From Evidence Use to Development Outcomes

An Evidence Review of Studies from a Global Living Evidence Map

Purpose and scope

This evidence review considers selected studies in the *Art and Science of Promoting Evidence-Informed Policymaking* evidence map that report development-related outcomes alongside activities intended to promote or support the use of evidence. The cases were examined to explore how evidence was used in different settings, the changes reported in association with these activities, and the extent to which the available documentation supports a relationship between evidence use and development outcomes.

Within the Art and Science project, development impact outcomes refer to changes in development indicators associated with increased use of evidence. These indicators are not prespecified and may span different sectors, relating to any of the 17 Sustainable Development Goals (SDGs), including changes in health, education, agricultural production, economic circumstances, and other areas of development (World Health Organization [WHO], 2024, p. 13). The studies considered in this evidence review are drawn from the Art and Science of Promoting Evidence-Informed Decision-Making: A Global Living Evidence Map, maintained by PACE (November 2026 update).

This evidence review considers selected studies from the November 2026 Global Living Evidence Map. Cases were chosen because they reported development-related outcomes alongside activities intended to promote or support evidence use and provided sufficient information to describe these processes. Development-related outcomes were considered in relation to the changes reported in the studies, rather than assumed to result directly from evidence use. The cases are illustrative rather than exhaustive. Reported outcomes and limitations are presented in line with the available study information, including any limitations in measurement, comparison or attribution. No formal appraisal of study quality was undertaken.

The illustrative cases reflect different approaches to evidence use, including routine data use in health-service planning, community dialogue, knowledge translation, participatory research, and research-informed policy decisions. They also illustrate variation in the types of outcomes reported and how these were documented, ranging from changes in service coverage and clinical practice to agricultural and employment-related outcomes. Their inclusion does not imply that they demonstrate the effectiveness of particular evidence-informed policymaking approaches or provide comparable levels of evidence of impact. Instead, they offer an opportunity to examine documented experiences, reported changes and the limitations of the available evidence.

Illustrative cases

Orobaton et al. (2007): UPHOLD Programme (Uganda Performance in Health Organizations for Delivery), Uganda

Context and evidence use. The UPHOLD programme supported health services across thirty-four districts in Uganda. The programme included district capacity development and the use of Lot Quality Assurance Sampling (LQAS) surveys. These surveys generated local data to support the planning and monitoring of health services. The findings were incorporated into district work-planning processes to inform programme and district targets. Annual results were discussed with district politicians and technical staff, helping to strengthen accountability for service performance. The study also reports that the use of LQAS positively influenced district and national staff attitudes towards evidence-based planning and decision-making.

Reported changes. The evaluation reports improvements in several health-service indicators during the programme period. Insecticide-treated net use increased across districts, while coverage among children under five in Bushenyi was reported to have increased over the period. The proportion of children under five with recent fever who received appropriate treatment within 24 hours also increased, from 30.7% in 2004 to 39.7% in 2005. The study further reports increase in the use of HIV counselling and testing services and in the number of mothers counselled on the prevention of mother-to-child transmission of HIV. These changes were observed during the programme period and should not, based on the reported findings alone, be interpreted as attributable solely to the programme.

Qualification. These changes are reported over time and are not accompanied by a comparison group in the study. The increase in service use also occurred alongside an expansion in the number of sites providing services. Although the study describes how LQAS data informed planning and strengthened accountability, it does not establish the extent to which the reported changes in service coverage and uptake resulted from evidence use, rather than other programme activities or contextual factors.

Kaseje et al. (2010): The evidence-based dialogue model/ the Community Strategy for the Implementation of the Kenya Essential Package for Health (KEPH), Kenya

Context and evidence use. Kaseje et al. (2010) describe an evidence-based dialogue model developed by Great Lakes University of Kisumu and the Ministry of Health to support community participation in health-service planning and decision-making. The approach brought together communities and health-service providers to review and discuss facility and community data, identify local health priorities, and inform management and resource-allocation decisions.

