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Applying the GRADE Evidence-to-Decision framework to inform a Public Health Policy: an experience from Chile

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Abstract

Background: The GRADE Evidence-to-Decision (EtD) framework was developed to support systematic, transparent, and structured processes for translating research evidence into healthcare recommendations. While widely used in clinical guideline development, its application in public health policymaking remains less documented. Population-level decisions require consideration of broader contextual factors, including implementation feasibility, equity, and health system constraints. This study documents the application of the GRADE EtD framework within Chile's Ministry of Health to inform a policy decision on milk fat content in a national child nutrition programme.

Methods: The study used the GRADE EtD framework adapted for health system and public health decisions. A structured research question was formulated using a PICO approach, and evidence was synthesized to inform EtD criteria covering benefits and risks, certainty of evidence, values and preferences, resource implications, equity, acceptability, and feasibility. Evidence reports on effectiveness, cost-effectiveness, and population values were prepared through systematic searches of major bibliographic databases. Additional contextual reports addressed programme costs and implementation considerations. A multidisciplinary expert panel reviewed the evidence and completed the EtD assessment during two deliberative meetings, leading to a final recommendation.

Results: The EtD process examined whether children aged 24–71 months should receive whole or reduced-fat milk in the national programme. Evidence synthesis identified limited observational studies with very low certainty across critical outcomes, showing no clear benefits of whole milk and possible small risks for susceptible children. Values and preferences were variable, and no cost-effectiveness studies were identified. Although whole milk was slightly cheaper, equity and public health considerations favoured reduced-fat milk. The expert panel issued a conditional recommendation for reduced-fat milk, accompanied by implementation, monitoring, and periodic evidence review plans.

Conclusions: This experience demonstrates the feasibility of applying the GRADE EtD framework to inform complex public health policy decisions where evidence is limited and contextual factors are critical. By structuring deliberation and documenting value judgments, the approach supported transparent and accountable decision-making. The experience suggests that evidence-to-decision frameworks can support health systems to integrate research evidence with programmatic and equity considerations when designing population-level health interventions.

Background

The "Grading of Recommendations Assessment, Development and Evaluation (GRADE) Evidence to Decision (EtD)" framework was developed by the GRADE Working Group to support systematic, transparent, and structured processes for mobilizing research evidence into healthcare decisions and recommendations. The framework provides explicit criteria to guide deliberations on issues such as the balance of benefits and harms, certainty of the evidence, resource implications, equity, acceptability, and feasibility. By structuring these judgements, the framework aims to improve the transparency and

consistency of decision-making while ensuring that recommendations are grounded in the best available evidence (1,2).

Since its introduction, the GRADE EtD framework has been widely adopted in the development of clinical practice guidelines and recommendations at the individual-level care. In these contexts, it supports guideline panels in translating findings from systematic reviews into recommendations regarding diagnostic strategies, therapeutic interventions, and other aspects of patient care (3). Its structured format helps make explicit the reasoning underlying recommendations and clarifies how evidence and other considerations inform final judgements.

However, decision-making in public health and health policy presents additional challenges compared with clinical guideline development. Policymakers often assess interventions that operate at the population level and must consider a broader range of contextual factors, including implementation feasibility, health system constraints, societal values, and potential equity implications. Recognising these complexities, methodological guidance has been developed to extend the use of the GRADE EtD framework beyond clinical care to support evidence-informed policymaking (EIPM) in public health and health systems (4).

Despite these developments, empirical evidence documenting the application of EtD frameworks in real-world public health decision processes remains limited. Two recent scoping reviews identified 15 frameworks designed to support EIPM in public health (5,6). Seven of these frameworks have a generic scope applicable across health domains, including the GRADE EtD framework, the World Health Organization's (WHO) INTEGRATE Evidence framework, the CDC framework for planning and improving evidence-based practices, and the Nepal framework for prioritising policy choices, while eight were developed for specific policy areas such as immunisation programmes, non-pharmaceutical interventions for COVID-19, and the prevention of non-communicable diseases (6). However, documentation of their practical use is scarce. Only twelve publications describing user's EtD experiences were identified, and these reported the application of just two frameworks: GRADE EtD and the WHO INTEGRATE (5).

To address this gap, this article documents the application of the GRADE EtD framework to inform a public health decision within the Ministry of Health (MoH) in Chile. Specifically, it reports the use of a system typically employed in clinical guideline development, to support decision-making regarding a national child nutrition programme. By reporting this experience, the study contributes empirical insights into how structured evidence-to-decision approaches can be adapted and applied to support population-level health policy decisions in governmental settings.

