Advisory Committee to the Editors: 2nd Meeting Report

Anne Mills, Chair
London, England
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Background

The *DCP3* Advisory Committee to Editors (ACE) convened its second meeting at the Congress Centre in London, England on May 7-8, 2014. This meeting was an opportunity to update ACE members on *DCP3*'s progress since the last meeting and give *DCP3* guidance on how to move forward with the project. Specifically, the meeting was intended to allow ACE members to:

- Receive *DCP3* Secretariat report back on initial ACE recommendations
- Review Chapter 1 main messages of cancer and essential surgery volumes
- Hear and discuss DCPN mid-term review results
- Provide advice on dissemination channels for completed volumes and interim products

Day One: May 7, 2014

Welcome and Introduction

ACE Chair, Anne Mills from the London School of Tropical Medicine and Hygiene, opened the meeting by reviewing and explaining the purpose of agenda items. Meeting participants introduced themselves.

Session One: Response to the First ACE Meeting Report

Presentation: Dean Jamison (Series Editor)

Dean Jamison opened the session with a presentation that reviewed the ACE recommendations from the 2013 meeting, and explained how DCPN has responded to these recommendations over the past year. The main areas of focus included: purpose, content, methods, peer review, dissemination, and evaluation.

ACE Comment #1: *DCP3* may be overly academic.

Response: *DCP3* has 3 channels of influence for policy change, including the engagement of our community of contributors, the use of *DCP3* findings in education materials, and the production of derivative policy documents including *Global Health 2035*, the Copenhagen Consensus reports on child health and NCDs, the *Lancet's* Global Investment Framework for Women's and Children's Health, and *Scientific American* series on NCDs.

ACE Comment #2: *DCP3* should avoid becoming an encyclopedia.

Response: While editors are still sorting through this, there are plans to consolidate chapters where appropriate and to have consistent basic structures throughout the publication for cohesiveness. Additionally, DCP3 will take CEA beyond analysis of individual interventions by looking at policies and platforms. DCP3 will quote country and regional data throughout volumes, have explicit discussion on high priority investments, put emphasis on prevention and diagnosis, and cover cross-cutting health issues in Volume 1.

ACE Comment #3: *DCP3* should have a well-established peer review process.

Response: Each chapter is independently peer reviewed by qualified reviewers selected by the US Institute of Medicine with the cooperation of the Inter-Academy Medical Panel. Production timelines of

the first two volumes precluded a full volume review panel, which had been recommended by the ACE at its first meeting. This step will be reinstated with all volumes, bearing in mind practical constraints.

ACE Comment #4: *DCP3* should have a clear and effective dissemination plan.

Response: We have established a technical advisory committee on communications chaired by Carlos Rossel of the World Bank, and we have plans to hire a communications specialist. The DCP3 secretariat gave further details on communications strategy during section six (below).

Response

In response to Dean's presentation, ACE members underscored the need to involve policy-makers in the production process, and to create clear, concise policy messages. They also expressed concerned about the consistency of data and economics work across chapters and the quality of output given the publication's ambitious timeline.

Session Two: DCP3 Progress and Status Report Update

Presentation: Rachel Nugent (Project Director)

Rachel presented on the current status of the project and the production timeline. Currently DCP3 is planned to be published in 9 sequential volumes between October 2014 and early 2016. Surgery will be the first published volume, followed by the Cancer volume, and then the Reproductive, Maternal, Neonatal, and Child Health volume. This timeline is subject to changes given the results of the MTR.

The community of *DCP3* contributors is vast: 300 authors currently contribute to 165 chapters overseen by 31 editors. Of the 165 planned chapters, *DCP3* has received 69 chapters, the IOM has peer reviewed 30 chapters, and 10 chapters are in production at the World Bank.

Response

ACE members agreed that there is an important trade-off between quality and timeliness. Non-summary chapters should be published in a timely way because they are more time-sensitive and their electronic versions can be updated. The summary chapters are most important, therefore *DCP3* should spend more time polishing the summary chapters, being clear about the volume's added value to the field, and have them go through the *Lancet* review process.

