# EVALUATION OF THE DCP SERIES

MARCH 2018

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# 1. INTRODUCTION

**Dalberg Global Advisors (Dalberg) conducted an independent evaluation of the Disease Control Priorities (DCP) series, 2nd and 3rd editions (DCP2 and DCP3) on behalf of the Bill and Melinda Gates Foundation (BMGF).** The goals of this evaluation are to i) assess the influence of DCP2 and 3 on health policy and priority setting in low- and middle-income countries (LMICs), ii) distill, from DCP's experience, insights into what works best to translate evidence to policy at the country level, and iii) determine what these findings imply for DCP's and BMGF's efforts going forward.

**This report provides an overview of Dalberg's methods and finding. Additional details can be found in the annex.** The report has been kept intentionally short to provide a concise overview of key findings, and includes a summary of:

- The background and context to the evaluation;
- The criteria and methodologies used to evaluate the DCP series and build strategic recommendations;
- An assessment of DCP's influence on global- and country-level policymaking *(outcome evaluation),* and an assessment of why DCP was/was not able to achieve influence *(process evaluation);*
- Lessons learned for how to maximize the influence of global publication on country-level policies; and
- The implications for DCP3, and the DCP Secretariat, going forward.

The list of all consulted stakeholders can be found in the annex, along with a summary of the survey results and each country case study (Ethiopia, Mexico, and India).

**Dalberg gratefully acknowledges the cooperation and support of the Department of Global Health (DGH) at the University of Washington in this evaluation, as well as the participation of all key informants who contributed their perspectives.**

# 2. EXECUTIVE SUMMARY

**The DCP series was established to inform evidence-based health resource allocation and policymaking at the global and country levels.** The World Bank first published DCP in 1993; BMGF funded DCP2 (2006) and DCP3 (2015 - 2017) as part of its grant portfolio supporting evidence-to-policy translation.

**This evaluation assesses the awareness, additionality, relevance, and efficacy of DCP2 and DCP3 at the global and country levels.** The scope of the outcome evaluation included analyzing the extent to which DCP has been used directly in policy-making processes within low- and middle-income countries (LMICs) (referred to as country-level policymaking). The evaluation also examined the extent to which DCP was used to inform the work of global institutions (funders and normative institutions), that, in turn, would contribute to policy decisions that affect LMICs. The outcome evaluation employed four criteria: i) the extent to which target stakeholders are *aware* of the DCP series, ii) DCP's *additionality* in relation to other information sources, iii) DCP's perceived *relevance* for policymakers and iv) DCP's *use in, and influence on,* health resource and allocation decisions.

**The evaluation methodology includes an outcomes evaluation, which triangulates information gathered from a stakeholder survey, semi-structured interviews, six case studies, and desk research.** The survey was sent to 122 country-level stakeholders across 10 countries (half of which had no prior DCP engagement) and 100 global-level stakeholders (half of which were outside of the DCP network); 61 stakeholders responded (29 at the country level, 26 at the global level, and six unidentified). While efforts were made to minimize sample bias, the sample is nonetheless likely biased in favor of DCP. Thirty-four global interviews were conducted, as well as 58 country-level interviews in Ethiopia (26), Mexico (18), and India (14), and six targeted interviews in countries / regions with reported DCP influence (Malawi, China, EMR). Citation and linguistics analysis were also conducted on key policy documents that were identified via the surveys, case studies, and interviews. Across all of these data sources, the sample size is too small to draw statistically significant conclusions, but provides indicative perspectives on DCP's influence.

**The process evaluation aims to understand why DCP3 was, or wasn't, set up to influence global- and country-level policy decisions as a way of determining whether the DCP Secretariat is positioned to drive efficacy going forward.** In acknowledgement of the fact that many DCP3 volumes were not published until the end of 2017, and that policy influence can take significant time to manifest, the process evaluation assesses the extent to which the DCP Secretariat is positioned to drive the efficacy of DCP3 going forward, based on factors that may have contributed to, or limited, its influence to date. The process evaluation included DCP Secretariat interviews and a document review.

### *Key findings: DCP's contribution to policymaking in global institutions*

**At the global level, the most relevant use case for DCP was as a source for policy influencers to inform advocacy efforts. Here, DCP was seen as a relevant, credible, and additive source of evidence that replaced the need for a literature review.** Some technical advisors (internal within global health teams and external at advocacy organizations or normative bodies) and academics reported using DCP, among other sources, as a reference point for cost-effectiveness information to support advocacy efforts with decision makers at global donor institutions (i.e., for drawing

additional attention or funding to a specific health area). In these instances, DCP's utility was driven by the credibility that the publications carry. Stakeholders that used DCP in this way also stated that DCP's synthesis of evidence is additional, replacing the need for literature reviews.

**Stakeholders working for global health agencies and funders did not report using DCP in specific policy decisions, as they commission their own analyses and their decisions are driven more by global targets and internal priorities than by cost-effectiveness data.** While 77% of global-level policymakers surveyed were aware of DCP, its reported use is lower than for the Lancet, WHO-Choice, and IHME's Global Burden of Disease database. Current allocation formulae and methodologies across the Global Fund, GAVI and bilateral funders tend to be driven more by burden and severity analysis rather than cost-effectiveness considerations, and while this evidence is an important input, global targets and internal priorities often drive decisions. There may be an opportunity to shift these priority-setting processes to more systematically incorporate cost-effectiveness, but DCP does not appear well positioned to serve as a key resource in this process, as those institutions that do consider cost-effectiveness in their resource allocation decisions tend to rely more on local data than global estimates, and require more timely data and evidence than DCP has been able to offer.

**There were mixed reviews of DCP's efficacy and relevance as a tool that global institutions can use in their own interactions with country-level decision makers**. Some global-level institutions, notably WHO-EMRO, reported that DCP3 is a helpful tool in their efforts to provide member countries with technical advisory support for national policymaking, particularly around essential health packages. However, the actual format of the DCP volumes is generally seen as too long, complex, and not sufficiently tailored to specific country contexts to realize its full potential as an aide to global institutions' technical advisory work to member countries.

### *Key findings: DCP's contribution to policy decisions within low- and middle-income countries*

**At the country level, there were select instances of where DCP was, or is being, used in policymaking, with varying degrees of influence and levels of attribution to the DCP Secretariat.** As a caveat to this part of the evaluation, please note that assessing the contribution of a global public good to a wide array of national-level policy outcomes is a highly challenging exercise, particularly given the multiple pathways that are involved in policy influence, as well as the serendipitous nature of how certain windows can open, and close, for major influence. To that end, evaluators employed two approaches to understanding how DCP has contributed to policymaking within countries. The first approach involved examining a select set of examples that were nominated by key informants as instances when DCP likely had strong contributions. The second approach was more bottoms-up in nature, in which evaluators asked all stakeholders and survey respondents, in a free-form question, to list any specific examples they were aware of where DCP made any possible contributions, in an effort to understand the full *breadth* of potential use cases.

All of the examples of influence sourced from across both methodologies were then further explored using a mix of stakeholder interviews, citation analysis, and linguistic analysis. The results are as follows:

- ***Strong influence*** in the development of a surgery flagship program (SaLTs) in Ethiopia, where interventions were taken wholesale from the DCP3 volume one's recommended package.

- ***Medium influence*** in Malawi, where DCP2 informed recommendations on the Essential Health Package.
- ***Low influence*** in China, where a DCP2-derivative publication was used to inform the creation of child development program; in Mexico, where DCP2 may have had some influence on national health reform due to an overlap of authors and actors; and in India, where anecdotal evidence suggests that Indian DCP authors informally shared findings with decision makers, India-specific DCP2 reports helped shape technical advisory groups' recommendations, and district policymakers "valued" recommendations translated from the India-specific DCP2 report.

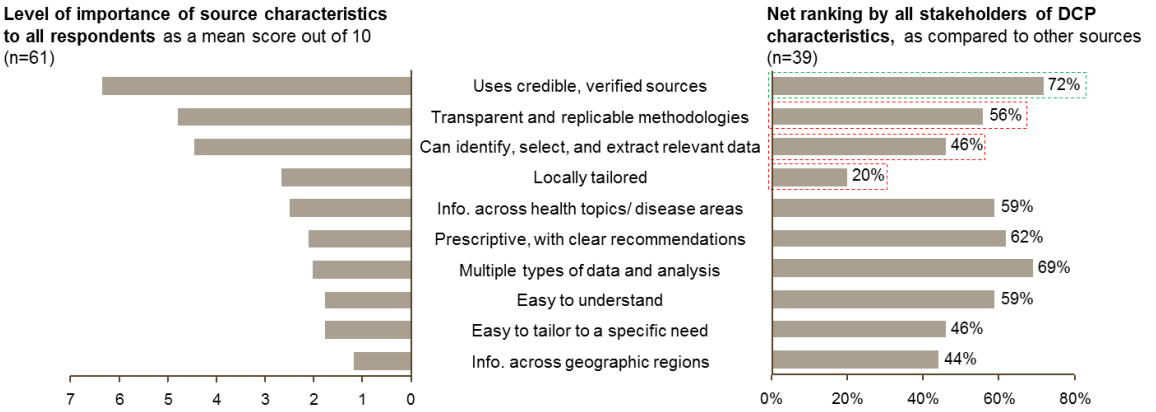
DCP3 is currently being used to prioritize non-communicable disease (NCD) interventions and to create a revised essential health package in Ethiopia, to inform an article with recommendations for the next Mexican health reform, and to develop essential health packages in select Eastern Mediterranean Region (EMR) countries, but it is too soon to evaluate efficacy in these cases.

**Where DCP was used, it was found to be additional for a specific policy decision—mostly related to packages—and was relevant when it was translated to the country context through the incorporation of local data and considerations.** Country-level stakeholders saw DCP as additional as a one-stop-shop for information on intervention cost-effectiveness that could serve as a starting point for a health strategy or essential package. As such, DCP was most relevant to policymakers and advisors faced with specific policy questions, mostly related to packages. In these contexts, it was most relevant when it had been translated to the local context (e.g., adjusted to include local data and considerations).

**This use often coincided with the presence of a local champion** — an individual with strong technical capacity and policy networks**,** sometimes from within the DCP network, sometimes external — who was instrumental in bringing DCP to the attention of key decision makers at opportune moments in the decision-making process and facilitating its translation, making it relevant and applicable to the decision at hand.

**The survey, interviews, and consultations with the DCP Secretariat identified no further instances of country-level influence, and while stakeholders reported that DCP's packages were additional, limitations around its relevance hindered further uptake.** Across countries, stakeholders valued DCP's intervention package tables, which were not available elsewhere. However, stakeholders across countries agreed that without translation, DCP's applicability was limited because it does not include local data, and that WHO guidelines were a preferred, more influential information source. Many stakeholders reported that DCP was too long, technical, and dense to be relevant and actionable for most policymakers.

**Figure 1: Characteristics ranked most important in an information resource, and perceptions of DCP on those characteristics, among all respondents surveyed and all who recognized DCP[1]**




### *Process evaluation*

**While it may be too soon to see DCP3 outcomes, minimal involvement of policymakers in DCP3's creation may have limited DCP3's influence on policy, and may limit its potential future influence.** From its conception, DCP3 was intended to target technical experts, rather than policymakers. As a result, while some ACE members or contributors had direct or indirect policy experience, the Secretariat didn't have the capacity, or intention, to engage policymakers systematically in DCP3's creation. The Secretariat took steps to course correct after the Mid-Term Review (MTR), most notably by hiring staff to focus on country engagement and reformulating volume nine. However, production delays led the Secretariat to shift resources away from dissemination and translation (including policymaker engagement) in order to finish the volumes. Recognizing that volume nine was the most relevant volume for policymakers, the Secretariat delayed translation activities until it was finished at the end of 2017. As a result, dissemination, translation, and policymaker engagement activities have been minimal, and country-level impact is likely to be delayed and will require additional resources.

### *Lessons learned on positioning global publications for influence*

**The evaluation findings highlight a number of lessons about what is needed to maximize the influence of a global cost-effectiveness publication on country-level policies:**

The role for global cost-effectiveness publications in priority setting: **Since priority setting is necessarily a localized process, a global publication should aim to provide guidelines, a priority setting methodology, and/or an accompanying dataset that can be used in local analysis.** While these products can theoretically be used across a range of countries, they will be most relevant if they are formulated to answer a specific set of questions (e.g., packages for UHC) for specific geographies, and respond to the needs of policymakers in those target countries.

Bridging the gap between research and policy: **Policymakers should be engaged in the creation of a global publication to identify specific questions and evidence needs and, crucially, to help to bridge the gap between academia and policy.** Cultural and systemic barriers to collaboration (e.g., mistrust, differing priorities, incentives, and timelines) often hinder the uptake of evidence in

[1] Net ranking refers to the percentage of respondents who ranked DCP as "the best" or "among the best" as compared to other sources, minus the percentage who ranked DCP as "slightly worse than the rest" or "among the worst."

decision making. Engaging policymakers from target countries in a publication's creation (e.g., as an active advisory committee, via policy forums to solicit recommendations and feedback) can help to bridge this gap and dramatically increase relevance and uptake of global publications.

Proactive and ongoing dissemination and translation: **Global publications should be proactively brought in to relevant policy processes at the local level, and must be translated through a consultative process to make evidence applicable for specific decisions.** Passive dissemination via publication, launches, and finding-sharing workshops are necessary but not sufficient to drive uptake, and must be accompanied by ongoing efforts to identify demand for evidence in particular policy decisions, bring global evidence into policy processes, and support translation. Translation requires collating or collecting local data, reconciling this data with global frameworks or inputs to generate contextualized recommendations, and relaying these recommendations to decision makers. It should ideally involve decision makers themselves to ensure buy-in and increase the chances that translation recommendations are used in policy, as well as local stakeholders (researchers and MoH staff) to begin to institutionalize the knowledge and process so it can be used again in the future.

The role for local champions: **Politically and technically savvy local champions who can navigate country decision-making architectures, develop relationships with decision makers, and regularly survey opportunities for influence, should lead dissemination and translation.** Effective dissemination is dependent on champions on the ground who can systematically identify opportune moments to bring evidence into policy dialogues, and identify the right stakeholders to engage with that evidence to influence decision making. To be maximally effective, champions should have strong local networks, technical expertise, political savvy, and dedicated capacity to support dissemination and translation.

The role of WHO***: In order to have sufficient credibility and uptake for systematic and long-lasting influence, any global publication should engage WHO in creation, dissemination, and translation, and secure its partnership and endorsement.*** WHO and its guidelines are the first port of call for countries seeking evidence to support decision making. Collaborating with WHO from the beginning of evidence conceptualization is critical to ensure alignment of content, particularly for guidelines. Given its authority and networks, WHO can also serve as a critical channel for dissemination at the regional and country levels, and can be involved as an influential voice in translation activities.

The need for capacity building***: A global publication's influence will be limited, either to a specific moment in time or in its final impact, if it does not coincide with substantial capacity building in target countries.*** Workshops, trainings, fellowships, education programs, or support for new ministry economic units can all help to generate demand for evidence, institutionalize evidence use for decision making, and enable countries to translate global publications – and generate their own evidence – with limited external support. Local capacity for policy implementation also needs to be strengthened, as national policy change is necessary but not sufficient to achieve health outcomes.

### *Implications for DCP going forward*

**DCP3's packages have a unique value for decision making in certain country settings, if translated to the local context, and fill a gap not currently met by WHO.** Stakeholders reported the

recommended intervention packages (particularly the package in volume nine) are additional, especially as a framework for designing packages for emerging priority areas (e.g. surgery) or updating essential health packages that align with the UHC goal, as WHO has not yet explicitly published a UHC recommended package.

**However, as evidenced in the evaluation, DCP has some shortcomings in terms of its policymaker engagement, its intentional dissemination and translation, and its WHO engagement.** DCP was not intentional about the countries, policymakers, or influencers it was targeting (as it envisioned a technical audience); dissemination, translation, local network building, and capacity building activities were limited and non-strategic given the Secretariat's lack of capacity, resources, and networks; and while some WHO staff served as authors, DCP didn't align with, or secure formal institutional partnership or endorsement from, WHO.

**Future efforts should address these challenges in order to maximize DCP's potential impact.** Given the potential opportunity for further future impact, this evaluation answers three questions around near- and longer-term next steps for DCP:

*How can DCP maximize its influence going forward?*

**Given the additionality of DCP3's packages, the Secretariat's immediate future efforts should focus on aligning its recommendations and establishing a partnership with WHO.** In order to maximize its potential influence going forward, as already commenced by the Secretariat, DCP3 will need to align vertical and cross-cutting intervention packages with WHO recommendations, articulate how DCP and WHO guidelines and resources can fit together, and establish an institutional partnership to leverage WHO's credibility and network as a dissemination pathway. The precise nature of WHO engagement is to be determined, but could entail an informal partnership or a more formal affiliation.

**In collaboration with WHO, the Secretariat should select a group of target countries, for which DCP3's package is relevant and needed, and commence dissemination and translation activities.** Given the country-level differences in decision-making architectures, the Secretariat should select a group of target countries, and carefully tailor all dissemination and translation activities to each context. Target countries should ideally have demand for cost-effectiveness evidence and external support, to address a relevant policy decision (i.e., designing an essential health package for UHC).

*Who is best positioned to lead these efforts?*

**To effectively lead these efforts, the Secretariat will need to build its internal translation capacity and capability, potentially by moving out of a Seattle-based organization, or by establishing local partnerships.** The DCP Secretariat was set up to create a credible, rigorous publication, and does not currently have sufficient skills, networks, geographic placement, or local credibility to effectively facilitate translation. As a result, in order to effectively oversee translation efforts, the Secretariat should consider relocating, hiring additional staff with the required skills sets, and/or creating partnerships with established institutions already supporting policymaking in target countries.

