Proposed Public Health Policy Briefs Outline

I. Introduction

Proposed Public Health Policy Briefs should identify a public health problem and present an objective summary of the problem. Proposals should be concise and accurate, and references should be used effectively to justify the call for defined action by entities external to APHA. The recommended format for the proposed Policy Brief is relatively simple and should facilitate clear and succinct expression. Supporting evidence is presented in paragraph form, with action steps listed in a table opposite the evidence-based strategy to which they correspond. Original submissions cannot exceed 2750 words (1.5 line spacing, 11pt font, Arial font) in narrative text length and 35 references.

A maximum of three, but at least two, evidence-based strategies supported by no more than a total of ten action steps for the policy may be included. All proposed evidence-based strategies should incorporate the social determinants of health and aim to improve the public's health. All action steps must be external to APHA.

The Evidentiary Review Committee will NOT review proposed Public Health Policy Briefs that fail to include each section below.

II. Required Components Descriptions

1. Title Page (1 Page)

a. Title: The title should accurately and succinctly state the public health policy and the type of strategy the policy brief addresses (for example, "Support for National Nutrition Monitoring"). The title should not cite a specific piece of legislation or administration.

b. **Relationship to Existing Active APHA Policy Statements/Policy Briefs**: In this section, authors should list by name and number all active (i.e., not archived) APHA policy briefs (previously known as policy statements) related to this public health problem. To view APHA policy briefs, please see the APHA policy statement database. The authors should explicitly state whether there are no active APHA Policy Statements/Briefs related to the public health problem to be addressed by the proposed policy brief. This section intends to allow readers to find and review additional policy briefs on the topic or related matters. Only a list is required (i.e. no further explanation is needed). ONLY LIST. Include the policy number and title.

c. Sponsorship/Co-Sponsorship: *Sponsorship* means that an APHA member unit is submitting the proposed policy brief. A signed letter from the member unit chair and/or president indicating sponsorship/co-sponsorship should accompany the submission (see the template in Appendix 6). Proposed policy briefs will not be accepted without sponsorship from an APHA member unit.

d. Summary Abstract: In 250 words or less, summarize the problem statement and recommendations contained in the proposed policy brief. This section should NOT contain any references. Identify keywords related to the proposed policy brief (maximum 5).

2. Author Page (No word count):

Author identification (If multiple authors, please list the primary contact first and then list the other authors in alphabetical order):

a. Name
b. Organization
c. Address
d. Phone Number
e. Email
f. APHA Member Number
g. APHA Member Unit Affiliation (e.g., Section/SPIG/Caucus/Forum/Student Assembly/Affiliate)

Note: The first author listed will be the corresponding author. Contact information for the first author will be available during the review process. Name and APHA Member Unit Affiliation will be listed for all other authors. All individuals who contributed to the authorship of the policy brief must be APHA members.

3. **Public Health Policy Brief (Word Count 2,750 Words; Excluding 35 References):** The following sections must be addressed using the appropriate headers:

Section 1: Problem Statement [Recommended maximum of 1000 Words]

1. **Evidence of the Problem and Gaps in Knowledge:** What problems does the policy brief address and why is action necessary? Provide evidence of the existence of the problem, it's extent and impact. Discuss any gaps in public health or scientific knowledge of the problem.
2. **Target Population:** What problem does the proposed policy brief address, and who is impacted? Clearly identify the target population (that is, the population affected by this policy, not the actors) and their needs and wants. Identify if the population has been consulted or how the needs were identified. Detail the following with supporting evidence.
    a. **Burden:** The overall impact of the public health topic or issues issue on a population (for example disease or a health condition in the population). This can be measured in terms of morbidity (illness), mortality (death), economic costs, and/or decreased quality of life.
    b. **Risk:** The probability or likelihood that an individual or population will be impacted by the issue (for example experience a health-related event, such as disease, injury, or death). Can be modifiable or non-modifiable.
    c. **Disproportionate Impact:** Occurs when a specific population group experiences a greater burden of disease, health risk, or poor outcomes compared to others, often due to social, economic, or environmental inequalities.

