrastructure
- Time constraints
- Training programs
- Human resources
- Financial resources

Partnerships, collective action and support

- Stakeholders' involvement
- Exchange tools and structures
- Collaborative processes

Culture

- Alignment between research and policy
- Credibility of evidence
- Culture of support for the use of evidence
- Involvement of decision makers in research
- Stakeholders' preferences
- Receptiveness to change

A summary of the groupings in each dimension is presented below. In Appendix 3, the information extracted from the studies is presented according to the categories of these groupings.

Governance Dimension

This refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP. Thus, the creation of institutionalized structures or platforms that not only increase the visibility of KT throughout the system, but also protect them from ad hoc changes in policy and contexts, is considered to be of great relevance[1]. The seven elements presented below refer to the grouping of information collected from 18 studies.

Competition in decision-making (n = 3)[13,22,23] - Competing influences can function as barriers, but they could be allies, such as the role of the media and social marketing campaigns. Competing influences may include organizational, political and strategic factors, financial and resource constraints, personal experience, common sense, experts' opinion, public and stakeholders' pressure, community views and local competition.

Organizational context (n= 4)[7,13,21,26] - The context in which knowledge is produced may differ from the context in which it is applied in terms of politics, culture and economics. Other factors relate to the existence of guidelines or policy statements, legal or legislative support. Facilitators include having clear scope and objectives, responsibility and accountability, strong leadership, organizational support, organizational culture, teamwork, collaboration and communication.

Communication tools (n=7)[6,11,12,13,15,23,27] - The studies address the importance of establishing mechanisms and channels for effective and sustainable communication, both to build understanding in EIP and to share experiences. Improved communication and sustained dialogue between researchers and end-users, and trust between researchers and policymakers should be considered. Dissemination and communication tools include health information-sharing platforms, newsletters and personal communications, using a variety of formats and technologies. The need for establishing more effective scientific communication to decision makers, as well as facilitating access to research repositories, is also discussed. The integration of specific program tools into one single platform and the automation of data management processes are considered as facilitators.

Organizational management of EIP (n=10)[6,713,14,17,20,22,26,28,29] - Implementing a knowledge management system involves the use, transfer and translation of information, and a long-term vision is necessary to ensure continuous learning. Therefore, preventive efforts against possible disruption as a result of employees' retirement and turnover should be considered. Key factors also include preventing organizational isolation, meeting user needs, accountability in the use of evidence, conflicts of interest, peer support, political context and windows of opportunity, appropriate planning processes, conflicting priorities, effective communication, senior management support and political will, corruption, public mismanagement and political influences. Facilitators include desire and political will, trust, awareness and recognized need for change, value and expectations. Broad application of accessible methods, intervention audit and evaluation, evidence-based management in the core process, workforce development, empowerment and capacity building should also be considered.

Monitoring and evaluation (n = 6)[13,14,19,20,25,29] - Active monitoring of KT interventions is highlighted in these studies, including the importance of measuring and improving organizational readiness for change. This includes identifying measurable objectives and ensuring that evaluation measures reflect these objectives. Evaluations should be participatory, involving all relevant stakeholders, and efforts must be guided by theory to identify and address the contextual factors that are more relevant to any specific intervention. Situational analysis, combined with experts' opinion and gap identification, and appropriate feedback mechanisms can benefit the implementation of evidence-based practices.

Motivation for change (n = 3)[6,13,27] - To overcome challenges at the micro level, motivation and interest in approaching and studying research results should be stimulated, with a focus on targeted communication of results. It is necessary to recognize multilevel processes (professional, organizational, local) and the interactions between these levels. Noteworthy is the importance of investing in building and maintaining trust, and in motivating and organizing teams to incorporate research into practice. Sustainable change requires research aligned with policies, regulatory laws, governance and organizational structures.

Political relevance (n = 4)[11,13,17,20] - Lack of relevance to political needs, lack of cultural appropriateness, and acceptability or applicability in practice are considered barriers. Thus, a greater understanding of the transferability and applicability of evidence-based recommendations from one setting to another is important. Research findings may be seen as incompatible with the complexity of the contexts in which they are intended to be applied.

Standardized and Routinized Processes Dimension

Standardized processes, including tools and protocols, are considered important to ensure high-quality KT products and processes that policymakers trust and that, therefore, they are more likely to use. Furthermore, when these processes are well documented, serving as institutional memory, they can facilitate the sustainability and institutionalization of KT1. Data from nine studies were grouped into the following categories.

Information adequacy (n = 5)[13,17,20,21,23] - The complex nature of some evidence-based therapies or guidelines can make them difficult to understand and implement. Undue focus on randomized controlled trials, high scientific uncertainty, low local applicability, lack of focus on social determinants of health, and lack of complexity to approach multicomponent health systems function as barriers. Therefore, practical constraints and excessive amounts of information should be considered, adapting the approach to the local context and using participatory formats. Clarity/relevance/reliability of research results are considered important. Research approaches should be effective, arise from sources that are seen as impartial and reliable, and provide methodological details so that rigor can be assessed.

Information presentation (n = 3)[13,21,23] - The way research evidence is presented influences the interest of readers, particularly decision-makers. Therefore, reach can be facilitated by summaries with key messages tailored to the target audience, in which the relevance of the results and the key factors to contextualize the evidence are clear. Packaging tools include methods of synthesis, as well as visualization of research results. Researchers should clearly summarize their main findings and align evidence with current and future policy settings. Evidence should identify indicators relevant to health goals and be designed in a way that it can be easily incorporated into colloquial/experiential/commonsense knowledge.

Information delivery (n = 3)[13,16,23] - Effective knowledge translation in health organizations depends on customization and delivery of messages that consider the roles of individuals, the organizational climate, structural characteristics, and hierarchical power patterns to initiate organizational change. In the information delivery process, active multicomponent forms, targeted messages, educational visits, and summaries stand out. The effectiveness of current knowledge transfer processes, the usefulness of models to improve decision-making, and the establishment of priorities and deadlines for decision-making are discussed.

Information opportunity (n = 5)[6,11,13,15,23] - The lack of timely research results and of rapidly available and adequately filtered information, incompatible deadlines for research and policy formulation are seen as barriers. Hence the need for providing adequate knowledge at the time of decision-making, through the implementation of knowledge management in health organizations.

Leadership and Commitment Dimension

Sustained use of evidence depends on strong charismatic leadership. Leaders have the capacity to influence the lasting adoption of EIP through resource allocation, encouragement, support and guidance[1]. Seven studies have approached this issue.

Involvement of leaders (n = 5)[11,13,14,19,25] - Having a champion who can support the idea of a new way of doing things has contributed to a more complete and refined use of guidelines. Involving opinion leaders is considered essential to raise awareness and advocate for integrated solutions.

Leaders' profile (n=4)[13,19,27,28] - Leaders are often seen as providers of new knowledge and key influencers in the implementation of new initiatives. The competences required include writing and public speaking skills, as well as the capacity to extract added value from search engines and platforms.

Resources Dimension

Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP1. In this dimension, data from 17 studies were grouped.

Knowledge (n = 3)[6,13,22] - One of the barriers highlighted in the studies is the lack of knowledge or little familiarity with how to use research results and guideline recommendations.

Skills and competences (n=6)[6,12,13,17,21,23] - Insufficient skills and competences are a major barrier to implementing scientific evidence. These include difficulties in finding, evaluating and interpreting evidence, including limited digital skills and familiarity with databases, and low literacy in research methods. It is important to consider policymakers' research skills and research awareness. Policymakers may not have been supported to acquire the necessary skills or to use research evidence. Thus, it is worth considering specializing in data tasks, either by delegating them to specifically trained people, or by dedicating time for data-related tasks.

Organizational infrastructure (n=12)[6,11,12,13,15,17,20,21,23,25,26,27] - Another barrier approached in the studies is insufficient organizational resources, such as materials and equipment needed to access applicable research evidence, databases, and clinical decision support systems. Insufficient investment in implementation infrastructures, such as information systems, monitoring and evaluation, recruitment, and staff turnover, contribute to this scenario. Therefore, infrastructure to support implementation, including training, delivery systems, technical resources, strong leadership and advocates, provision of appropriate tools and devices, incentives and training for decision makers, significant time allocated to evidence-based management and timely interpretation of data, and adequate human resources, act as facilitators. It is also important to consider political will and a well-established expansion strategy. Attention should be given to the availability of and access to research, management and political support, and available material resources. Research evidence should be made more widely available to decision makers using email newsletters, professional public health organizations, or clearinghouses.

Time constraints (n=6)[6,13,17,27,28,29] - Time constraints due to inadequate management, staff organization, workload density, and labor shortages are factors that hinder the use of evidence, as well as monitoring and evaluation.

Capacity-building programs (n=9)[6,11,13,15,16,17,19,23,25] - Considering the barriers highlighted by the studies, it is necessary to have a policy or plan to implement various capacity-building activities, including research training, training in the use of specific technologies that support access to evidence, and understanding of effective KT strategies. In addition, the health system needs to strengthen its strategic capacity to facilitate an educational and training culture to motivate researchers to produce evidence suitable for policymakers. Mentoring as a means of training also supports knowledge translation, if power relations do not inhibit interpersonal exchange. Capacity building is also important to increase the researchers' abilities to effectively produce and disseminate evidence useful to decision-makers.

Human resources (n=6)[11,13,17,19,20,21] - Availability of staff or personnel resources, and staff turnover/continuity of employment may be barriers. The availability of human resources, in addition to the integration of librarians and health information experts in the organization, are factors that facilitate the use of evidence.

Financial resources (n=9)[6,11,12,13,17,20,21,23,28] - It is important that the resources allocated to ensure participation in evidence-based programs are not limited by financial barriers. There is a need for providing budgets for research-related activities, considering intervention costs and other economic factors. Funding should be provided for longitudinal and long-term research.

Partnerships, Collective Action and Support Dimension

Interaction among stakeholders is of great relevance for the institutionalization of EIPs, since partnerships provide a mechanism for continuous and diverse engagement around the same cause, joint problem-solving, identification of resources for KT and technical support[1]. This issue was addressed in 13 studies.

Stakeholders' involvement (n=4)[12,13,14,25] - There are still just a few organizations that involve users or the general audience in KT activities. Stakeholders' involvement in decision-making should be considered. This includes involving frontline staff and health managers in the design and development of research and mobilizing civil society. Authority structures and the dynamics of the relationship between data producers and users influence the regularity of evaluations and the use of data.

Exchange tools and structures (n=3)[13,14,19] - Connection and exchange tools, such as knowledge networks, facilitate the dissemination of health information and the likelihood of translating research evidence into policies. Participatory action structures based on interactive knowledge exchange, the use of mechanisms and networks for effective interaction, and cooperation between knowledge producers and users are of great value.

Collaborative processes (n=10)[6,11,12,13,16,17,21,26,27,28] - Knowledge translation capacity in health organizations is built through the coordination of institutional and individual networks within and between organizational units, which can function as vehicles for dissemination. Collaboration, timing/opportunity, and relationships with policymakers, researchers, and information staff should be considered. External facilitators refer to the importance and encouragement of the use of scientific evidence, interaction between researchers and decision-makers, support from the academic community and other stakeholders. It is important to develop collaboration and robust connections between researchers and decision-makers. Initiatives may involve intersectoral and interagency learning, collaborative decision-making with other community organizations, multi-stakeholder dialogues, and partnerships of universities and research institutes with local leaders responsible for research.

Culture Dimension

This refers to basic values, assumptions, artifacts and beliefs that are considered valid, and are disseminated and promoted as daily practices. Culture allows a collective understanding of what KT is, what value it can bring, and what can be expected in terms of activities and benefits[1]. Fifteen studies approached aspects of this dimension.

Research-policy alignment (n=6)[6,11,13,17,23,29] - Barriers include lack of perception of research-policy alignment or integration, limited involvement of decision-makers in the research process, and mutual distrust between researchers and potential users of evidence. Decision-makers may perceive a lack of research evidence and have negative perceptions of available research evidence. Attention should be paid to research agendas, project selection criteria, possible generalization of findings to other contexts, methodological rigor of research, and stakeholders' engagement.