**Alongside these efforts, the Secretariat should also identify local champions in each target country who can lead dissemination, help to facilitate the translation process, and begin capacity building activities.** The Secretariat, drawing on WHO's networks, should identify and employ well-networked, technically and politically savvy champions in target countries, and supply them with

the financial and material resources (e.g., templates for reconciliation of local data with DCP recommendations) they need to bring DCP into relevant policy conversations and facilitate translation. Simultaneously, the local champion (likely with additional resources) can start to identify opportunities for capacity building through workshops, technical assistance, or fellowships. Capacity building can start via translation activities, and then continue longer-term.

What does this mean for the future of the DCP enterprise?

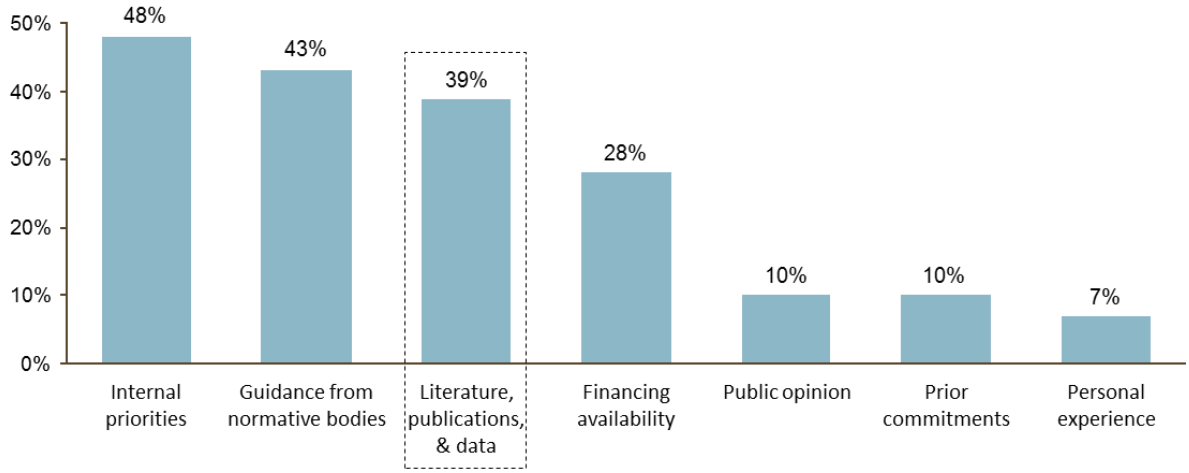
**The Secretariat should approach a dissemination and translation phase in an iterative manner, and use this learning to inform future efforts.** DCP should continue to assess and adapt its approach, learning from Dr. Alwan's work with WHO and EMR, as well as from policymakers themselves (e.g., via policy forums) on their needs, use of DCP, and what kind of support is most useful. Further evaluation at the end of this phase, combined with the lessons from this report, can be used to inform future efforts.

**Discussions around any future publication (e.g., a DCP4) should be put on hold to ensure it responds directly to needs. Future efforts will may look very different to previous publications.** While further analytic work may be needed in the near term, this should focus on addressing specific needs surfaced in country-level work, rather than a full-scale update of the publication. In the longer-term, future efforts to update the DCP evidence base should look beyond the constraints of the existing publication and business model. They must be rooted in an assessment of what policymakers need, designed in user-centered way around their preferences and behaviors, and created in a way that enables tailored use at the country level. Future efforts may not be a global publication at all, but could include, for example, a global, downloadable database of up-to-date cost-effectiveness evidence, a unit or partnership on UHC intervention packages with WHO, and/or targeted country-level evidence "hubs", where local capacity for evidence generation, use, and uptake in decision making is built.

# 3. BACKGROUND AND CONTEXT

**Low- and middle-income countries (LMICs) and their partners (e.g., donors and global health agencies) are increasingly seeking to increase the role that evidence plays in health policymaking.** While multiple factors—political, economic, ethical, and contextual—necessarily play a role in health priority setting, policymakers are increasingly looking for economic evidence to play a more prominent role. A survey of 61 global- and national-level decision makers and influencers found that evidence ranked third among seven potential factors influencing decision making—39% of all respondents cited "literature, data, and publications" as important factors, while "internal priorities" and "guidance from global normative bodies" were both rated more influential (Figure 2). While disease prevalence, intervention efficacy, needs analysis, and cost data are the types of data most frequently consulted, 50% of national-level policymakers surveyed used analysis on cost-effectiveness, financial risk protection, and an intervention's impact on health equity to inform most or many decisions, suggesting appetite for economic analysis that helps to optimize resource allocation. The increased uptake of this kind of evidence for decision making could help to ensure the effective use of resources to deliver optimal health outcomes.

**Figure 2 - Importance of factors in health decisions, by % of all respondents who ranked each factor as high importance (n=61)[2]**




**In this context, organizations like DCP and BMGF are considering how best to support the increased uptake of evidence in decision making.** Given the relative nascence of existing evidence-to-policy and knowledge transfer and exchange (KTE) efforts, there is a need for experimentation with different approaches to understand what works best, who needs to be involved, and when these efforts are best placed to have a lasting impact (recognizing, of course, that the answers to these questions may vary across contexts, and that there may be no universally applicable approaches). This evaluation assesses the efforts of the DCP series in this light, examining where and how—even among competing factors—its evidence was able to influence decision making, or, where it did not, what factors could have increased its chances of impact, with an eye toward what future investments are needed to support health policy decision makers in their use of evidence going forward.

[2] Note that these factors are not mutually exclusive, as, for example, literature, publications, and data could be used to inform normative body guidance, prior commitments could have influenced internal priorities, etc. However, this chart does provide an indicative sense of where evidence falls among other factors in terms of its use.

# 4. EVALUATION QUESTIONS

**The goal of the Disease Control Priorities (DCP) series has been to help policymakers'—particularly in LMICS -- set healthcare priorities according to evidence-based processes.**[3] *Disease Control Priorities, first edition* (DCP1), first published by the World Bank in 1993, assessed the efficacy and cost-effectiveness of interventions for major diseases in LMICs. *Disease Control Priorities, second edition* (DCP2), published in 2006, updated and extended several aspects of DCP1—for example, taking into account the implications of expanded intervention coverage on health systems. Building on DCP1 and DCP2, *Disease Control Priorities, third edition* (DCP3) aims to assist decision makers in budget allocation for health, and goes beyond its predecessors by presenting economic evaluation of policy choices affecting "access, uptake, and quality of interventions and delivery platforms for low- and middle-income countries (LMICs)."[4]

**This evaluation assesses DCP2 and DCP3's influence on priority setting at the global and country levels.** While the DCP grant has evolved over time, its overarching (and most recently articulated) objective is to "inform evidence-based priority setting, policy, and resource allocation for health in low- and middle-income countries."[5] The scope of the evaluation includes exploring the extent to which DCP has been used directly within country-level policy making processes. The evaluation also examines the extent to which DCP was used to inform the work of global-level institutions (funders and normative bodies) that, in turn, would contribute to policy decisions at the national level, especially in LMICs. This evaluation does not include work conducted by the Institute for Health Metrics and Evaluation (IHME) (a component of prior iterations of the DCP grant), or any consideration of DCP1.

**In particular, this evaluation examines the awareness, additionality, relevance, and efficacy of DCP2 and DCP3, as well as the extent to which the DCP Secretariat is positioned to drive further DCP3 efficacy going forward.** It will assess the extent to which relevant stakeholders are aware of the DCP series, the additionality of the series in relation to other available publications or information sources, the perceived relevance of DCP as a source for informing health policy decisions, and the efficacy of DCP2 and DCP3 in influencing health priorities and policies. Awareness, additionality, and relevance are important criteria insofar as they determine if DCP has been well positioned for use by LMICs; ultimately, however, efficacy—for which all other criteria are necessary but insufficient conditions—is the most critical factor on which DCP will be evaluated. In acknowledgement of the fact that many volumes of DCP3 were not published until the end of 2017, and that policy influence can take significant time to manifest, this evaluation (via the process evaluation) also assesses the extent to which the DCP Secretariat is positioned to drive the efficacy of DCP3 going forward. In addition to assessing these criteria, the evaluation will provide strategic recommendations to both BMGF and DCP/DGH on how to best support evidence-to-policy translation in the future.

**This evaluation assesses DCP2 and DCP3, rather than the broader DCP grants.** Given the multiple shifts in the program design over this period, an understanding that advocacy activities can and should evolve over time as an organization adjusts its approach to meeting intended outcomes,

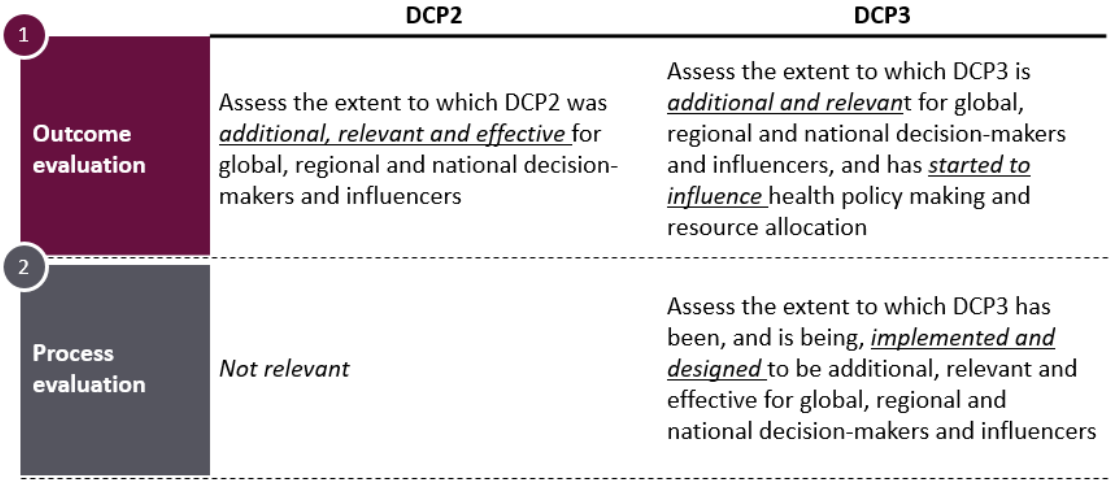
[3] Inferred from multiple documents, including the DCPP supplemental grant request (December 2003); the DCPN-DGH post-MTR proposal (June 2014), page 9; and the DCPN-DGH Theory of Change (December 2014)
[4] "About the Project." About the Project | DCP3. Accessed February 01, 2018. http://dcp-3.org/about-project
[5] DCPN-DGH Theory of Change document, December 2014.

and an expressed desire on the part of BMGF and DGH to focus on actionable recommendations for the future, the evaluation will not look at the extent that DCP has delivered on the original program design. It will not assess all of the objectives and outcomes articulated for DCP over the evolution of the grants, but instead will focus on relevance and effects on priority setting at the global and national level. As a result, the evaluation will not assess DGH's specific activities against the grant results framework, but rather the extent to which it achieved the outcomes that correspond to this overarching objective.

# 5. METHODOLOGY

**This evaluation comprises a DCP2 and DCP3 outcome evaluation, supplemented by a DCP3 process evaluation.** The outcome evaluation, as described above, assesses relevance, additionality, and (in the case of DCP3, leading indicators of) efficacy for both editions, examining use and influence of the DCP editions as of December 2017. The process evaluation examines the extent to which DCP3 has been, and is being, implemented and designed to be additional, relevant, and effective for global- and country-level decision makers and influencers in order to understand the likelihood of potential future influence.

**Figure 3: Evaluation approach**




## OUTCOME EVALUATION

**The outcome evaluation used a mixed methods approach, triangulating information from a survey, semi-structured interviews, and targeted desk research to corroborate findings and try to overcome some of the challenges of assessing the contribution of a global publication**. As a caveat to this part of the evaluation, please note that assessing the contribution of a global publication to a wide array of policy outcomes, particularly at the country level, is a highly challenging exercise, given the multiple pathways that are involved in policy influence, as well as the serendipitous nature of how certain windows can open, and close, for major influence. To that end, two approaches were employed for understanding how DCP has contributed to national-level policymaking. The first approach involved examining a select set of policy decisions that were nominated by key informants as likely examples of a strong DCP contribution. In an effort to understand the full *breadth* of potential use cases, the second approach was more bottom-up in nature: stakeholders and survey respondents were asked, in a free-form question, to describe any specific examples they were aware of in which DCP made policy contributions. Using a mix of stakeholder interviews and desk research (citation and linguistic analysis), evaluators further explored each of the examples of influence sourced from across both methodologies.

***Survey***

**The survey included broad questions about the use of evidence; more specific questions on preferred information sources and characteristics; and, for those familiar with DCP, specific questions testing the relevance, comparative advantages, and use of the DCP series.** The survey was sent to 222 stakeholders: 122 country-level stakeholders across 10 countries as outlined in Table 1 (five of which had had some prior DCP engagement—Malawi, South Africa, Afghanistan, China, Argentina—and five which did not—Kenya, Nigeria, Jordan, Indonesia, Colombia), including key policymakers, advisors, research institutions, local donors, and local partners, as well as 100 global-level stakeholders (half of whom were DCP authors or collaborators and half of whom were outside of the DCP network). Global-level stakeholders included academics and policymakers or advisors at global institutions such as the WHO, the Global Fund, Gavi, the World Bank, and bilateral donor agencies. Sixty-one stakeholders responded to the survey, including 29 at the country level and 26 at the global level (six were unidentified). Thirty-eight percent of respondents (across both the global and country levels) identified as academics, while 46% identified as representatives of decision-making institutions (i.e., national-level policymakers or global- or regional-level policymakers or donors).

**Table 1: Countries selected for the survey**

| Region | Countries with DCP involvement | Countries with no DCP involvement |
|---|---|---|
| **Sub-Saharan Africa** | South Africa; Malawi | Nigeria; Tanzania |
| **Eastern Mediterranean Region** | Afghanistan | Jordan |
| **Latin America** | Argentina | Colombia |
| **Asia** | China | Indonesia |

**The survey sampling attempted to avoid sample bias; however, a high percentage of outreach was to DCP authors and collaborators (50% of global stakeholders), which may skew the responses.** All survey outreach described the survey as a broad inquiry into the use of evidence in health policy decision making (without specific reference to DCP), to avoid a response bias among those who recognized DCP. However, given the relatively high percentage of target respondents who were DCP authors and collaborators, some degree of bias in favor of DCP recognition and use may be inevitable in these responses.

***Interviews***

**Evaluators constructed 34 semi-structured, qualitative interviews at the global level to understand DCP's relevance, additionality, and efficacy, and to gain insights into the support needed for evidence-to-policy translation more broadly.** These included interviews with policymakers, donors, and influencers such as representatives from the World Bank, WHO, Gavi, the Global Fund, and global academic institutions, including 13 DCP collaborators.

**At the country level, evaluators conducted in-depth case studies on Ethiopia (26 interviews), Mexico (18 interviews), and India (14 interviews), as well as targeted interviews with stakeholders from China, Malawi, and EMR to explore specific noted instances of DCP influence.** These country case studies sought to test the awareness, relevance, additionality, and efficacy of

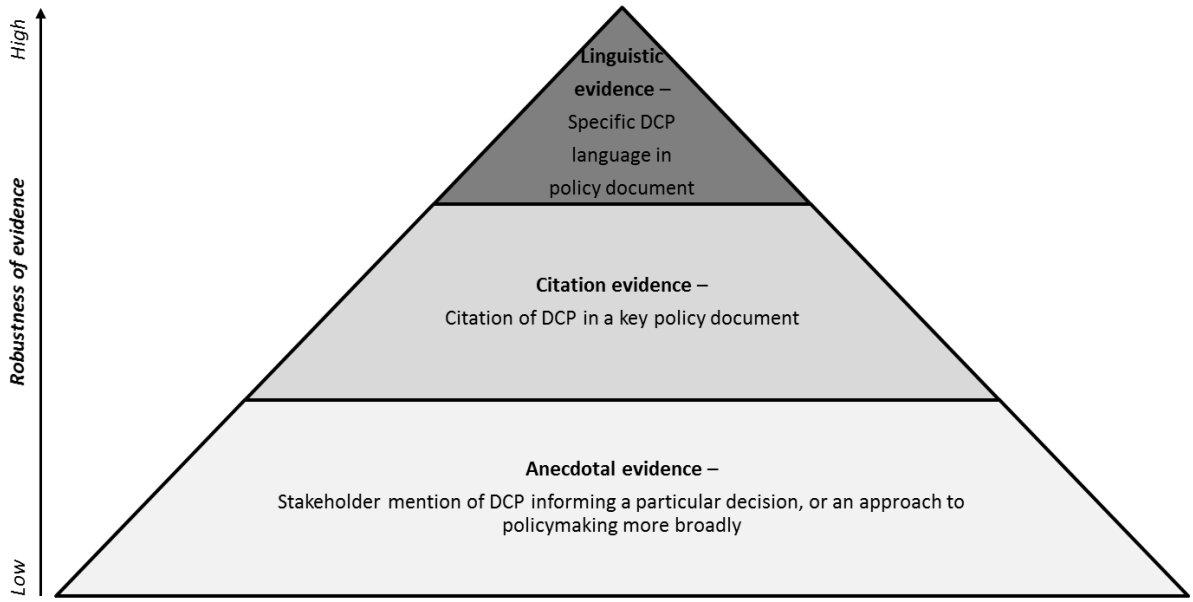
DCP at the country level; to explore specific instances of influence as applicable; and to understand the broader context, needs, and opportunities for evidence-to-policy translation at the country level. Ethiopia, Mexico, and India were chosen for in-depth case studies based on recommendations from the DCP Secretariat as to where DCP was most likely to have had influence; as such, they are not indicative of likely influence in countries where DCP has had little or no engagement, but rather represent the maximum level of influence one would expect to find. China, Malawi, and EMR were selected for targeted follow-up research to explore specific instances of influence that had come to light through global-level conversations.