Policy context and decision problem

Chile faces a persistent burden of excess malnutrition in early childhood and ranks among the ten countries with the highest levels of childhood obesity worldwide (7). Overnutrition has increased sharply in recent decades and constitutes a major public health priority. National monitoring data show that

between 2020 and 2024 the combined prevalence of overweight and obesity among children under five reached approximately 35% annually (8). Among children aged 4–5 years the situation is even more concerning: in 2024 almost half were affected by overweight or obesity (≈48%; ≈25% and ≈23%, respectively) (8).

Since 1954, Chile's National Complementary Food Programme (PNAC) has provided fortified products to support maternal and child nutrition. The PNAC includes five subprogrammes targeting children under six years of age, preterm infants under one year, children up to two years allergic to cow's milk protein, pregnant and breastfeeding women, and individuals with inborn errors of metabolism (9). Originally designed to address undernutrition and infectious diseases, the programme now operates in an obesogenic environment characterised by a high burden of chronic non-communicable diseases (10,11). Consequently, the nutritional composition of PNAC products has been periodically revised to reflect changes in the country's epidemiological profile.

In 2020, the Ministry of Health's Department of Food and Nutrition convened a multidisciplinary expert panel to review the formulation of a dairy beverage distributed through PNAC for children aged 2–6 years. While the nutritional experts broadly agreed regarding most nutritional components, disagreement persisted in respect of fat content. Some experts supported maintaining a low-fat formulation using skimmed milk, citing the high prevalence of childhood overweight and obesity. Whereas others advocated for increasing the fat content, arguing that a higher energy density beverage would be potentially more efficient in meeting nutritional requirements, while increasing satiety for longer.

Given the difficulty in reaching consensus, the Department of Food and Nutrition requested support from the Evidence-Informed Health Policy Unit (UPSIE), which promotes the systematic use of research evidence in public health and health system decision-making (12). The Unit proposed applying the GRADE Evidence to Decision framework to structure the deliberation and inform the policy decision of whether PNAC should provide whole or reduced-fat cow's milk to children aged 24–71 months (13).

Methods

The methodological approach followed the GRADE EtD framework tailored for public health policymaking. Although most GRADE EtD criteria are similar across different types of decisions, the *health system and public health decisions* framework was selected because it explicitly incorporates considerations relevant to population-level decisions, including equity (4). Also, the GRADE guidance was used for synthesising evidence of effects and grading the certainty of evidence (14).

The EtD system includes 3 main sections: the question, an assessment and a recommendation. The research question was structured using the PICO/POCO framing model (Population, Intervention/Option, Comparison, Outcomes). The assessment was performed using the EtD template proposed by GRADEpro GDT (15) on "Health system and public health recommendation". The template outlines 12 criteria to structure panel deliberations and value judgement appraisal: (i) priority of the problem, (ii) magnitude of desirable effects/benefits, and (iii) of undesirable effects/risks, (iv) certainty of the

evidence of effects, (v) population values and preferences, (vi) balance between desirable and undesirable effects, (vii) magnitude of resource requirements (costs), (viii) certainty of the evidence of costs, (ix) cost-effectiveness, (x) impact on health equity, (xi) acceptability, and (xii) feasibility of implementation.

The fat-content EtD process applied 11 of the 12 proposed criteria. “Certainty of cost evidence” was not assessed because resource estimates relied on general assumptions rather than empirical cost studies or economic evaluations. For each criterion, the panel reviewed the available evidence (when applicable), discussed the relevant considerations, and formulated a structured judgement supported by the methodological team. Once the EtD template was completed, the panel formulated the final recommendation, incorporating additional considerations related to implementation.

Evidence reports were prepared by the methodological team, using structured templates to ensure rigour, transparency, and consistency. Searches for scientific evidence reports covering effectiveness, population values and preferences, and cost-effectiveness, were conducted between January and February 2021 in MEDLINE and EMBASE (via Ovid) and Epistemonikos, without restrictions on publication year or language. Searches were structured around the concepts of the PICO/POCO question.

The “Evidence report on effectiveness” focused on systematic reviews’ analysis; the “Evidence report on cost-effectiveness" was based on a review of economic evaluations; and the “Evidence report on population values and preferences” included both systematic reviews and primary empirical studies using qualitative or quantitative methods. For every evidence report, the title and abstract selection was conducted independently by two researchers, while full text selection was performed by a single researcher. Both selection stages used the software Covidence (16).

Two additional contextual reports were produced: a “benchmark cost report” based on market price analyses and adjustment estimates, and an “implementability report” drawing on administrative data, regulations, and programme management information. Panel judgements and deliberations were documented using the GRADEpro GTD platform (15).

