



Using Evidence About “Best Buys” to Advance Global Health

by Ramanan Laxminarayan and Lori Ashford

How much should it cost to save a life? If you had a million dollars for health, what would be the best way to spend it? How can we change incentives for health systems to adopt cost-effective interventions? These are some of the questions addressed by the Disease Control Priorities Project (DCPP), an international partnership launched earlier this decade to help policymakers decide how best to allocate their scarce health resources. The questions are pertinent today because the vast improvements in health over the last 50 years have not been shared equally across the globe. While life expectancy has risen dramatically worldwide—six years per decade just between 1960 and 1990—wide differences remain between developed and developing countries.

Low-income countries do not have to wait to become wealthy to become healthier, however. Experience has shown that, even in the absence of income growth, using existing knowledge and technologies can reduce deaths and illnesses even in the poorest countries. These health improvements, in turn, will help countries achieve their development goals.

DCPP provides the latest evidence on “best health buys” in developing countries, based on studies that have identified successful and cost-effective interventions. Evidence about what works, however, is only a starting point. Planning strategically about where and how much to invest, delivering health services more efficiently, and ultimately increasing the total resources available for health will be key to advancing global health.

The Disease Control Priorities Project

DCPP was launched in 2001 to help policymakers in developing countries identify the most pressing health problems and most effective strategies to address them. A joint effort of the Fogarty Center of the U.S. National Institutes of Health, the World Health Organization, and the World Bank, the project received major support from the Bill & Melinda Gates Foundation. Its

main product is the 2nd edition of *Disease Control Priorities in Developing Countries (DCP2)*—an expansion and update of the 1st edition published in 1993, whose findings were incorporated in the World Bank’s widely disseminated 1993 *World Development Report: Investing in Health*.

More than 500 health experts contributed to *DCP2*, which contains 73 chapters with wide-ranging information on the diseases and health conditions that afflict people worldwide. In addition to examining the disease burden (deaths and disabilities) resulting from specific health conditions, the chapters highlight cost-effective interventions based on careful analysis of prevention and treatment alternatives in different health care settings. A companion volume, *Priorities in Health*, available in seven languages, synthesizes *DCP2*’s main messages into a plain-language reference guide for policymakers. Another major volume, *Global Burden of Disease and Risk Factors*, serves as a single source of data on health conditions worldwide as of the early 2000s, and gives details on the underlying methods for the cost-effectiveness calculations and conclusions presented in *DCP2*.

DCPP’s resources are primarily aimed at public-sector health administrators, but they also provide an abundance of information for donor and technical assistance agencies, health professionals in the public and private sectors, and educators and advocates concerned with global health.

A Focus on Cost-Effectiveness

DCPP identified cost-effective opportunities that policymakers often ignore or underfund, as well as current investments that consume unnecessary resources. The project compared the cost-effectiveness of diverse health interventions using disability-adjusted life years (DALYs), a metric developed in the early 1990s to express health gains or losses in a common unit. DALYs measure the extent to which premature death and

disability lower people's health status, and allow analysts to compare the value of health interventions that have multiple or different health outcomes, occurring at different ages.¹

DCPP researchers aimed to identify the health services and strategies that would avert the most DALYs at the lowest cost. For example, heart disease is a major killer in rich countries and increasingly so in poorer ones. But the average cost of a coronary artery bypass is \$37,000 per DALY averted, well beyond the per capita income of most countries. In contrast, a polypill—several medications for preventing heart disease combined in a single pill—costs only \$409, on average, per DALY averted. While there is no “best” level of cost-effectiveness, governments should ideally choose to invest more in the lower-priced intervention and less in the higher-priced one—with all other things being equal.

DALYs and other measures of cost-effectiveness have limitations, however. The reliability of the estimates depends on the quality of available data, which is weak in many developing countries. Other factors also enter into policy decisions, such as the capacity of health systems, financial constraints, and cultural and ethical considerations. Equity is also a consideration, because it may be more cost-effective to serve people living in urban areas than those living in widely dispersed, rural areas—who tend to be poorer. Governments may intentionally direct more resources for serving vulnerable, hard-to-reach populations, thereby increasing the cost per person or cost per health outcome.

Best Buys in Health

DCPP examined the burden of hundreds of health conditions in developing countries and the cost-effectiveness of hundreds of interventions to address them. The findings are catalogued in the main *DCP2* volume and its companion materials. Some of the best health buys proved surprisingly simple—and often overlooked.