Credibility of evidence (n=4)[6,7,13,17] - Organizations face new dynamics of diverse cultures and situations in their settings, and managers are needed to make the right choices. However, the selection of information sources by decision-makers is often determined by availability rather than quality, and questions may arise about the usefulness of research results. Among barriers, lack of credibility of evidence, negative perceptions of the use of research as a bureaucratic and untimely process, irrelevance of research, and unclear definition of evidence are mentioned.

Supportive culture for the use of evidence (n = 5)[13,16,17,19,25] - The key to effective knowledge translation in health organizations is the support to innovation, fostered by obvious reasons for organizational change, open exchange despite power differences, and employee engagement. Knowledge translation is enhanced when healthcare professionals perceive and identify themselves positively with the organization. In this process, a supportive culture for the use of evidence, organizational openness to testing innovations and a culture of learning, as well as staff perseverance and resilience, are essential.

Involvement of decision-makers in research (n=8)[6,9,11,13,14,17,27,28] – Stakeholders' participatory processes positively influence the incorporation of innovation evidence. Efforts should be made to involve stakeholders early in the process of conceiving and initiating research, foster exchange between researchers and health professionals by providing methodological support and reporting clinical experiences, identifying social barriers to change users' behavior, create local ethics committees, and promote engagement and training of leaders and managers.

Stakeholder preferences (n = 2)[13, 28] - It is important to recognize users' needs, preferences and adherence to treatment when these interfere with evidence-based recommendations. In addition, it should be considered that preferences in the choice of evidence vary according to the professional group, and that evidence can only be used to legitimize decisions already made.

Receptivity to change (n = 5)[7,13,20,23,28] - Each institution's structures and processes represent a unique organizational setting, including the way they operate. These structures and processes are, either jointly or individually, capable of promoting or hindering discrete actions in terms of provisions for adopting and applying evidence. Decision-makers may be in an environment where collecting and evaluating research is seen as "non-work." Attention must be paid to the culture of decision-making, motivation and awareness of evidence, and resistance to the introduction of new practices due to capacity constraints.

2.5.3. INDICATORS OF MONITORING AND EVALUATION OF KNOWLEDGE TRANSLATION

Of the 24 studies included in the summary, six approach monitoring and evaluation (M&E) indicators of the implementation and/or institutionalization of KT8,10,12,13,18,24 (Table 3). The focus of all studies is KT and, in one of them, this focus is directed towards evidence-informed decision-making - EIDM8. In another study[13], KT essential mechanisms and determinants are presented to monitor the impact of health information systems - IS.

Although only six studies specifically address M&E indicators, the discussion therein is well developed, providing a set of information sufficient for a quality discussion on the subject.

On the other hand, it is important to note that studies that do not specifically address M&E can, in a certain way, be reinterpreted to obtain indicators. Thus, a critical factor for both KT and EIDM can serve as a focus for developing M&E indicators.

The studies approach the monitoring and/or evaluation of KT through qualitative parameters. One of them[24] approaches both qualitative and quantitative parameters. The quantitative dimension of this study is characterized by simple wording, focused on frequencies or rates. In this or other studies, there is no composite indicator, consisting of variables that, when associated, may or may not indicate a certain pattern.

M&E indicators are presented through categorizations, that is, groupings of aspects, ideas or actions/activities that have an affinity with each other. Some authors combine two categorizations to propose M&E indicators. For example, Bhuiya et al. (2023)[10] list indicators related to four categories (development, evaluation, adaptation and involvement of the user of knowledge) and represented by four KT domains (dissemination, implementation, sustainability and scalability). Another study[8] combines KT activities/components (customized organizational support, group training, targeted communication and evidence summaries) with levels of evidence-informed decision-making (individual level, organizational level and system level).

M&E indicators, as well as the critical factors related to EIDM, were synthesized into six dimensions proposed by Kuchenmüller et al. (2022)[1]: Governance; Standardized and routinized processes; Leadership and commitment; Resources; Partnerships, collective action and support; Culture.

Table 3. Aggregated list of EIDM M&E indicators

Dimensions	Indicators
Governance	Applicability of research in decision making[24] Increased demand for or value of KT products or knowledge by policymakers[24] Context of use of evidence[12] Researcher's feedback on project alignment with priorities[24] Improvements in health status and equity resulting from EIDM18 Improvements to health systems policies resulting from EIDM18 Changes in policies or programs consistent with the evidence produced and greater availability of research evidence - relevant and understandable - aimed at policymakers[24] Quality and frequency of the organization's demand for evidence[12] Assistance at the individual level - Support to increase team confidence, skills and access[8] Organizational-level support to enhance the culture of evidence-informed decision-making within the public health team and promote the use of evidence by the public health team[8],24 Use of participatory approaches[10]
Standardized and routinized processes	Capacity to evaluate the sustainability and/or scalability potential of Knowledge Translation tools - Adoption of a method to evaluate the implementation, sustainability and/or scalability potential[10] Capacity to identify the stakeholders' need for information 10,12,13 Capacity to identify equity considerations[10] Capacity to monitor, evaluate and communicate the results of evidence-based interventions[12,24] Capacity to systematically summarize knowledge - Conducting a non-systematic knowledge synthesis process as part of the process of developing a practical Knowledge Translation tool[10] Targeted communication - sending materials, such as recent publications of scientific studies or reviews, and publicizing upcoming conferences and events, as well as training opportunities[8] Conducting iterative processes - Processes to refine practical Knowledge Translation tools based on feedback and relevant information[10] Expertise in practical Knowledge Translation tools[10] Inclusion of reflexivity and/or critical reflection - A description of the developer's reflexivity and/or critical reflection that may impact Knowledge Translation development[10] Number of projects leading/expecting to change behavior and progressive elimination of external financing[24] Percentage of papers submitted for publication[24] Using theory to inform the creation of the practical Knowledge Translation tool[10]

Dimensions	Indicators
Leadership and commitment	Evaluation of team engagement with evidence[24] Customized organizational support - Monthly contact between the program leader and employees via telephone[8]
Resources	Increasing the capacity of national teams through activities[18] Increasing Knowledge Translation capacity among external stakeholders[18] Increasing Knowledge Translation practice and production/availability of products by national teams[18] Percentage increase in pre/post skills scores for training and contribution to decision-making by partners and policymakers[24] Capacity to evaluate determinants - Use of qualitative approaches or mixed methods to evaluate the determinants (barriers and facilitators) of the use of Knowledge Translation in a specific context[10] Knowledge Translation (KT) capacity and skill building[18] Essential skills for using data[12] Data availability[12] Online availability of website or evidence database[24] Participant's experience with evidence-based policymaking[24] Input Indicators: Structure, Financial resources, Human resources, Effective management, Technical assistance[18] Changes in government-allocated funding[24] Number/percentage of trainees reporting the intention to use the acquired competences[24] Data quality/Evidence[12],13 Periodic group training in a central location with a modular approach to cover the principles of evidence-informed public health, formulation of answerable questions, search for evidence, trust, applicability analysis, transferability and evaluation, and activities designed to encourage networking between councils[8] Use of KT products by national teams and external stakeholders[18] Systematic and routine use of evidence in public policy development[18]

Dimensions	Indicators
Partnerships, collective action and support	Acceptance and/or influences of evidence and financial and organizational support to knowledge transfer partnerships[24] Application of shared user-centered design process[10] Increased trust and openness among partners[24] Increased joint activity around the project[24] Involvement of users and evidence producers[10],12,13 Number/percentage of members present at activities - Hiring of external consultants - Hiring of external organizations and/or teams[10] Development of evidence syntheses in partnerships with other institutions[8] Feedback on knowledge and perceptions of the network and sustainability of the partnerships built[24] Identifying knowledge users for engagement[10] Number of knowledge transfer partnerships[24] Number of projects involving users[24] Regular occurrence of political dialogues on priority issues and KT activities considered beneficial to bring stakeholders together and facilitate the development of partnerships[24] Partners' opinions on the use of research results[24] Production of collaborative activities and stakeholders[18] Production of research projects with policymakers[24] Production of research projects with policymakers; opinions of partners on the use of research results[24] Promotion of driving, engagement, exchange and integrative efforts around KT24 Use of participatory approaches[10]
Culture	Increased interest in research among local young people[24] Increased use of evidence and EIDM values by policymakers, the media and society[18],24 Organizational culture to promote and use research results for decision-making[24] Culture to promote and use research results in decision making, and feedback on context/culture[24] Institutionalization of sustainable EIDM18 Lessons learned from program evaluation - Using lessons learned or evaluating previously implemented interventions, innovations or programs to inform development - Sustainability and Scalability[10] Changes in policies or programs consistent with the evidence produced[24] Level of institutional commitment to EIDM18 Number of products related to organizational climate[24]

Source: Dimensions adapted from Kuchenmüller et al. (2022)[1].

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2.7. Appendices

Appendix 1. Search strategies conducted on 04/02/2024

- #1 Evidence-informed decision making (EIDM) / EIP
- #2 Institutionalization
- #3 Public health management organizations
- #4 #1 AND #2 AND #3
- #5 Critical factors / organizational factors / organizational arrangements
- #6 Indicators / monitoring / evaluation
- #7 #5 OR #6
- #8 #4 AND #7

Search strategies

Database	Search strategy	Results
Virtual Health Library (VHL)	#1 "Evidence-informed Decision-making" OR "Evidence Informed Decision Making" OR "Evidence-informed Decision" OR "Evidence Informed Decision" OR "Evidence-based Decision-making" OR "Evidence Based Decision Making" OR "Evidence Based Policymaking" OR "Evidence-based Decision" OR "Evidence Based Decision" OR MH:"Política Informada por Evidências" OR MH:"Política Informada por la Evidencia" OR MH:"Evidence-Informed Policy" OR "Política Informada por Evidências" OR "Política Informada por la Evidencia" OR "Evidence-Informed Policy" OR "Política Baseada em Evidências" OR "Políticas Baseadas em Evidência" OR "Política Baseada em Evidência" OR "Políticas Informadas por Evidência" OR "Política Informada por Evidência" OR "Políticas Informadas por Evidências" OR "Evidence-Based Policy" OR "Evidence-Informed Policies" OR "Evidence Informed Policy" OR "Evidence Informed Policies" OR "Evidence Based Policy" OR "Evidence-based Policies" OR "Evidence Based Policies" OR "Políticas Basadas en Evidencias" OR "Política Basada en Evidencias" OR "Políticas Informadas por Evidencias" OR "Política Informada por Evidencias" OR "Política Basada en la Evidencia" OR "Políticas Informadas por la Evidencia" OR MH:SH1.010.010.005* OR "Evidence-to-policy" OR "Evidence to Policy" OR "Research-to-policy" OR "Research to Policy" OR "Knowledge Translation" OR "Knowledge Use" OR "Evidence Use" OR "Research Use" OR "Knowledge Transfer" OR "Research Utilization" OR "Research Utilisation" OR "Knowledge Utilization" OR "Knowledge Utilisation" OR "Evidence Utilization" OR "Evidence Utilisation" OR "Knowledge Broker" OR "Knowledge Broking" OR "Knowledge Dissemination" OR "Evidence Dissemination" OR "Research Dissemination" OR "Knowledge Exchange" OR "Knowledge Mobilisation" OR "Knowledge Mobilization"	66
	AND	
	MH:"Avaliação do Impacto na Saúde" OR MH:"Evaluación del Impacto en la Salud" OR MH:"Health Impact Evaluation" OR "Avaliação do Impacto na Saúde" OR "Evaluación del Impacto en la Salud" OR "Health Impact Evaluation" OR "Health Impact Evaluations" OR MH:E05.318.308.237* OR MH:N03.349.380.210.500* OR "Critical Factor" OR "Critical Factors" OR "Key-factor" OR "Key Factor" OR "Key-factors" OR "Key Factors" OR "Organizational Factors" OR "Organizational Factor" OR "Organizational Factors" OR "Organizational Factor" OR "Organizational Arrangement" OR "Organizational Arrangements" OR "Organizational Arrangement" OR "Organizational Arrangements" OR "Indicators" OR "Indicator" OR "Monitor" OR "Monitoring"	
	AND	