The study compared intervention and comparison facilities and community units across six districts in Nyanza Province, covering 17,668 households in intervention areas and 1,817 households in comparison areas. At intervention sites, village household registers, updated every four months, and manually analysed facility data were displayed on chalkboards, alongside facility suggestion boxes. Health centre and dispensary committee members at intervention sites more frequently reported planning, budgeting and approval of improvement plans as their functions than at baseline and in comparison sites.

Reported changes. Between the 2005 baseline and the 2007 evaluation, intervention sites recorded greater improvements than control sites across several indicators. Measles immunisation coverage among children aged 12–23 months increased from 63% to 87% in intervention sites, compared with a decline from 62% to 58% in control sites. Health-facility childbirth increased from 32% to 41% (control: 26% to 23%), insecticide-treated net use among children under five increased from 67% to 77% (control: 53% to 50%), and household water treatment increased from 57% to 70% (control: 68% to 54%). The reported improvements at intervention sites were statistically significant, although the result for health-facility childbirth was at the threshold of statistical significance. Following these findings, the Ministry of Health adopted the model as a strategy for implementing the Kenya Essential Package for Health (KEPH) nationally. Great Lakes University of Kisumu subsequently developed implementation guidelines and training materials to support its rollout.

Qualification. The comparison-site design provides a basis for examining differences between intervention and control settings. However, baseline values differed between the two groups for some indicators, including insecticide-treated net use and household water treatment, and the comparison sample was substantially smaller than the intervention sample. The reported indicators primarily capture service coverage and use. Furthermore, the record provides no outcome data following national adoption of the model. Consequently, the findings do not establish the longer-term effects of national implementation or isolate the

contribution of dialogue to the reported changes.

Thomson et al. (2019): Alberta Knowledge Translation Unit (KTU), Canada

Context and evidence use. Thomson et al. (2019) describe the Alberta Knowledge Translation Unit (KTU), a knowledge translation platform. The Platform conducted a needs assessment of the local knowledge translation community to identify stakeholder needs and used the findings to develop a programme theory, subsequently articulated through the 4C Model, to guide its work. Thomson et al. (2019) also conducted a formative, interview-based evaluation of the Platform. As an illustrative example of its work, the authors describe an earlier project in which an embedded knowledge translation expert supported stakeholders to co-develop a strategy for implementing basal-bolus insulin therapy for hospital inpatients with diabetes. The article reports a 13% absolute increase in therapy ordering, a 2% reduction in hyperglycaemic patient-days and a 14% reduction in length of hospital stay following implementation. These findings relate to the earlier insulin therapy project and should not be interpreted as outcomes directly measured by the formative evaluation of the Platform.

Reported changes. Citing the earlier insulin therapy implementation project, Thomson et al. (2019) report a 13% absolute increase in the ordering of basal-bolus insulin therapy, alongside a statistically significant reduction in hyperglycaemic patient-days and a 14% (2.4-day) reduction in length of hospital stay. These changes were reported following implementation of the therapy and should not be interpreted as establishing a direct causal relationship between the individual outcomes.

Qualification. These figures are before-and-after changes within a single health-service project, reported second-hand. There is no comparison group, and it is not clear how the changes were measured and attributed, or whether the 2% reduction is absolute or relative. They should not be interpreted as an estimate of the effect of the knowledge translation platform.

Agrawal et al. (2008): Communication of Banana Growers Project under the IDRC Rural Poverty and Environment (RPE) Program, Uganda

Context and evidence use. Agrawal et al. (2008) describe an initiative addressing banana bacterial wilt in Uganda through research and engagement with farming communities and local stakeholders. The Communication of Banana Growers project adopted a participatory community-based approach to managing the disease. Although the initiative is presented as an example of research informing agricultural practice, the available account provides limited detail on the specific evidence generated, how it was communicated or how farmers incorporated it into their disease-management practices.

Reported changes. The evaluation reports the project's claim that its participatory community-based approach enabled farmers to control banana bacterial wilt in 60%–100% of severely affected banana gardens.

