Evidence into action

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EVIDENCE INTO ACTION: POLICY BRIEF EXEMPLAR TO SUPPORT ATTAINMENT OF NURSING NOW

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Abstract

AIM: To provide a framework for the production of policy briefs, and offer a practical example of how evidence can be turned into a succinct document to inform policy and bring about change targeted at delivering universal health coverage (UHC).

INTRODUCTION: Policy makers are too busy, or do not have the necessary expertise, to read and comprehend complex scientific papers. As a result, policy briefs that capture and present the essential points are needed if evidence-informed policy is to be developed and implemented.

METHOD: A two-page example of how evidence from meta-analytical and systematic reviews can be presented to identify options and recommendations to address a major global disease burden.

RESULTS: The example uses a simple, seven-section template for developing a policy brief. The essential characteristics of each section are provided. The briefing, targeted at the global level, provides information on the major challenges associated with the treatment of individuals with diabetes.

DISCUSSION AND CONCLUSIONS: This paper demonstrates how to use existing research evidence to address the pursuit of UHC relevant to a wide range of geographies, settings or disadvantaged groups.

IMPLICATIONS FOR POLICY: Gaps in UHC and major disease burdens such as diabetes can be pursued through entities such as country-based Nursing Now groups. In addition, ongoing opportunities exist through ICN's annual International Nurses Day and WHO's regular regional meetings to inform and influence policy discussions at national and sub-national levels. By focusing on a small number of global topics each year, measurable changes in addressing the burden of disease can be achieved while simultaneously keeping the nursing profession's contribution center stage.

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In its 13th general program of work, the World Health Organization (WHO, 2018a) seeks to extend universal health coverage (UHC) to an additional 1 billion people, improve protections for 1 billion people experiencing health emergencies, and improve the general health and well-being of 1 billion people. Collectively, these targets are referred to as the "triple billion goals" (WHO, 2018a). These goals are fully aligned with several of the Sustainable Development Goals (SDG), particularly those relating to SDG 3 (United Nations General Assembly, 2015). Indeed, WHO's upcoming publication addressing the current state of the world's nursing (SOWN) profession examines in detail the triple billion goals and identifies the role that nurses can play in attaining them. The SOWN report will also provide quantitative information on a range of factors relating to the nursing workforce in Member States, including data on types of nurses, how they are educated and regulated, and their practice and gender. Additionally, the SOWN data will provide a basis for longer-term advocacy on how the profession can influence policy decision-making. To capture this data, WHO, the International Council of Nurses (ICN), and the Burdett Trust for Nursing are collaborating with a wide range of stakeholders on the Nursing Now Program, a three-year campaign to raise the profile and status of nursing worldwide. Furthermore, regarding the pursuit and attainment of UHC, Benton et al. (in press) identified the opportunity to build on available evidence by mobilizing the profession toward influencing policy. This paper provides a practical example of how available evidence can be turned into a briefing to influence policy and bring about change targeted at delivering UHC.

Setting the Scene

Every year, the nursing profession celebrates the birth of Florence Nightingale on 12 May. 2020, 200 years since her birth, sees a special celebration, with WHO declaring it "The Year of the Nurse and the

Midwife." WHO acknowledges that nurses and midwives account for almost half of the global health workforce and play a critical role across a range of care settings (WHO, 2018b). Additionally, WHO has recognized the need for an additional 9 million nurses by 2030 if countries are to reach SDG 3 – the attainment of health and well-being.

Based on the findings of the United Nations High-Level Commission (2016), WHO has also concluded that investing in nurses and midwives represents good value for money, delivering a triple return of improved health outcomes, improved global health security and inclusive economic growth. Nonetheless, it is important to recognize that many countries, irrespective of their wealth, need to ensure that value for money is achieved if maximum access to services is to be delivered. To do this, spending on health care interventions must be informed by the best available evidence (Grimshaw and Hutchinson, 1995; Organization for Economic Cooperation and Development, 2010). It is therefore appropriate, two centuries on, to revisit one of the founding contributions that Nightingale gave the profession: evidence-based practice (Aravind and Chung, 2010; Mackey and Bassendowski, 2016).

Problems with Evidence

Sutherland et al. (2013) highlighted that legislators and policy advisors sometimes have considerable trouble making sense of scientific papers. Accordingly, Sutherland et al. (2013) offered 20 tips for interpreting scientific evidence and concurrently provided advice to scholars to present their findings in a manner more easily understood by policymakers. Notably, Sutherland et al. (2013) pointed out that policymakers are not interested in science per se but rather what it can do for the problems they face. Additionally, Boyd (2013) noted that although many papers go through a peer-review process, it may not be rigorous enough to ensure that systematic bias is removed, and suggested that a set of standards and audit procedures should be applied to the evidence before it could be used to reliably inform policy.

In effect, this is why entities such as the Cochran Collaboration and the Joanna Briggs Institute provide standard guidance to critique and synthesize evidence (Handoll et al., 2008; Joanna Briggs Institute, 2015).

Another challenge for legislators, and indeed the nursing community, is the sheer volume of evidence and opinion-based material being produced. Pan et al. (2018), looking at scientific production in general, highlighted that there is currently a 4% increase in annual published output and 1.8% annual growth in the number of papers being cited. The combined impact is a doubling of cited work every 12 years. Accordingly, if policy messages are to be received and understood by legislators, it is essential material is presented succinctly and clearly. We therefore contend that if nursing is to be heard, nurses must have the necessary skills to produce and communicate persuasive policy briefs.

An Exemplar of a Nursing Contribution to UHC

Chrisp (2019) highlighted an enormous, worldwide increase in non-communicable diseases (NCDs) such as diabetes. Benton et al. (in press) confirmed the availability of a wealth of evidence to address this health challenge, and WHO (2018c) has provided up-to-date information on its magnitude at both aggregate and country levels. Furthermore, with diabetes as the exemplar, it is possible to demonstrate how nursing solutions can be used to simultaneously resolve the four other dimensions that Crisp (2019) suggests should be addressed as part of the Nursing Now campaign. These dimensions include increased use of specialist and advanced practice nurses, a shift toward primary care-led services, the contribution of midwifery, and an increased focus on health promotion, prevention and public health.

Producing a Policy Brief

According to Stoker and Evans (2016), it is important to remember that policy papers and briefs are usually geared toward a non-academic audience that frequently does not have extensive expertise in the topic. Policy briefs often focus on narrow topics that diagnose an issue, present alternatives and, if there is enough evidence to support a definitive stance, recommend a solution (International Centre for Policy Advocacy [ICPA], 2017). Invariably, the recipient of these briefs is looking for a clear, succinct document that is produced with an awareness of the existing positions of the policymaker. Table 1 provides a synopsis of the sections contained within a typical policy brief and their associated characteristics (ICPA, 2017; ffrench-Constant, 2014).