**Interview findings were triangulated across stakeholder groups, including both decision makers and influencers, and, for the most part, were consistent.** Evaluators conducted interviews with policymakers themselves, as well as with influencers such as ministry advisors, implementing partners, academics, and in-country donors. Unless otherwise noted, there were no major discrepancies in perspectives across stakeholder groups.

***Targeted desk research***

**Evaluators conducted targeted desk research, including citation and linguistic analysis, when interviews suggested potential instances of country-level influence.** Evaluators examined key policy documents in order to identify, beyond the anecdotal evidence emerging in interviews, instances of DCP citation or, in some cases, the adoption of specific language, frameworks, or concepts from the DCP series. Linguistic evidence represents the most robust and conclusive evidence of DCP influence; citation influence suggests that DCP contributed to a policy or decision, but does not provide sufficient evidence to attribute DCP's influence; and anecdotal evidence from interviews is the least robust evidence and most difficult to attribute directly to DCP.

**Figure 4: Types of evidence of efficacy, by level of robustness**




**Across the instruments used in the outcome evaluation, the sample size is too small to draw statistically significant conclusions, but can nonetheless provide indicative perspectives on DCP's**

**overall impact.** Neither the survey sample nor the set of interviewees is large enough to be conclusive, but together they provide a broad set of perspectives on DCP's use by different stakeholders in different contexts, and offer insight into its relevance, additionality, and efficacy. Evaluators tried to minimize bias in the sample as much as possible. For the survey, recipients who were familiar with or had been engaged by DCP were balanced, where possible, with those unconnected to the DCP network. In the in-depth country case studies, interviews were conducted with DCP-recommended stakeholders, as well as with influential stakeholders identified through independent networks, to understand whether, and how, DCP's influence had permeated beyond the people directly involved or engaged in its creation.

## PROCESS EVALUATION

**The process evaluation complements the outcome evaluation by assessing the extent to which DCP3 has been designed, crafted, and disseminated to influence policymaking at global and country levels going forward.** To do so, it evaluates DCP3's organizational effectiveness across a number of key dimensions: vision, leadership and governance, learning and evolution, structure and processes, reporting, internal capacity, and external partnerships.

**The DCP3 process evaluation consisted of interviews with all current members of the DCP Secretariat, as well as a review of key documents.** Interviewees included Dean Jamison, Charlie Mock, Brie Adderley, Kristen Danforth, David Watkins, and Ala Alwan.

# 6. OUTCOME EVALUATION

## GLOBAL LEVEL

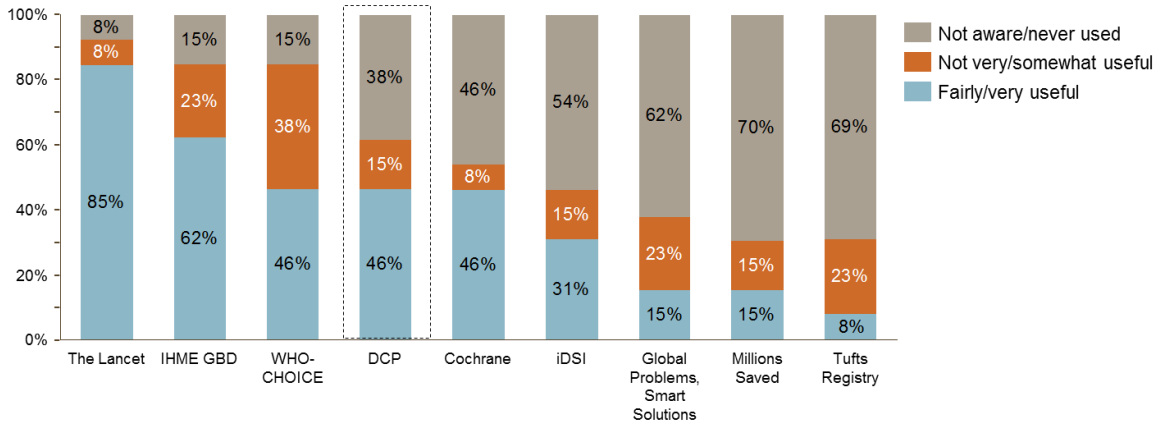
**If DCP is meeting its objective of influencing global decision makers, one would expect to see DCP used to shape policy decisions in global institutions or to inform the institutional or individual guidance provided by global institutions (funders and normative bodies) that, in turn, would contribute to policy decisions at the national level.** The first objective of engaging a global-level policymaker with a global publication is to influence institutional allocation and policy decisions made by bilateral and multilateral funders, such as the resources an organization spends on a particular disease or the interventions the organization chooses to support. As such, one would expect to see examples of DCP systematically informing institutional policies and resource allocation—directly or indirectly—among donors (such as USAID) and health agencies (such as the Global Fund and Gavi). The second objective is to indirectly influence country-level policy by influencing the institutional guidance that global institutions—including multilaterals, bilaterals, and norms-setting agencies such as WHO—provide to countries. One would therefore expect these institutions to have recommended DCP to, or shared DCP's findings with, national decision makers.

**Some policy influencers reported using DCP evidence to support advocacy efforts to funders, as DCP was a relevant, credible and additive source of evidence that replaced the need for a literature review.** Technical advisors (internal within global health teams and external at advocacy organizations or normative bodies) and academics reported using DCP, among other sources, as a reference point for cost-effectiveness information to support advocacy efforts with decision makers at global donor institutions (i.e., for drawing additional attention or funding to a specific health area). Many of these advisors and academics explicitly acknowledged the DCP publications as high-quality, valuable documents that replaced the need for literature reviews on a given topic, and believed DCP's extensive network made it highly credible. DCP has also been used as an educational resource, for example, influencing the structure of a widely-sold global health textbook and courses for undergraduates and graduates. While those who use the textbook may go on to become policy influencers, the ultimate influence of this pathway on policy outcomes is nearly impossible to trace.

**While the majority were aware of DCP, stakeholders working for global health agencies and funders did not report using it in specific policy decisions, as they commissioned their own analyses and their decisions were driven more by global targets and internal priorities than by cost-effectiveness data.** The majority of stakeholders in multilaterals and bilaterals (77% surveyed; 88% interviewed) were aware of the DCP series and 62% of those surveyed and 46% of those interviewed reported having ever read or used it in some way. Figure 5 shows which global information resources surveyed global decision makers had used, and which they perceived as most useful. While these resources are not directly comparable, as they provide different types of evidence (not limited to cost-effectiveness analysis and recommendations) in different formats (e.g., interactive tools, databases, articles, volumes), this graph does suggest that DCP was seen as relatively less useful than some other sources – 46% of survey respondents from global policymaking institutions found DCP fairly or very useful to health policy decisions, as compared to

85% and 62% for the Lancet and IHME's Global Burden of Disease study, respectively.[6] Many stakeholders reported that DCP offered limited additionality for actual decision making due to the fact that a) their technical teams used or commissioned primary evidence for decisions and b) priorities ultimately were determined by other factors (e.g., politics and internal priorities) and were more heavily influenced by WHO or global targets set through the World Health Assembly or the Sustainable Development Goals (SDGs). Indeed, collectively, global-level decision makers ranked evidence as the second most important factor in influencing decisions—behind internal priorities and just ahead of financing availability and global norms.

**Figure 5 - Perceived usefulness of different sources among global decision makers, by % of respondents who reported usefulness of each source (n=13)**




**Stakeholders at Gavi, the Global Fund and USAID also reported that DCP's content was not directly relevant for allocation decisions—which prioritized local burden, cost, and efficacy data rather than cost-effectiveness, and required more timely data than DCP offers.** Global stakeholders from the Global Fund, Gavi, and bilateral funders reported that DCP's content had limited relevance for their allocation decisions, which were often driven more by burden and severity than cost-effectiveness, or for selecting which interventions to support, which was primarily based on efficacy data. Twenty-three percent of global policymakers surveyed reported using cost-effectiveness evidence to inform most decisions, compared to 54% for disease prevalence and efficacy data. While this suggests a potential opportunity to influence global-level priority-setting processes to more systematically use cost-effectiveness, DCP does not appear to be the right resource to do so. Technical advisors reported that decisions relied more on local data from internal databases or from WHO than global estimates, and looked for the most recent evidence available at the decision point. As a systematic review, DCP is dated as soon as it is published.

**Some global stakeholders involved in the DCP network reported using DCP in their guidance around intervention selection to country decision makers, although use was not consistent within institutions.** Some global-level decision makers and advisors engaged by the DCP network (e.g., WHO-EMRO and World Bank), as well as academics, reported using DCP in their discussions with, and presentations to, national policymakers around which interventions should be used to tackle a specific disease burden—for example, at WHO-PAHO regional meetings. Evaluators heard

[6] DCP summaries have been published in the Lancet, so some stakeholders may have accessed them there but not recognized DCP as a separate publication. While sources included in the survey are not exhaustive, they do represent a sample of widely-known initiatives supporting health policy decision making.

reports of instances in which these influencers helped connect policymakers to DCP3 and facilitated translation. Policymakers in Iran and Jordan, for example, approached WHO-EMRO representatives for support translating DCP3 to the local context; the representatives were able to connect these policymakers with the DCP Secretariat. Uptake and use of DCP within institutions varied (e.g., uptake by the World Bank health team was good, but there was less uptake in economic or country teams; uptake of DCP in WHO was concentrated in EMR) and was concentrated around DCP's network.

**Many stakeholders reported that DCP3's density and length limited its usability for country-level decision makers, and that it would need substantial translation to the local context before they would recommend its use at a country level.** Decision makers and advisors recognized that the information in DCP could be useful and additional at the country level, but was presented in a format that was too complex, high level, and exhaustive for policymakers to use. As one stakeholder from a multilateral institution remarked, "DCP publications are more of an encyclopedia, rather than something countries could use to set policies."

## COUNTRY-LEVEL

**If DCP is meeting the objective of influencing country-level priorities, one would expect to see DCP used to shape national resource allocation and policy decisions.** In this case, there would be evidence that countries are using DCP either as a reference point or to inform a framework for decision making on resource allocation, national health priorities and strategies, or the design of health intervention packages, especially for essential health packages. At a minimum, one would expect to see anecdotal evidence of DCP's use to inform key decisions. Citation in key policy documents would be more robust evidence of this influence, and linguistic evidence (e.g., clear adoption of DCP frameworks, language, or ideas) would constitute the strongest evidence that influence had occurred.

**Instances of DCP's influence were found in six of the eight countries where informants believed DCP had influence, and there was one report of influence in the five countries not nominated by informants.** Evaluators found examples of DCP's influence (of varying strength, and often low) in all case-study countries (Ethiopia, Mexico, and India)—this was expected, as key informants nominated these countries as places where DCP likely had contributed strongly to policy decisions. Of the five countries where informants believed DCP had had some engagement or influence, evaluators identified examples DCP being used in a specific policy in three countries (China, Malawi, and Afghanistan) (survey results identified no examples in South Africa or Argentina). Across the additional surveyed countries—which were selected because they had no known history of DCP engagement, and therefore were more representative of DCP's country-level influence globally—only one further instance of DCP3's specific influence on policy was identified. This was in Nigeria, although no additional details were provided. Given that our in-depth analysis focused on countries with DCP engagement or which DCP had nominated, and that (with the exception of an unsubstantiated reference to Nigeria) no examples were found outside of these countries, we would not expect to find further examples of significant influence in countries outside of this evaluation's scope (fortuitous, ad hoc, unknown uptake is certainly possible, but highly unlikely).

**DCP2 and DCP3 were used to varying degrees in four instances to help define health packages and in three instances as part of broader policy-setting discussions.** Where DCP was used in

specific policy decisions, it was to help define or update basic health packages within or across diseases. DCP2 was used to shape Malawi's Essential Health Package, as part of the Health Sector Strategic Plan, to indirectly inform the design of a school feeding program in China, and, via an India-specific DCP2 publication, to help technical advisory groups recommend packages to achieve universal health coverage (UHC) in India. DCP3 was used in the development of a surgery flagship program (SaLTs) in Ethiopia. DCP2 had more broad influence in three other efforts: to provide a platform for idea exchange during a major health reform in Mexico, to advise national-level policymakers in India, and to recommend district-level interventions in India.

**DCP3 is currently being used in four instances—three efforts to define health packages and one to support health sector reform; in these cases, DCP3's influence remains to be seen**. DCP3 is currently being used to help define intervention packages in Ethiopia and in multiple EMR countries, including in the prioritization of and advocacy for non-communicable disease interventions by the Lancet Non-Communicable Diseases and Injuries (NCDI) Commission in Ethiopia, the recommendation for a revised essential health package in Ethiopia generating from a ministry official's PhD research, and the development of essential health packages in countries across EMR. DCP3 is also being used to shape prominent academics' recommendations on health reform to the next Mexican administration.

**The strength of DCP's influence varied widely across these instances and was often brought to bear through indirect, circuitous pathways, enabled by fortuitous circumstances rather than intentional engagement.** Ethiopia's Federal Ministry of Health's (FMOH) SaLTs strategy shows the most robust (linguistic) evidence of direct DCP influence, as interventions were taken wholesale from the DCP3 recommended package in volume one. The Malawi example also shows relatively strong influence—cost-effectiveness ratios from DCP2 were extracted to inform recommendations on Malawi's essential package, and DCP was cited once in the 2011-16 Health Sector Strategic Plan (HSSP). Other influence pathways were more indirect, with only anecdotal evidence substantiating the influence. In China, for example, a DCP2 chapter served as the starting point for a secondary publication on school feeding (with which some DCP2 authors were involved). This publication piqued the interest of the Chinese government and contributed—with additional translation and consultation—to the creation of a new child development program. In Mexico, the overlap of key actors between the national health reform and DCP2's creation made possible an exchange of ideas that may have contributed to the reform, but most stakeholders report that DCP2's influence was likely limited. In India, country-specific reports[7] were used rather than DCP2 itself; the reported influence of DCP2 was low or unknown, with anecdotal evidence suggesting that Indian DCP authors on occasion shared findings informally with decision makers; the translated DCP publication helped shape some technical advisory groups' recommendations; and some district policymakers "valued" recommendations—although evaluators found no evidence of DCP use in specific policies and programs. While it is too soon to evaluate the potential influence of DCP on future country-level policymaking, some examples (e.g., Ethiopia's essential services package, EMR consultations) appear relatively well positioned for DCP influence given the buy-in and involvement of key decision makers. Meanwhile, the pathways by which DCP might influence policies in other contexts (e.g., a forthcoming advocacy article in Mexico) remain unclear.

[7] Choosing Health, Karnataka State report

**Table 2 - Country-level influence of DCP**

| Country | Use | Description | Strength of influence | Strength of evidence |
|---|---|---|---|---|
| Malawi | DCP2: Essential Health Package (EHP) | **DCP → MoH technical advisor:**<br>• An MoH technical advisor at the University of Malawi who helped update the Health Sector Strategic Plan (HSSP), including the EHP, found DCP2 during his research<br>• He extracted the relevant cost-effectiveness ratios (CERs) from DCP2 to prioritize interventions for Malawi's EHP<br>• Used DCP2's list of cost-effective interventions as a framework for validating interventions already in the EHP and justifying new additions for each high burden disease and condition, especially in new health areas, such as NCDs and mental health | **Medium:** DCP2 CERs were used to inform the EHP. However, DCP2 was one of many sources used, and only used to identify CERs. In addition, consultations suggested that the recommended EHP was not ultimately feasible given resource constraints, suggesting potential limitations of the methodology used for the update. | **Citation** |
| China | DCP2: School feeding program | **DCP → follow-up publication by DCP authors → Government of China:**<br>• DCP2 involved authors from top institutions in writing ch. 58, "School-Based Health and Nutrition Programs"<br>• A group of DCP2 authors embarked on a follow-up analysis to the chapter, focused on the justification for school-based interventions, and published their findings in "Rethinking School Feeding" (2009)<br>• The Chinese government accessed "Rethinking School Feeding," published a Chinese version, and invited several of the authors to participate in the planning process for a child development program | **Low:** DCP2 was indirectly influential by bringing together a network of authors from top agencies focused on school health, who later published a detailed book on school feeding programs. The resulting Chinese Child Development Program was based on this book, not on DCP2 | **Anecdotal** |
| India | DCP2: Consultations with DCP authors | **DCP → DCP authors/sub-grantees → MoHFW decision makers:**<br>• DCP authors were advisors to Indian policymakers and shared DCP findings/ recommendations with them in group and private consultations<br>• The consultations formed part of the evidence base for decisions | **Low:** While DCP's network was well positioned to influence decision makers, their input was non-systematic and one of many inputs | **Anecdotal** |
| | DCP2: National/ local reports | **DCP → sub-grant → Indian publications → advisory committees→ decision makers:**<br>• Through a sub-grant, DCP2 was translated to the national level in, "Choosing Health: An Entitlement for all Indians," and to the state level (Karnataka only)<br>• Authors gave findings to technical advisory groups, which submitted recommendations to policymakers | **Low:** DCP recommendations were one of many inputs used to create recommendations to the government, and it is unclear if the recommendations were ultimately adopted | **Anecdotal** |
| | DCP2: DESH | **DCP → sub-grant → Indian publications → communication materials → decision makers:**<br>• CGHR created district-specific policy briefs and implementation guides from the Choosing Health report and, with MoHFW endorsement, distributed to 10 district decision makers in ~300 districts<br>• Decision makers reviewed the materials, but it is unclear what recommendations were implemented | **Unclear:** Evaluation of program has not been completed, and impact on decision making and health outcomes is unclear | **Unclear** |