The most cost-effective health care solutions can be as simple and inexpensive as advising people at risk of heart disease to take an aspirin a day, and teaching mothers to keep their newborns clean and warm. Among the many surprising findings: A newborn can be resuscitated with a self-inflating bag that costs as little as \$5 in developing countries, and the bag can be reused an infinite number of times.

The project identified 10 best health buys—based on cost per DALY averted—that have proven effective in developing countries:

1. Vaccinate children against major childhood diseases, including tuberculosis, diphtheria, whooping cough, tetanus, polio, and measles (the traditional expanded program of immunization).
2. Monitor children's health to prevent or, if necessary, treat childhood pneumonia, diarrhea, and malaria.
3. Tax tobacco products to increase consumers' costs by at least one-third and reduce cases of cardiovascular disease, cancer, and respiratory disease (see Box 1 on page 4).
4. Prevent the spread of HIV through a coordinated approach that includes: promoting 100 percent condom use among populations at high risk of infection; treating other sexually transmitted infections; providing antiretroviral medications to pregnant women; and offering voluntary HIV counseling and testing.
5. Give children and pregnant women essential nutrients, including vitamin A, iron, and iodine, to prevent maternal anemia, infant deaths, and long-term health problems.
6. Provide insecticide-treated bed nets, household spraying of insecticides, and preventive treatment for pregnant women to drastically reduce malaria in areas where it is endemic.
7. Enforce traffic regulations and install speed bumps at dangerous intersections to reduce traffic-related injuries.
8. Treat tuberculosis patients with short-course chemotherapy to cure infected people and prevent new infections (see Box 2 on page 5).
9. Teach mothers and train birth attendants to keep newborns warm and clean to reduce illness and death.
10. Promote the use of aspirin and other inexpensive drugs to prevent and treat heart attack and stroke.

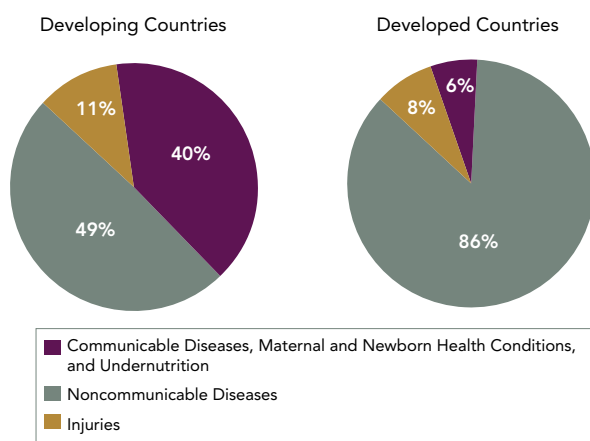
Other critical health measures—such as emergency surgery to treat injuries, childbirth complications, and abdominal conditions like appendicitis—can be more expensive in some places but worth the investment because they treat serious conditions that would otherwise be fatal or severely disabling. DCPP found emergency surgery to be most cost-effective in South Asia and Sub-Saharan Africa, where the cost of health services is relatively low and the burden of disease due to conditions requiring surgery is high.² (See Box 3 on page 7.) This finding was surprising, because health experts had long considered surgery an unaffordable luxury in the poorest countries.

Putting Cost-Effectiveness in Context

To guide policies more precisely, data on cost-effectiveness must be viewed alongside information about the larger context, such as the prevailing burden of disease, existing health interventions, and the capacity of the health system. The burden caused by a particular disease is key because policymakers will want to direct health spending to interventions that are likely to have the greatest impact on the nation's health. In developed countries, for example, a large share of health resources is devoted to addressing noncommunicable diseases, such as heart disease and stroke, cancer, diabetes, and other illnesses associated with comfortable lifestyles (overeating, smoking) and greater longevity.

Many developing countries face a “double burden” of disease. They are still grappling with diseases related to poverty—communicable diseases such as malaria and tuberculosis; poor maternal and newborn health; and undernutrition—while also seeing a rise in the diseases that typically affect more affluent populations. By 2001, noncommunicable diseases accounted for nearly half of the disease burden of developing countries (see figure). In addition, injuries, most of which are preventable, account for a higher burden of disease in developing countries compared with developed countries.

BURDEN OF DISEASE, 2001



Note: The burden of disease is measured in disability-adjusted life years (DALYs) lost due to specific health conditions.

Source: Laxminarayan R. et al. 2006. “Advancement of global health: key messages from the Disease Control Priorities Project.” *The Lancet* 367: 1194.