INSERT TABLE 1 Near HERE

Table 1 Synopsis of typical sections of a policy brief and associated characteristics

Depending on the preferences of the person or group being briefed, it may be necessary to provide both a written briefing and a verbal or computer-mediated briefing (using slides, an audio podcast or short video). Irrespective of the format, the same material should be covered. It is also important that the writer of the brief is fully conversant with the current policy direction of the individual or entity receiving the brief. Policy positions can change rapidly. As a result, early identification of the current position is important, along with any assumptions that underpin the brief (ffrench-Constant, 2014).

Typically, a policy brief will be no more than one or two pages. For particularly complex, contentious or high-visibility issues, a longer, more elaborate, document may be needed. However, even under such circumstances, the page length will be limited to three to eight pages with any additional technical details being relegated to one or more appendices (ICPA, 2017).

The timing for the delivery of a brief will depend on whether the intent is to offer information and advocacy on an issue or to inform an upcoming discussion on a topic. If the former, the brief may be delivered months or even years ahead of policy change. In such cases, the advocate for the position may revisit the decision-maker on several occasions as a means of building trust and confidence in the advocate or to ascertain if the policymaker has questions or concerns that can be ameliorated by providing further information. In cases where a minister or other government official is looking to make a decision, the briefings should be delivered to the policymakers in good time for them to seek clarification but not so far in advance that they will have to revisit the material later. In our experience, delivering policy briefs 48 hours in advance of any decision or substantive discussion is sufficient to equip the decision-maker with the necessary facts, options, and relative strengths and weaknesses of proposed positions.

A Worked Example – Diabetes a Global Concern

Normally, in developing a brief, coverage would be in alignment with the geographic focus of the entity being informed. Geographical focus can range from global, regional, country, county, or even smaller units such as cities, organizations or community-based teams. Writing a brief tailored to the responsibility/policy authority of the decision-maker is extremely important to ensure relevance of the advice to the problem at hand. Ideally, authors should know the briefing type and format preferences of the individual they are seeking to inform (ICPA, 2017). The more the briefing is aligned with the preferred layout and style preference, the more likely you will be in getting key points across. Finally, it is important to reflect and evaluate how the briefing was received. Did it meet the principal recipient's needs? The authors should pay attention to any questions raised and determine whether further elaboration should be added if the briefing were to be repeated (ICPA, 2017).

Improving Access and Reducing the Cost of Diabetes Care through Nursing and Midwifery Practice

Purpose:

To identify options and recommend a solution for improved access and reduced cost burdens of the increasing global health problems associated with the non-communicable disease (NCD) diabetes.

Context:

- Diabetes is a chronic, serious disease occurring when the pancreas produces insufficient insulin (a hormone that regulates blood sugar) or when the body is unable to use insulin[1, 2].
- Diabetes is on the increase and is no longer a disease predominantly prevalent in affluent nations, as middle income countries now bear the most marked increases in prevalence[3].
- From 1980-2014, the estimated number of adults living with diabetes has jumped from 108 to 422 million[1]. The disease impacts 8.5% of the adult population – or 1 in 12 people[2].
- Uncontrolled diabetes has significant adverse consequences for health and well-being, including blindness, raised blood pressure, peripheral nerve damage, increased risk of stroke and heart attack, renal failure and risk of lower limb amputation[2, 4-6].
- With increasing levels of obesity, gestational diabetes is also on the rise and places both mothers and babies at increased health risk[6].
- These disease burdens can impact individual and family finances, as well as national economies[5].
- By expanding nursing's scope of practice to include nurse prescribing, cost-effective improvement in patient outcomes can be achieved[7].
- Many countries have pledged to reduce premature mortality from NCDs, including diabetes, by 33% by 2030. Tactics include achieving UHC and providing access to affordable essential medicines[1].
- Data from the United States indicate that diabetes is 17% more prevalent in rural areas than in urban areas[3].

Options:

1. Effective approaches to treat and prevent diabetes and its associated complications are available[5]. Nurses and midwives in all settings and geographies can deliver cost-effective and efficient interventions that include advice on regular exercise, healthy eating, avoiding smoking and controlling blood pressure, which can be effectively delivered[7]. When applied to entire populations, these interventions result in health improvement for those with diabetes and those in good health[8]. The interventions have a low potential for adverse consequences and can be delivered by a wide range of nurses and midwives[7].
2. Expanding the scope of the nurse and midwife, include prescriptive authority, will facilitate the delivery of targeted, nurse-led, person-centered care focusing on preventive and cost-effective management for people with chronic disease[7-9]. Nurses and midwives are better distributed geographically than physicians and can increase access to services in remote and rural settings when they are able to work to their full scope of practice[7, 10]. However, full scope of practice for nurses often faces resistance from other health practitioners who feel nurses are encroaching on their territory, as well as from outdated legislation that imposes ridged limits[9].

Recommendation:

- To make positive and timely progress toward reducing premature death and improving health care efficiency, both options should be pursued either sequentially or concurrently. The first option can be advanced by encouraging the profession to pursue these steps and ensuring that regulatory bodies, through the use of rules, shape the curriculum content of programs to adequately cover preventive aspects of care.
- In the case of option 2, whether nursing is regulated via title protection or scope of practice, these proposals may require legislative change. If so, government should prioritize time in the legislative agenda to facilitate the rapid development of targeted, funded, nurse-led person-centered services, with the goal to increase access, improve quality and reduce costs. Both options are supported by strong evidence[7, 10] and authoritative recommendations by WHO[2].

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Discussion

The example in this paper is framed at the global level, but the topic could easily be scaled back to address an individual country, state or province, or even a small community-based needs assessment (Evans-Agnew et al. 2016). Furthermore, the 2019 UHC monitoring report highlighted the need to look at sub-populations rather than aggregate figures (WHO, 2019). Specifically, the WHO (2019) report highlights that while the national performance of a country may look good, this average level of achievement may hide geographical pockets of inequality, gender differences or disadvantaged groups where more targeted responses are needed. Indeed, nurses have been shown to be ideally suited and capable of addressing health inequalities (Sawyer et al. 2013; National Advisory Council on Nurse Education and Practice, 2016; Heller et al., 2017). Accordingly, this may be a particular strength to stress in advocating for nurse-led policy solutions.