Database	Search strategy	Results
	MH:"Tomada de Decisões Gerenciais" OR MH:"Toma de Decisiones en la Organización" OR MH:"Decision Making, Organizational" OR "Tomada de Decisões Gerenciais" OR "Toma de Decisiones en la Organización" OR "Decision Making, Organizational" OR "Decisões Administrativas" OR "Tomada de Decisões Institucionais" OR "Tomada de Decisões Empresariais" OR "Tomada de Decisões Administrativas" OR "Decisões Gerenciais" OR "Decisão Gerencial" OR "Decisão Administrativa" OR "Organizational Decision Making" OR "Organisational Decision Making" OR "Toma de Decisiones en la Empresa" OR "Toma de Decisiones Organizacionales" OR "Toma de Decisiones Institucionales" OR "Toma de Decisiones Gerenciales" OR "Toma de Decisiones Empresariales" OR "Toma de Decisiones Administrativas" OR MH:N04.452.190* OR MH:SP4.707.368.630.638* OR MH:"Política Organizacional" OR MH:"Política Organizacional" OR MH:"Organizational Policy" OR "Política Organizacional" OR "Política Organizacional" OR "Organizational Policy" OR "Política Institucional" OR "Organizational Policies" OR "Institutional Policy" OR "Institutional Policies" OR "Organisational Policy" OR "Organisational Policies" OR MH:I01.655.500.550* OR MH:I01.880.604.825.550* OR MH:N03.623.500.550* OR MH:"Cultura Organizacional" OR MH:"Organizational Culture" OR "Cultura Organizacional" OR "Organizational Culture" OR "Organizational Cultures" OR "Organisational Culture" OR "Organisational Cultures" OR MH:N04.452.606* OR MH:"Administração em Saúde Pública" OR MH:"Administración en Salud Pública" OR MH:"Public Health Administration" OR "Administração em Saúde Pública" OR "Administración en Salud Pública" OR "Public Health Administration" OR "Avaliação de Ações de Saúde Pública" OR MH:N04.452.794* OR MH:SP1.101.300* OR MH:"Administração de Serviços de Saúde" OR MH:"Administración de los Servicios de Salud" OR MH:"Health Services Administration" OR "Administração de Serviços de Saúde" OR "Administración de los Servicios de Salud" OR "Health Services Administration" OR "Gerência de Serviços de Saúde" OR "Gestão dos Serviços de Saúde" OR "Gestão de Serviços de Saúde" OR "Gerência dos Serviços de Saúde" OR "Health Service Administration" OR "Gestión de los Servicios de Salud" OR "Gestión de Servicios de Salud" OR "Gerencia de los Servicios de Salud" OR "Gerencia de Servicios de Salud" OR MH:H02.269* OR MH:N04* OR MH:SP1.101.150*	
	AND	
	NOT MEDLINE	

Database	Search strategy	Results
Campbell Collaboration	#1 Anywhere: "Evidence-informed Decision-making" OR "Evidence Informed Decision Making" OR "Evidence-informed Decision" OR "Evidence Informed Decision" OR "Evidence-based Decision-making" OR "Evidence Based Decision Making" OR " Evidence Based Policymaking" OR "Evidence-based Decision" OR "Evidence Based Decision" OR "Evidence-informed Policy" OR "Evidence Informed Policy" OR "Evidence-informed Policies" OR "Evidence Informed Policies" OR "Evidence-based Policy" OR "Evidence Based Policy" OR "Evidence-based Policies" OR "Evidence Based Policies" OR "Evidence-to-policy" OR "Evidence to Policy" OR "Research-to-policy" OR "Research to Policy" OR "Knowledge Translation" OR "Knowledge Use" OR "Evidence Use" OR "Research Use" OR "Knowledge Transfer" OR "Research Utilization" OR "Research Utilization" OR "Knowledge Utilization" OR "Knowledge Utilization" OR "Evidence Utilization" OR "Evidence Utilization" OR "Knowledge Broker" OR "Knowledge Broking" OR "Knowledge Dissemination" OR "Evidence Dissemination" OR "Research Dissemination" OR "Knowledge Exchange" OR "Knowledge Mobilization" OR "Knowledge Mobilization" #2 Anywhere: "Health Impact Evaluation" OR "Health Impact Evaluations" OR "Critical Factor" OR "Critical Factors" OR "Key-factor" OR "Key Factor" OR "Key-factors" OR "Key Factors" OR "Organizational Factors" OR "Organizational Factor" OR "Organizational Factors" OR "Organizational Factor" OR "Organizational Arrangement" OR "Organizational Arrangements" OR "Organizational Arrangements" OR "Indicators" OR "Indicator" OR "Monitor" OR "Monitoring" #3 Anywhere: "Decision Making, Organizational" OR "Organizational Decision Making" OR "Organizational Decision Making" OR "Organizational Policy" OR "Organizational Policies" OR "Organizational Policy" OR "Organizational Policies" OR "Institutional Policy" OR "Institutional Policies" OR "Organizational Culture" OR "Organizational Culture" OR "Organizational Cultures" OR "Organizational Cultures" OR "Public Health Administration" OR "Health Services Administration" OR "Health Service Administration"	7

Database	Search strategy	Results
EMBASE (via Elsevier)	#1 'Evidence-informed Decision-making' OR 'Evidence Informed Decision Making' OR 'Evidence- informed Decision' OR 'Evidence Informed Decision' OR 'Evidence-based Decision-making' OR 'Evidence Based Decision Making' OR 'Evidence Based Policymaking' OR 'Evidence-based Decision' OR 'Evidence Based Decision' #2 'Evidence-informed Policy' OR 'Evidence Informed Policy' OR 'Evidence-informed Policies' OR 'Evidence Informed Policies' OR 'Evidence-based Policy' OR 'Evidence Based Policy' OR 'Evidence-based Policies' OR 'Evidence Based Policies' #3 'Evidence-to-policy' OR 'Evidence to Policy' #4 'Research-to-policy' OR 'Research to Policy' #5 'Knowledge Translation' OR 'Knowledge Use' OR 'Evidence Use' OR 'Research Use' OR 'Knowledge Transfer' OR 'Research Utilization' OR 'Research Utilisation' OR 'Knowledge Utilization' OR 'Knowledge Utilisation' OR 'Evidence Utilization' OR 'Evidence Utilisation' OR 'Knowledge Broker' OR 'Knowledge Broking' OR 'Knowledge Dissemination' OR 'Evidence Dissemination' OR 'Research Dissemination' OR 'Knowledge Exchange' OR 'Knowledge Mobilisation' OR 'Knowledge Mobilization' #6 #1 OR #2 OR #3 OR #4 OR #5 #7 'Health Impact Evaluation'/exp OR 'Health Impact Evaluation' OR 'Evaluation, Health Impact' OR 'Evaluations, Health Impact' OR 'Health Impact Evaluations' OR 'Impact Evaluation, Health' OR 'Impact Evaluations, Health' #8 'Critical Factor' OR 'Critical Factors' OR 'Key-factor' OR 'Key Factor' OR 'Key-factors' OR 'Key Factors' #9 'Organizational Factors' OR 'Organizational Factor' OR 'Organisational Factors' OR 'Organisational Factor' OR 'Organizational Arrangement' OR 'Organizational Arrangements' OR 'Organisational Arrangement' OR 'Organisational Arrangements' #10 'Indicators' OR 'Indicator' #11 'Monitoring'/exp OR 'Monitoring' OR 'Monitor' #12 #7 OR #8 OR #9 OR #10 OR #11 #13 'Organizational Decision Making'/exp OR 'Decision Making, Organisational' OR 'Decision Making, Organizational' OR 'Institutional Decision Making' OR 'Organisational Decision Making' OR 'Organizational Decision Making' #14 'Organizational Policy'/exp OR 'Institutional Policy' OR 'Organisational Policies' OR 'Organisational Policy' OR 'Organizational Policies' OR 'Organizational Policy' OR 'Policies, Organizational' OR 'Policy, Organizational' OR 'Policies, Organisational' OR 'Policy, Organisational' OR 'Policies, Institutional' OR 'Policy, Institutional' OR 'Institutional Policies' #15 'Organizational Culture'/exp OR 'Organisation Culture' OR 'Organisational Culture' OR 'Organization Culture' OR 'Organizational Culture' OR 'Organizational Cultures' OR 'Organisational Cultures' #16 'Public Health Administration' OR 'Administration, Public Health' #17 'Health Services Administration' OR 'Administration, Health Services' OR 'Health Service Administration' OR 'Administration, Health Service' #18 #13 OR #14 OR #15 OR #16 OR #17 #19 #6 AND #12 AND #18 #20 #19 AND [embase]/lim NOT ([embase]/lim AND [medline]/lim)	7

Database	Search strategy	Results
Epistemonikos	#1 Title/abstract: (Evidence Informed Decision Making) OR (Evidence Informed Decision) OR (Evidence Based Decision Making) OR (Evidence Based Policymaking) OR (Evidence Based Decision) OR (Evidence Informed Policy) OR (Evidence Based Policy) OR (Evidence to Policy) OR (Research to Policy) OR (Knowledge Translation) OR (Knowledge Use) OR (Evidence Use) OR (Research Use) OR (Knowledge Transfer) OR (Research Utilization) OR (Research Utilisation) OR (Knowledge Utilization) OR (Knowledge Utilisation) OR (Evidence Utilization) OR (Evidence Utilisation) OR (Knowledge Dissemination) OR (Evidence Dissemination) OR (Research Dissemination) OR (Knowledge Exchange) OR (Knowledge Mobilisation) OR (Knowledge Mobilization) #2 Title/abstract: (Health Impact Evaluation) OR (Critical Factor) OR (Key Factor) OR (Organizational Factor) OR (Organisational Factor) OR (Organizational Arrangement) OR (Organisational Arrangement) OR Indicators OR Indicator OR Monitor OR Monitoring #3 Title/abstract: (Organizational Decision Making) OR (Organisational Decision Making) OR (Organizational Policy) OR (Organisational Policy) OR (Institutional Policy) OR (Organizational Culture) OR (Organisational Culture) OR (Public Health Administration) OR (Health Service Administration)	202
Google Scholar	(“Evidence Informed Decision Making” OR “Evidence Informed Decision” OR “Evidence Based Decision Making” OR “Evidence Based Policymaking” OR “Evidence Based Decision” OR “Evidence Informed Policy” OR “Evidence Based Policy” OR “Evidence to Policy”) AND (“Organizational Decision Making” OR “Organisational Decision Making” OR “Organizational Policy” OR “Organisational Policy” OR “Institutional Policy” OR “Organizational Culture” OR “Organisational Culture” OR “Public Health Administration” OR “Health Service Administration”)	989

Database	Search strategy	Results
Health Systems Evidence	("Evidence-informed Decision-making" OR "Evidence Informed Decision Making" OR "Evidence- informed Decision" OR "Evidence Informed Decision" OR "Evidence-based Decision-making" OR "Evidence Based Decision Making" OR "Evidence Based Policymaking" OR "Evidence-based Decision" OR "Evidence Based Decision" OR "Evidence-informed Policy" OR "Evidence Informed Policy" OR "Evidence-informed Policies" OR "Evidence Informed Policies" OR "Evidence- based Policy" OR "Evidence Based Policy" OR "Evidence-based Policies" OR "Evidence Based Policies" OR "Evidence-to-policy" OR "Evidence to Policy" OR "Research-to-policy" OR "Research to Policy" OR "Knowledge Translation" OR "Knowledge Use" OR "Evidence Use" OR "Research Use" OR "Knowledge Transfer" OR "Research Utilization" OR "Research Utilisation" OR "Knowledge Utilization" OR "Knowledge Utilisation" OR "Evidence Utilization" OR "Evidence Utilisation" OR "Knowledge Broker" OR "Knowledge Broking" OR "Knowledge Dissemination" OR "Evidence Dissemination" OR "Research Dissemination" OR "Knowledge Exchange" OR "Knowledge Mobilisation" OR "Knowledge Mobilization") AND ("Health Impact Evaluation" OR "Health Impact Evaluations" OR "Critical Factor" OR "Critical Factors" OR "Key-factor" OR "Key Factor" OR "Key-factors" OR "Key Factors" OR "Organizational Factors" OR "Organizational Factor" OR "Organisational Factors" OR "Organisational Factor" OR "Organizational Arrangement" OR "Organizational Arrangements" OR "Organisational Arrangements" OR "Indicators" OR "Indicator" OR "Monitor" OR "Monitoring") AND ("Decision Making, Organizational" OR "Organizational Decision Making" OR "Organisational Decision Making" OR "Organizational Policy" OR "Organizational Policies" OR "Organisational Policy" OR "Organisational Policies" OR "Institutional Policy" OR "Institutional Policies" OR "Organizational Culture" OR "Organisational Culture" OR "Organizational Cultures" OR "Organisational Cultures" OR "Public Health Administration" OR "Health Services Administration" OR "Health Service Administration")	1