Pam Das of the *Lancet* then gave a brief summary of the plans for *Lancet* publication of DCP3 chapter ones (summary chapters). The *Lancet* will publish the overview chapter of each volume as they are ready; the series will be branded as a special project. These chapters would be subject to an independent *Lancet* review and should have something new to say. Additionally, the *Lancet* will most likely commission comments and editorials on the *DCP3* articles, to be published concurrently. With final DCP3 publication, the Lancet will prepare a special series issue of the DCP3 chapters.

Tony Measham stressed the importance of building in time and budget for evaluation, and noted that it is not too early to create a plan for a DCP3 evaluation. There was no evaluation of DCP2 which the ACE agreed was a lost opportunity.

Session Three: Review of Chapters 1 of Cancer and Surgery Volumes

Cancer Volume

Presentation: Hellen Gelband (CDDEP)

Hellen gave an overview of Volume 6 (Cancer), which includes 16 chapters by 67 authors on overview, burden, interventions, and economics of global cancer. She highlighted a need for more high-quality cancer surveillance to inform resource allocation, as poor cancer treatment wastes resources. Cancer control packages should include tobacco control, HBV and HPV vaccination, screening and treatment for precancerous cervical lesions, diagnosis and treatment of breast cancer, prioritization of highly curable childhood cancers, and affordable palliative care. Based on the experience of other countries, countries should aim to spend 5% of the health budget on cancer-related interventions.

Prabhat Jha built on Hellen's presentation by examining the importance of tobacco taxation, particularly in India and China. He emphasized the usefulness of counting deaths to find the true prevalence of cancer in low-resource settings, finding that cancer is incorrectly identified as a disease of the wealthy.

Response

Commenters and ACE members gave the following feedback on the draft chapter. Regarding structure, the key messages should be much more compelling and persuasive, equity and quality should be addressed up front, and cost-effectiveness figures should be consistent throughout the volume. Counting the dead was seen as a good metric for cancer burden, however the chapter needs to include DALYs for comparison with other volumes and to capture quality in the metrics.

Sevket Ruacan and Rifat Atun questioned the 5% health budget target, requesting evidence for this in LMICs and suggesting that it may be more useful to instruct ministries of health on how to expand their cancer coverage rather giving them a target. Members also thought the discussion of cancer costs could be clearer, including a breakdown of cost inputs, a mention of drug cost databases, and an acknowledgement of cancer treatment heterogeneity. The cost discussion is especially important as it is a way to mobilize resources and get cancer on the global health agenda.

Looking forward, ACE members thought messages should be practical ones about implementing cancer interventions in low-resource settings, such as how to improve registries, how to move beyond the current WHO cancer package, and how to prioritize interventions within current packages. There was an emphasis on learning what works in low-resource settings rather than repeating interventions that are successful in high-resource settings. Tobacco taxation should be a priority, but not described as a silver bullet; e-cigarettes should be addressed. Palliative care should be top priority, with an acknowledgement of the assisted suicide debate.

Efficiency should also be a key point, with several suggestions:

- Do not screen if you cannot treat
- Invest in high quality diagnostics to avoid drug misuse
- Only publically finance curable cancers
- Build efficient twinning infrastructure

Equity can be addressed by noting that cancer treatment is pro-poor when it is affordable.

Surgery Volume

Presentation: Charles Mock (University of Washington)

Charles gave a presentation on the key messages in the Essential Global Surgery volume, including the definition of essential surgery, the volume's structure, and the key messages. Each key message was paired with opportunities for improvement at the national and international level. There is a large health burden from conditions, mainly pregnancy and injury, which is treatable by surgery. The main barriers are resources, both physical and human, and poor quality of care. Countries should pursue strategies to implement cost-effective surgical procedures that are highly successful and feasible in low-resource settings; these strategies should address sequencing, access, and infrastructure.

Response

Meeting participants were happy with this presentation, praising the clear messages, even tone, and discussion of platforms. Suggestions for improving key messages include emphasizing compelling statistics (training first-responders costs only $7/year, training checklists halve complications), the importance of surgery for maternal and neonatal care, and the linkages between surgery priorities and other health system strengthening priorities. Adding boxes, perhaps with country cases, would help highlight these provocative points.