Benton et al. (2016) noted, in terms of influencing policy, nurses should look for opportunities at individual organizational levels. Indeed, Benton et al. (2016) argued that such opportunities, particularly at the ward or department level, offer development experience for nurses to test and hone their policy advocacy skills. Furthermore, at the individual organizational and sub-organizational levels, the impact of such activity can have a near immediate impact on the role that the profession plays in the delivery of person-centered care (Ghebrehiwet, 2011). More recently, Benton et al. (in press) demonstrated that a wealth of material is available in the form of meta-analytical, systematic and integrative reviews that can be used to produce policy briefs on topics supportive of the attainment of UHC and other SDGs as well as a diverse range of issues relevant to addressing today's health needs. As noted in the WHO (2019) monitoring report, while some success has been made toward attaining UHC, progress is still too slow. Accordingly, the WHO (2019) report makes a strong case for additional investment in prevention

and delivery interventions through primary care-led services. Certainly, there is overwhelming evidence that nurses can deliver quality preventive services efficiently and effectively (Browne et al. 2012). It has been repeatedly demonstrated that nursing is better positioned than other disciplines to reach rural and other outlying communities where health inequalities are often more prevalent (Gorski, 2011; National Advisory Council on Nurse Education and Practice, 2016; Heller et al., 2017). Furthermore, it is important to note that nurses have already indicated their willingness to be actively involved in addressing non-communicable diseases such as diabetes (Decola et al. 2012).

While this paper has focused on how to draft a policy brief targeted toward high-level policymakers who need to make a decision at a point in time, it is also important to remember the power of exemplars, images and narrative. Statistics are important, but stories and images about the human impact of the proposed solution can turn facts to life and be a highly effective addition to the briefing (Stoker and Evans, 2016). This is particularly the case if the brief is designed to initiate dialogue and advocate for a new position that has not been previously addressed (JR McKenzie Trust, 2011). Organizations such as the ICN often provide illustrative examples of the work that nurses do across diverse populations, geographies and services. Crisp et al. (2018), in their monograph launched at the 2018 World Innovations Summit for Health, effectively used exemplars to illustrate the wide range of innovative approaches being used by nurses to address UHC. These vignettes, coupled with infographics, have a long history that reaches back to the work of Nightingale when she used the polar area diagram to document the causes of death during the Crimean War. Such techniques and vignettes provide impactful reinforcement to the written word (Benton et al. 2019).

Reports associated with well-researched meta-analysis and systematic reviews, along with the supporting evidence tables, can result in publications of well over 100 pages. Churchill once apologized for the length of one of his letters, saying that to write a shorter version would have taken him more time. Reducing a multitude of evidence to a two-page briefing is not an easy task, but one that is essential if research is to be turned into policy action (ICPA, 2017). With education and practice, briefing skills can be developed that offer succinct, impactful information to decision-makers enabling them to craft timely, evidence-based policy (Stoker and Evans, 2016). Such efforts are important if the hard work of nurse researchers is to shape practice and improve population health (Jacobs et al. 2012).

Conclusions and Policy Recommendations

This paper has shown how to use existing research evidence to develop material capable of informing policy and legislative change. With the global focus on nursing and midwifery triggered by the bicentennial celebration of the birth of Florence Nightingale and the global campaign Nursing Now, the potential to influence policy to improve UHC through the actions of the nursing profession has been enhanced.

Addressing gaps in UHC and major disease burdens such as diabetes can be pursued at the individual level or through entities such as country-based Nursing Now groups that have formed to bring nursing's advocacy and policy expertise to the fore. In addition, ongoing opportunities exist through, for example, ICN's annual International Nurses day, WHO's regular regional meetings, and policy discussions at national and sub-national levels, for nursing to bring its expertise to the policy table.

By focusing globally on a small number of topics each year, coordinated by entities such as the ICN or the International Confederation of Midwives and targeted toward issues upcoming on the World Health Assembly agenda, measurable changes in addressing the burden of disease can be made while simultaneously keeping the nursing profession's contribution center stage. This will require the ongoing production and synthesis of evidence targeted toward addressing the achievement of UHC and the SDGs.

Mobilizing nursing's voices toward a common purpose is a challenge the profession must embrace if the health and well-being of populations are to improve and the contribution of the profession recognized. To do this effectively we offer one final comment, borrowing from the title of a paper by Wong et al. (2008) who looked at delaying the onset of diabetic retinopathy. Wong et al. (2008) stressed that "*timing is everything*" and if nurses are to use their voices effectively in influencing policy we should keep these three words along with several other imperatives in mind. That is, to optimize the impact of our tribute to the 200th anniversary celebrations of Nightingale's birth, and to make nursing's voice resonate across the world with renewed impact, we should brief the right people, at the right time, with an understandable message, supported by evidence and brought to life with patient-centered examples.

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Headings	Characteristics
Title	The title should be succinct and capture the key content of the briefing.
Purpose	The purpose of the briefing, whether for information or to make a decision, should be clearly stated.
Context	This section should provide essential facts and draw upon available evidence, mapped to existing policy directions all presented in plain language.
Options	A balanced set of options highlighting both positive and negative consequences of the proposed action, along with a realistic estimate of any costs or benefits, should be documented along with any relative risks or limitations that may be associated with the various options.
Recommendations	A clear set of recommendations, sensitive to the current and foreseeable context and cognizant of existing policy priorities, as well as an indication of how the recommendations may be implemented, should be stated.
References	Any key documents that are used as sources for facts stated in the briefing should be included in this section.
Author	Information on who produced the briefing, and how they can be contacted for additional information, should be clearly stated.

Table 1 Synopsis of typical sections of a policy brief and associated characteristics

Editor, In the hope that your changes to the manuscript are satisfactory, I hope you can get this back to us soon so that it can be published early in 2020. Please add DOIs to the references where these are available. Associate Editor Comments to Author: Thank you for your very nice contribution with this policy brief exemplar. One of our reviewers needed an extension, hence the delay in getting a decision to you. Both reviewers have some excellent suggestions for revision that will enhance the final manuscript. We use an anti-plagiarism software called iAuthenticate. It shows a 16% overlap with other published sources. However, that can be readily managed by enclosing material taken directly from other sources by "double quotes". The software was supposed to omit the references contained in the exemplars so we can ignore that in the final manuscript. I have attached the similarity report so that you can see where material needs to be quoted. Thanks again for this manuscript If you look at the attached Cross Check report, you will find that it has an xx% non-originality score. Paraphrase what has already been published. Please look carefully at our author guidelines (attached) to find out how you need to reference material. Critically all references need to be done correctly. When directly citing material, note that more than 6-7 words must be put in double inverted commas (" ") and the author and year and page number included. However, we prefer paraphrasing of material with correct referencing.	We have reviewed the comments and believe that we have identified and addressed all the issues raised. We have added DOIs when available. We have reviewed the overlaps and made some adjustments but, as you note, a number of the commonalities identified are references and these have been ignored as you suggest. Thank you for sending the report. It enabled us to critically review the text and make several minor changes where necessary. In general, we found that the total number of words did not replicate large sections of text, but did, throughout several areas of the paper, result in replication of words and phrases identified by the iAuthenticate package as being found in the other papers. Noted. We have chosen to use the paraphrasing approach, as only two of the identified works are common to our paper. In particular, we have rewritten the material from the cited work by WHO (2016) Global Report on Diabetes, Geneva, World Health Organization.
Comments to the Author (required) Thank you for undertaking this important work. I have made comments and suggestions on an attached file and will be pleased to review a second draft. I would like to see the content in the exemplar be strengthened as noted, knowing how important this tool is and likely will be used world-wide by nurses at all levels.	Thank you for your helpful comments. We believe we have addressed the various issues. We've documented the actions taken in this table.