3. **Context: Explain the central context around the problem and plans to address it with evidence of cause and effect. Consider the following and include as relevant:**

    a. **Historical considerations:** How have past events and societal changes, including wars, economic shifts, or mass migrations, for example, impacted the problem? How have scientific knowledge and public values shaped the problem's perception and management over time? Also, explore past mistakes and successes in addressing the problem.
    b. **Cultural considerations:** What are the shared values, beliefs, and practices that influence the population's understanding of problems, desired solutions, and the acceptability of policies?
    c. **Ethical considerations:** What are the ethical dimensions to the problem and its potential impact on stakeholders' rights, values, and well-being?
    d. **Health systems considerations:** What institutions and organizations are present to promote, sustain, or restore health? How do these systems function, and are they accessible?

    e. **Economic and resource considerations:** How is the problem impacted by resource allocation, income distribution, employment, and overall economic well-being?
    f. **Social considerations:** How do factors like social support and inclusion, discrimination, and violence influence populations' experience with the problem and the desire for a solution?
    g. **Political considerations:** How do political ideologies, funding structures, power dynamics, interest groups, and government structures influence the problem's definition and the potential for solutions?
4. **Counterpoint Review:** The authors must provide context for alternative explanations or opposing arguments to the extent and existence of the problem and ethical, equitable, and legal considerations when appropriate. Clearly address why each identified opposing argument/evidence is invalid or less relevant (in general or regarding the proposal), referencing scientific or other authoritative evidence.

Section 2: Evidence-Informed Strategies & Action Steps [Recommended maximum of 1750 Words, not including the table]

In this section, the member unit must identify the appropriate evidence-informed strategies that directly ameliorate the problem and the action steps to implement said strategies. There may be up to 3 evidence-informed strategies (minimum of 2) and up to 10 action steps total for policy, with at least one action step required to focus on education to the broader public and one action that can be taken or promoted on the state level.

Given these limitations, the following contextual elements of feasibility, justification, and appropriateness of the proposed strategies and actions should be considered and discussed, if applicable:

a. political salability- Is there political will/commitment obtained through public opinion and pressure from interest groups, lobbying, and advocacy? What is the decision-making process, the political agenda, and the means of knowledge sharing? Political salability is based on the idea that decision makers are not receptive to research unless it serves political gain (predetermined decision/evidence sought to justify the problem).
b. ethical considerations- To include autonomy, nonmaleficence (not causing more harm), beneficence, justice, service to society and accountability to those served.
c. capacity constraints- Knowledge and skills of individuals and organizations, partnerships, networking, structure (organizational composition), funding, training, will, interest, advocacy, process, leadership, communities of learning (knowledge sharing), support for innovation, and value. What needs to be present in the setting to support evidence uptake/ability to carry out the objectives?
d. economic feasibility- Examine a project's costs and financial benefits; an appropriate comparison of benefits and costs associated with the project (money

and resources available for implementation, cost effectiveness, and opportunity cost).

e. level of trust- Are actors or policymakers trusted enough to influence the proposed actions? Is there trust in the action and strategies themselves from actors, policy makers and the target population? Are the action steps easily understood and is there advantage over alternative action well demonstrated? Are the examples of use with success or promotion by those with similar "values" or "culture"
f. degree of support- The value is associated with the proposed actions and those who developed and/or are implementing the knowledge base.
g. cost of implementation- Who bears the costs? How costly is it to take this action? What is the opportunity cost. What would be needed in terms of time, training, and research and development, and what effects would the action steps have on productivity?

1. **Evidence-Informed Strategies:** State what strategies are being proposed to address the public health problem. They should directly align with and address problems raised in the Problem Statement section. Each strategy should be numbered. There may be a maximum of three Evidence-Informed Strategies (minimum of 2).

Evidenced-Informed Strategies may include:

- Education of the specific organizations or groups
- Laws, policies, or regulations directed to a legislative or administrative body (e.g., requiring paid leave)
- Support for further scientific research (e.g., relationship of childhood lead poisoning to criminal behavior.)
- Response to an existing problem (e.g., flu shots recommended or required for all health care workers)
- Remediation (e.g., due to environmental contamination)

For each strategy proposed, the following must be addressed and labeled as such:

a) **Support for the effectiveness of the Evidence-Informed Strategy:** Provide the most relevant and highest-level available evidence for the effectiveness of the strategy, demonstrating the proposed strategy's impact on the problem.
b) **Justification:** Provide evidence and rationale for each evidence-informed strategy. Include a discussion of ethics and equity, as well as cost effectiveness or efficiency and support for the impact at the proposed level of intervention.
c) **Feasibility:** Provide evidence of the strategy's feasibility and appropriateness with attention to an analysis of the risk, harm, and benefit

of the approach, particularly as it relates to the human rights of the population.