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| Mexico | DCP2: Mexican health reform | **DCP ← → decisionmakers:**<br>• Key Mexican decision makers and influencers (e.g. Julio Frenk, Jaime Sepulveda, Eduardo Gonzalez Pier) were involved in both DCP2 creation (began in 2002) and the Mexican health reform (2002–2003)<br>• The DCP network may have created a platform for the exchange of ideas among Mexican decision makers and other DCP collaborators during the final stage of the reform<br>• DCP1, not DCP2, was consulted for the reform, but early ideas from DCP2 development may have played a small role. However, it is more likely that the Mexican reform experience influenced DCP2 | **Low:** Interviews and literature suggest Mexico may have had greater influence on DCP2 than vice versa, as the reform was already implemented at the time of DCP2 publication, and there was no indication of influence after DCP2 publication. | **Anecdotal** |
| | DCP3: advocacy paper and ongoing translation activities | **DCP → local champions→ local research institution (INSP):**<br>• INSP researchers are citing DCP in a forthcoming article making recommendations to the next administration on programmatic health reforms, which may or may not be taken up by policymakers<br>• In addition, Dr. Sepulveda / UCSF translated some of DCP3 into Spanish, and are organizing Mesoamerican launch in Feb., which will include small-scale translation activities (uptake by policymakers and influencers following the launch is TBD) | **TBD, low likelihood:** Some communications and translation activities are underway**,** but influence is still in the academic sphere, and the impact of the forthcoming article on policy is highly uncertain, depending on engagement of the next administration and its receptivity to evidence. | **TBD** |
| Ethiopia | DCP3: SaLTs strategy | **DCP → Decision maker in FMOH:**<br>• DCP invited MoH Dr. Kesete to the ACE and included Ethiopian authors, which increased credibility<br>• Dr. Kesete was looking for an FMOH flagship initiative during a time when global momentum was building around safe surgery<br>• Dr. Kesete gave the Medical Services director—who had strong capacity—an explicit mandate to translate DCP3 vol.1 into the Ethiopian context for the SaLTs (surgery strategy) | **High:** DCP3 volume 1 was directly used as a framework for the SaLTs strategy, and all 44 interventions suggested in DCP3 were adopted. | **Linguistic and citation** |
| | DCP3: NCDI Lancet Commission | **DCP → global research institution (Lancet) (via DCP-E champion) → local researchers & policy advisors (incl. former CoS to MoH):**<br>• In his capacity as Lancet NCDI commissioner, DCP-E lead Ole Norheim saw the opportunity to use DCP in the commission<br>• Dr. Norheim extracted relevant DCP evidence to create presentation and workshop materials (e.g., spreadsheet with relevant NCD data)<br>• These materials were used to inform a multi-stakeholder Ethiopian commission, which assessed the evidence in the local context to prioritize NCD interventions, and build the FMOH investment case<br>• The aim of the commission and link to policy is still TBD | **TBD, medium likelihood:** NCDI commission is well positioned to influence decision makers as it includes FMOH stakeholders. However, it has not yet identified a link to a specific policy decision or presented findings, so its path to policy influence is unclear. | **TBD** |
| | DCP3: Essential health | **DCP → DCP-E →policy advisors:**<br>• The DCP-E PhD program is supporting and funding Dr. Getachew, the former CoS to the State Minister, in | **TBD, medium likelihood:** While policy influence remains to be seen and would be in 2–5 years, and efforts are currently an academic exercise, Dr. Getachew is well positioned to engage the FMOH, | **TBD** |

| | | | | |
|---|---|---|---|---|
| | services package | getting his PhD, and connected him to DCP information to inform his research<br>• Dr. Getachew will compare the DCP essential package against the local context and data to make recommendations for the Ethiopian essential health services package<br>• Upon return to the FMOH, he will use this research to inform a committee and consultations on revising the package | already has buy-in from top ministers, will return to the FMOH when he completes his PhD, and is receiving strong support from DCP-E. | |
| EMR count-ries | DCP3: Policy forums | **DCP → Policy forums (led by Dr. Alwan) → decision makers:**<br>• ACE member Ala Alwan, the WHO-EMRO regional director, urged DCP to increase country translation<br>• Dr. Alwan, with support from the Secretariat and a separate grant from BMGF, used his position as regional director to convene five policy forums and introduce DCP3 to policymakers across EMR countries<br>• When faced with relevant policy decisions (e.g. creating a health package or health sector plan), select EMR decision makers have approached DCP directly for support, or have requested support from other actors in using DCP3 (e.g. BMGF, WHO) | **TBD, medium likelihood:** There is demand for support in using DCP from multiple EMR countries, including Iran, Afghanistan, and Jordan, and translation activities are just starting (with efforts in Afghanistan further along). Note that it is unlikely that DCP can support all EMR translation activities with the remaining time and budget. | **TBD** |

**These instances of influence reflect different levels of investment (on the part of the DCP Secretariat or sub-grantees) in disseminating and translating DCP, with greater investment not always linked to stronger influence.** In some cases (e.g., in India), significant investment was undertaken to create a localized companion publication to DCP – though this did not necessarily translate into stronger influence given lack of a direct pathway of influence to policymakers. In a second model, a high-leverage investment in an individual champion (i.e., Dr. Alwan) is helping to spur uptake and potential influence across multiple countries. In other instances (e.g., DCP-Ethiopia), DCP dissemination or translation is one component, or an externality of, a broader investment in capacity building, which is helping to position DCP for success with limited additional cost. Finally, there were some instances where there was limited investment beyond engaging key individuals (e.g., Dr. Kesete in Ethiopia, Dr. Frenk in Mexico) in the publication's creation, enabling them to bring the publication into policy decisions they were involved with. However, this model is highly dependent on the engagement of powerful, evidence-receptive policymakers during DCP creation, which was limited beyond the examples mentioned, and on fortuitous circumstances (e.g., a relevant policy decision, growing global momentum around an issue, appetite and capacity for evidence translation and use) that are difficult to replicate. The different models and levels of investment were ad hoc and circumstance-dependent, rather than the result of intentional, targeted efforts on the part of the Secretariat, so it is difficult to assess the relative impact and cost of different engagement models.

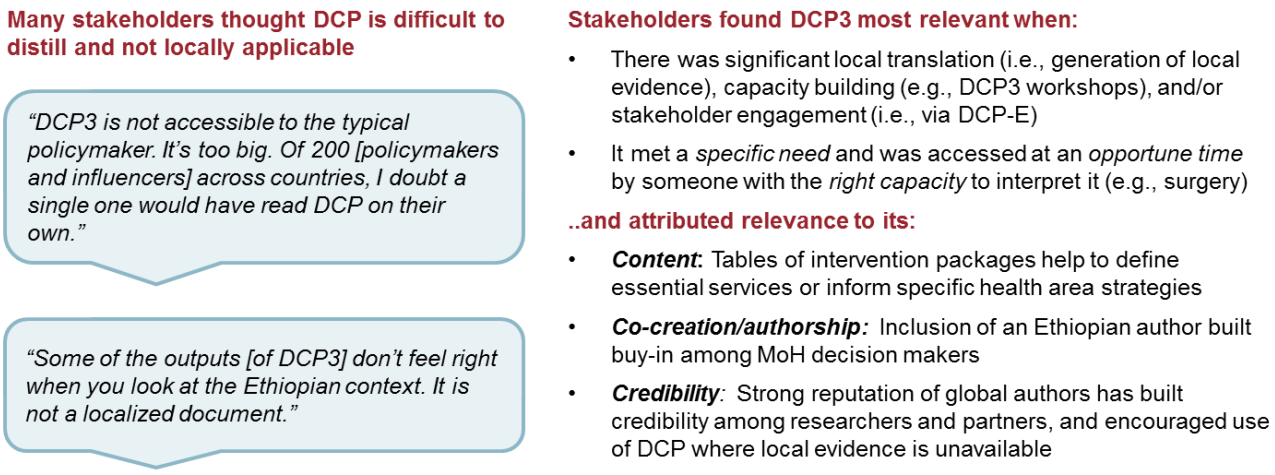
**Where DCP was used, stakeholders felt it was additional as a comprehensive, one-stop-shop for intervention packages and cost-effectiveness analysis, compiling otherwise disparate data to help countries prioritize interventions for a specific health area or a basic health package.** Stakeholders across countries saw value in DCP's tables of intervention packages, which could be used as a framework for essential packages (Malawi, Ethiopia) or for specific strategies (surgery in Ethiopia), and many noted that the recommended packages for essential universal health coverage

in DCP3 volume nine were unique and not available elsewhere. In addition, many technical advisors remarked that DCP saved them time and effort by compiling different sources, though they noted that, had DCP not existed, they ultimately would have collected the data themselves. DCP was seen as particularly additional in lower-income countries that did not have strong research capacity and thus lacked local evidence or the ability to conduct systematic reviews themselves. Some stakeholders (e.g., in China and Mexico) also noted that the DCP network was helpful in bringing together different credible experts to exchange ideas, but also acknowledged that other fora (e.g., professional associations, conferences, Lancet commissions) served similar functions.

**Stakeholders who used DCP found it most relevant when it responded to a timely, specific need (e.g., for an essential package or a particular health strategy); its use was facilitated in part because it was viewed as highly credible.** DCP was most relevant to policymakers and advisors facing specific questions, mostly related to packages (e.g., which surgical interventions to include in Ethiopia's surgical strategy; how to develop a package for UHC in EMR countries), and when policymakers had awareness of, or access to, DCP as a tool to help answer the issue at hand. DCP was thus most relevant in countries with relatively less developed health systems that did not have sufficient essential packages already in place and that needed support to develop them. DCP's perceived credibility likely increased its relevance in situations where policymakers were facing pertinent questions and looking for references—67% of country-level stakeholders surveyed who were familiar with DCP found it to be the best, or among the best of comparable publications in terms of credibility; country-level stakeholders identified credible, verified sources as the most important characteristic in an information resource.

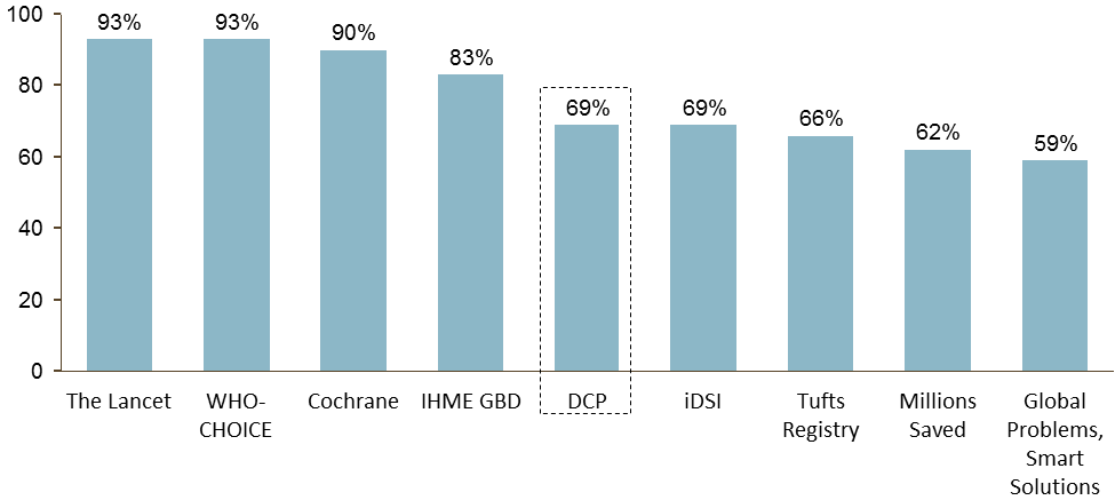
**Stakeholders also reported that DCP was most relevant when it was translated to the country context, both because this ensured that it was locally applicable and because many stakeholders viewed DCP as too long, technical, and dense to be relevant and actionable for most policymakers.** Indeed, among identified instances of influence, it was rare that high-level policymakers—except those with strong academic backgrounds—picked up and used DCP directly. More often, local researchers or technical staff were the ones to read DCP, and they typically reported reading only the summaries (e.g., Lancet summaries) or the tables of interventions, suggesting that these synthesized versions were more accessible, useful, and relevant than the full volumes. Given the reported importance of local data and contextualized recommendations (nearly all country-level interviewees expressed preferences for local data), DCP was also seen as most relevant when it had been translated to the local context, with local data mapped against the DCP framework to ensure applicability. For example, in Malawi, a technical working group mapped local data against the interventions listed in DCP2, using DCP's cost-effectiveness ratios as a benchmark to assess interventions in the Malawian context, and using the DCP framework to validate and justify interventions' inclusion in the essential health package. In Ethiopia, the NCDI Commission extracted the interventions related to NCDs from across DCP3 volumes into a spreadsheet, and led workshops to supplement DCP findings with local cost and efficacy data to prioritize NCD interventions in the country context.

**Figure 6 - Perspectives on relevance from Ethiopia case study**




**Relevance thus often relied on the presence of a champion—an individual with a technical background and close ties with both policymakers and the academic community, sometimes part of the DCP network, sometimes external—who brought DCP to the attention of policymakers and facilitated translation.** Local champions who were aware of the DCP series and understood the contexts in which it could be a relevant source often identified opportune moments for influence, brought DCP to the attention of key decision makers, and facilitated translation to ensure applicability in the local context. Sometimes these champions were part of the DCP network. In Ethiopia, Dr. Ole Norheim, the lead of a separate DCP-Ethiopia grant, relied on strong networks and engagement with Ministry of Health stakeholders to proactively find opportunities to bring DCP into policy dialogues and exercises. For example, he brought DCP into the NCDI Commission's work and facilitated the workshop to translate it locally; he also supplied an FMOH advisor, who is completing his PhD as part of DCP-E's capacity-building work, with DCP3 products to inform his thesis on revising the essential health package, and is supporting him in translating and applying the findings. In EMR, similarly, Dr. Ala Alwan, under an additional BMGF grant, has engaged high-level policymakers through policy forums to showcase how and where DCP can be useful, and is now supporting translation activities to meet countries' specific needs. In other cases, these champions were external. In Malawi, for example, an external researcher, Cameron Bowie, who was advising the Ministry of Health on its new Health Sector Strategic Plan and Essential Health Package, had come across DCP2 in his research, found its cost-effectiveness ratios relevant, brought it into the technical working group informing the Ministry's decisions, and facilitated its translation to the Malawian context. In all instances, champions were critical to achieving influence, but the DCP Secretariat did not systematically, intentionally, and explicitly engage and activate a network of champions. Rather, separate grants or passionate individuals drove uptake, somewhat independently of the Secretariat.

**Figure 7: Country-level survey respondents' awareness across sources (n=29)**




**In countries where DCP had no engagement, there was moderate awareness of DCP, and some comparable publications (e.g., the Lancet) were more widely known.** While awareness was relatively high in countries where DCP had specific related grants (71% in Ethiopia), only 55% of country-level survey respondents were familiar with DCP (65% in countries with DCP engagement, 50% in countries without).[8] By comparison, 93% of country-level stakeholders were aware of the Lancet and WHO-CHOICE, 90% were aware of Cochrane, and 83% were aware of IHME's Global Burden of Disease study.[9]

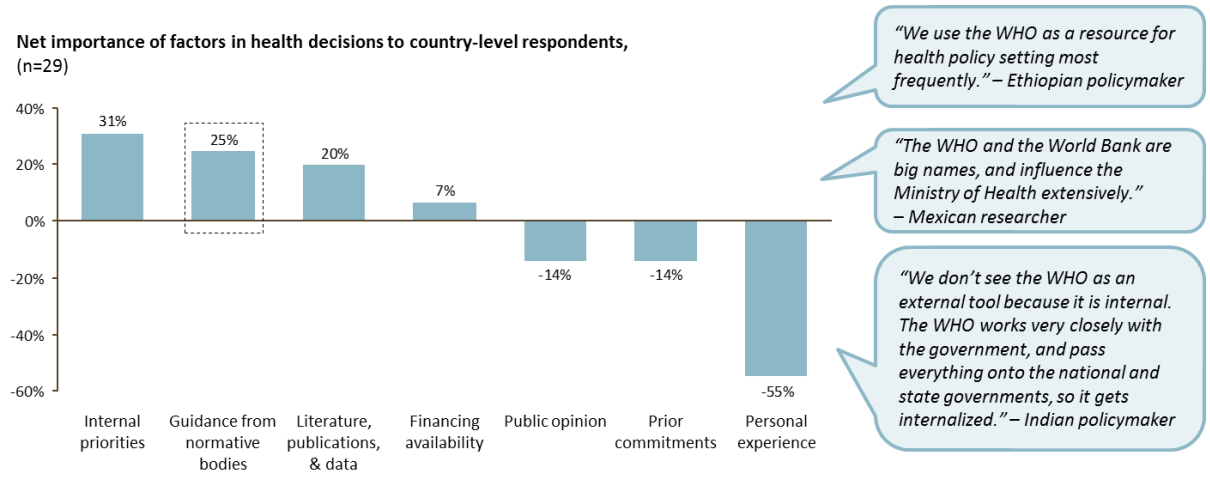
**Stakeholders reported a lack of local data—and difficulty translating the global framework to a local context—strongly detracted both from DCP's additionality and its relevance, and hindered uptake.** Stakeholders across countries agreed that DCP could not be used without translation because it did not include local-level cost, efficacy, epidemiological, or health system performance data, which, as country-level survey respondents pointed out, were among the most influential data shaping national policies (disease prevalence, needs analysis, efficacy, and cost data were used most often among country-level survey participants). While champion-led translation efforts, as described above, supported DCP's relevance as a global-level overarching framework, some stakeholders noted that DCP was not always structured in a way that facilitated local translation. They explained that not all methodologies, assumptions, and underlying data points were clearly stated, a challenge considering that national policymakers surveyed found transparent, replicable methodologies to be among the most important characteristics in a resource (after credibility). Many interviewees cited an appetite among policymakers for simpler, more visual resources with a tighter focus on implications and with the ability to be tailored easily to the country context.