Health interventions that address a large disease burden (in terms of DALYs) and are cost-effective (in terms of cost per DALY averted) provide good value. Tables 1 and 2 show the best health buys that DCPD identified for South Asia and Sub-Saharan Africa, along with the total burden of disease addressed by the interventions. In both regions, the best buys include immunizing children against the major childhood diseases, providing emergency surgery for injuries and other urgent health complications, supporting an essential package of maternal and newborn care, and undertaking a coordinated approach to prevent HIV/AIDS.

Other interventions, such as improving the safety of blood supply to prevent new HIV infections, may be highly cost-effective but affect only a small number of people or provide a small improvement in health. Whether to invest in these interventions is a matter of judgment and availability of funds. These are only a few examples of the myriad options that policymakers must weigh. The more information about costs and burden of disease that policymakers have, the better they will be able to decide among alternative investments.

TABLE 1: BEST BUYS IN SOUTH ASIA

HEALTH INTERVENTION	COST (IN US \$) PER DALY AVERTED*	BURDEN OF TARGETED DISEASES (MILLIONS OF DALYS)*
Childhood immunization	\$8	28
HIV/AIDS prevention	\$9-126	7
Surgical services and emergency care	\$6-212	48-146
Tuberculosis (prevention and treatment)	\$8-263	14
Management of acute respiratory illnesses (under age 5)	\$28-264	10-26
Cardiovascular diseases (prevention and management)	\$9-304	26-39
Tobacco use and addiction	\$14-374	16
Maternal and neonatal care	\$127-394	38-48

TABLE 2: BEST BUYS IN SUB-SAHARAN AFRICA

HEALTH INTERVENTION	COST (IN US \$) PER DALY AVERTED*	BURDEN OF TARGETED DISEASES (MILLIONS OF DALYS)*
Childhood immunization	\$1-5	14-31
Prevention of traffic crashes	\$2-12	6
Malaria prevention	\$2-24	35
Surgical services and emergency care	\$7-215	25-134
Management of childhood illnesses	\$9-218	10-45
Cardiovascular diseases (prevention and management)	\$9-273	5
HIV/AIDS prevention	\$6-377	57
Maternal and neonatal care	\$82-409	30-38

*Ranges in cost per DALY averted reflect variation in costs across interventions and locations. Ranges in burden of targeted disease arise from differences in estimates provided by different sources.

Note: A DALY is a composite unit that measures the amount of health lost due to a particular disease or condition. The components of the interventions listed in the table are described in the text referring to the 10 “best buys” in health.

Source: Laxminarayan, R., J. Chow, and S.A. Shahid-Salles. 2006. “Intervention Cost-Effectiveness: Overview of Main Messages,” in *Disease Control Priorities in Developing Countries*, 2d edition, ed. D.T. Jamison et al.: 54-55.

Planning Strategically Within Countries

The pattern of disease can vary greatly from one country to another and also within countries; thus, policymakers should not study and address diseases in isolation. They should use all of the available evidence about the disease burden in their country and develop packages of interventions that provide the greatest value for money—thereby attaining the greatest health improvements for the most people at the lowest cost. This approach should result in allocating substantial resources for the poor, who typically suffer the greatest disease burden and would benefit most.

Cost-effectiveness must be considered not just for specific interventions, but also for different levels of care, such as community health centers, district hospitals, and second- and third-level (referral) hospitals. The evidence from *DCP2* suggests that governments should focus on ensuring that

BOX 1: CURBING TOBACCO USE

Cigarette smoking and other forms of tobacco use impose a large and increasing public health burden worldwide. Today, more than 1.1 billion people smoke, with about 83 percent living in developing countries. Tobacco use is linked to an estimated 5 million deaths annually, from cardiovascular disease, lung and other cancers, and respiratory diseases.

Interventions to curb tobacco use reduce a large burden of deaths and are highly cost-effective. They include:

- Raising tobacco taxes by up to 70 percent;
- Providing universal access to therapies that help people quit smoking;
- Restricting smoking in public places and workplaces;
- Educating the public about the risks of tobacco addiction; and
- Banning tobacco advertising and promotion.

Tobacco taxes discourage people from starting smoking and encourage smokers to quit; they also can increase governments’ tax revenues. The cost-effectiveness of raising cigarette prices by 33 percent ranges from \$3 to \$42 per DALY averted in low-income countries. Nicotine replacement therapy (costing from \$55 to \$751 per DALY averted) and other non-tax interventions listed above are relatively less cost-effective, but still belong in any tobacco control program.