Qualification. The reported range is a project-reported claim rather than an independently verified or pooled estimate. The available account does not provide sufficient detail on the measurement method or the basis for the range. The report also notes that outcomes across the portfolio were not tracked through a systematic process, with partners finding detailed outcome documentation challenging. The available record does not establish whether the initiative resulted in changes in household food security or farm income. These outcomes are therefore not attributed to the initiative.

Osiolo and Genesis Analytics (2025): Growth and Economic Opportunities for Women (GrOW) East Africa Programme (includes the Network of Ethiopian Women's Associations (NEWA) Project in Ethiopia, APHRC Project in Kenya, and AFIC Project in Uganda)

Context and evidence use. Osiolo and Genesis Analytics (2025) report on research and

evaluation activities under the Growth and Economic Opportunities for Women (GrOW) East Africa programme. The study describes examples of research informing policy and institutional decisions. These include the conversion of youth centres into job hubs in Ethiopia, as part of the NEWA project; the ratification of a childcare law in Nakuru County, Kenya, associated with the African Population and Health Research Centre (APHRC); and a decision by Uganda's public procurement authority to reserve 15% of public contracts for businesses owned by women, youth and persons with disabilities, associated with the Africa Freedom of Information Centre (AFIC). The childcare law and the procurement decision are linked to separate projects associated with the African Population and Health Research Centre (APHRC) and the Africa Freedom of Information Centre (AFIC), respectively.

Reported changes. The study also reports employment-related findings from an evaluation of the NEWA project in Ethiopia, which tested soft-skills and job-hub interventions among female university graduates in Addis Ababa, Hawassa and Jimma. Reported unemployment was 63.9% among participants receiving soft-skills training and 58.1% among those receiving the combined intervention, compared with 77.3% in the control group. The reported differences relative to the control group were statistically significant ($p<0.05$).

Qualification. The employment findings are based on comparisons with a control group and concern female university graduates in Ethiopia. The Ethiopian job-hub example and the employment findings come from the same project, but the combined-intervention design does not separate the contribution of the job-hub decision from the other interventions tested. The childcare legislation in Kenya and procurement decision in Uganda concern separate projects, and the available account does not establish a direct relationship between these policy changes and the employment findings. The study therefore provides examples of reported policy influence alongside employment findings, without clearly establishing the connection between them.

Other examples and distinctions in the evidence

Other studies illustrate the importance of distinguishing between changes in policy, practice and service delivery, and subsequent development-related outcomes. They also highlight differences in how outcomes are measured, reported, and linked to evidence-use activities.

Black and Hutchings (2002) describe a decline in surgery for glue ear following the dissemination of research evidence and clinical guidance in the United Kingdom. Although the decline in surgery began in the mid-1980s, it accelerated following the publication of the guidelines in November 1992. Between 1992/93 and 1997/98, the rate of surgery in NHS hospitals almost halved, although considerable variation was observed across the thirteen health districts. The rate of referrals by general practitioners also appears to have halved during this period. The decline occurred during the period following publication of the guidelines. However, the available study findings do not establish whether, or to what extent, the dissemination of the guidelines contributed to changes in surgical practice. These findings suggest changes in service utilisation; the study does not establish whether these changes were accompanied by improvements in children's health outcomes.

Neilson and Smutylo (2004), describing the Tanzania Essential Health Interventions Project (TEHIP), report that burden-of-disease and resource-allocation tools were used in district planning. The Burden of Disease (BoD) tool helped district decision-makers recognise malaria as a major health problem and highlighted gaps between the resources allocated to malaria interventions and those required. Used alongside the Mapping Malaria Risk in Africa (MARA) tool, which identified geographical and seasonal variations in malaria risk, the evidence helped justify increased district funding and inform the allocation of resources towards malaria interventions. Respondents associated the use of these tools with changes in district funding and intervention

decisions. A TEHIP report further attributes reductions in mortality rates in the two project-supported districts to the implementation of health interventions, supported by an additional US$1 per capita per annum in health-care funding. However, the mortality finding is reported in a project report rather than presented in the available extract as a primary measure.