Database	Search strategy	Results
Medical Literature Analysis and Retrieval System Online (MEDLINE, via PubMed)	#1 "Evidence-informed Decision-making" OR "Evidence Informed Decision Making" OR "Evidence-informed Decision" OR "Evidence Informed Decision" OR "Evidence-based Decision- making" OR "Evidence Based Decision Making" OR "Evidence Based Policymaking" OR "Evidence-based Decision" OR "Evidence Based Decision" #2 "Evidence-informed Policy" OR "Evidence Informed Policy" OR "Evidence-informed Policies" OR "Evidence Informed Policies" OR "Evidence-based Policy" OR "Evidence Based Policy" OR "Evidence-based Policies" OR "Evidence Based Policies" #3 "Evidence-to-policy" OR "Evidence to Policy" #4 "Research-to-policy" OR "Research to Policy" #5 "Knowledge Translation" OR "Knowledge Use" OR "Evidence Use" OR "Research Use" OR "Knowledge Transfer" OR "Research Utilization" OR "Research Utilisation" OR "Knowledge Utilization" OR "Knowledge Utilisation" OR "Evidence Utilization" OR "Evidence Utilisation" OR "Knowledge Broker" OR "Knowledge Broking" OR "Knowledge Dissemination" OR "Evidence Dissemination" OR "Research Dissemination" OR "Knowledge Exchange" OR "Knowledge Mobilisation" OR "Knowledge Mobilization" #6 #1 OR #2 OR #3 OR #4 OR #5 #7 "Health Impact Evaluation"[Mesh] OR "Health Impact Evaluation" OR "Health Impact Evaluations" #8 "Critical Factor" OR "Critical Factors" OR "Key-factor" OR "Key Factor" OR "Key-factors" OR "Key Factors" #9 "Organizational Factors" OR "Organizational Factor" OR "Organisational Factors" OR "Organisational Factor" OR "Organizational Arrangement" OR "Organizational Arrangements" OR "Organisational Arrangements" #10 "Indicators" OR "Indicator" #11 "Monitor" OR "Monitoring" #12 #7 OR #8 OR #9 OR #10 OR #11 #13 "Decision Making, Organizational"[Mesh] OR "Decision Making, Organizational" OR "Organizational Decision Making" OR "Organisational Decision Making" #14 "Organizational Policy"[Mesh] OR "Organizational Policy" OR "Organizational Policies" OR "Organisational Policy" OR "Organisational Policies" OR "Institutional Policy" OR "Institutional Policies" #15 "Organizational Culture"[Mesh] OR "Organizational Culture" OR "Organisational Culture" OR "Organizational Cultures" OR "Organisational Cultures" #16 "Public Health Administration"[Mesh] OR "Public Health Administration" #17 "Health Services Administration"[Mesh] OR "Health Services Administration" OR "Health Service Administration" #18 #13 OR #14 OR #15 OR #16 OR #17 #19 #6 AND #12 AND #18	841

Database	Search strategy	Results
PDQ-Evidence	#1 Title/abstract: (Evidence Informed Decision Making) OR (Evidence Informed Decision) OR (Evidence Based Decision Making) OR (Evidence Based Policymaking) OR (Evidence Based Decision) OR (Evidence Informed Policy) OR (Evidence Based Policy) OR (Evidence to Policy) OR (Research to Policy) OR (Knowledge Translation) OR (Knowledge Use) OR (Evidence Use) OR (Research Use) OR (Knowledge Transfer) OR (Research Utilization) OR (Research Utilisation) OR (Knowledge Utilization) OR (Knowledge Utilisation) OR (Evidence Utilization) OR (Evidence Utilisation) OR (Knowledge Dissemination) OR (Evidence Dissemination) OR (Research Dissemination) OR (Knowledge Exchange) OR (Knowledge Mobilisation) OR (Knowledge Mobilization) #2 Title/abstract: (Health Impact Evaluation) OR (Critical Factor) OR (Key Factor) OR (Organizational Factor) OR (Organisational Factor) OR (Organizational Arrangement) OR (Organisational Arrangement) Indicators OR Indicator OR Monitor OR Monitoring #3 Title/abstract: (Organizational Decision Making) OR (Organisational Decision Making) OR (Organizational Policy) OR (Organisational Policy) OR (Institutional Policy) OR (Organizational Culture) OR (Organisational Culture) OR (Public Health Administration) OR (Health Service Administration)	66

Database	Search strategy	Results
Social System Evidence	(“Evidence-informed Decision-making” OR “Evidence Informed Decision Making” OR “Evidence-informed Decision” OR “Evidence Informed Decision” OR “Evidence-based Decision-making” OR “Evidence Based Decision Making” OR “Evidence Based Policymaking” OR “Evidence-based Decision” OR “Evidence Based Decision” OR “Evidence-informed Policy” OR “Evidence Informed Policy” OR “Evidence-informed Policies” OR “Evidence Informed Policies” OR “Evidence-based Policy” OR “Evidence Based Policy” OR “Evidence-based Policies” OR “Evidence Based Policies” OR “Evidence-to-policy” OR “Evidence to Policy” OR “Research-to-policy” OR “Research to Policy” OR “Knowledge Translation” OR “Knowledge Use” OR “Evidence Use” OR “Research Use” OR “Knowledge Transfer” OR “Research Utilization” OR “Research Utilisation” OR “Knowledge Utilization” OR “Knowledge Utilisation” OR “Evidence Utilization” OR “Evidence Utilisation” OR “Knowledge Broker” OR “Knowledge Broking” OR “Knowledge Dissemination” OR “Evidence Dissemination” OR “Research Dissemination” OR “Knowledge Exchange” OR “Knowledge Mobilisation” OR “Knowledge Mobilization”) AND (“Health Impact Evaluation” OR “Health Impact Evaluations” OR “Critical Factor” OR “Critical Factors” OR “Key-factor” OR “Key Factor” OR “Key-factors” OR “Key Factors” OR “Organizational Factors” OR “Organizational Factor” OR “Organisational Factors” OR “Organisational Factor” OR “Organizational Arrangement” OR “Organizational Arrangements” OR “Organisational Arrangements” OR “Indicators” OR “Indicator” OR “Monitor” OR “Monitoring”) AND (“Decision Making, Organizational” OR “Organizational Decision Making” OR “Organisational Decision Making” OR “Organizational Policy” OR “Organizational Policies” OR “Organisational Policy” OR “Organisational Policies” OR “Institutional Policy” OR “Institutional Policies” OR “Organizational Culture” OR “Organisational Culture” OR “Organizational Cultures” OR “Organisational Cultures” OR “Public Health Administration” OR “Health Services Administration” OR “Health Service Administration”)	0

Database	Search strategy	Results
Web of Science (Savedrecs.ris file)	#1 ALL = ("Evidence-informed Decision-making" OR "Evidence-informed Decision" OR "Evidence-based Decision-making" OR "Evidence-based Policymaking" OR "Evidence-based Decision" OR "Evidence-informed Policy" OR "Evidence-based Policy" OR "Evidence to Policy" OR "Research to Policy" OR "Knowledge Translation" OR "Knowledge Use" OR "Evidence Use" OR "Research Use" OR "Knowledge Transfer" OR "Research Utilization" OR "Research Utilisation" OR "Knowledge Utilization" OR "Knowledge Utilisation" OR "Evidence Utilization" OR "Evidence Utilisation" OR "Knowledge Dissemination" OR "Evidence Dissemination" OR "Research Dissemination" OR "Knowledge Exchange" OR "Knowledge Mobilisation" OR "Knowledge Mobilization") #2 ALL = ("Health Impact Evaluation" OR "Critical Factor" OR "Critical Factors" OR "Key-factor" OR "Key Factor" OR "Key-factors" OR "Organizational Factor" OR "Organisational Factor" OR "Organizational Arrangement" OR "Organisational Arrangement" OR "Indicators" OR "Indicator" OR "Monitor" OR "Monitoring") #3 ALL = ("Organizational Decision Making" OR "Organisational Decision Making" OR "Organizational Policy" OR "Organisational Policy" OR "Institutional Policy" OR "Organizational Culture" OR "Organisational Culture" OR "Public Health Administration" OR "Health Services Administration" OR "Health Service Administration")	37

Source: Own preparation.

Appendix 2. Excluded eligible studies and reasons for exclusion

Reference	Reason for exclusion
Ayoubian A, Nasiripour AA, Tabibi SJ, Bahadori M. Evaluation of Facilitators and Barriers to Implementing Evidence-Based Practice in the Health Services: A Systematic Review. Galen Med J. 2020 Mar 14;9:e1645. doi: 10.31661/gmj.v9i0.1645.	It does not refer to the context of interest
Berthelsen C, Hølge-Hazelton B. The Importance of Context and Organization Culture in the Understanding of Nurses' Barriers Against Research Utilization: A Systematic Review. Worldviews Evid Based Nurs. 2021 Apr;18(2):111-117. doi: 10.1111/wvn.12488.	It does not refer to the context of interest
Bhuiya AR, Makarski J, Hayden L, Perrier L, Munce S, Lewis I, Graham ID, Holroyd-Leduc J, Straus SE, Stelfox HT, Strifler L, Lokker C, Li LC, Leung FH, Dobbins M, Ritchie LMP, Squires J, Rac V, Fahim C, Kastner M. Identifying candidate quality indicators of tools that support the practice of knowledge translation: a scoping review protocol. JBI Evid Synth. 2023 Jan 1;21(1):264-278. doi: 10.11124/JBIES-22-00055.	Scoping review protocol
Greenhalgh C, Montgomery P. A systematic review of the barriers to and facilitators of the use of evidence by philanthropists when determining which charities (including health charities or programs) to fund. Syst Rev. 2020 Aug 27;9(1):199. doi: 10.1186/s13643-020-01448-w.	It does not refer to the context of interest

Reference	Reason for exclusion
Shayan SJ, Kiwanuka F, Nakaye Z. Barriers Associated With Evidence-Based Practice Among Nurses in Low- and Middle-Income Countries: A Systematic Review. Worldviews Evid Based Nurs. 2019 Feb;16(1):12-20. doi: 10.1111/wvn.12337.	It does not refer to the context of interest

Source: Own preparation.

Appendix 3. Details of the critical factors identified

Governance: **It refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP, including institutionalized structures or platforms that foster interaction and bridge the boundaries between research and policy. Said platforms not only enhance the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts[1].**	
Factors	**Description**
Competition in decision making	Competing influences on decision-making, role of media; utilization of the role of media and social marketing campaigns[13]; Parallel efforts[22]; Competing influences, including organizational, political and strategic factors; financial and resource constraints; personal experience; common sense; experts' opinion; public and stakeholders' pressure; community views and local competition have constrained the use of research evidence in public health decision-making[23].
Organizational context	Organizational decision-making and evidence-execution are constrained by the legal and ethical frameworks under which organizations operate; the context in which knowledge is produced may differ in terms of politics, culture, economics etc., from the context in which it is applied[7]; Legislative constraints[13]; Policy guidelines or statement; importance of the policy; legal or legislative support; other pressures on the policy[21]; Facilitators include clear scope and objectives; responsibility and accountability; strong leadership; organizational support; organizational culture; teamwork, collaboration, and communication[26].