I think that this article would be useful to publish in the journal. I see some sentence structure issues which I think would improve the article. The policy brief example should have citations in text for example. See below:	We have taken the opportunity to review the entire text while addressing the specific points raised, we have also made several additional revisions.
P 4 line 22: I think "regards" should be "regarding" or "with regards to" with a comma	We have made this change.
after Benton p. 5 line 36: remove "there have been" and add "has occurred"	We have made the suggested change.
At the end of the sentence page 5, line 37. Remove "there are" and say, "a wealth of evidence is available."	We have made the suggested change.
Continue through paper to try to simplify sentences like these.	We have reviewed the entire text and made a number of further changes.
p. 7 line 14 -This ?? ranges (what does "this" refer to)?	We reworded the sentence to make the meaning clear.
p. 7 line 19 in brief: Should be "this disease represents…"	We have addressed this.
p. 8 line 39: need to add: "Which" can be delivered by	We have inserted this.
p. 8 – I think you need references in this policy brief – or evidence to support your propositions	The references cited in the brief have now been linked to the various propositions using the Vancouver style of referencing as this is less intrusive, particularly for non-academic audiences, to the flow of the text.
p. 9: …profession to pursue these steps and ensuring that regulatory bodies, through the use of rules, shape the curriculum content of programs… I am not sure we should be asking legislatures to dictate curriculum rather this should be in the purview of the profession itself.	An increasing number of countries have moved toward a co-regulatory model where the profession is provided the power to set practice and education standards through legislation. Accordingly, we have left the text as is.
General: I think that refs should be integrated throughout the policy brief within text citations.	If the recipient of the brief is an academic, then this may be appropriate. But for most ministers, the Vancouver style of referencing is preferred as they find it less intrusive to the flow of the text.

Comments from Reviewer # **Overall Impression:** This article, with some minor editing done to the Introduction and Briefing exemplar, and with a few more references cited and listed, will provide an important contribution in support of the journal's aims.	Thank you very much for your kind words and for the constructive feedback.
The article's current introduction doesn't align optimally with the aim stated in the abstract, which appears first and thus influences the reader's expectations of what follows. Minor re-ordering of the paragraphs will deal with this issue. Without this change, readers may be confused about, and impatient with confirming, the intended purpose and aim of the paper. Move the entire section on p. 2, from lines 3 through 39, below the section entitled, "Improving Access and Health…". Begin the article with the current p. 2 line 46 through p. 3, line 28. This will improve logic and flow while providing the stated purpose and aim of the article closer to the beginning.	Thank you for noting this. We have made the resequencing suggestions and feel this improves the logic and flow of the paper. This action has been taken. Ditto. We agree.
The article posits the importance of using a Briefing Template but authoritative references for the writing style used within the template (i.e.: beyond the Subject Matter Expert's 'critique and synthesis' of scientific evidence itself) were hard to identify on the reference list. The discussion on p. 5 is helpful re: the characteristics. Readers ideally should be able to find examples on the reference list.	We have added relevant references, selected based on being up-to-date and freely available as web downloads. We have addressed this with the addition of two further references.

The Options in the exemplar need to be stated more clearly and strongly, including numbering by priority/importance. Each priority's opening sentence ought to be written as a clear, succinct call to action. Also, the sample 'Options' presently include content that should be moved higher up into the Context (sometimes Context is divided into two sections called Background, Discussion). In this way the content in the succinctly stated Options will link back to the evidence, justifying them.	We have edited the language in the options and recommendations sections.
When the Options are clearly stated, supported by evidence used both logically and strategically, then policymakers are far more likely to use the Nursing organization's brief and cite it themselves when writing their own briefing materials for government-level decision- making.	We have taken this into account in redrafting the exemplar text.
See my examples below, of reworking your draft Options for your reference: OPTION 1. Expand [= call to action] available approaches for the treatment and prevention of diabetes [answers 'the what'] and its associated complications that can reduce premature death. State (don't describe) a few pros and cons that link back to the already-stated facts higher up in the Brief. OPTION 2. Incrementally expand [= call to action with method embedded] the scopes of practice for nurses and midwives [answers 'the what'] in consultation and collaboration with potentially- impacted members of other professions [answers 'the how' it's done], while concurrently examining and identifying any required amendments to legislative, regulatory and practice- related statutes and standards. [Also state a few pros and cons that link to the facts].	Thank you for these suggestions. The redrafting of option 2 calls for expansion of the scope of practice, and as such builds upon option 1.

Given my above comments, the second bullet under 'Options' is not written as an e "Option." Options should link back to the Context/Background and Discussion, which will have already been presented as Facts and analysis, enabling the Options that follow to be action-oriented, based on evidence.	By including an additional point in the context section and resequencing the option 2 language, we have a clear additional option (Expanded Scope of Practice).
Each Option should be a succinct statement setting out 'what you want the policymaker to know and conclude, what 'right' actions or next steps need to be taken, and when. Tell the policymaker what will happen when they take the action, and what will happen if they don't. In my opinion, I think it's important to give the readers a stronger example of effective options, and a 'more tightly written example that shows how the content in the Options links back to the evidence stated in the Context.	We agree, and as a result of editing the text we now believe we have addressed this feedback.
This section should clearly state the recommended Option(s) with brief rationale. Use one sentence to say how the cons can be managed or how high or low risk they are. In the exemplar you may wish to make your statement "more crunchy sounding" by writing: "Both options are recommended. They are viable and timely. Organizations are already in place, funds are already allocated for the on-going work and new money to expand services is available from . The risk of implementing these options, such as , is predictably far lower than the foreseen consequences of not implementing them, based on the evidence from . The following organizations are ready and available to support XXX WHO's/government's/organization's agenda to achieve its stated goals of XXXXXXXX." The authoritative material about writing style, should you choose some, should be cited and briefly discussed on p. 5 or 6.	As noted, the two options are viable and can be pursued either together or separately, with the second option more likely to get pushback from physicians. We have included this point and elaborated upon it slightly in the discussion section.