2. **Alternative Strategies-** Detail alternative strategies that have been tried or proposed to address the problem. Justify the strategy proposed in relation to these alternative strategies (e.g., more cost-effective, greater reach, better equipped to address inequity, etc.).

3. **Action Steps:** Following the above, consider the evidence-informed strategies and describe the Action Steps needed to promote or implement each. Action steps should be feasible, ethical, and equitable to undertake. They should also be culturally and linguistically appropriate to any affected populations. The focus of the action steps should be on the problem rather than specific legislation/regulation.

Action steps must:

- **be directed at an entity(ies) external to APHA**
- **identify an actor(s) to undertake the actions**.

Action Steps should address one action: The action step must include the desired outcome. Action steps should be discrete and not cumulative unless the Evidentiary Review Committee has granted special permission. An action step can be related to more than one strategy.

The general structure of an action step should follow a S.M.A.R.T (Specific, Measurable, Achievable, Relevant, Time Sensitive) approach when possible.

At least one action step must be directed toward educating the field and the public and at least one action step must include an action that can be taken or promoted at the state level.

This section should be organized in table format – not a narrative (See below). References are unnecessary in this section because they should have been included in the evidence informed strategies section if pertinent.

The completed table will include the following sections:

- **Evidence-Informed Strategy:** The associated evidence-informed strategy that supports the action step(s). An action step may be listed twice if it addresses two Evidence-Informed Strategies
- **Proposed Action Steps:** The proposed Action Step.
- **Advocacy Level: Identify the level of engagement required for advocacy. These options include federal, state, local (e.g., city or community), or tribal.**

Evidence-informed strategies should be ranked in order of priority and

timeliness.

	Evidence-Informed Strategy		Action Steps	Advocacy Level
1		1		
		2		
		3		
2		1		
		2		
3		1		
		2		

4. **References:** Authors must provide appropriate references to authoritative evidence. Include the best available references that support the text (e.g., relevant peer-reviewed literature, government documents, evidence-informed reports). Please see the Reference Guide in Appendix 2.
    a. Do NOT use automatic referencing (i.e., Endnotes). Each reference should be numbered and manually entered. Number each new reference the first time it appears and use that number to refer to the reference every time it is cited in the proposed Policy Brief.
    b. Provide the full citation for each numbered reference cited in the text of the proposed Policy Brief. The citation format is that of the 11th Edition of the American Medical Association: guidelines available in Appendix B. For all online references, include the accessed date. These should be checked just before submission.
    c. Provide links to the full text of articles online (when available). Links should be functioning.
    d. Double-check that each in-text number aligns correctly with the numbered reference.

III. Formal Policy Brief Outline

1
Title Page

2:
Author Page

3:
Policy Brief [2700 Words; 35 References]

Problem Statement (Max 1000 Words)

a) Problem and Target Population (Recommended No More Than 150 Words)
b) Context
c) Alternative Explanations of the problem (Recommended No More Than 250 Words)

Evidence-Informed Strategies and Action Steps for Implementation (Recommended Max 1750 Words, not counting Action Steps table)

a) Proposed Evidence-Informed Strategy 1 (Recommended 500 Words)
    a. Justification
    b. Feasibility
b) Proposed Evidence-Informed Strategy 2 (Recommended 500 Words)
    a. Justification
    b. Feasibility
c) Proposed Evidence-Informed Strategy 3 [Optional] (Recommended 500 Words)
    a. Justification
    b. Feasibility
d) Alternative strategies (Recommended 250 Words)

e) Action Steps for Implementation Table

	Evidence-Informed Strategy		Action Steps	Level of Advocacy
1		1		
		2		
		3		
2		1		
		2		
3		1		
		2		

4: References

IV. Statement on Required Evidence and the Precautionary Principle.

APHA is committed to promoting the scientific foundation of public health intervention, health policy, and global health equity. This requires that APHA develop policy briefs that improve health and health equity, which are solidly based on the best available evidence.