Chayama et al. (2020) discuss the implementation context for HIV Treatment as Prevention in British Columbia. The study refers to broader epidemiological changes following the province-wide expansion of Treatment as Prevention (TasP), including increased viral suppression associated with the expansion of antiretroviral therapy (ART) and efforts to retain people in treatment. The article also refers to declining HIV incidence across all regions of British Columbia and across the exposure categories included in the 2017 HIV/AIDS Report by the BC Centre for Disease Control (BCCDC). However, these incidence trends are drawn from the provincial report and should not be interpreted as outcomes directly measured or attributed to the implementation activities examined in Chayama et al. (2020).

Other examples focus on changes in information systems, data quality, or clinical processes. Braa et al. (2012), for example, describe data-use workshops and changes in the use of routine health information in Zanzibar. The source notes that greater use of rapid diagnostic tests changed how malaria cases were classified and reported. A resulting decline in reported malaria incidence should therefore be interpreted in light of changes in diagnostic practice, rather than assumed to represent an equivalent decline in underlying disease occurrence. Similarly, studies reporting improved health information system data quality or protocol adherence describe potentially relevant changes in service processes but do not necessarily document subsequent development outcomes.

These examples are relevant to understanding the various stages between evidence use and development-related change. They do not all provide the same type or level of outcome evidence.

Observations from the illustrative cases

The illustrative cases show several pathways through which evidence was brought into decision-making and implementation. These include the use of locally generated data in district health planning, dialogue between communities and service providers, knowledge translation within healthcare facilities, participatory engagement in agricultural practice, and research informing policy and institutional decisions. Across these settings, evidence use was accompanied by reported changes in service coverage, clinical practice, agricultural outcomes, employment-related indicators, and policy decisions. However, the extent to which these changes can be linked to evidence use varies considerably.

A recurring distinction concerns the relationship between evidence use and the interventions or activities associated with reported outcomes. Some studies document changes in development-related indicators following interventions that incorporated evidence-use activities, but do not isolate the contribution of evidence use itself. For example, improvements in health-service coverage or employment outcomes may reflect the combined effects of several programme components. Consequently, evidence of improved outcomes following an intervention should not automatically be interpreted as evidence that the use of research or data produced those improvements.

The studies also differ in how outcomes are documented. Service uptake, changes in clinical practice, institutional decisions and population-level health or economic outcomes are related but distinct. A change at one stage may form part of a pathway towards development outcomes, but it should not automatically be interpreted as evidence that those outcomes occurred.

The findings should therefore be read as accounts of particular experiences and reported

changes, rather than as evidence of the comparative effectiveness of specific Evidence-Informed Policymaking (EIPM) approaches.

Source and interpretation note

This evidence review draws on studies included in The Art and Science of Promoting Evidence-Informed Policymaking: A Global Living Evidence Map, focusing on those that report development-related outcomes alongside efforts to promote evidence use. Study descriptions and reported outcomes are presented in line with the information available in the mapped records and, where available, the full study reports, drawing on evidence map data as at the November 2026 update. Where information on outcome measurement, comparison or attribution is limited, this is acknowledged in the relevant case.

The development-related indicators discussed in this evidence review are presented as reported in the reviewed studies. Their inclusion does not, in itself, establish that an outcome was achieved or that evidence use contributed to it. "Not reported" indicates that the relevant information was not available in the material reviewed and should not be interpreted as evidence that an activity or outcome did not occur.

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About PACE

The Pan-African Collective for Evidence (PACE) is a non-profit organisation that supports evidence-informed policymaking across Africa. Its vision is a world free of poverty. PACE works to unlock the potential of evidence capacities, evidence communities, and evidence synthesis to strengthen institutionalised evidence-to-policy systems and support meaningful development and transformation. For more information: https://pace-evidence.org/art-and-science

About this review

This evidence review is part of a series showcasing how policymakers can use the Global Living Evidence Map on Evidence-Informed Policymaking (EIPM).

Source of studies:

All studies discussed in this evidence review were drawn from The Art and Science of Promoting Evidence-Informed Policymaking: A Global Living Evidence Map.

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