See fact sheet, “Tobacco Addiction,” April 2006, at www.dcp2.org/file/52/DCPP-Tobacco.pdf, and Chapter 46 of *DCP2*.

BOX 2: PREVENTING AND CONTROLLING TUBERCULOSIS

Tuberculosis is the second largest cause of death from an infectious agent worldwide—killing about 1.7 million people in 2003. Despite declines in cases in some countries, the number of cases is growing worldwide (an estimated 8.8 million cases in 2005), in part driven by the spread of HIV in Africa.

Treating all forms of active TB with short-course chemotherapy is among the most cost-effective of all health interventions, because it cures infected individuals and prevents the spread of the disease. An internationally recommended strategy, DOTS (directly observed treatment short-course) costs \$5 to \$35 per DALY averted in developing countries. Successfully implementing it requires:

- Political commitment;
- Correctly diagnosing cases;
- Administering the standard course of drugs under observation;
- Ensuring regular drug supplies; and
- Maintaining a standard surveillance and reporting system.

The BCG (Bacille Calmett-Guerin) vaccination for children is also cost-effective (\$40 to \$170 per DALY averted), in reducing the burden of TB associated with meningitis in children. But because BCG hardly affects the huge burden of pulmonary TB in adults, the development of a new vaccine targeting adults is highly desirable.

The management of TB in people infected with HIV requires higher investment than is needed for DOTS alone. Nevertheless, the cost is still typically less than \$1 per day of healthy life gained—a strong argument for integrating treatment for HIV patients into an enhanced TB control strategy.

See fact sheet, “Tuberculosis,” April 2006, at www.dcp2.org/file/3/DCPP-TB.pdf, and Chapter 16 of *DCP2*.

primary health care systems work well, with local district hospitals as a focal point. Such systems could address up to 90 percent of health care needs in developing countries.

DCP2 showed that basic health care in district hospitals can be highly cost-effective, at \$13 to \$104 per DALY averted. In addition, the project found that training lay first-responders to emergencies and volunteer paramedics costs between \$5 and \$11 per DALY averted, depending on the region. Equipping ambulances with trained paramedics costs \$46 to \$137 per DALY averted in urban areas, and two to four times as much in rural areas. These are relatively inexpensive, but often overlooked, strategies for saving people’s lives.

Planning strategically requires reliable evidence, however, which depends on well-functioning reporting systems. In most developing countries, reporting systems from the community and district level to higher levels are still weak and not well coordinated. Strong health information systems, including surveillance for early detection of outbreaks of disease, will be critical for planning and investing in the most appropriate health interventions.

Strengthening Health Systems

The cost-effective interventions described in *DCP2* will not reach their full potential as long as skilled health personnel and physical infrastructure are lacking in many developing countries. In addition to choosing the most cost-effective and high-impact interventions, policymakers and planners must ensure that health systems are strong enough to carry them out.

Strengthening health systems is a wide ranging subject, requiring action on many fronts. Some areas of health system reform include: strengthening human resources; improving oversight and regulation of public and private health services; reforming organizational structures; and targeting public health spending to ensure that the neediest people receive services.

A lack of trained health personnel, from nurses and doctors to higher-level managers, is severely affecting health services in the poorest countries. Because these personnel support the entire health system, many health system reforms may not succeed until the shortage of human resources is overcome. Health managers at the district level, in particular, need information, tools, and training to adapt their services to the local disease burden.

Progress Following the Launch of DCP2

Since the early 2000s, the global health community has made progress in several critical areas, boosted in part by the greater visibility that major health problems received after the launch of DCP2 and related health initiatives. Examples include worldwide progress in controlling tobacco use; advances in newborn survival; promoting essential surgery in Sub-Saharan Africa (see Box 3 on page 7), and new approaches to curb the spread of HIV.

TOBACCO CONTROL

The WHO Framework Convention on Tobacco Control is a 21st century achievement in global health: It is the first international treaty that WHO has negotiated. The treaty is based on scientific evidence from around the world on the harmful effects of tobacco on health, and on what is known about the most effective ways to curb the demand for and supply of tobacco products (see Box 1 on page 4).

To reduce the demand for tobacco, the treaty calls for increasing taxes and prices, protecting people from exposure to tobacco smoke, regulating the content and labeling of tobacco products, banning certain types of advertising and promotion, and helping addicted people reduce their dependence on tobacco. To curb supply, the treaty calls on countries to end illegal trade in tobacco products and sales of tobacco to minors, and support economically viable alternatives to the tobacco industry.