However, defining what counts as valid evidence can be difficult. A clear definition of what constitutes meaningful and valid evidence required for public health intervention and health policy development is often difficult to achieve. In some cases, while there may be no disagreement about the extent and nature of the public health problem, there may be little evidence that a given policy or intervention may be successful. In other cases (e.g., regional conflicts or certain types of environmental pollution), the extent and nature of the threat to public health may be the subject of disagreement, and the evidence policy may be the purported source of contention.

While the importance of "*best available evidence*" cannot be understated, it should nonetheless be acknowledged that the decision to address or identify a health state in each population as a problem in need of a solution itself involves an evaluative judgment. There is often tension between the "*best available evidence*" and the sense of immediacy to act.

This section provides the Associations' framework for developing and reviewing proposed public health policy briefs that consider both evidentiary and value frameworks.

About Evidence

This section provides a guide to understanding how the Governing Council has defined and operationalized evidence, how to useevidence in the Policy Brief process to develop action steps, and the considerations authors and reviewers must make when developing Public Health Policy Briefs.

The Association recognizes there is no universal best available evidence for every public health problem. Indeed, the specifics of each public health problem and recommended actions define, by necessity, what type of evidence is most relevant. It is critical to seek the best available evidence. It is also important to note the difference between a value statement, i.e., preventing disease is essential *(does not need evidence),* and the fact, i.e., regulation will improve health *(requires evidence in support)*.

Still, the Policy Brief must demonstrate consideration of evidence availability and limitations. Facts cannot be asserted without proof. It is necessary to show that claims are backed by facts. This includes

1) the existence of the given health problem
2) the likely outcome of the proposed intervention

You may include qualitative and quantitative evidence, but trust, legitimacy, and prestige must be considered.

There is a need to triangulate data to show convergence when using non-scientific data sources *(textual, contextual, observational, accepted expert opinion*). In addition, corollary supporting or related evidence from similar research can be used, but context/applicability must be considered.

As defined below, the **precautionary principle** prevails when there are threats of serious or irreversible damage, but full scientific certainty is not yet established to prevent injury and disease.

What constitutes evidence?

Evidence is defined as any observation that raises the probability that a given factual statement is true. Evidence is not to be seen as the equivalent of proof; it simply supports a factual claim.

The following are examples of three different types of factual statements relevant to a public health action:

- *Associative: Agent A is associated with outcome B*
- *Causative: Agent A causes outcome B*
- *Proxy: Agent A (e.g., case rate for malaria) approximates B (incidence of malaria) when direct observation or estimation of A is not possible*

A public health action or recommendation should consider the best available evidence for all relevant factual statements, including the existence and nature of a given health problem and the likely outcomes of a proposed intervention. However, note that evidence for a given health problem differs from evidence that a proposed intervention will fix the problem. Table 1 summarizes the types of evidence in no particular order.

Table 1. Types of Evidence

Type of Evidence	Characteristics
Empirical	Derived from experience that results from observation and experiment (as opposed to theory). Heavily used in the sciences, empirical evidence is also relied upon in the humanities and social sciences.
Experimental	An experiment is typically used to test a hypothesis or theory. Replication of the results is the standard test of validity. Experimentation is a form of empirical evidence and is very prominent in sciences.

Authoritative	A common way of supporting a claim is to cite an authority's views or estimate of the problem.
Statistical	A primary tool for those in the natural and social sciences. It is important not to take statistics at face value, but to critically evaluate the appropriateness of the statistical test and the relevance of the finding.
Textual	Although most forms of evidence are typically textual (words on a page, images, video footage, etc.), here we are referring to instances where the "language" itself is fundamentally important, i.e., parts of the text must be explained and argued for. This type of evidence is frequently used in literary studies, but also in law, media studies and other fields.
Media	Newspaper, television, internet accounts by established news media personnel and posts by individuals.

(Adapted from: Rosenwasser, D. & Stephen, J. (2009). *Writing Analytically*. Boston: Thomson Wadsworth, pp. 116-11)

A public health action or recommendation, by its nature, is built on both evidence and values. The following are examples of recommended actions and the implicit values or assumptions underlying them:

"Congress must regulate agent A in order to reduce levels in the environment to prevent cases of disease B among population X."