Governance: **It refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP, including institutionalized structures or platforms that foster interaction and bridge the boundaries between research and policy. Said platforms not only enhance the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts[1].**	
Factors	**Description**
Communication tools	Development and establishment of mechanisms and channels for effective and sustainable communication to build understanding and share experiences; dissemination of research findings among organizations; development of technology, such as online research conference platforms, and support to their capacity[6]; Inadequate dissemination methods[11]; Integration of program-specific tools into a single platform and automation of data management processes[12]; Dissemination and communication tools include health information sharing platforms, newsletters and personal communications; use of wikis, discussion forums, blogs and social media, virtual communities of conference practice and technology, knowledge exchange portals, electronic communication channels (newsletters containing summaries of current research developed and sent directly by e-mail to managers); reports distributed through professional organizations or through a clearinghouse; national portal for access to evidence[13]; Create common language/two-way communication between policymakers and researchers; establish more effective scientific communication[15]; Improved communication and sustained dialogue between researchers and end-users; trust between researchers and policymakers[23]; Adequate organizational communication through newsletters and other strategies; easy access to research repositories[27].

Governance: **It refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP, including institutionalized structures or platforms that foster interaction and bridge the boundaries between research and policy. Said platforms not only enhance the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts[1].**	
Factors	**Description**
Organizational management of EIPs	Low dissemination of knowledge[6]; The implementation of a knowledge management system involves using, transferring and translating information, preventing potential loss of understanding induced by employees' retirement and turnover, acquiring competitive benefits, continuous learning, preventing organizational isolation and meeting user's needs[7]; Lack of responsibility in the use of evidence; conflicts of interest; inadequate peer support at the organizational or institutional level[13]; Context/windows of political opportunity; global governance structure; severity of the health problem and effective interventions[14]; Deficient planning processes; lack of processes; rigid goals specific to program teams; conflicting priorities; poor communication; lack of support from senior management[17]; Lack of political will[20]; Corruption; public mismanagement, deficient public management culture; weak coordination mechanisms[22]; Facilitators include desire and political will; trust; awareness and recognized need for change; value and expectations; widespread application of accessible methods; intervention audit and evaluation; considering evidence-based management in the core process; workforce development, empowerment and capacity building[26]. Explicitly "political" aspects influencing the incorporation of innovations; lack of power to change processes[28]; In general, evaluations resulted in management adjustments, rather than effective changes in programming or resource allocation[29].

Governance: **It refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP, including institutionalized structures or platforms that foster interaction and bridge the boundaries between research and policy. Said platforms not only enhance the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts[1].**	
Factors	**Description**
Monitoring and evaluation	Loyalty monitoring and oversight of KT efforts; measuring/improving organizational readiness for change; performance ratings; active monitoring of KT interventions; formal evaluation of KT activities deemed highly challenging; identifying measurable objectives and ensuring that evaluation measures reflect these objectives; "participatory" evaluations with all relevant stakeholders; theory-driven effort to identify and address the contextual factors most relevant to any specific intervention; broader coverage and equity of access to evidence-based interventions; conducting a community evaluation before completing specific program objectives[13]; Reliable indicators[14]; Evaluation, monitoring and feedback: appropriate feedback mechanisms benefited the implementation of evidence-based practice, preserving engagement among staff that implemented the change[19]; Establishment of monitoring and evaluation systems; verification of costing and economic modeling and other intervention approaches[20]; Situational analysis, added to experts' opinion and identification of gaps[25]; Indicators not always appropriate to evaluate what was intended[29].
Motivation for change	To overcome challenges at the micro level, motivation and interest in approaching and studying research results should be stimulated, with a focus on targeted communication of results; trust should be developed between decision-makers and researchers[6]; Increase personal readiness for change; acknowledge multi-level processes (professional, organizational, local system) and interactions between these levels; approach complex environmental factors and include measures of community sustainability and institutional change in the outcomes; ground KT activities on existing theories of behavior change; facilitate the implementation of empirically valid interventions in health care (i.e. policy measures aimed at supporting the provision of screenings, as well as organizational changes influencing the operational characteristics of preventive services), building and maintaining trust[13]; Motivating and organizing teams to incorporate research into practice; sustainable change requires research aligned with policies, regulatory laws, governance and organizational structures[27].

Governance: **It refers to a wide range of functions related to rule-making and guidance to achieve the institutionalization of EIP, including institutionalized structures or platforms that foster interaction and bridge the boundaries between research and policy. Said platforms not only enhance the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts[1].**	
Factors	**Description**
Political relevance	The topic in question is not a priority in the political agenda[11]; Lack of relevance of political needs; weak considerations on political support or feasibility; lack of cultural appropriateness, acceptability or applicability in practice; applicability of the evidence-based intervention at the local level; reach of key intervening parties in the communities where interventions would be delivered, including non-clinical settings; greater understanding of the transferability and applicability of evidence-based recommendations from one setting to another[13]; Incompatibility of research with the complexity of reality[19]; Failure to adapt intervention approaches to the local context[20].

Standardized and routinized processes: **To ensure high-quality KT products and processes that policymakers trust and, therefore, are more likely to use, standardized processes, including tools and protocols, are needed. Complemented by well-documented processes, they facilitate the sustainability and institutionalization of KT processes, serving as institutional memory and reducing reliance on individuals with knowledge and skills[1].**	
Factors	**Description**
Information adequacy	Complex nature of some evidence-based therapies or guidelines; perceived usability by health professionals and behavior change, in practice, vary according to the type of information and communication technology; practical constraints[13];
	Excessive amount of information[17];
	Adapt the scaling approach to the local context and use participatory approaches[20];
	Clarity/relevance/reliability of research results; importance of research results[21];
	Perspectives from international policy consultants, research leaders; undue focus on randomized controlled trials; scientific uncertainty; low local applicability; lack of focus on social determinants of health; and lack of complexity to address multicomponent health systems; research approaches should show effectiveness (through study design and/or statistical presentations) and consensus; evidence should emerge from sources that are seen as impartial (such as peer-reviewed research) and reliable; and provide methodological details so that rigor can be evaluated[23].

Standardized and routinized processes: To ensure high-quality KT products and processes that policymakers trust and, therefore, are more likely to use, standardized processes, including tools and protocols, are needed. Complemented by well-documented processes, they facilitate the sustainability and institutionalization of KT processes, serving as institutional memory and reducing reliance on individuals with knowledge and skills[1].	
Factors	**Description**
Information presentation	One-page summaries with key messages tailored to the target audience; clear relevance of results and important factors to contextualize evidence; systematic reviews, with a standard for easy interpretation of results; quick and easy reference, clarity, timeliness and strength of evidence; packaging tools include synthesis methods, such as policy briefs and visualization methods; application tools include surveillance data and modeling/simulation to explore the behavior and performance of processes and interventions[13];
	Format of search results[21];
	Impact of research presentation on its use in decision-making; presentation (which was seen as aimed at an academic audience) and interpretation; researchers should clearly summarize their main findings; researchers should align evidence with current and future policy environments; evidence should identify indicators relevant to health goals; research should make suggestions for implementation; research evidence should be designed so that it is easily incorporated into colloquial/experiential/commonsense knowledge[23].
Information delivery	Multi-component active delivery of information (as opposed to access to online registration only; targeted messages, educational visits and briefings; multimodal delivery of KT interventions at the organizational level[13];
	Effective knowledge translation in health organizations depends on the customization and delivery of messages that consider the roles of individuals (knowledge articulators, influencing agents, among others), organizational climate and structural characteristics, as well as hierarchical power patterns to initiate organizational change (top-down versus bottom-up)[16];
	Effectiveness of current knowledge transfer processes; usefulness of models to improve decision-making; and definition of priorities and deadlines for decision-making[23].
Information opportunity	Develop guidelines that promote best clinical practices[6];
	Opportunity[11];
	Lack of timely search results; lack of quickly available and adequately filtered information;
	Providing the right knowledge at the right time for decision-making through the implementation of knowledge management in health organizations[15];
	Incompatible timeframes for research and policy formulation[23].

Leadership and commitment:
Strong charismatic leadership is essential to create the conditions for sustained use of evidence. Leaders have the capacity to influence the lasting adoption of EIP directly through the allocation of (human and material) resources, and indirectly through encouragement, support and guidance[1].

Factors	Description
Leaders' involvement	Good leadership, government support and commitment[11];
	Involvement of opinion leaders (person usually nominated by colleagues as "educationally)[13];
	Leadership to raise awareness and advocate for integrated solutions[14];
	Having an advocate or "champion" to defend the "new way of doing things" has led to a more complete and refined use of evidence-based practice implementation guidelines[19];
	Committed teams and leaders[25].
Leaders' profile	Extracting added value from websites and search engines[13];
	Leaders were often seen as providers of new knowledge and as key influencers in the implementation of new initiatives[19];
	The required competence includes writing and oratory skills, as well as awards and incentives[27];
	Empowered physicians influence evidence incorporation decisions[28].

Resources:
Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP[1].

Factors	Description
Knowledge	Difficulty in using research results and making recommendations in clinical practice[6];
	Lack of knowledge or agreement with guidelines; little familiarity or confidence in the effectiveness of a specific evidence-based therapy; gaps in practical knowledge[13];
	Information gaps and underused information[22].

Resources: **Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP[1].**	
Factors	**Description**
Skills and competences	Insufficient skills for critical evaluation; low levels of technological literacy; lack of familiarity with databases; lack of knowledge about Evidence-Based Practice concepts; lack of sufficient training and skills in research methods[6];
	Consider specializing in data tasks, delegating to specifically trained people or having dedicated time for data-related tasks[12];
	Lack of skills to search for, evaluate and interpret evidence/systematic reviews; lack of competences to evaluate, understand and apply research evidence, including digital skills; limited skills or competence to use a specific therapy; insufficient implementation capacity[13];
	Level of instruction in research methods[17];
	Policymaker's research skills; policymaker's research awareness; practitioner's research skills; practitioner's research awareness[21];
	Policymakers were not supported (through training, structure of documents used for informing decisions, and senior managers' expectations) to acquire the necessary skills or use research evidence[23].

Resources: **Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP[1].**	
Factors	**Description**
Organizational infrastructure	Lack of access to evidence and research; insufficient organizational resources, such as materials and equipment needed to implement research, and inadequate facilities to conduct research[6];
	Accessible research database[11];
	The availability of these resources influenced the motivation of individual workers[12];
	Lack of resources or organizational support; lack of infrastructure, limited medical facilities to support evidence collection; lack of access to and availability of applicable research evidence; lack of access to database; clinical decision support systems[13];
	Use of appropriate tools and user-friendly systems for knowledge management[15];
	Lack of internal resources for research; lack of data and systems; limited access to information[17]; processes for integrating evidence; administrative support; availability of operational data[17];
	Insufficient investment in implementation infrastructure, including training, monitoring and evaluation systems, recruitment and staff turnover; infrastructure to support implementation, such as training, delivery systems, technical resources, strong leadership and advocates; political will; a well-established scaling strategy; and strong advocacy[20];
	Availability of and access to improved research/dissemination; managerial support (practical); political support (will); available material resources; managerial will[21];
	Problems in dissemination of and access to research evidence; research evidence should be made widely available to decision-makers using newsletters via email, professional public health organizations or clearinghouses[23];
	Provision of appropriate tools and devices[25];
	Facilitators include sufficient infrastructure or structures; financial resources; allocating considerable time for evidence-based management and timely interpretation of data; adequate allocated staff resources[26];
	Incentives, availability of tools and training for decision-makers are important[27].

Resources: **Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP[1].**	
Factors	**Description**
Time constraints	Lack of time; time constraints due to inadequate management, staff organization and workload density, labor shortage[6];
	Time, clinical workload and other pressures[13];
	Time constraints[17];
	Existence of positions and time allocated to research[27];
	Lack of time[28];
	Time and budget constraints hampered the evaluation[29].
Capacity building programs	Policy or plan to implement various EBP[6] capacity-building activities;
	Training professionals in the skills needed to implement policies[11];
	Capacity building, training and continuing education; investigation training and capacity-building programs; training in the use of specific technologies that support access, i.e. electronic health records, and use of evidence; staff trained in the teaching and practice of Evidence-Based Medicine (EBM); understanding of effective KT strategies[13];
	Conducting training programs or courses for researchers to understand the policymakers' needs in the appropriation of scientific data; the health system needs to strengthen its strategic capacity to facilitate an educational and training culture to motivate researchers to produce evidence suitable for policymakers[15];
	Clear standards and goals in training increase acceptance of organizational change; mentoring as a means of training, also supports knowledge translation, if power relations do not inhibit interpersonal exchange[16];
	Human resources training and rewards[17];
	Education and training also impacted the effectiveness of implementing these practices[19];
	Capacity building to increase researchers' abilities to effectively produce and disseminate useful evidence to decision-makers, improving policymakers' abilities to critically evaluate and interpret these results[23];
	Use of "pilot strategies" as learning and triggering changes[25].