[8] Note that 31% of respondents indicated that they were "not aware" of DCP when asked about its use. However, when the 17% who reported that they had "never used" DCP were asked why not, 80% said they were unaware, suggesting awareness is actually 55% across respondents (65% in countries with engagement, 50% in countries without). Because respondents did not have the second opportunity to note lack of awareness for other publications, the higher figure is reported in the graph above to enable comparison.

[9] Measures awareness of DCP, not actual use. As noted above, DCP summaries have been published in the Lancet, so some stakeholders may have accessed them there but not recognized DCP as a separate publication; sources included in the survey are neither exhaustive nor directly comparable.

**Across countries, stakeholders reported that WHO guidelines were more influential than DCP, and lack of WHO endorsement had limited DCP's relevance.** Among 29 country-level stakeholders surveyed, the most influential factors in decision making were "internal priorities" and "guidance from normative bodies." While DCP would not be expected to compete with the WHO—given their differing mandates, governance structure, and reaches—the resources they provide (including, but not limited to, WHO-CHOICE) have overlapping use cases, namely as a reference for intervention selection.[10] This suggests a missed opportunity for collaboration (some WHO staff were engaged as authors, but there has not been institutional level engagement and alignment with DCP). Instead, many stakeholders reported that some of DCP's recommendation contradicted WHO's, which were preferentially used. WHO guidelines were often a country's first reference point, while resources without WHO backing were less likely to be widely trusted and adopted.

**Figure 8: Net importance of factors in health decisions to country-level respondents (n=29)**




11,12

[10] While WHO-CHOICE is a widely known resource (93% recognition among country-level survey respondents) that provides decision support based on cost-effectiveness, it is not a perfect substitute for DCP. While 66% of country-level survey respondents found it very or fairly useful (as compared to 38% for DCP), interviews did not suggest widespread use, and some interviewees noted that the tool was too complex and unwieldy to be used for policy decisions without significant support.

[11] Net score: on a scale of 1-7 from relatively most important to relatively least important, % of respondents who ranked a factor as 1 or 2, minus the % of respondents who ranked it 6 or 7.

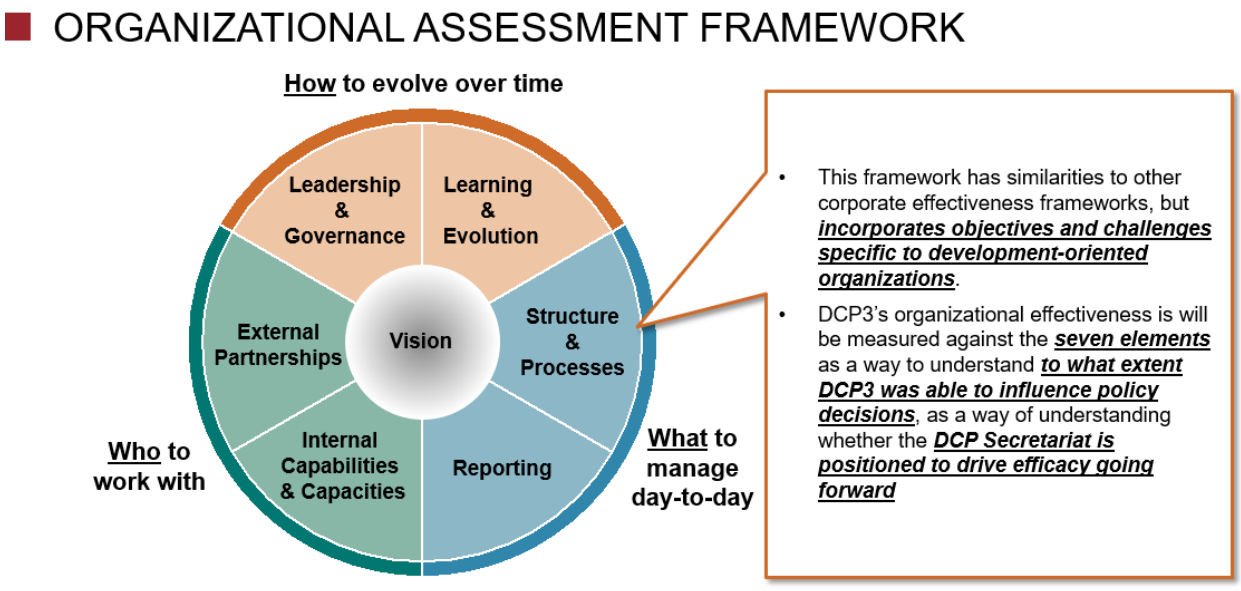
[12] As noted above, these factors are not mutually exclusive (i.e., other factors may influence guidance from normative bodies), but the data does suggest that normative guidance plays an important role.

# 7. PROCESS EVALUATION

**The process evaluation aims to understand to what extent DCP3 was set up to influence global and country policy decisions, as a way of determining whether or not the DCP Secretariat is positioned to drive DCP3's efficacy going forward.** In acknowledgement of the fact that many volumes of DCP3 were not published until the end of 2017, and that policy influence can take significant time to manifest, the process evaluation assesses the extent to which the DCP Secretariat is positioned to drive the efficacy of DCP3 going forward, based on factors that may have contributed to, or limited, its influence to date.

**By assessing key elements of the DCP3 organization, the process evaluation highlights a number of factors that may have limited DCP3's efficacy in the past and may continue to do so in the future.** The components of the organizational assessment framework include an assessment of DCP3's *vision*; DCP3's operating model in terms of *leadership and governance, structure and processes, capabilities and capacities, external partnerships* and *reporting*; and DCP's *evolution* over time. This framework has similarities to other corporate effectiveness frameworks, but incorporates objectives and challenges specific to development-oriented organizations such as DCP.

**Figure 9: Process evaluation assessment framework**




**VISION: DCP3 was designed to engage technical experts as a path to influence—which limited direct engagement of, and tailoring for, policymakers.** DCP3's authors envisioned it as an update and expansion of DCP2, following the processes used in DCP2 and developing new economic methods that incorporated measures of financial risk protection and equity, both of which were gaining importance in decision making. DCP3 moved to a multivolume publication split by health verticals to enable readers to engage with volumes of interest, rather than the whole publication. Each volume included a recommended intervention package. The volume split was designed to appeal to DCP3's target audience of technical experts predominantly interested in their area of expertise. In contrast, a consolidated publication would have been more appropriate for

policymakers, who make decisions across verticals. Indeed, the survey found that decisionmakers preferred information sources that included information across health areas (they ranked it fourth out of ten characteristics), whereas academics found this characteristic to be relatively less important (ranked eight out of ten). In selecting a technical target audience, the Secretariat pursued an indirect pathway to influence in which technical experts, as well as editors and authors, would serve as policy influencers if and when they engaged with, or entered, the ministry of health through various channels. As such, while a few ACE members and contributors had direct or indirect policy experience, and there was some engagement with other policy reviews (e.g., Lancet Commission on Investing in Health) the Secretariat had limited active engagement with policymakers during creation or dissemination, and did not design the publication for a policymaker audience.

**LEADERSHIP AND GOVERNANCE: Early disagreements within DCP3's leadership, a lack of focus on policymaker engagement, and the challenges of governing a large group of voluntary contributors led to production delays, which limited time and resources for other activities, particularly for translation.** The disputes and split between DGH and IHME at the beginning of the grant meant that DCP3 production did not begin until the end of 2010, a year and a half after the grant started. After this point, leadership remained stable under Dean Jamison, and there was limited process disruption when Charlie Mock took over part-time from Rachel Nugent. However, throughout the grant, DCP's leadership focused on engaging technical experts and did not prioritize or emphasize the need to engage policymakers. The Secretariat was responsible for governing volume production and relied on volunteer contributors who prioritized quality over timely delivery. While this approach yielded high-quality materials, it also resulted in production delays and additional coordination work for the Secretariat, which did not create incentives or accountability to avoid this problem. Subsequently, the Secretariat had limited time and resources to focus on dissemination and translation. As such, alternative governance models could be considered going forward. The Advisory Committee to the Editors (ACE) repeatedly advised the Secretariat to dedicate greater focus to dissemination and translation activities, but the Secretariat lacked the resources to respond.

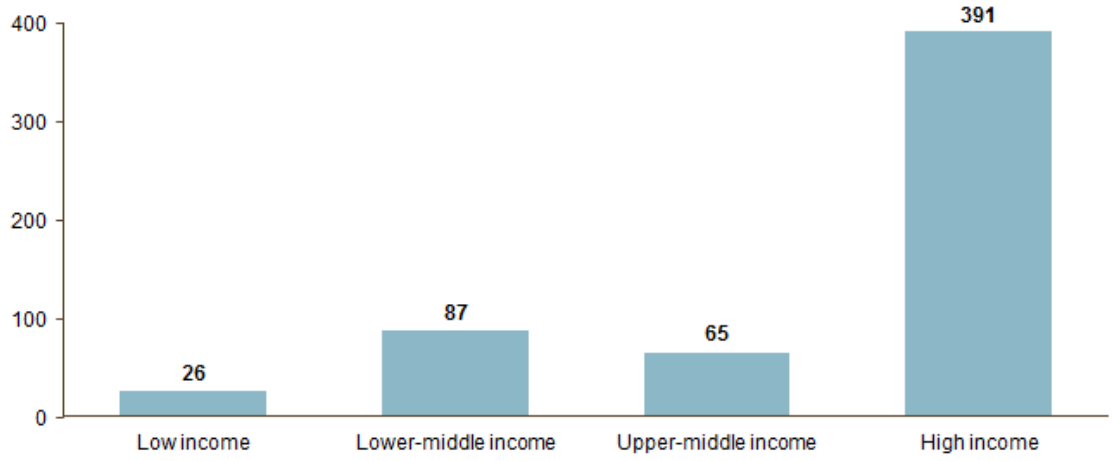
**STRUCTURE AND PROCESSES: After the Mid-Term Review (MTR), the Secretariat took some steps to adjust its structure to increase country engagement and to repackage DCP3's content into a relevant format for policymakers (i.e., via volume nine); however, the Secretariat left sub-grantees to manage country engagement and the harmonization of volumes one through eight took longer than expected.** After explicit critique in the MTR, the Secretariat hired Kristen Danforth, in part to support country engagement, and deepened partnerships with Ala Alwan at WHO, as well as Ole Norheim, as channels for reaching policymakers and influencers. However, volume production requirements meant Danforth's efforts were redeployed and country engagement was almost entirely outsourced to Dr. Alwan in EMR and Dr. Norheim in Ethiopia, under separate grants. While both Dr. Alwan and Dr. Norheim were better positioned to lead country engagement activities, the Secretariat provided minimal direction or guidance, especially in Ethiopia, to support these activities (the DCP-Ethiopia grant had no explicit mandate to disseminate or translate DCP3, but was focused on capacity building for economic evidence more broadly). Volume nine, the final volume that translated and harmonized packages across vertical volumes in an attempt to appeal to the way policymakers make decisions, was not part of DCP3's

original vision, and therefore additional processes were needed for its creation. These were initiated toward the end of the grant period, and—as volume nine relied on the completion of other volumes—its creation was left for last; it was not completed until the end of 2017.

**CAPABILITIES AND CAPACITY: The Secretariat had the capabilities and capacity to create DCP3, but lacked the knowledge, experience, and local networks to drive dissemination and translation, limiting policymaker engagement.** The DCP Secretariat credibly guided all technical elements and engaged a wide network of experts, creating an extensive, high-quality publication. Staff had limited experience working with policymakers (until the addition of Kristen Danforth and Dr. Alwan in 2014), and as an academic institution based in Seattle, DGH did not have the location, networks, experience, or opportunity for interaction to support LMIC engagement. DCP's budget was almost entirely expended on volume production, so the Secretariat had insufficient resources to simultaneously complete volume production and lead communication, dissemination, and translation activities. As a result, translation activities were outsourced to external partners (supported by additional grants), and communication and dissemination activities were deprioritized. At the current stage in the grant, the remaining funding is likely inadequate for extensive dissemination and translation; additional funding will likely be required to deliver planned activities.

**EXTERNAL PARTNERSHIPS: DCP's external partnerships were predominantly with academics, rather than with policymakers or institutions with access to policymakers, and country partnerships were largely opportunistic rather than strategic.** DCP mobilized an extensive network of technical experts as contributors (600+) and on the ACE. Eighty percent of contributors were from upper-middle- or high-income countries and typically lacked direct pathways to influencing LMIC decision makers; very few editors, authors, or ACE members were policymakers. DCP's partnerships in Ethiopia and EMR did facilitate direct policy engagement; however, as the focus on EMR did not align with BMGF's target countries, many partnerships with countries (e.g. Egypt, Oman, Qatar) in the EMR had to be deprioritized.

**Figure 10: DCP contributors by country income level (n=569)[13]**




[13] DGH is still collecting data for 190 authors, who are not included in the graph

**REPORTING: The Secretariat reported reactively rather than periodically, and reporting was focused on outputs rather than in relation to the results framework.** The Secretariat submitted progress reports and budgets to BMGF as requested (reports were submitted in March 2012, January 2013, December 2013, September 2015, and September 2017); these reports detailed progress against outputs rather than against the agreed upon results framework. The lack of focus on the results framework and the sporadic, reactive nature of the reporting may have diluted the evidence indicating that DCP was deviating from its stated objective of influencing policymaking, and thus needed to correct its course.

**EVOLUTION: The Secretariat evolved in response to the MTR, but these changes were incremental compared to the major changes that the MTR felt were needed for DCP3 to deliver on its objectives.** The Secretariat took a number of actions in response to the MTR. With BMGF support, the Secretariat reformulated the results framework to increase focus on country translation and established country partnerships to help deliver these objectives. However, responsibility for delivering the updated country translation objectives, as described above, was left entirely to country partners, who operated under separate BMGF grants. Dr. Alwan was brought in to focus on country engagement, though his work was also supported under a separate grant. The biggest change to the central Secretariat's structure, processes, or activities (under the main DCP grant) was hiring Kristen Danforth to support country partnerships. However, as noted above, her role soon shifted to volume production support. In response to the MTR, as well as findings from EMR policy forums and growing momentum around UHC, the Secretariat reformulated volume nine to provide a synthesized essential health package, but made few changes to the contents and recommendations of volumes one through eight. Recognizing that volume nine was the most relevant volume for policymakers, the Secretariat explicitly put translation activities on hold until it was finished.

**As a result of these challenges, impact at the country level is likely to be delayed, and will not happen without additional time, manpower, or money.** Thus, noted in the outcomes evaluation, DCP3's efficacy has been fairly limited outside of EMR and Ethiopia. In all likelihood, these limitations will continue given that policymaker engagement has been limited, broader dissemination and translation activities have been minimal, and the original DCPN grant is ending.

# 8. LESSONS LEARNED ON POSITIONING GLOBAL PUBLICATIONS FOR INFLUENCE

**The evaluation findings highlight a number of lessons about what is needed to maximize the influence of a global cost-effectiveness publication on country-level policies.** Based on DCP's past successes and limitations, there are a number of important lessons and key principles for the creation, dissemination, and translation of global publications that can help to best position future publications to influence country-level policymaking.

### THE ROLE FOR GLOBAL COST-EFFECTIVENESS PUBLICATIONS IN PRIORITY SETTING

**Given that priority setting is necessarily a local process requiring localized inputs, a global publication should aim to provide guidelines, a methodology for priority setting, and/or an accompanying dataset that can be used in local analysis.** Stakeholders nearly unanimously expressed preference for local inputs (on disease burden and health system performance in addition to cost, efficacy, and cost-effectiveness) for priority setting, and acknowledged that country-level priority setting is an inherently complex and political process. Given this dynamic, a global evidence publication cannot expect to serve as a wholesale input into this process, but rather can provide global-level tools that can be adapted at the country level. When it comes to cost-effectiveness, these could include:

- A set of **guidelines** laying out the most cost-effective interventions for given diseases, burdens, and contexts;
- A framework or **methodology** for priority setting, such as a guide or tool that helps policymakers understand how to reconcile different epidemiological, cost, efficacy, and health system inputs, with recommended guidelines, to determine priorities;
- A **dataset** that provides the best available, easily extractable evidence on cost-effectiveness from different geographies, that can serve as benchmarks or proxies for local data.

**While such products could theoretically be used across a range of countries, they will be most relevant if formulated to answer a specific set of questions for specific geographies.** While global publications often aim to be applicable across a range of questions and settings, in reality this limits their potential for achieving deep, country-level influence. For example, while some stakeholders in Afghanistan highlighted that DCP3's packages were relevant for designing essential health packages, they also suggested that what was really needed was a package tailored for emergency settings. Stakeholders in Mexico, meanwhile, reported that many of DCP3's recommendations were too basic for Mexico's more developed economy and health system (e.g., DCP3 recommended policies or packages had already been implemented). In order to exercise deep influence at the country level, a publication should be formulated to respond to a specific set of questions, needs, and preferences of policymakers in a select set of countries, and the target countries and focus topics (e.g., helping countries define packages that align with UHC goals) should be defined up front, before a global publication is designed.