Sample resources to read re: Briefing Material/Note writing styles: (a) https://www.publicsectorwriting.com/?page_id=6 (I declare no conflict of interest or affiliation with this group); (b) Your own choosing of *Briefing Document STYLE Template Examples* (at least 2) from any of the following: the UK, Europe, Australia or Canada (for example from Canada: Source- world-wide web, accessed October 26, 2019 at https://www.healthevidence.org/practice-tools.aspx and https://www.healthevidence.org/practice-tools.aspx#PT6.	Thank you for these suggestions.
P. 11, lines 30- 32: This sentence is incomplete.	We have addressed this.
The conclusion would be strengthened if a reference to 'nurses creating and presenting evidence-based Briefing materials at strategic times in the policy-development cycle to policy-makers' was repeated again.	We have inserted some additional content to address these comments.

P.6, line 6 - The article suggests "48 hours" as a time frame to deliver Briefing material to policy- makers. What source advises this? I don't agree with this statement at any level since, in my experience, especially since policy-making initiatives can take months and more often years to bring about change by organizations and governments, 48 hours would be far too late to make any difference or impact. Perhaps more explanation and context is needed to justify this time frame if you believe it is correct. In my jurisdiction many non-government organizations (NGOs) begin approaching policy-makers with their own briefs one or more years in advance of any desired legislative or policy change, and only after a government's strategic policy document or plan is publicly released. I would say NGO's need to prepare their briefs between one and two years in advance of any desired date for change. Of course, if the intent is to submit a brief as a reaction to an event rather than pro-actively, then a 48 hour window may be advised.	We have examined this carefully as it is clear from the comment that the reviewer's thinking and ours were different. We were looking at this from a ministerial briefing perspective, getting a product to the minister (the last point made by the reviewer). However, the reviewer raises an important additional aspect, which we see as laying the groundwork and shifting the thinking – a concept we have integrated into the paper.
I notice the term, "institutional level" and "institution" is used without using "organizational" anywhere, which I think is more acceptable in today's healthcare world. I would suggest softening the term "institutional" by substituting or including "organizational," which I think is more current.	Agreed. We have made the suggested changes.
Overall, the article reads and is developed extremely well, and my comments above are intended to improve the strength and flow of the introduction, and to strengthen the content and quality of the exemplar in keeping with the many briefing materials I have read over the years from governments and NGOs across the world. These include international organizations, federal governments and various countries' national organizations, universities, state and provincial governments, and healthcare entities representing nursing and other professional organizations who want to effect change.	We appreciate your thoughtful and constructive comments.

It has been a privilege to read and comment on this proposed article and I would be please to review it a second time.	Thank you for your kind words and most helpful suggestions.

EVIDENCE INTO ACTION: POLICY BRIEF EXEMPLAR TO SUPPORT ATTAINMENT OF NURSING NOW

Abstract

AIM: To provide a framework for the production of policy briefs, and ~~offers~~offer a practical example of how evidence can be turned into a succinct document to inform policy and bring about change targeted at delivering universal health coverage (UHC).

INTRODUCTION: ~~-~~ Policy makers are too busy, or do not have the necessary expertise, to read and comprehend complex scientific papers. As a result, policy briefs that capture and present the essential points are needed if evidence-informed policy is to be developed and implemented.

METHOD: A two-page example of how evidence from meta-analytical and systematic reviews can be presented to identify options and recommendations to address a major global disease burden.

RESULTS: The example uses a simple, seven-section ~~simple~~ template for developing a policy brief. The essential characteristics of each section are provided. The briefing, targeted at the global level, provides information on the major challenges associated with the treatment of individuals with diabetes.

DISCUSSION AND CONCLUSIONS: ~~-~~This paper ~~has demonstrated~~demonstrates how to use existing research evidence to ~~develop material capable~~address the pursuit of ~~informing policy and legislative change. The briefing is capable of being targeted towards~~UHC relevant to a wide range of geographies, settings or disadvantaged groups.

IMPLICATIONS FOR POLICY: ~~-~~ Gaps in UHC and major disease burdens such as diabetes can be pursued through entities such as country-based Nursing Now groups. ~~–~~In addition, ongoing opportunities exist through~~,~~ ICN's annual International Nurses Day and WHO's regular regional meetings~~,~~ to inform and influence policy discussions at national and sub-national levels. By ~~focussing globally~~focusing on a small number of global topics each year, measurable changes in addressing the burden of disease can be achieved while simultaneously keeping the nursing profession's contribution center stage.

EVIDENCE INTO ACTION: POLICY BRIEF EXEMPLAR TO SUPPORT ATTAINMENT OF NURSING NOW

In its 13th general program of work, the World Health Organization (WHO, 2018a) seeks to extend universal health coverage (UHC) to an additional 1 billion people, improve protections for 1 billion people experiencing health emergencies, and improve the general health and well-being of 1 billion people. Collectively, these targets are referred to as the "triple billion goals" (WHO, 2018a). These goals are fully aligned with several of the Sustainable Development Goals (SDG), particularly those relating to SDG 3 (United Nations General Assembly, 2015). Indeed, WHO's upcoming publication addressing the current state of the world's nursing (SOWN) profession examines in detail the triple billion goals and identifies the role that nurses can play in attaining them. The SOWN report will also provide quantitative information on a range of factors relating to the nursing workforce in Member States, including data on types of nurses, how they are educated and regulated, and their practice and gender. Additionally, the SOWN data will provide a basis for longer-term advocacy on how the profession can influence policy decision-making. To capture this data, WHO, the International Council of Nurses (ICN), and the Burdett Trust for Nursing are collaborating with a wide range of stakeholders on the Nursing Now Program, a three-year campaign to raise the profile and status of nursing worldwide. Furthermore, regarding the pursuit and attainment of UHC, Benton et al. (in press) identified the opportunity to build on available evidence by mobilizing the profession toward influencing policy. This paper provides a practical example of how available evidence can be turned into a briefing to influence policy and bring about change targeted at delivering UHC.

Setting the Scene

Every year, the nursing profession celebrates the birth of Florence Nightingale on 12 May. 2020, 200 years since her birth, sees a special celebration, with ~~the World Health Organization (WHO)~~WHO

declaring it “The Year of the Nurse and the Midwife.” WHO acknowledges that nurses and midwives account for almost half of the global health workforce and play a critical role across a range of care settings (WHO, ~~2018a~~2018b). Additionally, WHO has recognized the need for an additional 9 million nurses by 2030 if countries are to reach ~~Sustainable Development Goal (~~SDG~~)~~ 3~~-~~ – the attainment of health and well-being.