Discussants and members agreed that the surgery burden of disease and cost-effectiveness were two main strengths of the volume, although there was still room for improvement. Burden of disease could be bolstered by distinguishing conditions avertable by surgery, the extent of emergency surgery, and how the burden has changed over time. The economics could be improved by costing platforms and health systems in addition to individual interventions, as well as using deaths averted before 70 years of age as a metric. Several attendees noted that they would like to see more content regarding equity, financial risk protection, and whether policies are pro-poor. Charles noted evidence that public finance and increased access to surgery may increase medical impoverishment due to transportation costs, but these studies did not take a societal perspective.

There was consensus that the summary chapter needed more practical details on implementation, pathways to expansion, and health system strengthening. Charles noted that the implementation research field in LMICs is weak. Checklists for surgical quality should be preceded by structural prerequisites, or a structural checklist, and increased resources should be accompanied by adequate training in how to use the resources. Surgical championing and national commissions may be necessary for implementation in some settings.

Other important points included a discussion of task-shifting, which is controversial and requires delicate handling to not alienate important audiences. Committee members would like to see the chapter address the social aspect of accessing surgery, the use of minimally invasive surgeries, blood banking, and the use of anesthesia or palliative care. Conflict and post-conflict communities were discussed, and it was agreed upon that the matter would be addressed in the Environmental Health and Injury Prevention volume.

Session Four: Report on Peer Review Process

Presentation: Gillian Buckley (IOM)

Gillian introduced the Institute of Medicine's (IOM) peer review process. Each chapter is reviewed by one expert, plans for volume reviews by interdisciplinary panels are on hold. A total of 31 reviewers came from various backgrounds, nearly 50% from LMICs. A common complaint is that commentators had trouble reviewing chapters independently of the full volume.

Response

Meeting participants agreed that reviews, by nature, will vary in usefulness; so far, they have been most useful in flagging controversial topics or advocacy statements.

The midterm review (MTR) team questioned the rigor of the review process, and the ACE identified reviewer consistency as a major issue, both within and across volumes. *DCP3*'s response to these concerns includes the fact that Sue Horton will be reviewing the economics across all volumes to ensure consistency. In addition, all chapters will have been read by at least one external reviewer, at least two editors, one volume coordinator, and by Mary Fisk at the World Bank. Weak chapters will be dropped at the discretion of volume editors.

Members inquired about *DCP3*'s failure thus far to implement a panel review of each volume. *DCP3* editors cited timeline and feasibility issues, however there is still potential to convene panels. *DCP3* requested ACE help in identifying a group of both technical and economic experts to review each volume as a whole. Other suggestions for improvement in review credibility and consistency include having two reviewers during the IOM process, a field expert and an economist. Pam Das of the *Lancet* also suggested hiring a general consultant for volume overviews.

Day Two: May 8, 2014

Session Five: Results of the DCPN Mid-Term Review

Presentation: Damian Walker (Bill and Melinda Gates Foundation)

Damian Walker gave an overview of the DCPN grant midterm review (MTR) report from the Gates Foundation review committee. The 2008 grant was made with the goal of improving global health resource allocation, although *DCP3* was not explicitly stated in the original grant and did not have an allocated budget. Damian is the third manager of the grant and has managed it for the past two years.

The MTR raised technical concerns regarding *DCP3's* health policy relevance, insufficient systematic reviews, economic relevance, review processes, dissemination plans, and shelf life. Additional issues included lack of expert judgment solicitation and the fact that ECEA is still at the proof-of-concept stage. The MTR gave three recommended options for the grant as it moves forward: realign the two arms of the grant, complete the project in 2016 as planned, or have an expedited shut down by 2015. Dean Jamison and Chris Murray will present reports, and the Gates Foundation will review these reports and make a final decision.

Response

ACE members soundly disagreed with an expedited shut down of the project, and re-emphasized that *DCP3* has tremendous value and relevance. However, for a high quality product, *DCP3* would likely need a no-cost extension past 2016.

ACE advice for *DCP3*, in light of the MTR, is to make *DCP3* findings relevant to policy-makers by involving policy-makers in the production process, prioritizing products that they will use, and targeting policy-makers in the dissemination process. Additionally, *DCP3* should be clearer about its use of the terms 'systematic review' or 'systematic searches.' Lastly, to ensure a quality product, *DCP3* should rethink its production timeline, consolidate chapters, bolster review process, and improve systematic review process.