Implicit values or assumptions:

- Prevention of disease B in population X is important. *Value judgment.*
- Congressional regulation will indeed reduce exposure to agent A. *Factual claim—requires evidence.*
- Prevention of disease B is more important than treatment of the disease. *Value judgment*
- *M*ore funding for research on disease X is needed "Having disease X is a problem. *Value judgment*
- The amount of research dollars spent translates into quality research. *Factual claim—requires evidence.*

Hierarchical Evidence Typologies

Table 2 provides an example of the many evidence hierarchies ordered from the 'strongest' evidence (category I) to the 'weakest' evidence (category III).

Table 2. Example of an Evidence Hierarchy

Levels of Evidence	Example
Category I:	Evidence from multiple converging randomized controlled trials.
Category II-a:	Evidence from at least one or more properly randomized controlled trial Converging evidence from more than one well-designed controlled trials without randomization
Category II-b:	Converging evidence from well-designed cohort or case-control analytic studies, preferably from more than one center or research group.
Category II-c:	Evidence from multiple times series with or without intervention or dramatic results in uncontrolled experiments such as the results of the introduction of penicillin treatment in 1940 during WWII.
Category III:	Opinions of respected authorities, based on clinical experience, descriptive studies, and case reports, or reports of expert committees. Converging evidence from numerous qualitative data sets yielding expert opinions or general acceptance of the postulate

Source: Harris, R.P. et al. (2001)

However, the best available evidence is defined in accordance with a given statement. While evidence hierarchies rank types of evidence from strongest (like randomized controlled trials) to weakest (expert opinions), this does not mean they apply equally to all situations.

The type of evidence that's strongest depends on the specific public health question being asked. For some statements, qualitative data may be most relevant. Quantitative data, which is higher in the hierarchy, may be applicable for other statements. ***Evidence hierarchies can be misleading because they are not crafted with the specific topics under consideration.*** We cannot know *a priori* which type of evidence is stronger unless we know what question that evidence is being used to answer. The author and reviewer of each Policy Brief should consider the appropriateness of a given evidence hierarchy.

Other factors can also impact the appropriateness of the evidence.

Academic journals are generally regarded as the *sine qua non* for evidence-based information, provided the journal is reputable, scholarly, and relevant to the topic. Ideally, published articles are reviewed by knowledgeable peers who evaluate the paper concerning whether the methodology is appropriate to the research question, the sample size—if relevant—is adequate, the choice of analysis methods is appropriate, the results are accurately interpreted, and the conclusions are warranted. Peer-reviewed research is not required but should be included if available.

Within peer-reviewed journals, it is critical to note that there is publication bias (e.g., negative findings are often not published) and that it is not insignificant and should be considered. Further, peer-reviewed studies are not about establishing certainty or even minimizing uncertainty; all are subject to limitations. Attention to the journals' quality and reputation, including impact factors and editorial board membership, should serve as an additional guide in evaluating the evidence cited.

A Note on The Use of Systematic Review Panels and Reporting Structures

In addition to looking at individual articles and reports on a subject, various disciplines have created or supported organizations, panels, and other vehicles to assess the credibility and quality of available evidence. Evidence for a given statement may have been previously reviewed and weighted using a pre-defined method with a predetermined set of necessary scientific expertise. Organizations such as the Equator Network (https://www.equator-network.org/), The Cochrane Collaboration (www.cochrane.org), and others have established methods to ensure the quality and replicability of findings. These resources should be consulted where applicable and widely adopted to help evaluate the evidence's quality.

Consideration of Validated Evidence in Other Arenas

In some cases, peer-reviewed studies may not be available for example, when the topic is too current or the possibility of conducting a study for peer review is remote. As a result, certain topics may have limited peer review studies. However, when this is not available, if there is other good evidence, this evidence should be considered. Evidence in relation to the effects or experiences may be available through media reports, legal testimony, and focus groups.

The lack of peer-reviewed evidence should not be the only criterion for not accepting or proposing a public health policy brief. Indeed, Policy Briefs may be proposed within the context of a relative lack of information regarding how the proposed intervention may result in a desired outcome or the value of one intervention relative to another possible intervention.