As of June 2008, 168 countries and territories signed the treaty, and 157 ratified it nationally. Such an achievement demonstrates that the world's governments understand the evidence on tobacco's harmful effects and agree that the solutions are both necessary and feasible. As with any solutions that require changing behavior, however, implementation will be both challenging and complex.

SAVING NEWBORN BABIES

The problem of newborn deaths has been on policymakers' back-burner for decades, in spite of the fact that 38 percent of all deaths of children under age 5 occur in the first month of life. The lack of attention has been partly due to a belief that high technology care would be needed to save newborn lives.

Contrary to this belief, DCP2 found that about 40 percent of newborn deaths could be averted with simple solutions carried out in the home and community. These solutions include

keeping a newborn warm and clean, breastfeeding early and exclusively, protecting against infection through proper hygiene, and treating infections with antibiotics. Incorporating this package into standard maternal and child health care has proven highly cost-effective. In India, the newborn care package can cost as little as \$24 per DALY averted, and in Sub-Saharan Africa as low as \$46 per DALY averted.³

Around the time that *DCP2* went to press, newborn survival made headlines in a series of articles that appeared in the journal, *The Lancet*, and in WHO's *2005 World Health Report*. Several international partnerships devoted to maternal and child health also called for expanding available solutions in countries with unacceptably high newborn death rates.⁴

These global efforts helped put newborn babies on governments' health policy agendas—in many countries for the first time. As a result, progress has been seen in major policy statements, budget commitments, and new or revitalized initiatives in South Asia and Sub-Saharan Africa—the regions with the highest burden of newborn deaths. For example, in Africa, at least 20 countries have requested technical assistance to develop or strengthen newborn health programs. The African Union adopted a “Roadmap for Maternal Health” that called for increased emphasis on newborn survival.

Examples of actions in specific countries include:

- India is training 300,000 village workers whose primary responsibility will be newborn care.
- Pakistan is adding that responsibility to its successful Lady Health Workers program, which employs 100,000 workers.
- Tanzania's Ministry of Health is integrating newborn survival into local health planning. A district planning tool that ties the local burden of disease to the district health budget has been adapted to show the large number of newborn deaths, increasing the districts' interest in investing in newborn health.

NEW APPROACHES TO CURB THE SPREAD OF HIV

Medical and behavioral research has provided many of the breakthroughs that have helped curb the global AIDS pandemic. Successful prevention programs rely on many well-tested components: 100 percent condom use among populations most at risk of contracting HIV; voluntary testing and counseling to allow people to learn their status and receive

support; and preventing mother-to-child transmission of HIV through antiretroviral therapy, among other behavior-change measures. Health experts have long called for research into other prevention measures, particularly because prospects for an AIDS vaccine are dim in the near future.

An additional prevention measure, male circumcision (MC), came to light following clinical trials in South Africa, Kenya, and Uganda in the mid-2000s. *DCP2* had noted that the evidence suggesting that MC decreases the risk of acquiring HIV was strong. By 2007, the evidence from additional studies was irrefutable, leading WHO to recommend that countries add MC to national HIV prevention programs, particularly in countries in Sub-Saharan Africa where large percentages of men are uncircumcised. MC is cost-effective because the procedure is inexpensive, requiring only an

outpatient facility and local anesthesia (it is even more cost-effective when performed on infants). In terms of saving lives, one simulation showed that in the next 20 years, MC could prevent 5.7 million people of both sexes in Africa from contracting HIV and 3 million from dying—at least as effective as the long-hoped-for AIDS vaccine.⁵

Global Health Challenges Ahead

Despite continued progress in controlling the world's major diseases, four important global health challenges remain:

- The rapid growth of noncommunicable diseases in developing countries, while their public health systems are still grappling with the conventional diseases of poverty.

BOX 3: EXPANDING ACCESS TO SURGERY IN THE POOREST COUNTRIES

Surgical services have typically not been a priority in many developing countries because they are considered unaffordable in places where doctors and well-equipped facilities are scarce. Yet DCP2 researchers found that surgery need not be provided in expensive, high-technology hospitals and that it can be highly cost-effective—even on par with widely accepted preventive health care such as child immunizations.