~~Furthermore, based~~Based on the findings of the United Nations High-Level Commission (2016), WHO has also concluded that investing in nurses and midwives represents good value for money, delivering a triple return of improved health outcomes, improved global health security and inclusive economic growth. Nonetheless, it is important to recognize that many countries, irrespective of their wealth, need to ensure that value for money is achieved if maximum access to services ~~are~~is to be delivered~~..~~. To do this, spending on health care interventions ~~needs to~~must be informed by the best available evidence (Grimshaw and Hutchinson, 1995; Organization for Economic Cooperation and Development, 2010). It is therefore appropriate, two centuries on, to revisit one of the founding contributions that Nightingale gave the profession~~,~~: evidence-based practice (Aravind and Chung, 2010; Mackey and Bassendowski, 2016).

~~**Improving Access and Health**~~

~~In its 13th general program of work, WHO (2018b) seeks to extend universal health coverage (UHC) to an additional 1 billion people, improve protections for 1 billion people experiencing health emergencies, and improve the general health and well-being of 1 billion people. Collectively, these targets are referred to as the “triple billion goals” (WHO, 2018b). These goals are fully aligned with several of the SDGs, particularly those relating to SDG 3 (United Nations General Assembly, 2015). Indeed, WHO’s~~

~~upcoming publication addressing the current state of the world's nursing (SOWN) profession examines in detail the triple billion goals and identifies the role that nurses can play in attaining them. The SOWN report will also provide a technical description of the nursing workforce in Member States, including the number and types of nurses, education, regulation, practice, leadership, and gender issues. Additionally, the SOWN data will provide a basis for longer term advocacy on how the profession can influence policy decision making. To capture this data the World Health Organization, the International Council of Nurses and the Nursing Now Campaign are collaborating with a wide range of stakeholders. Furthermore, regards the pursuit and attainment of UHC Benton et al. (in Press) identified the opportunity to build on available evidence by mobilizing the profession toward influencing policy. This paper provides a practical example of how available evidence can be turned into a briefing to influence policy and bring about change targeted at delivering UHC.~~

~~The~~ Problems with Evidence

Sutherland et al. (2013) highlighted that legislators and policy advisors sometimes have considerable trouble making sense of scientific papers. Accordingly, Sutherland et al. (2013~~),~~) offered 20 tips for interpreting scientific evidence and concurrently provided advice to scholars ~~that they needed~~ to present their findings in a manner more easily understood by policymakers. Notably, Sutherland et al. (2013) ~~highlighted that policymaking was both an art and developing science and importantly~~ pointed out that ~~legislators~~policymakers are not interested in science per se but rather what it can do for the problems they ~~want to resolve. Addittionally~~face. Additionally, Boyd (2013~~,~~)) noted that although many papers ~~do~~ go through a peer-review process, it may not be rigorous enough to ensure that systematic bias is removed, and suggested that a set of standards and audit procedures ~~needed to~~should be applied to the evidence before it could be used to reliably inform policy. In effect, this is why entities such as

the Cochran Collaboration and the Joanna Briggs Institute provide standard guidance to critique and synthesize evidence (Handoll et al., 2008; Joanna Briggs Institute, 2015).

Another challenge for legislators, and indeed, the nursing community, is the sheer volume of evidence and opinion-based material being produced. Pan et al. (2018), looking at scientific production in general, highlighted that there is currently a 4% increase in annual published output and 1.8% annual growth in the number of papers being cited. The combined impact is a doubling of cited work every 12 years. Accordingly, if policy messages are to be received and understood by legislators, it is essential material is presented succinctly and clearly. We, therefore, contend that if nursing is to be heard, nurses must have the necessary skills to produce and communicate persuasive policy briefs.

An Exemplar of a Nursing Contribution to UHC

Chrisp (2019) highlighted that there had been an enormous, worldwide increase in non-communicable diseases (NCDs) such as diabetes. Benton et al. (2020in press) confirmed that there is the availability of a wealth of evidence available to address this health challenge, and WHO (2018c) has provided up-to-date information on its magnitude exists at both aggregate and country levels (WHO, 2018c). Furthermore, with diabetes as the exemplar, it is possible to demonstrate how nursing solutions can be used to simultaneously resolve the four other dimensions that Crisp (2019) suggests require toshould be addressed as part of the Nursing Now campaign. These dimensions include the increased use of specialist and advanced practice nurses, a shift toward primary care-led services, the contribution of midwifery, and an increased focus on health promotion, prevention and public health.

Producing a Policy Brief

According to Stoker and Evans (2016), it is important to remember that policy papers and briefs are usually geared toward a non-academic audience that frequently does not have ~~a great deal of~~extensive expertise in the topic. Policy briefs often focus on narrow topics that diagnose an issue, present alternatives and ~~recommend a solution (~~, if there is enough evidence to support a definitive stance, recommend a solution (International Centre for Policy Advocacy [ICPA], 2017). Invariably, the recipient of these briefs is looking for a clear, succinct document that is produced with an awareness of the existing positions of the policymaker. Table 1 provides a synopsis of the sections contained within a typical policy brief and their associated characteristics~~.~~ (ICPA, 2017; ffrench-Constant, 2014).

INSERT TABLE 1 Near HERE

Table 1 Synopsis of typical sections of a policy brief and associated characteristics

Depending on the preferences of the person or group being briefed, it may be necessary to provide both a written briefing and a verbal or computer-mediated briefing (using slides, an audio podcast or short video). Irrespective of the format, the same material ~~needs to~~should be covered. It is also important that the writer of the brief is fully conversant with the current policy direction of the individual or entity receiving the brief. Policy positions can change rapidly. As a result, early identification of the current position is important, along with any assumptions that underpin the brief~~.~~ (ffrench-Constant, 2014).

Typically, a policy brief will be no more than one or two pages. For particularly complex, contentious or high~~-~~visibility issues, a longer, more elaborate, document may be needed. However, even under such circumstances, the page length will be limited to three to eight pages with any additional technical details being relegated to one or more appendices~~. Normally,~~ (ICPA, 2017).

The timing for the delivery of a brief will depend on whether the intent is to offer information and advocacy on an issue or to inform an upcoming discussion on a topic. If the former, the brief may be delivered months or even years ahead of policy change. In such cases, the advocate for the position may revisit the decision-maker on several occasions as a means of building trust and confidence in the advocate or to ascertain if the policymaker has questions or concerns that can be ameliorated by providing further information. In cases where a minister or other government official is looking to make a decision, the briefings should be delivered to the policymakers in good time for them to seek clarification but not so far in advance that they will have to revisit the material ~~nearer the time that they will be questioned on the topic. Typically~~later. In our experience, delivering policy briefs 48 hours in advance of any decision or substantive discussion is sufficient to equip the decision-maker with the necessary facts, options, and relative strengths and weaknesses of proposed positions.