In some cases, the tightly controlled experimental conditions defined by prespecified inclusion and exclusion criteria used in clinical trials are rarely available for studying public health interventions or problems, which occur in "real-world" settings where researchers have much less control of confounding variables. In other cases, this is

due to the unethical nature of specific public health experiments. Sometimes, conducting large-scale, multifaceted public health research is impossible. In these cases, corollary supporting evidence, related evidence from similar research, or expert opinion may be the best evidence available – and, as such, should be considered appropriately.

Furthermore, not every policy of concern to APHA may have been the subject of a review and possibly not published in a peer-reviewed journal.

Nonscientific data sources may be textual, contextual, observational, accepted expert opinions, or derived from similar evidence sources[1]. In this case, those sources may be the best and, in some cases, the only data or evidence available. Under these circumstances, convergence of the various data sources is critical and necessary for supporting the statements or proposed policies, i.e., what is cited should converge or triangulate towards the same conclusions. If such a body of evidence does not converge, if it diverges, or if there is equivocation, then there is little evidence to support the policy brief, its purpose, or proposed outcomes.

How should we consider evidence and values frameworks in developing and reviewing Public Health Policy Briefs?

The Consideration of Risk, Harm, and Benefit

The role of evidence is to support factual statements. For example, that a certain chemical is a carcinogen and cancer rates are likely to occur if a given intervention is not adopted. However, classifying outcomes as “harmful” or “beneficial” involves an evaluative judgment that cannot be supported or refuted by empirical evidence. Furthermore, weighing likely harms against likely benefits involves a further comparative value judgment. Finally, adopting a position and the associated action steps in and of itself embody a value judgment that some action *ought* to be taken or not taken or that a given policy is the *best* among the available options. Therefore, evidence for factual claims, including probabilistic claims, interacts with judgments about values in constructing and adopting actionable steps.

Evidence alone is insufficient for determining or supporting the optimal potential action. The potential for harm or meaningful benefit is also a critical concern, particularly within the context of accepted public health ethics.

When constructing and evaluating potential policy briefs, clarifying the dimensions of risk, harm, and benefit is useful.

- A *risk* is a possible future harm, typically considered to involve a setback to a person’s interests, particularly in life, health, or welfare.
- A *benefit* is something of positive value, such as improvement in health or

[1] https://semo.libguides.com/c.php?g=1296240&p=9634655

welfare.

In assessing risk, both the probability of harm and the magnitude of that harm should be considered. Similarly, in assessing benefits, the probability and magnitude of the benefit should be considered.

Finally, the appropriate comparison is not risks versus benefits since risk statements are probabilistic, and statements of benefit are not. Rather, the appropriate comparison is the likelihood and magnitude of harm versus the likelihood and magnitude of benefit.

Determining the probability of a given outcome is a factual question that should be addressed using the best available evidence. However, value judgments involve classifying that outcome as a benefit or harm, determining the magnitude of the benefit or harm, and weighing likely harms versus likely benefits.

What does this all mean?

APHA Adoption of the Precautionary Principle

The Governing Council is committed to a clearly outlined process for developing, reviewing, and approving policy based on sufficient evidence to inform the development of high-impact Public Health Policy Briefs. Therefore, the Governing Council and APHA has supported and reaffirmed its support for the Precautionary Principle multiple times over the years. Adopting the precautionary principle has enabled APHA to take stands in support of one of its cornerstones, preventing injury and disease in situations and under conditions where full scientific certainty is not achievable.

and advocates for taking preventive action in the face of potential risks to health or the environment, even when complete scientific certainty is unavailable. The precautionary principle ensures that public health interventions can move forward when there are real and credible risks but when there is insufficient data to allow for absolute certainty, all while balancing the need for action with the limitations of scientific knowledge. However, a lack of information or data alone is insufficient grounds for intervention; there must still be a reasonable basis, rooted in the best available evidence, to take preventive measures.

The Precautionary Principle provides a counterbalance, ensuring minimal harm occurs when such action is required in conjunction with a lack of evidence.