The ACE committee also had advice for the Gates Foundation: be clear about the foundation's objectives and priorities so that *DCP3* can be relevant to those goals.

Presentation: Dean Jamison (Series Editor)

Dean made a presentation to respond to the MTR's suggestions. Responding to the main concern about relevance to policy makers, he asserted that *DCP3* is responding to policy needs by addressing health system strengthening and assessing the equity of health policies. The project currently has two main pathways to affect global health policy. The first is through education, influencing professors and students who will go on to become leaders in the field. Secondly, *DCP3* engages authors and health officials across the world by working with the World Health Organization (WHO), which is the world's best attempt thus far at putting health evidence into action. *DCP3* could do a better job at engaging policy-makers directly. Rachel requested that the ACE help *DCP3* prioritize strategies to better involve policy-makers in low- and middle-income countries.

Addressing other concerns, Dean stated that ECEAs are in the process of being vetted via journal submission. Overall, ECEAs were meant to be illustrative rather than systematic throughout the volumes; there was an assumption that WHO CHOICE data would be available for ECEAs, however this did not happen for various reasons. In terms of dissemination, Dean is confident that *DCP3*'s partnership with the World Bank will allow for tremendous communications capacity.

Session Six: Communications Strategy & Volume Launches

Presentation: Elizabeth Brouwer (DCP3 Secretariat)

Elizabeth gave an overview of *DCP3*'s current communications strategy. Current strategy involves *DCP3*'s website (www.dcp-3.org), a monthly newsletter, and Twitter activity (@DCPThree). Additionally, *DCP3*'s communication Technical Advisory Group (TAG) has made recommendations on future strategy. These recommendations include extracting key messages, leveraging partner's resources, and identify specific audiences to target for dissemination. Once they have identified key audiences, *DCP3* plans to tailor key messages.

She then outlined opportunities for the ACE to support *DCP3*'s communications effort, including:

- Participate in launch events and workshops

- Plug DCP3 in various personal or organizational communications platforms
- Facilitate partnerships with target audiences

Rachel added that *DCP3*'s overall goal across the volume time period (3 years) is to create a visible, sustained, recognizable theme of DCP and priority setting.

Response

ACE members offered many useful suggestions for *DCP3*'s dissemination strategy. For audiences, they identified three main groups: students, technical specialists, and policymakers. To reach students, members recommended approaching medical, public health, business, and undergraduate programs with *DCP3* materials. Additionally, get *DCP3* findings into textbooks and make it known that educators can use *DCP3* as a free resource. It might also be worth creating a MOOC (Massive Open Online Course).

Launches were discussed briefly as low-priority, and perhaps an inefficient use of resources. Folashade Omokhodion recommended combining launches where appropriate, or holding them in settings where the topic might be pertinent.

For dissemination, the committee advised finding key people in organizations, and identifying specific instruments to reach audiences. For derivative products, they recommended using talented writers and a quasi-journalistic style, with feature stories on particular issues or country case studies. Potential partners were suggested, including IAMP, In-Depth Network, and World Public Health Association.

Session Seven: Report on Executive Session

The ACE held a closed door session to discuss their thoughts on the entire *DCP3* enterprise and the meetings proceedings. In their report to the Secretariat, they focused on six areas:

1. Timeline
2. Peer Review Process
3. Policy-Maker Engagement
4. Adequate Budget
5. Independent Impact Evaluation
6. Quality End Products

The full report can be found in the Appendix to this document.

Appendix

The following ACE report from Anne Mills, Chair of the DCP3 Advisory Committee to the Editors, has been reviewed by all ACE members.

1. This report summarises the views of the ACE, following the second ACE meeting in London, 7-8 May 2014. This was an especially timely meeting, given (a) the stage of the work and (b) the Mid-Term Evaluation report.

2. The ACE warmly commended the progress with DCP3 made since its last meeting. It considered that good progress had been made with chapter development, and was pleased with the two initial draft volumes.

3. That said, the ACE was concerned that the deadlines set for production of the first two volumes are far too tight. It is vital that the Secretariat aim for a high quality and standardised product. While both draft volumes are of good technical quality, there are considerable differences in structure and presentation. These two volumes will set the style and tone for subsequent volumes so it is critical to get them right.