### BRIDGING THE GAP BETWEEN RESEARCH AND POLICY

**Policymakers should be engaged in the creation of a global publication to identify specific questions and evidence needs, and, crucially, to help to bridge the gap between academia and policy.** At global and country levels alike, researchers' work is largely siloed from the policy sphere. While recognizing the value of cooperation, both policymakers and academics often lack an understanding of how to engage with one another and face barriers (e.g., mistrust; differing objectives, priorities, and incentives; different timelines) to collaboration. This substantially hinders the uptake of evidence in decision making, and prevents academics from being go-to resources for policymakers. By actively engaging policymakers from target countries in a publication's creation (e.g., as an active advisory committee, via policy forums to solicit recommendations on what's needed and feedback on proposed products), creators can begin to bridge this gap, first and foremost by ensuring that the publication is designed to be useful to target policymakers. This engagement can also dramatically increase uptake of a global publication by generating demand for evidence, building awareness of its value, and creating shared ownership over the publication.

### PROACTIVE AND ONGOING DISSEMINATION AND TRANSLATION

**Global publications should be proactively brought in to relevant policy processes at the local level, and should go beyond publications, launches, and finding-sharing workshops.** Dissemination should target decision makers (i.e., high-level MoH officials) as well as key influencers—such as technical advisors (e.g., chiefs of staff, directorate heads, MoH economics units, or external partners tasked with supporting particular decisions), WHO, donors, and local research institutions (where established and trusted)—who systematically help to support and guide health decision making and are well positioned to effectively bring the evidence to bear on relevant decisions. Dissemination should not just be passive (e.g., publication via well-known channels such as the World Bank or the Lancet, workshops to share the publication's findings), as these serve predominantly to build awareness—which is necessary, but not sufficient, to drive uptake. Rather, dissemination should be proactive, whereby disseminators identify demand for evidence to answer a specific policy question, bring the global evidence base into that policy process, and support translation. DCP policy forums in EMR, for example, successfully built demand for DCP3, but WHO connections were required to bring DCP3 to policymakers' decisions and further connect policymakers with DCP3 for translation support.

**Global publications, by definition, will require local translation, which is the result of a consultative process that secures policymaker buy-in, engages with local stakeholders to reconcile global and local inputs so that the evidence is applicable to specific policy decisions, and supports the final policy creation.** Translation is a multistep process that includes:

1. *Identifying demand for evidence to answer a specific policy question.* Advisors or local champions can bring evidence to bear when relevant to a specific question facing policymakers, and consult decision makers to understand what additional evidence is required to supplement a global publication and enable a decision to be made.
2. *Collating or collecting local data.* Advisors should engage local research institutions, where needed, to conduct primary research or identify local data.
3. *Comparing local data to the global data creating specific recommendations*. Advisors, working alongside local MoH staff and researchers should extract relevant data points from

the global publication and compare them to the local data to understand discrepancies and adjust global recommendations accordingly—or else input local data into a global framework to see how outputs and recommendations change. With a publication like DCP that focuses on packages of interventions, this process might entail comparing implemented interventions with the local burden of disease and the DCP recommendations, adjusting the cost-effectiveness analyses to use local data where possible, and then using the results to determine which interventions should be added, left in, or removed from the existing package.

4. *Relaying recommendations to decision makers and supporting decision-making processes.* Advisors should convene decision makers and influencers to report findings and obtain buy-in, and where possible, support the process that converts recommendations into policy.

The translation process can be undertaken through workshops that acquaint stakeholders with the global evidence base, walk through the process of reconciling local and global data, and facilitate discussions among relevant experts, and can be made easier with spreadsheets or other tools that allow data points to be easily inputted, compared, and analyzed. It should ideally involve decision makers themselves to ensure buy-in and increase the chances that translation recommendations are used in policy, as well as local stakeholders (researchers and MoH staff) to begin to institutionalize the knowledge and process so it can be used again in similar situations.

### THE ROLE FOR LOCAL CHAMPIONS

**Local champions who can navigate different country decision-making architectures, develop relationships with decision makers, and regularly survey opportunities for influence, are better positioned than global institutions to lead dissemination and translation efforts.** Country-level decision-making processes vary widely, and depend on the administration in power. In some countries, decision makers are strong proponents of evidence and well-versed in global resources (e.g., former MoH Kesete in Ethiopia), so engaging them directly is likely the most promising pathway to uptake. In other countries, decision makers are primarily politicians, and rely on technical advisors to bring relevant evidence to bear. Thus, effective dissemination is dependent on champions who can identify which stakeholders are receptive to evidence and have the mandate or influence to incorporate it into key policy decisions, and can systematically identify opportunities to bring evidence into policy dialogues with those stakeholders at relevant moments. This is very difficult for a global institution based outside of the target country to do, and requires someone positioned on the ground and established in the country decision-making ecosystem.

**Effective local champions need to be trusted policy advisors, with a technical background and close ties with both policymakers and the academic community, and have sufficient capacity to support dissemination and translation.** To be maximally effective, champions should be nationals living in a country who fully understand and have networks across the country's decision-making ecosystem; have a sufficiently technical background to deeply understand and engage with global and local evidence alike; be a credible, trusted advisor to decision makers; and have links to local research institutions or personally have the capacity to collate and collect data. Importantly, the champion should have dedicated capacity to support dissemination and translation. While championing for a single publication may not be a full-time position, intentionally appointing champions with explicit mandates (and incentives) to support the uptake of a given publication,

rather than relying solely on "organic" champions who independently share publications, can dramatically increase uptake. A centralized model for engaging champions may be more effective, in which there is a single "evidence champion" in each country who brings in evidence from multiple global sources, builds relationships with decision makers and influencers, and helps them understand what evidence exists and where and how it should be applied.

### THE ROLE OF WHO

**In health, WHO is the default, trusted body for norms and guidance; in order for a global publication to have sufficient credibility and uptake for systematic and long-lasting influence, WHO should be involved in its creation, dissemination and translation, and—crucially—should endorse the end product.** Across all survey respondents, normative guidance exerts as much influence on policymaking as do literature, publications, and data—suggesting that global evidence is significantly more powerful when positioned as a WHO guideline, or at the very least has WHO institutional backing. Indeed, interviews confirmed that the WHO is the first port of call for countries seeking evidence to support decision making, and countries aim to align with WHO recommendations and guidelines wherever possible and available. Collaborating with WHO from the beginning of evidence conceptualization is critical to ensure alignment of content. If the global publication created is a set of guidelines, then WHO is ultimately the sole entity with sufficient credibility and authority to issue guidelines, and competing guidelines without WHO endorsement are unlikely to be picked up and could, detrimentally, create confusion. As such, every effort must be made to align guidelines with WHO. WHO can also serve as a critical channel for dissemination at the regional and country levels, as its offices have audience with key policymakers who rely on its advice. While WHO likely does not have capacity to facilitate translation activities, it should be involved as an influential voice in any processes facilitated by local champions.

### THE NEED FOR CAPACITY BUILDING

**Finally, a global publication's influence will be limited, either to a specific moment in time or in its final impact, if it does not coincide with substantial capacity building in target countries. This capacity building is required to increase demand for evidence, to ensure it can be used and translated without recurring external support, and to turn policy into health outcomes.** Building decision makers' capacity to use evidence through workshops creates demand for evidence, better positions decision makers to identify evidence gaps and needs, and increases their receptivity to evidence—increasing the likelihood that they will use a global publication when it is presented to them and seek it out in the future. Deeper capacity building—through long-term academic fellowships or education programs for ministry officials or technical assistance to ministry economic research units—can effectively build and institutionalize economic capacity, thereby enabling countries to independently translate global recommendations with limited external support. This capacity at the country level is vital in order for global publications to have long-term, sustainable influence. Capacity building with technical advisors, who can embed evidence use into regular processes, is particularly important given the frequency with which political administrations change. In parallel, building the capacity of local research institutions (e.g., through fellowships or new departments) to develop economic evidence can support a country's capacity for translation, as well as help instill a shift toward more local evidence generation, which is preferable to global inputs in the long run. Crucially, local policy implementation capacity must simultaneously be built to ensure that policies deliver impact. Efforts must be made to build local

implementation units that have the mandate, know-how, and capacity to implement high-quality programs that adhere to set policies. Only with this final step, after careful creation, dissemination, and translation, can a global publication truly be impactful.

# 9. IMPLICATIONS FOR DCP GOING FORWARD

### WHAT DO THESE LESSONS MEAN IN THE CONTEXT OF THE DCP PUBLICATION?

**DCP3's packages have a unique value for decision making in certain country settings, if translated to the local context, and fill a gap not currently filled by WHO.** Stakeholders reported that DCP3's recommended intervention packages, and the highest priority package outlined in volume nine in particular, were additional, especially as a framework for designing packages for emerging priority areas (e.g., surgery) or updating essential health packages that align with the UHC goal**.** While WHO has recommended "best buy" packages for some diseases, and has modelled the intervention and health system investments required to reach UHC, it has not yet published official guidance on the list of interventions needed to deliver a UHC package in different settings, which many stakeholders noted would be highly valuable, especially given the growing focus on UHC targets.[14] Stakeholders highlighted that DCP would be most valuable for countries if accompanied by translation support, as it does not currently contain all the required information to be directly relevant to decision makers (e.g., underlying data and assumptions in an easily extractable format), and local capacity for translation is limited.

**However, DCP has some shortcomings: it was not intentional about the countries or policymakers it was targeting; dissemination, translation, local network building, and capacity-building activities were limited and non-strategic; and it did not fully align with, or develop an institutional partnership with, WHO.** In its inception, DCP intended to target a technical audience, and outlined priorities within health verticals. Policymakers were therefore not systematically engaged in its creation, and DCP3 never set a specific, intentional strategy around which countries—and policy decisions within those countries—it was trying to support. As a result, DCP3 requires careful translation before it can feed into country policy decisions, and is largely seen as an academic publication. The Secretariat's lack of capacity (as almost all time, effort, and resources went into the creation of the document) and insufficient translation knowledge, expertise, and networks have led to limited and largely non-strategic accompanying dissemination, translation, and network-building activities outside of EMR and Ethiopia. Similarly, capacity-building activities with policymakers, technical advisors, and local researchers have been minimal. Finally, while 44 WHO staff were included as authors, and their respective chapters went through WHO approval processes, some of the final packages provide contradictory recommendations to WHO guidelines (i.e., DCP includes recommendations not made by WHO, or vice versa) and there was no formal, institutional-level alignment between DCP and WHO.

**Future efforts should address these challenges in order to maximize DCP's potential impact.** Given the potential opportunity for further future impact, this evaluation answers three questions around near- and longer-term next steps for DCP:

### HOW CAN DCP MAXIMIZE ITS INFLUENCE GOING FORWARD?

**Given the additionality of DCP3's packages, the Secretariat's immediate future efforts should focus on aligning its recommendations and establishing a partnership with WHO.** In order to

[14] Stenberg, Hanssen, et. al (2017), Financing transformative health systems towards achievement of the health SDGs: a model for projected resource needs in 67 low-income and middle-income countries, *Lancet Global Health* (funded by WHO). While this paper uses as an input a list of 187 interventions needed to achieve UHC, it does not position these as an explicit recommendation of an essential package.

maximize its potential influence going forward, as already identified and commenced by the Secretariat, DCP3 will first need to align all 21 vertical intervention packages with WHO recommendations, as well as align on the recommended essential health package, reconciling DCP with the methods, contents, and outputs of prior WHO work on UHC (e.g., their work on financing required to reach SDG 3)—and ideally position this as a joint WHO-DCP guideline. The output of this process should not be a full update to the DCP packages, but rather, an acknowledgement of the ways in which DCP and WHO's resources differ, an articulation of how they can complement one another and be used to support country-level decision making, particularly for UHC, and a WHO endorsement of the DCP evidence. With this partnership established, the packages will have a much greater chance of uptake and influence, as well as an immediate dissemination pathway via WHO's network. The nature of this partnership will depend on WHO appetite, capacity, and priorities, as well as practical and political feasibility, but could range from an informal affiliation to a more formal partnership. Links should be established both at the global level (e.g., with the expenditure, cost-effectiveness, and priority-setting team) as well as at the regional and country levels in target geographies to support dissemination and translation.

**In collaboration with WHO, the Secretariat should select a group of target countries for which DCP3's package is relevant and needed, and commence dissemination and translation activities.** Given the country-level differences in need and decision-making architectures, the Secretariat should select a group of target countries and carefully tailor all dissemination and translation activities to each context. To maximize the chances of influence and have the greatest impact on health outcomes, the countries selected should be facing a relevant policy decision, (i.e., they are designing an essential health package), high-level decision makers should be receptive to cost-effectiveness information, and countries should demonstrate need and demand for external support (i.e., have weak local capacity). These countries should also align with WHO priorities, and the priorities of any potential funders, and high-level country policymakers should sign a memorandum of understanding for engagement and support. Before commencing work in each country, the Secretariat and its partners should conduct an exercise to identify and map the different decision makers and influencers in each country, in order to understand the highest leverage entry points and influence pathways to bring evidence into policy processes.

### WHO IS BEST POSITIONED TO LEAD THESE EFFORTS?

**In order to most effectively lead these efforts, Secretariat will need to build its internal translation capacity and capability, potentially by moving out of a Seattle-based organization, or by establishing local partnerships.** The evaluation findings repeatedly highlight that active dissemination (i.e., getting the publication directly to policymakers, or indirectly through close, trusted advisors, at the opportune moment for decision making) and translation (the process of comparing global recommendations with local data and estimates, and drawing relevant conclusions) are required for a global publication to be influential. This requires a detailed understanding of the country-level decision-making architecture (who, how, and when are policies made), experience with the realities of policymaking processes, and established networks and relationships with decision makers and influencers. The DCP Secretariat currently has just one staff member with this skill set, and in its current form as an academic group housed within the University of Washington, does not have the institutional credibility to conduct translation work or the geographic placement to facilitate it. As a result, in order to effectively lead translation efforts,

the Secretariat should consider relocation, hiring additional staff with the required skills sets, and/or creating partnerships with established institutions already operating in this space, if present in target countries.

**Alongside these efforts, the Secretariat should identify local champions in each target country who can lead dissemination and help to facilitate the translation process.** As evidenced throughout this evaluation, having local champions on the ground can go a long way toward driving DCP3 uptake among policymakers. As such, the Secretariat, drawing on WHO's networks, should identify and employ well-networked, technically and politically savvy champions in target countries, and supply them with the financial and material resources (e.g., templates for reconciliation of local data with DCP recommendations) they need to facilitate translation and bring DCP into relevant policy conversations.

**The Secretariat can codify and collate translation processes and outputs, sharing learnings at the global level to support non-target countries.** While translation efforts should be targeted and localized, they may generate insights and resources that can be shared at the global or regional level to support countries undergoing priority-setting processes without formal DCP support. For example, the Secretariat can codify the processes different countries undertake to prioritize interventions for UHC (e.g., the different data inputs and the methodology for analyzing those inputs), extract and generalize tools and templates (e.g., spreadsheets, workshop materials) used to support these processes, and share these resources at the global or regional (e.g., through WHO workshops) to provide other countries with starting points or reference materials for their own priority setting. The Secretariat can also create a repository of the different interventions countries choose to prioritize, and the underlying data supporting those decisions, that other countries (especially those in the same region or with similar health system archetypes) can draw on as benchmarks, proxies, or comparators, particularly if they do not have robust local evidence or capacity.

**Simultaneously, the local champion (likely with other resources) can start to identify opportunities for capacity building of local stakeholders through workshops, technical assistance, or fellowships that should start with translation activities, and continue over the long term.** As noted above, building the capacity of decision makers, technical advisors, and local research institutions can help to generate demand for evidence, increase the uptake of global publications, and facilitate translation while institutionalizing evidence-based decision-making processes. In the short term, capacity building might consist of workshops on economic evidence for ministry officials, technical assistance on evidence use for a particular policy, or support to a local research institution to generate policy-oriented evidence for a given decision. In the longer term, it might entail creating and supporting health economics units within ministries or universities or providing fellowships to technical advisors to study health economics. If given sufficient resources, a local champion can facilitate these capacity-building processes. DCP-Ethiopia is currently leading many of these activities, and lessons from its work can inform future efforts.

### WHAT DOES THIS MEAN FOR THE FUTURE OF THE DCP ENTERPRISE?

**The Secretariat should approach a dissemination and translation phase in an iterative manner, continuously learning from policymakers what they need and how best to support them.** Dr. Alwan has begun to engage with WHO and with policymakers to bring DCP into decision-making

processes, but the optimal models for these types of engagement have yet to be defined, and will likely vary across countries and regions depending on the decision-making architecture. DCP should continue to assess and adapt its approach, soliciting input and feedback from policymakers—via policy forums as well as individual engagement—on their needs, their use of DCP, and what kinds of support are most useful to foster evidence-based decision making.

**On completion of this phase, the Secretariat should closely evaluate progress and combine this with gathered insights to assess what evidence and support policymakers need going forward.** This assessment should be used to shape any future efforts, which must be informed by a clear understanding of how, where, and why DCP was used, as well as its shortcomings, and what kinds of dissemination and translation support proved most effective in which contexts and why.

**Discussions around any future publication (e.g., a DCP4) should be put on hold to ensure that the document is a direct response to stated needs; in all likelihood, future efforts will need to move away from, and may look very different from, previous publications.** While further analytic work may be needed in the near term, this should focus on addressing specific needs surfaced in country-level work, rather than a full-scale update of the publication. When envisioning the future of the DCP enterprise, leaders should look beyond the constraints of the existing publication and business model to determine, from first principles and based on evaluation exercises, what kind of engagement will best support the uptake of evidence by country-level decision makers in target geographies. Any future efforts must be rooted in an assessment of what policymakers need, designed in a user-centered way around their preferences and behaviors, and created in a format that enables tailored use at the country level. In fact, future efforts may not take the form of a global publication at all, but could include, for example, a global, downloadable database of up-to-date cost-effectiveness evidence, a unit or partnership on UHC intervention packages with WHO, and/or targeted country-level evidence "hubs," which house local capacity-building for evidence generation, use, and uptake of decision making, and which bring together expertise across types and sources of evidence.