Conclusions

APHA policy briefs should always be supported by the **“best available evidence.”** This statement reflects a significant value of the Association and its members. **The**

Proposed Public Health Policy Brief must, therefore, engage the 'best available evidence,' defined as the most relevant (most directly related to the claim) and credible (reliable, accurate, based in fact, triangulated, from an authoritative source) data or information that can be used to support a public health decision or policy, given the current constraints of knowledge, resources, and context. This evidence is not limited to peer-reviewed, quantitative research but may include a combination of empirical, experimental, qualitative, and authoritative sources. It considers the nature of the public health problem, the type of intervention proposed, and the urgency of addressing it. The *best available evidence* should reflect the highest quality and most appropriate information for the given situation while acknowledging limitations and the necessity of using the precautionary principle when complete scientific certainty is unavailable. It encompasses:

- Quantitative data (e.g., statistical, experimental results)
- Qualitative data (e.g., expert opinions, observations),
- Contextual relevance (e.g., similarity to previous interventions or research),
- And triangulation of data sources when peer-reviewed studies are limited.

It is the most appropriate and defensible evidence available to inform policy decisions, always subject to critical evaluation of its quality, applicability, and limitations.

However, APHA and its members hold other values as well. As such,

1) There is often a need to take public health action in the face of uncertain evidence of the nature and scope of public health problems and the limited understanding that a given action will produce the desired outcome.
2) The "best available evidence" must be defined within the context of the specific public health statement or public health action under consideration.
3) APHA's adoption of a precautionary principle in line with the organization's values and mission.
4) The costs of inaction should be weighed against the costs of a given public health intervention or policy.

See Appendix 3 for Considerations for the Review of Evidence for a Public Health Policy Brief.

Appendix 1: Author Disclosure

Each author listed on the proposed Public Health Policy Brief must complete a separate form.

Name:	
Organization:	
Title:	
APHA Section/Caucus/SPIG/ Affiliate:	
APHA Member ID	
Email:	
Phone:	

Conflicts of interest (competing interests) include facts known to a participant in the development process that if revealed later, would make a reasonable reader feel misled or deceived (or an author or reviewer feel defensive). Conflicts of interest may influence the judgment of authors and reviewers; these conflicts often are not immediately apparent to others or the reviewer. They may be personal, commercial, political, academic, or financial.

Financial interests may include employment, research funding (received or pending), stock or share ownership, patents, payment for lectures or travel, consultancies, nonfinancial support, or any fiduciary interest in the company. The perception or appearance of a conflict of interest, without regard to substance, may also create conflict because trust is eroded among all participants.

All such interests (or their absence) must be declared in writing by authors upon submission of the proposed Public Health Policy Brief. If any are declared, they will be included with the Public Health Policy Brief proposal during the review process. It should be disclosed if there is doubt about whether a circumstance represents a conflict.

Required Disclosure: During the past 12 months, have you or your spouse or partner had a personal, commercial, political, academic, or financial interest or relationship that might potentially bias and/or impact the content of the proposed Public Health Policy Brief: Yes No

If yes, please list the interest or relationship:

Electronic or Typed Signature

Date

Appendix 2: Collaborating Unit Template Letter

Note: to be considered in the review process, this letter must be completed by the appropriate Member Unit Leader as described in these guidelines

Date: _____

Collaborating APHA Member Unit: _____

Name: _____

Title: _____

Email: _____

To the Evidentiary Review Committee

With this letter, I acknowledge that the member unit has collaborated on and reviewed the proposed Public Health Policy Brief (title)
_____.
The aforementioned member unit has reviewed and endorsed the Public Health Policy Brief statement, following all member unit procedures for such action.

Signed,

_____
TITLE, MEMBER UNIT

Appendix 3: Considerations for the Review of Evidence for Public Health Policy Briefs

The following questions provide a framework that can guide Public Health Policy Brief authors and reviewers:

- What is/are the statement(s) or claim(s) being made that require evidence?
- Is the best available evidence presented for a given statement (i.e., public health problem)?
- For a given statement (i.e., public health problem), has the evidence already been systematically reviewed by a body of experts (if so, how and by whom?)
- Is there counterevidence or missing evidence for a given statement (i.e., public health problem)?
- Is there convergence, equivocation, or divergence of findings across the available evidence?
- What are the relevant values at stake?
- What are the likely harms, both probability and magnitude?
- What are the likely benefits, both probability and magnitude?
- What are the views of relevant key players (particularly people who are likely to be affected by policy)?
- Is there evidence that the recommended action will be effective? Is this evidence valid, relevant, and supported by the body of knowledge?
- Consider other consequences (e.g., unintended) of the policy: What is the likelihood that this would occur? How much certainty do you have regarding this?
- Consider the consequences of not acting, including all the above (probability and magnitude of harm and benefit with respect to not acting).
- Considering intended and unintended consequences, weigh the probability and magnitude of harm against the probability and magnitude of benefit (as defined previously)