Resources:
Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, both inside and outside the organization, skilled in applying KT routinely and consistently over time is a central pillar of the institutionalization of EIP[1].

Factors	Description
Human resources	Frequency of staff turnover[11];
	Availability of human resources; integration of librarians and health information experts in the organization[13];
	Human resources constraints[17];
	Financial, personnel, workload and time resources were considered particularly important for the process of implementing evidence-based practice[19];
	Lack of human resources[20];
	Staff or personnel resources; staff turnover/employment continuity[21].
Financial resources	Budgets available for research-related activities[6];
	Lack of resources and financing; specific financing[11];
	Resources allocated to ensure that participation in evidence-based programs is not limited by financial barriers[12];
	Incentives and financial resources[13];
	Financial constraints[17];
	Intervention costs and other economic factors[20];
	Costs[21];
	Funding should be provided for longitudinal and long-term research[23];
	Lack of financial resources[29].

Partnerships, collective action and support:
Institutionalization is fostered as stakeholders interact in the “organizational field.” Partnerships are essential because they can foster the institutionalization of EIP by providing a mechanism for ongoing, multi-stakeholder engagement in the same cause, joint problem-solving, identification of resources for ongoing KT, and technical support[1].

Factors	Description

Partnerships, collective action and support: Institutionalization is fostered as stakeholders interact in the "organizational field." Partnerships are essential because they can foster the institutionalization of EIP by providing a mechanism for ongoing, multi-stakeholder engagement in the same cause, joint problem-solving, identification of resources for ongoing KT, and technical support[1].	
Factors	**Description**
Stakeholders' involvement	Few agencies involving users/general audience in KT activities; involving frontline staff and health managers in data collection, evidence and use[13];
	Mobilization of civil society[14];
	Active involvement of a range of implementers and the target community[20];
	Stakeholders' involvement in decision-making[25].
Exchange tools and structures	Authority structures and the dynamics of data producer and data user relationships influence the regularity of evaluations and data use[12];
	Networking and exchange tools, such as knowledge networks, facilitate the dissemination of health information and the likelihood of translating investigation into policy; participatory action frameworks based on interactive knowledge exchange (e.g. blended learning) rather than passive one-way approaches alone (e.g. lectures); networking for information sharing[13];
	Use of mechanisms and networks for effective interaction and cooperation between knowledge producers and users; strengthen research centers, with training of researchers, elimination of institutional barriers, and use of mechanisms and networks for effective interactions between policymakers[15];
	The success of implementing evidence-based practice has been associated with organizational networks and communication[19].

Partnerships, collective action and support: Institutionalization is fostered as stakeholders interact in the "organizational field." Partnerships are essential because they can foster the institutionalization of EIP by providing a mechanism for ongoing, multi-stakeholder engagement in the same cause, joint problem-solving, identification of resources for ongoing KT, and technical support[1].	
Factors	**Description**
Collaborative processes	Develop collaboration and robust connections between researchers and decision-makers[6];
	Successful collaboration with involvement of all stakeholders; support or involvement of important multilateral organizations[11];
	Fluid sharing of health information system data[12];
	Cross-sector and inter-agency learning; collaborative decision-making with other community organizations; agreement on goals and targets, collaborative decision-making, increased levels of social cohesion; pan-regional organizations shape decision-making about innovation at lower levels (i.e. referral networks, professional societies, and development of practice guidelines); availability of peer staff and technical resources, social networks; collaboration among community partners[13];
	Cohesion of the political community, institutions or steering committees (within larger organizations); multi-stakeholder dialogues[14];
	The capacity to translate knowledge in health organizations is built through the coordination of institutional and individual networks within and between organizational units, which can function as dissemination vehicles[16];
	Intra-organizational relations; inter-organizational collaboration[17];
	Collaboration; timing/opportunity; relationship with policymakers; relationship with researchers/information staff; contact with researchers/information staff; contact with policymakers[21];
	External facilitators include the mandatory and encouraged use of scientific evidence; interaction between researchers and decision-makers; support from the academic community and other players[26];
	Strong partnerships of universities and research institutes with local research leaders[27];
	Research organizations and other intermediaries favor the incorporation of innovation evidence[28].

Culture: **It refers to basic values, assumptions, artifacts and beliefs that are considered valid, and are disseminated and promoted as daily practices. Culture enables a common understanding of what KT is, what value it can bring, and what can be expected in terms of activities and benefits[1].**	
Factors	**Description**
Alignment between research and policy	Lack of perception about alignment or integration between research and policy; limited involvement in the research process[6];
	Lack of local data or local research; local research conducted to incorporate any evidence-based recommendations into the local context[11];
	Lack of joint understanding between researchers and decision-makers; require specific forms of evidence to inform decision-making[13];
	Gap between decision makers/researchers; mutual distrust[17];
	Perceived lack of research evidence among public health decision-makers; negative perceptions of available research evidence have commonly limited its use – abundance of "policy-free" evidence[23];
	Ministries in general do not have a prioritized set of research questions and are often institutionally divided; agendas of what to research and evaluate were weak and often not likely to have its impact evaluated; biased selection of what to evaluate to meet the interests of specific groups; difficulty in generalizing the finding to other contexts (low external validity); sample size was not always adequate; there was a lack of effective strategic prioritization of evidence-based decision-making within the government; insufficient involvement of government partner researchers[29].
Credibility of evidence	Doubt about the usefulness of research results[6];
	Organizations face new dynamics from different cultures and situations in their settings, and managers are required to make the right choices through evidence from other cultures and settings; this requires more comparative studies that concurrently look for emerging universality and cultural specificity; the selection of information sources by decision-makers is often determined by availability rather than quality; in relation to accessibility, it is stated that trust plays an important role in the selection of information sources by decision-makers[7];
	Lack of credibility of evidence; negative perceptions of the use of research, i.e. perceived as a bureaucratic/untimely process[13];
	Irrelevance of research; unclear definition of evidence; negative perceptions of research[17].

Culture: **It refers to basic values, assumptions, artifacts and beliefs that are considered valid, and are disseminated and promoted as daily practices. Culture enables a common understanding of what KT is, what value it can bring, and what can be expected in terms of activities and benefits[1].**	
Factors	**Description**
Culture of support for the use of evidence	Facilitating the preparation of physicians and organizations for implementation[13];
	The key to effective knowledge translation in health organizations is the support for innovation, fostered by obvious reasons for organizational change, open exchange across power differences, and employee engagement; Knowledge Translation is enhanced when healthcare professionals perceive and identify themselves positively with the organization[16];
	Culture of support for the use of evidence[17];
	Organizational openness to assess innovations and a culture of learning have been associated with successful implementation of evidence-based practice[19];
	Organizational culture favorable to the incorporation of EIP; team's perseverance and resilience[25].
Involvement of decision-makers in research	Involvement of stakeholders early in the research design and initiation process[6];
	Technical and scientific support from researchers to health professionals; exchanges between the methodological support provided by researchers and the clinical experience report offered by health professionals; health professionals actively included in the entire research process; participation of health professionals in specific research stages; participation of health professionals responding to interviews or in focus groups or workshops[9];
	Problems with stakeholders' engagement; community participation and participatory research[11];
	Partnerships with researchers to facilitate the use of evidence; reflection on the conceptual basis of knowledge mobilization activities[13];
	Conduct research with the participation of decision-makers; identify social barriers to change the behavior of evidence users[15];
	Focus of the researcher and decision maker on research application; experience in using research; contact between researchers and decision makers; mutual respect[17];
	Creation of local ethics committees; the capacity for investigation depends on the engagement of leaders and managers, as well as training for these players[27];
	Stakeholder's participatory processes positively influence the incorporation of innovation evidence[28].

Culture: **It refers to basic values, assumptions, artifacts and beliefs that are considered valid, and are disseminated and promoted as daily practices. Culture enables a common understanding of what KT is, what value it can bring, and what can be expected in terms of activities and benefits[1].**	
Factors	**Description**
Stakeholders' preferences	Patient's needs, preferences and adherence to treatment, when these interfere with evidence-based recommendations[13];
	Preferences in choosing evidence vary according to the professional group; financers prioritize local needs for evidence; nurses combine practical with scientific knowledge, while doctors give more value to scientific knowledge; general practitioners of primary care do not necessarily value scientific evidence; surgeons incorporate data that makes sense to them, often without explicit proof; evidence can be used to legitimize decisions already made; managers use evidence to counter doctors' decisions, which they consider irrational[28].
Receptiveness to change	The structures and processes of each healthcare setting represent a unique organizational environment, including the way the organization operates and performs; these structures (e.g. size, staffing) and processes (e.g. practical provisions, decision-making support) are, either individually or together, capable of promoting or hindering discrete actions in terms of adoption and implementation provisions[7];
	Decision-making culture (organizational resistance to change); lack of motivation and awareness of evidence/systematic reviews[13];
	Resistance to the introduction of new practices due to capacity constraints[20];
	The culture within which decision-makers were working considered the collection and evaluation of research as "non work" performed by those who needed to appear to be taking action[23];
	Little receptiveness of organizations to changes[28].

Source: Dimensions adapted from Kuchenmüller et al. (2022)[1].

3. Deliberative Dialogue

3.1. Introduction

"Deliberative dialogue" (DD) or "policy dialogue" is a Knowledge Translation (KT) resource that has been used to facilitate the sharing of knowledge among researchers, policymakers and other stakeholders on a specific topic[1].

This report covers the DD held on June 25, 2024, from 9 a.m. to 5 p.m., organized by the ESPIE Project team - Support for Institutionalization of Evidence-Informed Policies (EIP) in the SUS.

The DD objective was to discuss critical factors and monitoring and evaluation indicators for the institutionalization of EIP, considering the global evidence presented in the document "Critical factors for institutionalization of evidence-informed decision-making in public health organizations: evidence synthesis (preliminary results)".

The contributions of DD participants are intended to support the development of an Implementation Guide to support the institutionalization of EIP in the SUS health organizations.

The DD had the participation of 20 persons from the following organizations: Hospital Sírio-Libanês (HSL), specialists from the ESPIE/HSL project, field specialists from the ESPIE/HSL project, Department of Science and Technology of the Ministry of Health (Decit/SECTICS/MS), National Council of Health Secretaries (CONASS), National Council of Municipal Health Departments (CONASEMS), World Health Organization, Hospital do Coração, Instituto Veredas, Núcleo de Evidências Seriema/UNISO and Ministry of Human Rights and Citizenship.

The evidence synthesis analyzed by the DD participants was sent by email to the guests thirteen days before the meeting. In addition, they were encouraged to conduct an exercise of prioritization of critical factors, through an online form in which they could evaluate their perception, on a growing scale from 1 to 5, about the relevance of each critical factor for the context of the SUS.

After a brief opening speech, there was a round of presentation of the participants, a report on the rules for participation in the DD and the contents of the evidence synthesis.

Two sessions were held to discuss critical factors, and two sessions to discuss monitoring and evaluation indicators of the implementation process.

A DD evaluation was conducted by participants at the end of the event, using a specific form.

3.2. Contributions from the exercise of prioritization and resolution of critical factors

In the evidence synthesis, critical factors and monitoring and evaluation indicators were organized into six domains: Governance; Standardized and routinized processes; Leadership and commitment; Resources; Partnerships, collective action and support; and Culture. This categorization was based on the framework of Kuchenmüller et al. (2022)[2].

The contributions from the prioritization exercise and the DD resolution were grouped into two categories: those that should be incorporated to improve the evidence synthesis, and others that should be considered for preparation of the implementation guide.

General comments

Some comments made throughout the DD do not specifically refer to the dimensions addressed in the critical factors and indicators.

Towards improving evidence synthesis

The evidence synthesis format mixes barriers and facilitators; therefore, it is sometimes difficult to understand whether the category is positive or negative; the tendency is to see more barriers.

The language of the evidence synthesis is very scientific and needs to be more appropriate for managers. The document is in a generalist format; it would be important to make it more relevant to the Brazilian reality, with examples.