# ANNEX 1 – STAKEHOLDERS CONSULTED

| Global interviews | | | |
|---|---|---|---|
| **Name** | **Organization** | **Position** | **Stakeholder type** |
| Anne Mills | London School of Hygiene & Tropical Medicine | Deputy Director & Provost and Professor of Health Economics and Policy | Academic |
| Kalipso Chalkidou | Center for Global Development | Director of Global Health Policy and Senior Fellow | Academic |
| Amanda Glassman | Center for Global Development | Chief Operating Officer and Senior Fellow | Academic |
| Eduardo Gonzalez Pier | Center for Global Development | Visiting Fellow; Former Deputy Minister of Health of Mexico | Academic |
| George Alleyne | University of the West Indies | Former Director of PAHO (retired) | Academic |
| Jaime Sepulveda | University of California, San Francisco | Executive Director of UCSF Global Health Sciences | Academic |
| Peter Donkor | Kwame Nkrumah University of Science & Tech (Ghana) | Professor of Oral and Maxillofacial Surgery | Academic |
| Richard Skolnik | Yale University (retired) | Global Health Consultant | Academic |
| Yot Teerawattananon | Health Intervention & Technology Assessment Program | Founding Leader of HITAP | Academic |
| Anthony Measham | World Bank (retired) | Consultant in Health, Nutrition and Population | Academic |
| Marya Khan | Population Reference Bureau | Research Associate | Academic |
| Paul Richard Fife | Norad | Director of the Department for Education and Global Health | Donor |
| Lene Lothe | Norad | Assistant Director of the Department for Education and Global Health | Donor |
| Austen Davis | Norad | Senior Adviser to the Department for Education and Global Health | Donor |
| Irene Koek | USAID | Senior Deputy Assistant Administrator, Global Health Bureau | Donor |
| Kelly Flynn Saldana | USAID | Director, Office of Health Systems, Global Health Bureau | Donor |
| Abdo Yazbeck | World Bank | Lead Health Economist | Donor |

| | | | |
|---|---|---|---|
| Mickey Chopra | World Bank | Global Solutions Lead for Service Delivery | Donor |
| Christoph Kurowski | World Bank | Global Lead, Health Financing | Donor |
| Olusoji Adeyi | World Bank | Director of the Health, Nutrition and Population Global Practice | Donor |
| Marelize Gorgens | World Bank | Senior Monitoring and Evaluation specialist | Donor |
| Sophie Mathewson | Wellcome Trust | Global Policy Advisor | Donor |
| Alan Brooks | GAVI | Director for Health systems and immunization strengthening | Health agency |
| Nicolas Theopold | GAVI | Senior Strategy Manager | Health agency |
| Michael Borowitz | Global Fund | Chief Economist, Strategy, Investment & Impact | Health agency |
| Hannah Grant | Global Fund | Ex-head of Resource Allocation | Health agency |
| Carol D'Souza | Global Fund | Head of Resource Allocation | Health agency |
| Kesete Admasu | Roll Back Malaria | Director | Health agency |
| Amal Medani | Roll Back Malaria | Strategic Policy Adviser | Health agency |
| Amie Batson | PATH | Chief Strategy Officer and Vice President for Strategy and Learning | Health agency |
| Jose Antonio Izazola-Licea | UNAIDS | Senior Adviser to Resource and Finance Analysis | UN agency |
| Peter Godfrey-Fausset | UNAIDS | Senior Science Advisor | UN agency |
| Stefan Peterson | UNICEF | Chief of Health | UN agency |
| Branka Legetic | WHO-PAHO (retired) | Director of Health Economics & Financing | WHO |
| Zafar Mirza[15] | WHO-EMRO | Regional Advisor – NCDs | WHO |
| **Ethiopia interviews** | | | |
| **Name** | **Organization** | **Position** | **Stakeholder type** |
| Ole Norheim | University of Bergen | Professor; Co-leader of DCP-E | Background interview |
| Stephane Verguet | Harvard University | Assistant Professor; Co-leader of DCP-E | Background interview |
| Solomon Memirie | Harvard University | Takemi Fellow | Background interview |
| Solomon Zewdu | BMGF | Senior Program Officer, Ethiopia | Background interview |
| Kesete Admasu[16] | FMOH (former) | Minister of Health | Government |

[15] Zafar Mirza shared perspectives at the global level, and on DCP3's potential future use in EMR

[16] Kesete Admasu was interviewed as an Ethiopian stakeholder in his capacity as the former Minister of Health, and as a global stakeholder for his current role as director of Roll Back Malaria.

| | | | |
|---|---|---|---|
| Mahlet Habtemariam | FMOH (former) | Chief of Staff to the Minister of Health | Government |
| Abraham Mengistu | FMOH (former) | Director of Medical Services Directorate | Government |
| Getachew Teshome | FMOH; now being trained in Norway through DCP | Former Advisor to the State Minister of Finance | Government |
| Mizan Kiros | FMOH; now being trained in Norway through DCP | Former Director of the Resource Mobilization Directorate | Government |
| Meseret Zelalem | FMOH | Chief of Staff to the Minister of Health | Government |
| Daniel Burssa | FMOH | Chief of Staff to the State Minister of Programs | Government |
| Abraham Hailemlak | FMOH; Jimma University | Advisor | Government/ Researcher |
| Taye Balcha | Amhauer Hansen Research Institute; FMOH (former) | Director; former Chief of Staff to the State Minister of Programs | Government/ Researcher |
| Abebaw Wassie | Addis Ababa University | Associate Professor | Researcher |
| Miliard Derbew | COSECSA | President | Researcher |
| Mieraf Tadesse Tolla | Harvard University | Postdoctoral Fellow | Researcher |
| Tesfa Demelew | Ethiopian Public Health Association | Director of Research, Training, and Publication | Professional Association |
| Raphael Hurley | CHAI - Ethiopia | Director of Health Financing | NGO/ Implementing partner |
| Samantha Diamond | CHAI | Associate Director of Global Health Financing | NGO/ Implementing partner |
| Neil Gupta | Partners in Health | Clinical Director | NGO/ Implementing partner |
| Andargachew Kumsa | Partners in Health; FMOH former | Medical Director Ethiopia | NGO/ Implementing partner |
| Jyoti Tewari | DFID | Senior Human Development Advisor | Donor |
| Tito Rwamushaija | GAVI - Ethiopia | Senior Country Manager | Donor |
| Sai Pothapregada | The Global Fund | Ethiopia Portfolio Manager | Donor |
| Sofonias Getachew | WHO Ethiopia | National Officer of Managerial Process for National Health and HSS | WHO |
| William Graham | WHO Ethiopia | External Relations Officer | WHO |
| **Mexico interviews** | | | |
| **Name** | **Organization** | **Position** | **Stakeholder type** |

| | | | |
|---|---|---|---|
| Eduardo Gonzalez Pier[17] | Former MoH official | Sub-secretary of Health Development and Integration | Government |
| Jaime Sepulveda[18] | Former MoH official | Vice-minister of health | Government |
| Jose Carlos Pueblita | Former MoH official | State Minister of Finance | Government |
| Cristina Gutierrez Delgado | MoH official - Economic Analysis Unit | Researcher | Government |
| Nicolas Kubli | MoH official - Economic Analysis Unit | Director | Government |
| David Garcia Junco | Former Seguro Popular official | Director | Health provider |
| Patricia Guerra | IMSS Foundation | Director | Health provider |
| Rogelio Perez Padilla | National Institute of Respiratory Illnesses | Chief of the Department of Tabaco and Chronic obstructive pulmonary disease | Research institution |
| Octavio Gomez Dantes | National Institute of Public Health (INSP) | Senior researcher | Research institution |
| Mariana Barraza | Innova Salud / Former MoH official | Consultant / Researcher | Research institution |
| Maria Elena Medina-Mora | National Psychiatric Institution | Director | Research institution |
| Hector Arreola Ornelas | FunSalud | Coordinator of Health Observatory Initiative | Research institution |
| Victor Bacerril | National Institute of Public Health (INSP) | Researcher | Research institution |
| Carmen Santamaria | Bona Dea Salud | Director | Individual |
| Lisa Ramon | Pro Mujer | Deputy Director of Global Health | NGO |
| Arie Hoekman | UNFPA Mexico | Director | UN Agency |
| Ludovic Reveiz | PAHO | Lead, Evidence and Intelligence in Action for Health | UN Agency |
| Roberto Tapia | Slim Foundation | General Director | Foundation |
| **India interviews** | | | |
| **Name** | **Organization** | **Position** | **Stakeholder type** |
| Sujatha Rao | Ministry of Health and Family Welfare (former) | Union Secretary | Government |
| Rajiv Misra | Ministry of Health and Family Welfare (former) | Secretary of Health | Government |

[17] Eduardo Gonzalez Pier was interviewed both as a former MoH official in Mexico, and as a global academic
[18] Jaime Sepulveda was interviewed both as a former MoH official, and as a global academic

| | | | |
|---|---|---|---|
| Shiv Kumar | UNICEF (previously Ministry of Health and Family Welfare) | Global Development Economist (previously member of National Advisory Council) | Government |
| Ramanan Laxminarayan | The Center for Disease Dynamics, Economics & Policy | Director of CDDEP | Research institution |
| Prabhakaran Dorairaj | Public Health Foundation of India | Vice President for Research and Policy | Research institution |
| Prabha Sati | Centre for Global Health Research | Associate Director for Programme Outreach | Research institution |
| Anit Mukherjee | Center for Global Development | Policy Fellow | Research institution |
| Geetha Menon | National Institute of Medical Statistics | Scientist | Research institution |
| Vivekanand Jha | George Institute for Global Health, India | Executive Director | Research institution |
| Jorge Coarasa | World Bank | Senior Economist with the Health, Nutrition and Population Global Practice, India | Health agency |
| Shreelata Seshadri | Azim Premji University | Professor | Academic |
| Vikram Patel | Harvard Medical School | Professor of global health and social medicine | Academic |
| James Morton | James Morton & Co. | Owner/ Director | Consultant |
| Cherian Varghese | WHO | Coordinator for Management of NCDs | WHO |
| **Targeted interviews** | | | |
| **Name** | **Organization** | **Position** | **Stakeholder type** |
| Cameron Bowie | Malawi College of Medicine (former) | Former professor and MoH advisor | Academic |
| Jessica Ochalek | University of York, Centre for Health Economics | Research Fellow | Academic |
| Finn McGuire | Overseas Development Institute Malawi (former) | Fellow – Economist in the MoH | Research Institution |
| Stephanie Simmonds | Afghanistan Ministry of Health | Senior advisor to the Minister of Health | Government |
| Ala Alwan | WHO-EMRO (former) | Former Regional Director | WHO |
| Don Bundy | London School of Hygiene and Tropical Medicine | Professor of Epidemiology and Development | Academic |
| **Interviews with DCP Secretariat** | | | |
| **Name** | **Organization** | **Position** | **Stakeholder type** |

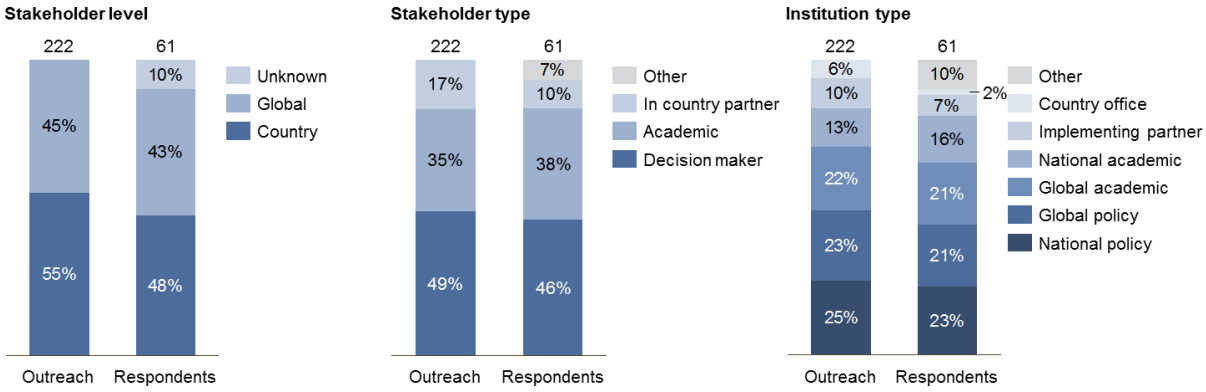
| | | | |
|---|---|---|---|
| Dean Jamison | DCP Secretariat | Principal Investigator & Series Editor | DCP |
| Ala Alwan | DCP Secretariat | Visiting Professor | DCP |
| Rachel Nugent | DCP Secretariat (former) | Former Project Director | DCP |
| Charlie Mock | DCP Secretariat | Projector Director & Series Editor | DCP |
| Brie Adderley | DCP Secretariat | Director of Project Management | DCP |
| Kristen Danforth | DCP Secretariat | Director of Strategic Planning | DCP |
| David Watkins | DCP Secretariat | Analyst and Contributor | DCP |

# ANNEX 2 – SURVEY RESULTS

**The survey was designed to solicit perspectives on DCP, and on the use of evidence more broadly, amongst a range of stakeholders.** The survey was sent to 222 people across the country and global levels, including to decision makers, donors, academics, in-country partners, and other influencers. Global outreach targeted 50% respondents from within the DCP network; and country outreach was 50% in countries that had some DCP engagement (with target respondents in those countries sourced from DCP collaborators, where possible). This was by design, to ensure sufficient perspectives from those who knew DCP well. However, it likely biased results, particularly in favor of DCP recognition and use.

**61 people responded to the survey, which is too small to be statistically significant, but can provide indicative evidence that complement more nuanced findings from interviews.** The sample of responses is fairly balanced across country/global and across institution types, and is roughly in line with the target sample. This summary presents results across all stakeholder types, but calls out any differences among groups as relevant.

**Figure 10: Breakdown of survey outreach and respondents by stakeholder type (n=222 – outreach and 61 - respondents)**

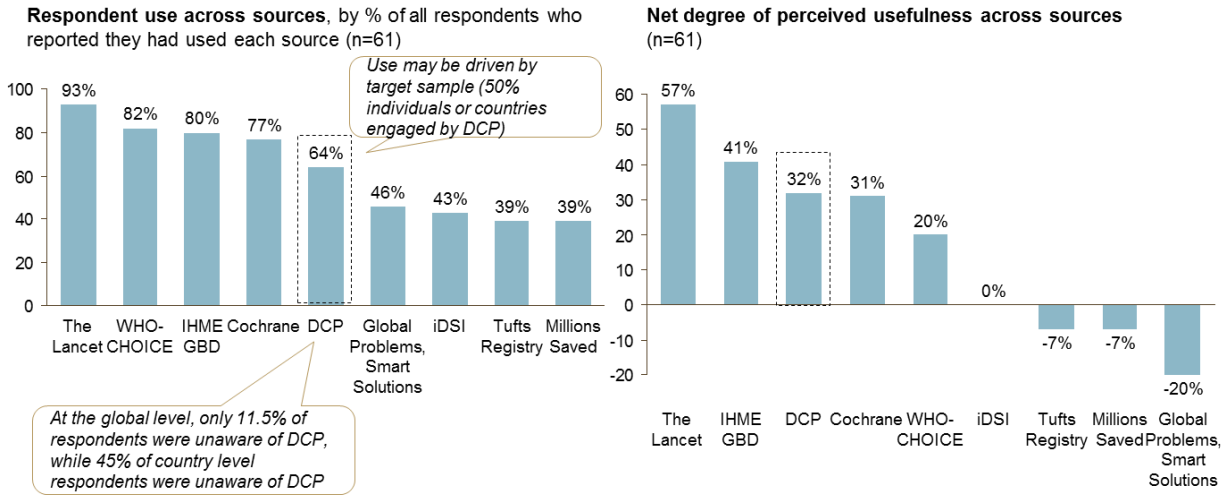



**Survey respondents suggest that evidence is a key – but not the most important – factor in decision making, and the most valuable evidence includes prevalence, efficacy, needs and cost data.** Thirty-nine percent rank "literature, publications, and data" as a top factor in decision making, but "internal priorities" and "guidance from normative bodies" are seen as more often influential.[19] Economic analysis on cost-effectiveness, equity, and financial risk protection is used relatively less often than disease prevalence, efficacy, needs, and cost data, though 62% still said cost-effectiveness analysis was used in many or most decisions. This suggests the evidence contained in DCP is relevant to many decisions, but there may be further opportunity to build demand and capacity for economic evidence.

[19] As noted above, the factors tested by the survey are not mutually exclusive, as, for example, literature, publications, and data could be used to inform normative body guidance, prior commitments could have influenced internal priorities, etc. However, this data does provide an indicative sense of where evidence falls among other factors in terms of its use.

**DCP is less well known than comparable sources, but ranks highly on credibility, which is the most important characteristic in an information source. It ranks less well on transparency, data extraction, and local tailoring.** DCP is less well known than the Lancet, WHO, IHME, and Cochrane, even with potential sample bias. However, those who recognize DCP perceive it as useful (it ranks third out of nine sources, behind the Lancet and IHME). Most (64%) respondents who knew DCP knew of all three volumes. Credibility was ranked the most important characteristic in an information source by far. Credibility appears to be a "hygiene factor" -- a basic requirement before an evidence base can even be considered, and a necessary but not sufficient characteristic for utility. DCP ranked highly in terms of its credibility, suggesting it meets an important bar for relevance. However, DCP ranked less well in terms of the next most important characteristics – transparent methodologies, ability to extract relevant data, and local tailoring. As heard in interviews, these factors are important to be able to translate a global publication to be relevant at the local level. The survey thus affirms interview findings that while stakeholders see DCP as a credible enough source to turn to, they are generally unable to apply it to a given decision without translation support.