Appendix 4: Endorsing Member Unit Template Letter

Note: to be considered in the review process, this letter must be completed by the appropriate Member Unit Leader as described in these guidelines. Endorsements **should only be sought after a second review by the Evidentiary Review Committee.** Endorsements submitted before this review will not be accepted. Endorsement Letters must be submitted no later than 72 hours ahead of the first Governing Council Session in which the Policy Briefs are scheduled to be discussed and voted on.

Date:

Endorsing Member Unit :

Name:

Title: _____

Email:

To the Evidentiary Review Committee:

With this letter, I acknowledge that the Member Unit has reviewed and endorses the proposed Public Health Policy Brief:
_____(Title) The aforementioned member unit has reviewed and endorsed the Public Health Policy Brief statement, following all member unit procedures for such action.
Signed,
_____
TITLE, MEMBER UNIT

Appendix 5: References Format Guide

(Based on AMA Reference Style)

Book

1. Okuda M, Okuda D. *Star Trek Chronology: The History of the Future.* New York: Pocket Books; 1993.

Journal or Magazine Article (with volume numbers)

2. Wilcox RV. Shifting roles and synthetic women in Star trek: the next generation. *Stud Pop Culture.* 1991;13:53-65.

Newspaper, Magazine, or Journal Article (without volume numbers)

3. Di Rado A. Trekking through college: classes explore modern society using the world of Star trek. *Los Angeles Times*. March 15, 1995:A3.

Encyclopedia Article

4. Sturgeon T. Science fiction. In: Lorimer LT, editorial director; Cummings C, ed-in-chief; Leish KW, managing ed. *The Encyclopedia Americana*. Vol 24. International ed. Danbury, Conn: Grolier Incorporated; 1995:390-392.

Book Article or Chapter

5. James NE. Two sides of paradise: the Eden myth according to Kirk and Spock. In: Palumbo D, ed. *Spectrum of the Fantastic.* Westport, Conn: Greenwood; 1988:219-223.

ERIC Document

6. Fuss-Reineck M. *Sibling Communication in Star Trek: The Next Generation: Conflicts Between Brothers.* Miami, Fla: Annual Meeting of the Speech Communication Association; 1993. ERIC Document Reproduction Service ED364932.

Web site

7. National Institutes of Health. NIH guidelines on the inclusion of women and minorities as subjects in clinical research. Available at: http://grants.nih.gov/grants/guide/notice-files/not94-100.html. Accessed on July 19, 2000.

8. Lynch T. DSN trials and tribble-ations review. Psi Phi: Bradley's Science Fiction Club Web site. 1996. Available at: http://www.bradley.edu/campusorg/psiphi/DS9/ep/503r.htm. It was accessed October 8, 1997.

Journal Article on the Internet

9. McCoy LH. Respiratory changes in Vulcans during pon farr. *J Extr Med* [serial online]. 1999;47:237-247. Available at: http://infotrac.galegroup.com/itweb/nysl_li_liu. Accessed April 7, 1999.

Government/Organization Reports:

10. US Bureau of the Census. *Statistical Abstract of the United States: 1999*. 119th ed. Washington, DC: US Bureau of the Census; 1999

Appendix 6: Sponsoring Member Unit Template Letter

Note: to be considered in the review process, this letter must be completed by the appropriate Member Unit Leader as described in these guidelines

Date: _____

Sponsoring APHA Member Unit: _____

Name: _____

Title: _____

Email: _____

To the Evidentiary Review Committee

This letter serves as confirmation that the proposed Public Health Policy Brief: _____ was submitted by _____ on behalf of the (Sponsoring APHA Member Unit) _____ the proposed Public Health Policy Brief has been reviewed and endorsed by the aforementioned member unit following all member unit procedures for such action.

Signed,

_____

TITLE, MEMBER UNIT