A more robust description of each factor is needed. Other types of classification for each level of the system should be used. Definitions should be well delimited. Some factors have an interface with other dimensions. Consider the experience of developing the competence profile.

There is a need for more connection with practice. The framework is somewhat rigid. Innovation is needed by creating a framework that is more suited to reality. Practice and implementation dimensions should be considered. The framework adopted included categorization, but other elements could be used. It should help us reflect, but we need to bring global data to the SUS. What are the variables that affect the SUS agenda?

The process should talk more closely with SUS public policies, planning and management from the perspective of the manager's routine. There is a need for understanding how the SUS dynamics work. Enrich critical factors with real-world challenges. Resignify evidence for the SUS.

Wouldn't it be worth ranking these critical factors? Cross-cutting factors include transparency and participation.

For the preparation of the implementation guide

It would be important to produce a more initiative-taking guide, valuing ways to overcome barriers, rather than emphasizing them.

Who is the guide intended for? Civil servants? The technical staff is the one who implements the policies. The guide should empower the team to raise awareness among the manager. It should address how to deal with each of the critical factors. The guide needs to prioritize these factors.

Think of a matrix of dimensions for the guide. It is necessary to adapt concepts. Concept about who is the manager in different organizations (macro, mezzo, micro). Look at guides on innovation, governance etc. (ENAP).

The level of maturity is incipient in most Brazilian organizations, including the Ministry of Health. Most will need a basic guide. How to start this process? Would the guide be intended to induce EIP for municipal managers (health secretaries)? Would the focus be on results? Should sustainability be the focus of the guide? There is a large load of factors for the local level. Incorporate an implementation dimension. Where to start?

The process should be ongoing due to the high turnover of municipal secretaries. Entities such as Health Regions and Regional Inter-management Comissions (CIR) are more permanent. Decision-making is relative, with enormous influence from factors outside health. There is a need for empowering small municipalities, which are the majority in the country.

Governance

“It refers to a wide range of rule-making and steering functions to achieve the institutionalization of EIP, including institutionalized frameworks or platforms that foster interaction and cover the boundaries between research and policy. Such platforms not only increase the visibility of KT across the system, but also protect it from ad hoc changes in policy and contexts.”[2]

Table 4 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 4. *Critical factors of the "Governance" dimension, modified after the DD.*

Critical factors	Median
Competition in decision making	4
Communication tools	5
Organizational management of EIPs	5
Restrictive legislation	3
Monitoring and evaluation	5
Motivation for change	5
Political relevance	5

Towards improving evidence synthesis

Some factors listed in the evidence synthesis were not suitable in Governance and were moved to other dimensions – "Alignment between research and policy" and "Manager involvement in research" were included in the Culture dimension; "Delivery of information" was included in the "Standardized and routinized processes" dimension.

For the preparation of the implementation guide

The synthesis is strongly anchored in EIP. It would be important to approach governance based on specific literature. Governance presupposes the elements that make institutionalization feasible. Thus, planning cannot be stuck.

There is no consensus in the literature on the term "governance," but it is necessary to consider at least three factors: (i) Knowledge management focusing on user's needs, (ii) Global vision of the knowledge sources available in the organization, and (iii) Relationship between governance and governability, the latter understood as "management's capacity to identify critical problems and formulate appropriate policies to address them."

EIPs have the potential to both strengthen and weaken decision-makers' careers. When discussing the usefulness of EIPs, it is important to address how to overcome the barriers to good policymaking by institutions.

In this process, one should consider advocacy for the use of evidence, the availability of a portfolio, institutional incentives that promote performance and the pursuit of explicit institutional objectives, bureaucratic rules and organizational culture that allow effective people management, institutional structure for knowledge translation with clear hierarchical chains of consultation and decision-making, independence and autonomy in the preparation of EIP.

Important aspects not listed among the critical factors are transparency and participation as assumptions to encourage the use of EIP.

Other issues to be considered include: the political and electoral context; frequent changes in management and the need for convincing the new manager; how decisions are made; how ideological factors influence the use of EIPs; peer pressure and visibility; pressure from interest groups; personal and group interests inside and outside the institution (including corruption); influence of ecosystem institutions; informal power structures; tacit mandates; fragmented power structures.

There is also a need for presenting clear concepts since some terms can have both positive and negative implications (such as "restrictive legislation").

The examples help to clarify concepts through events, institutional and social narratives. It was suggested that consultation be made with IPEA's publication on building state capacities, which addresses the cases of CONITEC and IBAMA[3].

Standardized and routinized processes

"To ensure high-quality KT products and processes that policymakers trust and are, therefore, more likely to use, standardized processes, including tools and protocols, are needed. Complemented by well-documented processes, they facilitate the sustainability and institutionalization of KT processes by serving as institutional memory and reducing reliance on individuals with knowledge and skills."[2]

Table 5 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 5. *Critical factors of the "Standardized and routinized processes" dimension, modified after the DD.*

Critical factors	Median
Information adequacy	5
Information presentation	5
Information delivery	5
Information opportunity	5

Towards improving evidence synthesis

The translation of the dimensions proved to be inadequate and was modified. The understanding is that it includes protocols for EIP, production of materials and processes in EIP, information management, institutional language.

For the preparation of the implementation guide

It is important to work with standardized processes that meet management's needs effectively and efficiently. Despite being routinized, these processes need to be dynamic.

Incentives for adoption and use of these processes should be considered, as well as conditions such as timing, resources and motivation for adoption, national or international standards that promote the use of evidence, strategies for managing conflicts of interest, transparency and accountability.

It is necessary to have a global vision of the sources of knowledge available in the organization that may exist but are not systematized and used. Well-documented processes that improve institutional memory and reduce dependence on certain individuals with knowledge and skills, should be adopted. Incorporate, as much as possible, the existing products developed by the ESPIE (2022)[4] and others that work in the area. Use monitoring indicators.

It is considered relevant to include prioritization and policy cycle and conduct priority definition exercises until the strengthening of an agenda for developing EIP.

The quality of information should also be considered, as well as the use of quality tools or protocols. Invest in communication, in communication tools.

Leadership and commitment

"Strong charismatic leadership is essential to create the conditions for sustained use of evidence. Leaders have the capacity to affect the long-lasting adoption of EIP directly, through the allocation of (human and material) resources, and indirectly, through encouragement, support and mentoring."[2]

Table 6 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 6. *Critical factors of the "Leadership and commitment" dimension, without modification after the DD.*

Critical factors	Median
Leaders' involvement	5
Leaders' profile	4

Towards improving evidence synthesis

Making a connection with the competence profile developed in ESPIE.

For the preparation of the implementation guide

There is a need for institutional openness so that leaders can set change agendas, in addition to institutional support and encouragement for potential leaders. There are "leaders with symbolic power" who exercise leadership because they are relevant references resulting from their experience (longevity) in the organization or an image of respect among other components.

Leadership is what provides support for institutionalization. What is a leader with legitimacy? Leadership needs to be inclusive, representative, and have effective articulation with the groups they belong to.

A relevant aspect is how to create capabilities and leaders who will work on the topic for a long time. Perhaps investing in civil servants who have stability, strengthening the bureaucracy or in mid-level civil servants.

Thus, it is also necessary to think about renewing leadership, raising awareness among leaders to act in EIP, mapping leadership, recognizing leaders and equipping leaders. There is a lack of well-discussed experiences on how to generate leadership.

Network participation can motivate institutional capacity since the power of coalition calls up the manager.

It is also necessary to consider the organizational context. A municipal leadership, for example, works to seek consensus, alignment, and collective understanding as a result of discussions between managers. Therefore, it is necessary to think about incorporating SUS planning and management instruments.

Resources

"Human, financial, material and information resources are essential inputs for the production and reproduction of social structures over time. Having a critical mass of people, inside and outside the organization, skilled in applying KT routinely and consistently over time, is a central pillar of the institutionalization of EIP."[2]

Table 7 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 7. *Critical factors of the "Resources" dimension.*

Critical factors	Median
Knowledge	5
Skills and competences	5
Organizational infrastructure	4
Time constraints	4
Training programs	5
Human resources	5
Financial resources	5

Towards improving evidence synthesis

Many of these factors could be classified as "competences," according to the ESPIE framework.

For the preparation of the implementation guide

The institutional appreciation of the professional growth of team members is particularly important, in addition to institutional incentives that promote performance and the pursuit of clear institutional objectives.

Commitment is necessary to avoid organizational collapse. It requires the capacity to seek resources to avoid organizational collapse, focusing on sustainability. Sustainability could be a factor that cuts across all dimensions since support and financing are necessary.

Independence and autonomy in EIP, specific types of reviews, technological resources (emergence of artificial intelligence) and continuing education should also be considered.

Partnerships, collective action and support

"Institutionalization is fostered through the extent to which stakeholders interact in the organizational field. Partnerships are essential because they can foster the institutionalization of EIP by providing a mechanism for ongoing engagement and involvement of multiple stakeholders in the same cause, joint problem-solving, identification of resources for ongoing TK, and technical support."[2]

Table 8 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 8. *Critical factors of the "Partnerships, collective action and support" dimension.*

Critical factors	Median
Stakeholders' involvement	5
Exchange tools and structures	4
Collaborative processes	5

Towards improving evidence synthesis

A relevant factor that could be highlighted for having its own characteristics is the learning and practice communities for knowledge management. More than a partnership or collaboration, it would be a collective learning and building, resulting from the grouping of people in the organization who face shared challenges.

For the preparation of the implementation guide

Analyze the cultural openness or interest and the bureaucratic feasibility for establishing external partnerships.

Was the "transparency" dimension of collective and collaborative processes understood? Ideally, this should occur at all stages of the evidence development process. It is necessary to build a bond of trust.

Promote regular policy dialogues to exchange ideas with partners, engage with stakeholders throughout the process, as from the definition of the research question.

Consider the synergy of projects and initiatives, collaborative processes, emphasize networks, mentoring and/or learning in partnerships.

Culture

"It refers to basic values, assumptions, artifacts and beliefs that are considered valid and are being disseminated and promoted as everyday practices. This dimension allows for a collective understanding of what KT is, what value it can bring, and what should be expected in terms of activities and benefits."[2]

Table 9 presents the critical factors included in this domain and the median resulting from the prioritization exercise.

Table 9. *Critical factors of the "Culture" dimension, modified after DD.*

Critical factors	Median
Alignment between research and policy	5
Credibility of evidence	5
Culture of support for the use of evidence	5
Involvement of decision-makers in research	4
Stakeholders' preferences	4
Organizational resistance to change	5

Towards improving evidence synthesis

Several factors that affect the culture of evidence use are listed in this case study[5].

Clarify what "Stakeholders' Preferences" would be.

Regarding "Organizational resistance to change," the term "resistance" does not seem appropriate. Organizational dynamics and culture are determined by a set of beliefs, values and practices that have been historically consolidated in the organization. Incorporating new beliefs, values and practices - such as valuing EIP - is a complex challenge, which should include other determinants and variables, without necessarily breaking with the prevailing organizational culture, as this would be overly complex. In other words, culture does not necessarily need to change, it adapts.

For the preparation of the implementation guide

Considering citizens' engagement and involvement at all stages facilitates the credibility of evidence and reduces organizational resistance, as managers are dedicated to reporting evidence, motivating change, and valuing access to evidence.

Including the community; upholding shared values; putting evidence at the heart of everyday life.

Incorporating marketing and communication for different audiences; increasing the confidence of policymakers and the general audience in evidence by communicating uncertainties.

3.3. Contributions from the resolution on monitoring and evaluation indicators

Unlike the resolution on critical factors, in which the dimensions were addressed one by one, participants made their comments globally for the indicators that were presented and listed in Tables 1 to 6.

During the DD, some clarifications needed to be made by the team preparing the evidence synthesis: the included studies had their own framework, but they were not used in the evidence synthesis; the synthesis is in accordance with the registered protocol; some of the results presented may be clues for the preparation of the indicators; the studies were of two natures: only propositional or with evaluation carried out, so, perhaps only those that were applied should be included; the purpose of the guide is to point out where improvements are needed, and the indicators are a support for the baseline and monitoring of implementation; the guide should include supporting indicators, and applicability is very subjective; the indicators will be used by the organizations themselves for their improvement; the guide will not be alone, it will always be accompanied by field experts; there will be eight case studies, some experiences can probably be replicated and others cannot.