**Figure 11: Information source use and perceived usefulness (n=61)** [20]



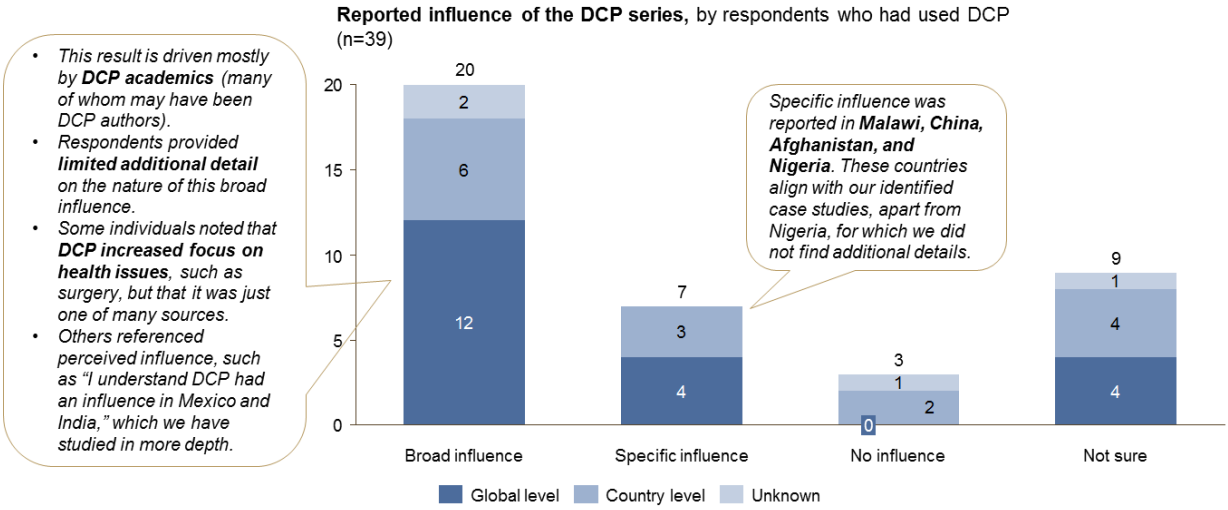

**DCP3 was also seen as an improvement on DCP2 on all metrics.** Those who knew both DCP2 and DCP3 reported that DCP3 was an improvement on every dimension. No other significant differences between the volumes were discernible.

**The survey highlighted four instances of DCP's country-level influence, three of which were in countries nominated by DCP and one outside of DCP's network.** Beyond examples already identified in interviews (Afghanistan, Malawi, China), only one additional instance of specific DCP influence was reported at country level (Nigeria), which could not be substantiated. Many cited that DCP had a broad influence[21], but few robust examples were provided.

[20] Net degree = % of respondents who reported a source was "very useful" or "fairly useful" minus % who reported it was "somewhat useful" or "not very useful"

[21] Broad influence was defined as "the publication has not influenced a specific policy, but has helped to shift the views, mindset or approach of policymakers."

**Figure 12: Reported influence of the DCP series, among respondents who had used DCP (n=39)**




# ANNEX 3 – COUNTRY CASE STUDIES

## ETHIOPIA

***Country context:***

In the highly centralized government of Ethiopia, the Minister of Health and his closest advisors set health policies and priorities at the federal level. Today, senior policymakers increasingly prioritize evidence as a decision-making factor and are interested in applying economic analyses to policy decisions, but capacity is low to conduct local economic health analysis.

In 2015, DCP began work in Ethiopia (e.g., supporting local cost-effectiveness analyses with local researchers) through DCP author Stephane Verguet. This work has since developed into a separate DCP-Ethiopia (DCP-E) grant led by Dr. Verguet and ACE member Ole Norheim. DCP-E's mandate is to build health economics and priority-setting capacity in Ethiopia. It uses DCP3 as an input, but is not focused on DCP3 dissemination.

***Evaluation:***

*DCP's influence in Ethiopia is promising, though most targeted and sustained efforts have been led by the DCP-E team, not the DCP Secretariat. The one instance of DCP Secretariat-led impact was driven by fortuitous circumstances rather than intentional targeted engagement.*

Awareness: Dr. Norheim has an extensive network in Ethiopia and has developed relationships with key policymakers and influencers. As a result, awareness of DCP among key informants in Ethiopia was high, with 71% reporting that they had heard of DCP, most (73%) through engagement with DCP-E.

Additionality: Stakeholders found DCP most additional as a one-stop-shop for intervention packages (i.e., via the summary tables of packages in each volume), both for specific strategies (e.g., surgery, non-communicable diseases) and for a cross-cutting essential health services package.

Relevance: Ethiopian stakeholders found DCP3 most relevant when accompanied by specific translation efforts (i.e., via DCP-E), when it met a specific need (e.g., for an intervention package of a particular strategy), or as a framework in the absence of local evidence. However, its lengthy format and lack of country tailoring make it difficult for decision makers to directly engage with the document. One stakeholder reported that DCP "is not accessible to the typical policymaker. It's too big. Of 200 [policymakers and influencers] I worked with across countries, none had heard of it on their own."

Efficacy: DCP3 has been or is being used in three instances in Ethiopia: two via DCP-E engagement (with where influence remains to be seen) and one via global-level engagement with former Minister of Health Kesete, combined with fortuitous local circumstances (DCP met a specific need; relevant decision makers had existing expertise, and local evidence was lacking).

- *Flagship surgery strategy (SaLTs):* MoH Kesete, a member of the ACE, was looking for a flagship initiative at during the time when global momentum was building around safe surgery. He gave the Medical Services director – who had strong technical capacity – an explicit mandate to translate DCP3 volume one into the Ethiopian context for the SaLTs strategy. The strategy used DCP3's framework, and adopted all 44 recommended interventions (along with others sourced through local consultation).
- *Lancet NCDI Commission:* In his capacity as Lancet NCDI commissioner, DCP-E lead Ole Norheim brought DCP3 to the Commission, extracting relevant DCP3 evidence to create a presentation and workshop materials (e.g., spreadsheet with relevant NCD data). These materials were used to inform a multi-stakeholder Ethiopian commission, which assessed the evidence in the local context to prioritize NCD interventions and build the investment case to the Ministry. The ultimate outputs of the commission and its link to policy is still to be determined.
- *Revising the essential health package:* The DCP-Ethiopia capacity building program is supporting and funding Dr. Getachew, the former Chief of Staff to the State Minister, in getting his PhD, and connected him to DCP3 to inform his research. Dr. Getachew will compare the DCP3 essential package against the local context and data to make recommendations for the Ethiopian package. Upon return to the Ministry, he will use this research to inform a committee and consultations on revising the package. Policy influence in the long term remains to be seen, but Dr. Getachew already has buy-in from top ministers and is receiving strong support from DCP-E, positioning him well for influence.

***Lessons learned: Evidence needed***

- **Structure:** Evidence is most useful when it is framed in such a way as to answer policymakers' key questions with clear recommendations; DCP3 begins to do so through its packages of interventions, particularly the UHC package. However, DCP does not currently have the network and credibility to serve as a known reference point for intervention packages without WHO support.
- **Content:** In Ethiopia, local evidence is always preferred to global evidence, but there is currently low local capacity for economic analysis despite growing interest among policymakers. Therefore, policymakers are willing to turn to global evidence like DCP3 as a framework. However, DCP3 does not allow for local tailoring without significant additional support.

- **Format:** To influence policy, evidence should be concise, focused on implications, and user-friendly. DCP3's multi-volume format is difficult to interpret and use without support, resulting in a strong preference for the Lancet summaries over full DCP volumes, which require additional work to extract the relevant data and content.

***Lessons learned: Dissemination and translation***

- Having a **strong networking presence** on the ground, such as Dr. Norheim, who can identify opportunities to bring evidence to bear and facilitate processes to translate DCP to the local context, is key to ensuring uptake and increasing DCP's relevance.
- Systematically and directly **involving MoH policymakers, like Dr. Kesete, and their advisors in up-front framing and evidence creation** ensures relevance and increases the likelihood of use.
- To support an ecosystem of evidence-based decision making in the long term, it is important **among policymakers and their advisors** to build the capacity to generate demand and the ability to use economic evidence to inform decisions, **and among local researchers** to support context-specific economic research that is linked to policy. DCP-E's initial capacity building is promising, but it is uncertain if their model would work in other country contexts.

## MEXICO

***Country context:***

The Mexican health system is highly fragmented and composed of multiple autonomous sub-systems (e.g., Ministry of Health, Social Security Institutions). While evidence, including cost-effectiveness analysis, influences health policy decisions, political interest is often the primary decision-making factor, though this is highly dependent on the administration. Local research capacity is strong, which reduces the relative importance of global publications, when evidence is used.

DCP's engagement in Mexico spans from DCP1 to DCP3 through involvement of influential Mexican decision makers as authors and editors in both DCP1 and DCP2, and collaboration with local champions who are leading DCP3 activities.

***Evaluation:***

*While DCP1 (out of evaluation scope) had a formative influence both on Mexico's overall approach to decision making and the interventions initially covered by its public health insurance program (Seguro Popular), the influence of DCP2 was much more limited; it is too early, meanwhile, to assess the influence of DCP3. As DCP1 already influenced the priority-setting process, DCP2 and DCP3 were unlikely to have more than marginal additional impact.*

Awareness: Awareness of the DCP series was low and limited to DCP collaborators and some of their immediate networks. Of those interviewed who were not collaborators, only 31% had heard of DCP—all of them through direct engagement with DCP authors and editors.

Additionality: While the creation of a platform for exchange of ideas, the compilation of disparate sources, and the codification of the economic case for investment in certain health areas produced some additionality, DCP2's and DCP3's additional influence was ultimately limited given the prior

adoption of DCP1 frameworks, the strong local research capacity, and the overlapping work of other global publications (e.g., Lancet, WHO).

Relevance: DCP1 provided influential frameworks during an important transition in Mexico's health system, yet many of DCP2's and DCP3's recommendations were too basic for Mexico's more developed economy and health system (e.g., they recommended policies or packages that had already been implemented), and strong local research capacity diminished the value of a generalized global publication. Furthermore, stakeholders noted that while DCP1 was picked up by academics who then became decision makers, DCP2 and DCP3 were not user-friendly, particularly for the less academic, more politically-minded leaders who are growing in prominence.

Efficacy: DCP1 influenced both the approach to health reform and the initial package of interventions included in Seguro Popular. Development of DCP2, which involved some of the same individuals driving the healthcare reform in Mexico, began during the end of the reform process, and so may have included cross-pollination of ideas, but the evaluators identified no specific instances of DCP2 influencing Mexican health policy. One stakeholder reported that "DCP1 was very important. DCP2 not as much…it was a dynamic exercise that allowed for exchange of ideas, but it may have been more in one direction than the other. After the package was done [in 2003], there were only marginal changes." It is too soon to evaluate DCP3's influence. Some academics are beginning to cite it in their proposals to policymakers, but it has not yet left the academic sphere. The upcoming February launch will generate awareness and test policymaker interest in the publication.

***Lessons learned: Evidence needed***

- **Structure:** DCP is not framed in a way that is relevant for a middle-income country, such as Mexico, as most recommendations have already been implemented or are too basic for the Mexican health system, suggesting that the current DCP publications will be most relevant for lower-income countries.
- **Content:** Mexico's relatively strong research institutions enable it to produce up-to-date, localized evidence (including in cost-effectiveness evidence), rendering many of DCP's global estimates irrelevant. Global studies with local data and cross-country comparisons can be influential, but DCP does not include this content.
- **Format:** Highly visual, tailored, easy-to-understand recommendations, delivered in non-academic language, have shown greater impact in Mexican decision-making processes. Evidence delivered similarly to the IHME Global Burden of Disease publication is preferred to DCP's multi-volume and academic format.

***Lessons learned: Dissemination and translation***

- Evidence is most likely to be taken up when academically-minded leaders have decision-making power. This suggests **DCP should target decision makers who are open to evidence, while engaging other politicians with more digestible information and hands-on translation activities**.
- Given the fragmented nature of decision making in Mexico, **DCP should engage with a broad and diverse set of decision makers and influencers**, moving beyond technically-minded MoH leads to engage politicians, MoF leads, and others who influence policy.

- Even when evidence is taken up by decision makers at the federal level, ultimate impact is limited by implementation challenges, suggesting the need for **greater engagement, knowledge flow, and capacity building with state and local implementing actors**.
- Relying on an initial network of decision makers (as DCP1/2 did) to disseminate and use DCP means that influence can disappear as administrations change. **Ongoing engagement in multiple networks is necessary to ensure lasting awareness, use, and impact of DCP**.

## INDIA

***Country context:***

India has a decentralized health system, and health strategies and implementation are predominantly formulated and carried out at the state level. At the central level, health policymaking processes, decision-making bodies, and influential groups and advisors are highly transient and vary by governing parties. The current administration is building and utilizing national research capacity, rather than turning to international support, reducing the relative influence of global publications. At the state level, health decision-making processes and health outcomes vary greatly, as does willingness and capacity to use evidence. Across levels, stakeholders reported that politics, disease burden, and health system needs are most important in influencing policy setting and resource allocation, and cost data and efficacy data (more so than cost-effectiveness) are used to select interventions once overarching priorities are set.

DCP's India engagement spans from DCP1 to DCP3 through involvement of leading Indian health advisors as authors and editors, and through a series of sub-grants for generating evidence and materials for DCP3, DCP2 translation, and dissemination of DCP's recommendations. As part of the DCP2 translation activities, DCP authors and sub-grantees created a national level report laying out an India-specific entitlement package based on DCP2[22], and a state level report[23] for Karnataka identifying the "best buy" solutions to address the state's leading causes of mortality. Findings from the "Choosing Health" Report were disseminated in the District Evaluation Study on Health (DESH), an India-wide randomized control trial to study the effects of an information delivery platform on key healthcare outcomes.

***Evaluation:***

*There is limited robust evidence to suggest DCP was directly used in national or state level policies, as most evidence was anecdotal. Choosing Health, the India-specific version of DCP2, was more additional and relevant as a resource because it was already translated to the national level, but was likely not efficacious due to its lengthy and academic format.*

Awareness: Due to the high proportion of DCP contributors and sub-grantees among those interviewed as part of the India case study, awareness among interviewees was generally very high. Of those interviewed who were not collaborators or sub-grantees, 88% had heard of DCP. However, the sample size was very low (n=8), and most were academics/ researchers or donors (response rate among current government staff was low), so it is not representative of awareness across stakeholder groups.

[22] Choosing Health: An Entitlement for All Indians

[23] Karnataka's Roadmap to Improved Health: Cost effective solutions to address priority diseases, reduce poverty and increase economic growth

Additionality: The India-specific packages in the "Choosing Health" and Karnataka reports were additional for national- and state-level decision makers because they were translated to the local context, and provided recommendations on national and state specific packages, not provided elsewhere. However, the DCP series had limited additionality for Indian policymakers, since factors other than evidence often have a greater influence on decision making, and other information sources, especially those that include local evidence, are preferred to global publications.

Relevance: India-specific DCP products were most relevant due to the inclusion of Indian authors and data, but stakeholders reported that they were still too complex and unsuitable for the target decision makers. Relevance of the DCP series in India was low because of its complex and technical content, and lack of actionable country-specific implications, as well as its lengthy content, textbook format, and lack of extractable and manipulatable data.

Efficacy: There were three identified instances of efficacy in India. However, all three were primarily supported by anecdotal evidence, and there is no evidence of changes in policy due to DCP influence. One stakeholder reported, "DCP2 became too voluminous - even though a summary report was produced, I'm not sure what impact it had on policymakers in India, or if it led to policy changes or projects – I doubt it." Another reported that "To date, the DCP series hasn't been that influential at the national or state level." DCP authors, who were also leading Indian health advisors, reported sharing findings and recommendations from DCP with policymakers in formal and informal consultations, but there is no direct evidence of a subsequent policy decision. Ideas from the "Choosing Health" and Karnataka reports were cited in recommendation documents submitted by technical working groups to policymakers, but the influence pathway was too indirect to attribute an ultimate policy decision to DCP2. Finally, the DESH study sent locally-relevant DCP2 materials to district-level decision makers in ~300 districts, but the evaluation of program has not been completed, and influence and impact on decision making and health outcomes is unclear.

***Lessons learned: Evidence needed***

- **Structure:** DCP evidence must be framed to answer policymakers' key questions, with clear recommendations. However, since the most relevant policymakers are at the state or district level, the structure should vary depending on the needs and capacities in each state.
- **Content:** Evidence must be locally tailored beyond the national level to the state and level, at a minimum, and at the district level, where possible. Health decisions and implementation vary greatly by state, and even the India-specific report, "Choosing Health," was not locally relevant enough at the state or district levels.
- **Format:** To influence policy in India, recommendations must be easy to understand, and include clear implementation guidelines. Since most health implementation is carried out at the district level, recommendations should be formatted as a clear step-by-step guide printed on paper. In addition, the recommendations must be translated to local languages.

***Lessons learned: Dissemination and translation***

- Stakeholders reported that, at the national level, the current government turns to internal expertise, rather than external support**.** As a result, **it is necessary to find local research partners with connections to, and credibility with, the government who can give DCP an audience with policymakers.**

- Due to the highly decentralized nature of decision making in India, it is important to **select states, assess the specific needs in each state in order to tailor recommendations further, and build relationships with policymakers and influencers at both the national and state level**. If DCP only focuses on the national level, it is unlikely to be influential on policymaking, or impact health outcomes.
- **Extensive capacity building is needed**, alongside any dissemination and translation efforts as the capacity to generate and use evidence greatly reduces as you go from the national to district level. Given the gaps in India's data, and the varying quality of what exists, significant efforts are needed to build local capacity and greatly increase the body of evidence stakeholders can draw from.