~~The example set out below looks at diabetes at the global level.~~ **A Worked Example – Diabetes a Global Concern**

Normally, in developing a brief, coverage would be in alignment with the geographic ~~coverage~~focus of the entity being informed. ~~This ranges~~Geographical focus can range from global, regional, country, county, or even smaller units such as cities, ~~institutions~~organizations or community-based teams. Writing a brief ~~specific~~tailored to the ~~area of~~ responsibility/policy authority of the decision-maker is extremely important to ensure ~~the~~ relevance of the advice to the problem at hand. Ideally, authors should know the briefing type and format preferences of the individual they are seeking to inform~~.~~ (ICPA, 2017). The more the briefing is aligned with the preferred layout and style preference, the more likely you will be in getting key points across. Finally, it is important to reflect and evaluate how the briefing was received. Did it meet the principal recipient's needs? The authors should pay attention to

any questions ~~that were~~ raised and determine whether further ~~clarity or~~ elaboration should be added if the briefing were to be repeated~~.~~ (ICPA, 2017).

Improving Access and Reducing the Cost of Diabetes Care through Nursing and Midwifery Practice

Purpose:

To identify options and recommend a solution for improved access and reduced cost burdens of ~~-~~the increasing global health problems associated with the non-communicable disease (NCD) diabetes.

Context:

- Diabetes is a chronic, serious~~, chronic~~ disease ~~and occurs~~occurring when the pancreas ~~does not produce enough~~produces insufficient insulin (a hormone that regulates blood sugar) or when the body ~~cannot effectively~~is unable to use ~~insulin~~insulin[1, 2].
- Diabetes is on the ~~rise~~increase and is no longer a disease ~~of~~ predominantly prevalent in affluent nations ~~with~~, as middle income countries now bear the most marked increases in ~~prevalence occurring in middle income countries.~~prevalence[3].
- ~~In~~ From 1980-2014, the ~~global estimate for~~ estimated number of adults living with diabetes ~~was 422 million - an increase~~ has jumped from 108 ~~million in 1980. This represent~~to 422 million[1]. The disease impacts 8.5% of the adult population – or 1 in 12 people[2].
- Uncontrolled diabetes has ~~dire~~significant adverse consequences for health and well-being, including blindness, raised blood pressure, peripheral nerve damage, increased risk of stroke and heart attack, renal failure and risk of lower limb ~~amputation~~amputation[2, 4-6].
- With increasing levels of obesity, gestational diabetes is also on the rise and places both mothers and babies at increased health ~~risk~~risk[6].
- These disease burdens can impact ~~on individuals~~individual and family finances, as well as national ~~economies~~economies[5].
- ~~UN member states~~By expanding nursing's scope of practice to include nurse prescribing, cost-effective improvement in patient outcomes can be achieved[7].
- Many countries have ~~set ambitious targets~~pledged to reduce premature mortality from NCDs ~~–~~, including diabetes ~~–~~, by ~~one third;~~33% by 2030. Tactics include achieving UHC~~;~~ and providing access to affordable essential ~~medicines, all by the year 2030.~~medicines[1].
- Data from the United States indicate that diabetes is 17% more prevalent in rural areas than in urban ~~areas~~areas[3].

Options:

1. Effective approaches ~~for the treatment~~to treat and ~~prevention of~~prevent diabetes and its associated complications ~~that~~are available[5]. Nurses and midwives in all settings and geographies can ~~reduce premature death are available. Interventions~~deliver cost-effective and efficient interventions that include advice on regular exercise, healthy eating, avoiding smoking and controlling blood pressure, which can be effectively ~~delivered by both nurses and midwives in all settings and geographies. These interventions can be~~delivered[7]. When applied to entire populations ~~and can~~, these interventions result in health improvement for those with diabetes and those in good ~~health~~health[8]. The interventions have a low potential for adverse consequences and can be delivered by a wide range of nurses and ~~midwives~~midwives[7].
2. ~~Models~~Expanding the scope of ~~proactive,~~ the nurse and midwife, include prescriptive authority, will facilitate the delivery of targeted, nurse-led, person-centered care ~~that focus~~focusing on preventive ~~patient self-~~and cost-effective management for people with chronic ~~disease are either more~~

~~effective and equally or less costly, or are equally effective and less costly, than the usual model of care~~disease[7-9]. Nurses and midwives are better distributed geographically than physicians and can increase access to services in remote and rural settings when they are able to work to their full scope of ~~practice.~~practice[7, 10]. However, ~~promoting~~ full scope of practice for nurses ~~sometimes~~often faces resistance ~~by~~from other health practitioners who feel nurses are encroaching on their territory ~~or where professional regulation imposes ridged limits imposed through~~, as well as from outdated legislation ~~on scopes of practice~~that imposes ridged limits[9].

Recommendation:

- ~~Both~~To make positive and timely progress toward reducing premature death and improving health care efficiency, both options ~~can~~should be pursued either sequentially or ~~in parallel~~concurrently. The first option can be ~~progressed~~advanced by encouraging the profession to pursue these steps and ensuring that regulatory bodies, through the use of rules, shape the curriculum content of programs to adequately cover preventive aspects of care.
- ~~Whether~~In the case of option 2, whether nursing is regulated via title protection or scope of practice, these proposals may require legislative change. If ~~legislative change is required~~so, government~~, on the basis of pursuit of increasing access, improving quality and reducing costs,~~ should prioritize time in the legislative agenda to facilitate the rapid development of targeted, funded, nurse-led person-~~centred~~centered services, with the goal to increase access, improve quality and reduce costs. Both options are supported by strong evidence[7, 10] and authoritative recommendations by WHO[2].

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~~World~~[9]Worswick ~~Health Organization (2018) Noncommunicable diseases country profiles (2018). Geneva, World Health Organization. https://www.who.int/nmh/publications/ncd-profiles-2018/en/~~

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Discussion

The example ~~used~~ in this paper is framed at the global level, but ~~this~~the topic could easily be scaled back to address an individual country, state or province, or even a small ~~rural~~ community-based needs assessment (Evans-Agnew et al. 2016). Furthermore, the 2019 UHC monitoring report highlighted the need to look at sub-populations rather than aggregate figures (WHO, 2019). Specifically, the WHO (2019) report highlights that while the national performance of a country may look good, this average level of achievement may hide geographical pockets of inequality, gender differences or disadvantaged groups where more targeted responses are needed. Indeed, nurses have been shown to be ideally suited and capable of addressing health inequalities (Sawyer et al. 2013; National Advisory Council on Nurse Education and Practice, 2016; Heller et al., 2017). Accordingly, this may be a particular strength to stress in advocating for nurse-led policy solutions.