4. It is also essential to allow enough time for synthesis of key messages and for peer review (see later).

5. Following considerable discussion of the MTR recommendation on systematic literature review methods, ACE recommended that the secretariat should be proactive in ensuring that volume editors and chapter authors make use of systematic searches and standardised grading of evidence. The secretariat should also be clear on the nature of the search service being offered. While recognising the impossibility of full Cochrane-style reviews for all the subject matter of DCP3, it is critical that systematic searches and assessment of quality of evidence be made use of by authors.

6. The ACE was disturbed by the apparent desire of volume editors to set goals/targets for their topic areas. This was felt to be inappropriate for three reasons:

    a. These are scholarly volumes, presenting information and analyses to inform policy; they should not aim to be normative.
    b. It is inappropriate for DCP3 to instruct sovereign states on what to do.
    c. The mission of DCP3 is disease control priorities in general, so no particular volume should make claims for especial consideration in resource allocation. Volume 1 would be where priorities across topics are addressed. Recommendations on resource allocation <u>within</u> volumes would be acceptable.

7. In further developing the content of DCP3, ACE recommended:

a. That any further Extended Cost-Effectiveness Analyses (ECEA) be concentrated in countries where ECEAs had already been completed, to improve the ability to compare across interventions within a country setting.
b. That league tables (ranking of interventions by cost-effectiveness) be included in Volume 1.

8. The ACE was not comfortable with dropping volume peer review. It recommended testing the following process on a pilot basis for 1-2 volumes:

- Each volume should be given a minimum of 3 and maximum of 5 reviewers, of whom one should be named as chair.
- The purpose would be a high level review of the entire volume, addressing coherence, consistency, potential for chapter consolidation and especially reviewing in depth chapter ones.
- ACE members stated they would be happy to each act as reviewer for one volume (some members might be willing to do more); they can also advise on potential reviewers.
- IOM should be asked to draft terms of reference for the review and criteria for membership of review teams; reviewers should ideally be those with sufficiently broad expertise to address the volume as a whole. ACE should be asked to comment on these terms of reference and criteria. Reviewers should independently do their reviews; these would then be shared across the review team and a teleconference convened between reviewers, volume editors and at least one series editor to share views and agree any key revisions, with these revisions minuted. The reviews and agreed revisions should be shared with ACE and the secretariat tasked to ensure the volume editors make sure any agreed revisions are put into effect.

9. The ACE also recommended that each chapter (excluding the surgery and cancer volumes) should be allocated two reviewers, one disease/topic specialist and one generalist (with economics, social science, or public health/health services/health systems expertise). The precise requirements should be tailored to the content of the chapter. The prime purpose of the reviews is to strengthen accuracy and presentation, rather than acceptability. Once one good review has been received, effort need not be devoted to chasing the second review if it is slow to come in.

10. The ACE discussed dissemination plans as well as early engagement with policymakers. The ACE considers that it is essential and urgent to engage policymakers in DCP3, to enhance its policy relevance. DCP3 should invest in this, with activities including the policy dialogue proposed by an ACE member. It recommended, where appropriate, that the 1/8/25 approach to summaries used in systematic literature reviews should be made use of.

11. The ACE discussed budgetary issues. It is not aware of the total budget or budget allocation, but would like to see sufficient resources made available for high quality products and strong communications.

12. The ACE enthusiastically endorsed the idea of adapting DCP3 products for a country or region. This would need additional funding and should involve genuine partnerships with country /

regional groups. Since the core DCP3 work could no longer directly address capacity strengthening, this additional country/regional work would have capacity strengthening as an additional benefit.

13. The ACE strongly recommends that an independent evaluation of Disease Control Priorities be done with decisions needing to be taken on timing, and scope (all of DCP1-3 or part). ACE would be happy to comment on terms of reference.

14. In terms of its future role, the ACE agreed that it could make a valuable contribution to volume review through future meetings. This should include all chapters and not just Chapter Ones. Material would need to be made available well in advance of the meeting, together with the volume reviews.

15. ACE agreed that the Chair should send these notes to the Gates Foundation with a covering letter, noting that the ACE had fully discussed the key points of the MTR as presented by Damian Walker and taken these into account in its recommendations.