Four types of surgery are most critical for saving lives and reducing disabilities in developing countries:

- Emergency care to injury victims, to avoid preventable deaths and reduce disabilities that burden families and communities;
- Addressing the complications of pregnancy and childbirth, such as obstructed labor;
- Managing a variety of abdominal conditions, such as appendicitis, ulcers, intestinal obstructions, and other conditions that can be life-threatening; and
- Elective surgery for relatively simple conditions such as cataracts, hernias, clubfoot, and middle ear infections.

DCPP found the highest burden of surgical conditions (in terms of DALYs lost relative to the size of the population) to be in Sub-Saharan Africa. Most of the health conditions requiring surgery are treatable, and many simple surgical procedures can be performed by trained clinicians without medical degrees. The costs attributable to surgical patients in district hospitals in Sub-Saharan Africa translate to only \$33 per DALY gained, making emergency surgical care among the most cost-effective interventions in the region.

Following the release of *DCP2*, the Rockefeller Foundation brought together leaders in surgery and related fields along with health policymakers and economists at a conference on expanding access to surgical services in Sub-Saharan Africa. The meeting, held in Bellagio in June 2007, took stock of evidence about the cost-effectiveness of surgical services in the poorest countries; assessed constraints to integrating surgery into district health services in Sub-Saharan Africa; and prepared a roadmap to improve access to surgical services in that region.

DCPP thus expanded an effort that had started in Sub-Saharan Africa several decades ago. In Mozambique and other East African countries, thousands of clinical officers (not doctors) have been trained and are performing essential surgery as competently as doctors. Programs have been carefully evaluated in at least three countries, showing that thousands of lives have been saved. DCP2 promises to spread this knowledge much more widely.

See fact sheet, "Promoting Essential Surgery in Low-Income Countries: A Hidden Cost-Effective Treasure," June 2008, at www.dcp2.org/file/158/dcpp-surgery.pdf, and Chapter 67 of *DCP2*; and "Experts Develop Roadmap to Promote Essential Surgery at the District Level," June 2007, at www.dcp2.org/news/57.

- The HIV/AIDS pandemic, which continues to spread unchecked in some countries.
- The possibility of an outbreak of another pandemic, such as SARS, avian flu, or dengue fever.
- The high prevalence of malaria, tuberculosis, diarrhea, and pneumonia that persists in the poorest countries.

To address these challenges, interventions that are known to be cost-effective should be adopted on a wider scale. For example, developing countries that are now facing a rise in noncommunicable diseases can apply many interventions that were first developed in industrialized countries, such as tobacco control programs, at a reasonable cost.

But policymakers need to recognize the importance of these health threats and respond to them. To develop appropriate responses, health information systems must be strengthened to monitor and report on new and existing cases of diseases and other health conditions, and to identify the populations that are most vulnerable and in need of services.

Recommended Actions

Policymakers and health program planners in developing countries have a wealth of information to draw from on the burden of disease and on interventions that have proven successful and affordable. To put this knowledge into practice, actions are needed on the part of both national governments and the international health community:

NATIONAL GOVERNMENTS

- Use the results of cost-effectiveness analysis to invest limited resources more wisely.
- Plan strategically to invest in those cost-effective interventions that address the largest disease burden in a country.
- Identify the health problems shared by industrialized and developing countries and opportunities for transferring knowledge.
- Expand the use of successful public-private partnerships for developing products and providing services.
- Increase the efficiency of health systems by introducing the latest health information technology and training health personnel to use it.

- Conduct operational research to determine how best to adapt important, long-term health interventions to a local setting.

“For prevention and treatment programs to work, policymakers must have access to the best possible research and analysis to ensure that their health investments save as many lives as possible.” – Ramanan Laxminarayan in *The Lancet* (Vol. 367), April 8, 2006.

INTERNATIONAL HEALTH COMMUNITY

- Increase support for global health research to attract and keep scientists in the developing world.
- Create a global health network that allocates a larger share of development assistance for research on neglected health conditions in developing countries.

While priority-setting can make limited resources go further, accomplishing all of these actions will not be possible without additional resources. The information provided by DCP2 helps fill important gaps in knowledge, but the knowledge cannot be put into practice if health systems remain severely underfunded and understaffed. Increasing the flow of resources to health, drawing on both donor support and national spending, will be essential to implement the cost-effective interventions that DCP2 has identified.

For More Information

DCP2 publications and resources can be found at www.dcp2.org. The entire *DCP2* volume is available and can be downloaded by chapter. Other tools and resources, such as fact sheets (highlighting the major findings of *DCP2* by topic area), graphics, maps, and feature stories are also available on the website.

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