Benton et al. (2016) noted, ~~that~~ in terms of influencing policy, nurses should look for opportunities at individual ~~institutional~~organizational levels. Indeed, Benton et al. (2016) argued that such opportunities, particularly at the ward or department level, offer development experience for nurses to test and hone their policy advocacy skills. Furthermore, at the individual ~~institutional~~organizational and sub-~~institutional~~organizational levels, the impact of such activity can have ~~an~~a near immediate impact on the role that the profession plays in the delivery of person-centered care~~.~~ (Ghebrehiwet, 2011). More recently, Benton et al. (in press) demonstrated that ~~there is~~ a wealth of material is available in the form of meta-analytical, systematic and integrative reviews that can be used to produce policy briefs on topics supportive of the attainment of UHC and other SDGs as well as a diverse range of issues relevant to addressing today's health needs. As noted in the WHO (2019) monitoring report, while some success has been made toward attaining UHC, progress is still too slow. ~~-~~Accordingly, the WHO (2019) report

makes a strong case for additional investment in prevention and delivery ~~of~~ interventions through primary care-led services. Certainly, there is overwhelming evidence that nurses can deliver quality preventive services efficiently and effectively (Browne et al~~.,~~. 2012). It has been repeatedly demonstrated that nursing is better positioned than other disciplines to reach rural and other outlying communities where health inequalities are often more prevalent (Gorski, 2011; National Advisory Council on Nurse Education and Practice, 2016; Heller et al., 2017). Furthermore, it is important to note that nurses have already indicated their willingness to be actively involved in addressing non-communicable diseases such as diabetes (Decola et al. 2012).

While this paper has focused on how to draft a policy brief targeted toward high-level ~~policy makers~~policymakers who need to make a decision at a point in time, it is also important to remember the power of exemplars, images and narrative. Statistics are important, but stories and images about the human impact of the proposed solution can turn facts to life and be a highly effective addition to the briefing ~~-~~(Stoker and Evans, 2016). This is particularly the case if the brief is designed to initiate dialogue and advocate for a new position that has not been previously addressed (JR McKenzie Trust, 2011). Organizations such as the ~~International Council of Nurses (~~ICN~~)~~ often provide ~~an~~ illustrative ~~example~~examples of the work that nurses do across diverse populations, geographies and services. Crisp et al. (2018), in their monograph~~,~~ launched at the 2018 World Innovations Summit for Health ~~(WISH),~~ effectively used exemplars to illustrate the wide range of innovative approaches being used by nurses to address UHC. These vignettes, coupled with infographics, have a long history that reaches back to the work of Nightingale when she used the polar area diagram to document the causes of death during the Crimean War. Such techniques and vignettes provide impactful reinforcement to the written word (Benton et al~~.,~~. 2019).

Reports associated with well-researched meta-analysis and systematic reviews, along with the supporting evidence tables, can result in publications of well over 100 pages. ~~Reducing them to a two-page briefing is not an easy task, but one that is essential if research is to be turned into policy action.~~ Churchill once apologized for the length of one of his letters, saying that to write a shorter version would have taken him more time. Reducing a multitude of evidence to a two-page briefing is not an easy task, but one that is essential if research is to be turned into policy action (ICPA, 2017). With education and practice, briefing skills can be developed that offer succinct, impactful information to decision-makers enabling them to craft timely, evidence-based policy ~~change~~ (Stoker and Evans, 2016). Such efforts are important if the hard work of nurse researchers is to shape practice and improve population health (Jacobs et al. 2012).

Conclusions and Policy Recommendations

This paper has shown how to use existing research evidence to develop material capable of informing policy and legislative change. With the global focus on nursing and midwifery~~,~~ triggered by the bicentennial celebration of the birth of Florence Nightingale and the global campaign Nursing Now, the potential to influence policy to improve UHC through the actions of the nursing profession has been enhanced.

Addressing gaps in UHC and major disease burdens such as diabetes can be pursued at the individual level or through entities such as country-based Nursing Now groups that have formed to bring nursing's advocacy and policy expertise to the fore. ~~–~~In addition, ~~further~~ ongoing opportunities exist through, for

example, ICN's annual International Nurses day, WHO's regular regional meetings, ~~-~~and policy discussions at national and sub-national levels, for nursing to bring its expertise ~~in addressing.~~ to the policy table.

By ~~focussing~~focusing globally on a small number of topics each year, coordinated by entities such as the ICN or the International Confederation of Midwives and targeted toward issues upcoming on the World Health Assembly agenda, measurable changes in addressing the burden of disease can be made while simultaneously keeping the nursing profession's contribution center stage. This will require the ongoing production and synthesis of evidence targeted toward addressing the achievement of UHC and the SDGs.

Mobilizing nursing's voices toward a common purpose is a challenge the profession must embrace if the health and well-being of populations are to improve and the contribution of the profession recognized. To do this effectively we offer one final comment, borrowing from the title of a paper by Wong et al. (2008) who looked at delaying the onset of diabetic retinopathy. Wong et al. (2008) stressed that "*timing is everything*" and if nurses are to use their voices effectively in influencing policy we should keep these three words along with several other imperatives in mind. That is, to optimize the impact of our tribute to the 200th anniversary celebrations of Nightingale's birth, and to make nursing's voice resonate across the world with renewed impact, we should brief the right people, at the right time, with an understandable message, supported by evidence and brought to life with patient-centered examples.

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Headings	Characteristics
Title	The title should be succinct and capture the key content of the briefing.
Purpose	The purpose of the briefing, whether for information or to make a decision, should be clearly stated.
Context	This section should provide essential facts and draw upon available evidence, mapped to existing policy directions all presented in plain language.
Options	A balanced set of options highlighting both positive and negative consequences of the proposed action, along with a realistic estimate of any costs or benefits, should be documented along with any relative risks or limitations that may be associated with the various options.
Recommendations	A clear set of recommendations, sensitive to the current and foreseeable context and cognizant of existing policy priorities, as well as an indication of how the recommendations may be implemented, should be stated.
References	Any key documents that are used as sources for facts stated in the briefing should be included in this section.
Author	Information on who produced the briefing, and how they can be contacted for additional information, should be clearly stated.

Table 1 Synopsis of typical sections of a policy brief and associated characteristics