It was suggested to check the WHO reference that uses another type of classification. The WHO checklist addresses the stages of maturity of institutions[6].

Other suggestions were: including a logical model for the guide (for whom, what etc.); quality and frequency of demand; existence of NEv, strategic planning, participation in some forum, knowledge platform; support at the level, quality, involvement, use of participatory approaches, promotion of efforts, production of research aligned with the priority agenda; what they understand by "evidence," how they use this evidence, if they use it for decision-making.

Other comments were: these indicators would not be applicable, for the most part, to small municipalities; local autonomy is important for the use of these indicators; it is necessary to deal with few indicators; carry out an evaluation with indicators that show the degree of local effort, gradation; define what type of gradation scale is best to make comparisons over time, it should not be qualitative.

The example of a study on migration was mentioned. If the process is one of induction, it would be important to have more indicators than the basic ones. The certification process involves five steps: registration, diagnosis, prioritization, certification and monitoring[7].

Tables 1 to 6. List of monitoring and evaluation indicators presented in the evidence synthesis

Table 1. *Governance Indicators*

☑ Customized organizational support
☑ Support at the individual level
☑ Context of evidence use
☑ Quality and frequency of demand for evidence
☑ Involvement of users and evidence producers
☑ Use of participatory approaches
☑ Promoting drivers, engagement, exchange and integrative efforts around KT
☑ Researcher's feedback on project alignment with priorities
☑ Applicability of research for decision making
☑ Targeted communication

Table 2. *Indicators of standardized and routinized processes*

☑ Capacity to identify the stakeholders' information needs
☑ Capacity to monitor, evaluate and communicate the results of evidence-based interventions
☑ Capacity to systematically synthesize knowledge
☑ Using theory to inform the creation of the practical KT tool
☑ Expert knowledge of practical KT tools
☑ Conducting iterative processes
☑ Inclusion of reflexivity and/or critical reflection
☑ Capacity to evaluate the sustainability and/or scalability potential of KT tools

Table 3. *Leadership and commitment indicators*

- ☑ Customized organizational support
- ☑ Organizational level support to improve the EIDM culture within the public health team, promote use of evidence by the public health team
- ☑ Capacity to take equity considerations into account
- ☑ Evaluation of team engagement with evidence

Table 4. *Resource Indicators*

- ☑ Group training
- ☑ Data availability
- ☑ Quality of data/evidence
- ☑ Essential competences for using data
- ☑ Capacity to evaluate the determinants
- ☑ KT capacity and skill building
- ☑ Increasing the capacity of national teams through activities
- ☑ Increasing KT practice and product production/availability by national teams
- ☑ Increasing KT capacity among external stakeholders
- ☑ Use of KT products by national teams/platforms and external stakeholders
- ☑ Systematic and routine use of evidence in the development of public policies
- ☑ Improvements to health system policies resulting from EIDM
- ☑ Input indicators - structure, financial resources, human resources, effective management, technical assistance
- ☑ Improved health status and equity resulting from EIDM

Table 5. *Indicators of partnerships, collective action and support*

- ☑ Development of evidence syntheses in partnerships with other institutions
- ☑ Hiring external consultants
- ☑ Identifying knowledge users for engagement
- ☑ Use of participatory approaches
- ☑ Number of projects involving users
- ☑ Application of user-centered shared design process
- ☑ Production of collaborative activities and stakeholders

Table 6. *Culture Indicators*

☑ Lessons learned from program evaluation
☑ Institutionalization of sustainable EIDM
☑ Level of institutional commitment to EIDM
☑ Increased use of evidence and EIDM values by policymakers, the media and society
☑ Number of products related to organizational climate
☑ Organizational culture to promote and use research findings for decision-making
☑ Changes in policies or programs consistent with the evidence produced
☑ Changes in government allocated funding
☑ Online availability of website or evidence database
☑ Increasing interest in research among local young people

3.4. Evaluation of Deliberative Dialogue

To evaluate the Deliberative Dialogue (DD), a printed form was distributed to participants at the end of the meeting. The form included seven structured questions, and one of them included an open field for suggestions. In addition to the questions, there was another open field at the end so that participants could make comments if they wished. Of the 19 participants invited to evaluate the DD, 16 completed the evaluation form.

Regarding the achievement of the DD objective (Question 1), 75% responded that it was fully achieved and 25% considered that it was partially achieved. There was no response indicating that the objective was not achieved.

Regarding the material distributed in advance (Question 2), 69% considered it to be sufficiently enlightening, 31% considered it to be partially enlightening and there was no response regarding material that was not enlightening.

Regarding the information presented during the DD (Question 3), 1 participant left this item blank, while 100% of respondents considered that such information was sufficiently enlightening.

Regarding whether all participants were free to express themselves (Question 4), 100% considered that there was such freedom.

Regarding the sufficiency of time to conducted the DD (Question 5), 69% responded “yes,” 31% responded “in part” and no one responded “no.”

Regarding the fact that DD provided important subsidies for the implementation of health programs/policies (Question 6), 100% considered that it did.

Regarding the fact that the guests represented the stakeholders involved in the problem (Question 7), 1 participant left this question blank. Of the 15 who responded, 56% said "yes," 34% said that there was some representation, and no one said "no." Among the 34% who responded "in part," the following remarks were made: there were no representatives from civil society or vulnerable groups; there was a lack of managers present; there were no municipal-level organizations or health professionals working at the frontline; there was a lack of managers from small municipalities; and there were no representatives from the National Health Council.

In the free field of the form intended for comments (if necessary), the following stand out:

- It was great to learn about the topic and listen to colleagues, considerations, but a second moment to involve those present in the next stages did not happen.
- Although there was no resolution on indicators, the DD brought important contributions to establish more appropriate indicators for the experience.
- There were high-level discussions with clear intent.
- The content was broad but unavoidable.
- DD was very mobilizing to inspire the next steps.
- There was not enough time for the complexity of the topic.
- There should be more discussions about monitoring/evaluation indicators.
- Congratulations, HSL! Always scoring lots of goals!
- DD, in general, in terms of monitoring/evaluation indicators, resulted in learning, although unfortunately there was no full dialogue regarding critical factors.

In summary, most participants assessed the DD positively, with percentages above 69%. In three of the seven questions, 100% of the participants responded positively. Among the comments related to referrals, the opinion that monitoring/evaluation indicators should be further developed stands out.

3.5. References

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4. Appendices

Appendix 1. Terms of Reference (TR)

Deliberative Dialogue on critical factors and indicators of EIP institutionalization

This dialogue is part of the implementation of the project "Support for Institutionalization of Evidence-Informed Policies (EIP) in the SUS," triennium 2024/2026, and is linked to Deliverable 1: Synthesis of evidence (including deliberative dialogue) on critical factors for the institutionalization of EIP and EIP implementation guide for SUS organizations (containing a framework of critical factors and tools for situational analysis), activity 1.1.2: Organization of a deliberative dialogue on the synthesis of evidence regarding critical factors for the institutionalization of EIP.

Deliberative Dialogue is a key instrument for knowledge translation, constituting an important strategy for engaging social players, in addition to the community in which they are inserted, during the planning, development and implementation of policies and services. It seeks to support decision-making and disseminate the best evidence for understanding and facing a high-priority problem[j].

Schedule:

9:00-9:10 a.m. - Welcome and presentation of participants: facilitators open the activity and ask participants to briefly introduce themselves;

9:10-9:20 a.m. - Presentation of the synthesis and dialogue theme: the facilitators, using multimedia resources, present an overview of the purpose, schedule and rules of the DD and, if necessary, inform that a Questions & Answers session will be held;

9:20-9:40 a.m. - Presentation of the evidence synthesis previously distributed to participants: facilitators present the problem, objectives, methods and results of the evidence synthesis;

9:40-10:40 a.m. - Session 1 - Resolutions on the synthesis of evidence and its applicability to the SUS context: according to the findings of the synthesis of evidence and its categorizations, the resolutions will be conducted in sequential sessions lasting up to one hour;

10:40-11:00 a.m. - Break;

j - https://www.gov.br/participamaisbrasil/consulta-publica-dialogos-deliberativos

11 a.m.-12 noon - Session 2 - Resolutions on the synthesis of evidence and its applicability to the SUS context: according to the findings of the synthesis of evidence and its categorizations, the resolutions will be conducted in sequential sessions lasting up to one hour;

12 noon-01:30 p.m. - Lunch;

1:30-2:30 p.m. - Session 3 - Resolutions on the critical factors identified and their applicability to the SUS context;

2:30-3:30 p.m. - Session 4 - Resolutions on monitoring and evaluation indicators and their applicability to the SUS context;

3:30-3:50 p.m. - Break;

3:50-4:30 p.m. - Systematization of resolutions: facilitators will reiterate the DD objectives and present a summary of the resolutions and collective understandings reached. Participants will be encouraged to express their opinions on the next steps and contributions to the DD theme;

4:30-5 p.m. – Filling out of the Evaluation form, thanks and closing.

Participants:

Technical team - HSL:

Jorge Otávio Maia Barreto

Maria Lúcia Teixeira Machado

Rachel Riera

Romeu Gomes

Silvio Fernandes da Silva

Tereza Setsuko Toma

Field Specialists - HSL:

Ana Lúcia Marinho Marques

Fernanda Campos de Almeida Carrer

Regimarina Soares Reis

Sandra Maria do Valle Leone de Oliveira

Guests:

Aurelina Aguiar de Lima (Decit/SECTICS/MS)

Cecília Setti (Brazilian Coalition for Evidence, Instituto Veredas)

Daniela Fortunato Rêgo (Ministry of Human Rights and Citizenship)

David Mamblona Marques Romão (WHO)

Heber Dobis Bernarde (CONASS)

Laura dos Santos Boeira (Instituto Veredas)

Luciane Cruz Lopes (UNISO, EVIPolicy Project)

Nilo Bretas (CONASEMS)

Patrícia de Campos Couto (Decit/SECTICS/MS)

Tatiana Yonekura (HCor)

Appendix 2. Instrument for evaluating the deliberative dialogue on critical factors and indicators of institutionalization of EIP

ESPIE Project - 06/25/2024

Dear participant: *We invite you to evaluate the meeting in which critical factors and indicators for monitoring/evaluation the institutionalization of EIP were discussed. Your opinion is very important not only to evaluate the meeting itself, but also to support new deliberative dialogues that may be promoted throughout the implementation of the ESPIE Project.* *We thank you in advance for your cooperation.* **ESPIE Project Coordination**
How was the objective of the deliberative dialogue achieved? (Deliberate on critical factors and monitoring/evaluation indicators for the institutionalization of EIP, considering global evidence and the organizational contexts of the SUS.) ☐ Fully achieved ☐ Partially achieved ☐ Not achieved
Was the material distributed before the deliberative dialogue sufficiently enlightening? ☐ Yes ☐ In part ☐ No
Was the information presented during the deliberative dialogue sufficiently enlightening? ☐ Yes ☐ In part ☐ No

Were all participants given freedom to express themselves? ☐ Yes ☐ In part ☐ No
Was there enough time for the dialogue? ☐ Yes ☐ In part ☐ No
Did the Deliberative Dialogue provide important support for the implementation of health programs/ policies? ☐ Yes ☐ In part ☐ No
Did the guests represent all stakeholders involved in the issue? ☐ Yes ☐ In part ☐ No
If your answer was "in part" or "no," please indicate who else you would invite.
If you wish, in the space below, clarify any previous answer(s) or make comments and/or considerations about the Deliberative Dialogue.
The ESPIE Project coordination team thanks you for your participation in the Deliberative Dialogue and in this evaluation.

HOSPITAL SÍRIO-LIBANÊS

CONASS Conselho Nacional de Secretários de Saúde

CONASEMS

PROADI SUS PROGRAMA DE APOIO AO DESENVOLVIMENTO INSTITUCIONAL DO SISTEMA ÚNICO DE SAÚDE

BRASIL BEM CUIDADO

SUS

MINISTÉRIO DA SAÚDE

GOVERNO FEDERAL BRASIL UNIÃO E RECONSTRUÇÃO