The Evidence-Informed Health Policy Unit led the EtD process, following a series of operational steps. First, it responded to the request from the Department of Food and Nutrition to support the development of an evidence-informed recommendation and agreed on the scope of the collaboration. Second, convened a multidisciplinary expert panel; all members declared potential conflicts of interest and signed confidentiality agreements. Third, formulated a structured research question. Fourth, conducted a series of evidence reports addressing effectiveness, population values and preferences, cost-effectiveness, reference prices, and implementation feasibility. Finally, facilitated two deliberative meetings during which the expert panel assessed the EtD criteria in light of the compiled evidence and their professional knowledge and expertise, documenting the judgments that informed the final recommendation.

Results

Once the Department of Food and Nutrition agreed with the methodology proposed by UPSIE and formally accepted delegating the decision on the milk's fat content to be consumed by children to an expert panel, the evidence-informed recommendation process was initiated.

1. Expert Panel and Question Formulation

The expert panel was formed by selected professionals with multidisciplinary backgrounds and strong experience in child nutritional health across clinical, academic, scientific societies and public health settings. Panellists were asked to sign conflict-of-interest (CoI) and confidentiality declarations. In the first meeting, the panel received an overview of the framework objectives, the methodology, and its stages. Also, the CoI forms were reviewed. Participants formally committed to adhering to agreed methodological principles, transparency in decision-making, and evidence-aligned recommendations. The initial orientation was crucial for helping members to clearly understand the process and their specific roles.

The research question agreed upon by the panel was: **In children aged 24 to 71 months, what is the effect of consuming whole cow's milk compared with reduced-fat cow's milk?** This question can be framed in the PICO/POCO structure as follows:

- Population: Children 24–71 months
- Intervention/Option: Whole cow's milk
- Comparison: Reduced-fat cow's milk
- Outcomes: Overweight or obesity, cardiovascular diseases (CVD), growth and development, and satiety

2. Evidence syntheses prepared for the panel

Effectiveness. 254 systematic reviews (SR) were identified, of which only two met the inclusion criteria. After reviewing the primary studies included in the selected SR, four prospective cohort studies (from the U.S. and Canada) were eligible for a narrative synthesis, with adjustment for confounding. Outcomes considered critical for decision-making were overweight, obesity, cardiovascular risk (as indicated by non-HDL cholesterol), and growth and development; however, satiety had no eligible evidence. Certainty was rated very low across critical outcomes because studies were observational with risks of bias, indirectness (e.g., age ranges, proxy outcomes), imprecision, and inconsistency.

Key findings for children 24–71 months (or close cohorts in preschool ages) were:

- **Overweight/obesity:** Compared with reduced-fat milk, whole milk showed null to protective associations for subsequent overweight/obesity in two cohorts; however, very low certainty precludes confident inference.

- **Cardiovascular risk:** In a Canadian cohort (2–8 years), higher milk fat percentage was not associated with odds of non-HDL cholesterol >145 mg/dL (adjusted OR=1.04; each 1% fat increase raised non-HDL by 0.035 mmol/L), again with very low certainty and indirectness (age band; surrogate outcome).
- **Growth/development:** One cohort reported slightly lower height-for-age z-scores with higher-fat milk at age 4 compared to outcomes at 5 years, with very low certainty.
- **Satiety:** No eligible evidence.

These findings reported inconsistent or non-adverse associations between full-fat dairy and adiposity in children, reinforcing uncertainty rather than providing a clear direction of effect.

Values and preferences. 283 references were identified, of which 17 were selected based on the inclusion criteria. Studies and ancillary sources indicated: (i) no clear differences in taste preference between whole and reduced-fat milk among 24–71-month-olds; (ii) cultural tendencies in Hispanic populations favouring whole milk; (iii) determinants of family choice include prior experience with the product and caregivers' perception of the child's weight. Overall, variability or uncertainty in what families would choose is likely.

Reference prices. Reference data suggested whole milk powder would be 7.2% less expensive than reduced-fat milk powder. If extrapolated (with caution) to PNAC volumes, this implied potential savings of CLP 375.4 million/year (≈ USD 530,000 at the April 2021 average exchange rate), subject to procurement realities, fortification, packaging, and potential demand changes.

Cost-effectiveness. No economic evaluations comparing whole vs. reduced-fat milk in the target population were identified.

Implementability. Either option (whole or reduced-fat) would require regulatory updates, technical specifications for product reformulation and fortification, adjustments to the distribution scheme, training of healthcare personnel, and family education. Infrastructure and staffing impacts were expected to be limited; funding is protected by law, though additional budget would likely be needed for reformulation, acceptability testing, and communication.

3. Evidence-to-Decisions judgments

The panel completed the EtD table (Table 1) with the following judgments and rationale:

- **Priority of the problem:** Yes. Deciding on milk fat for PNAC's 24–71-month segment affects 179,000 kg/month of product, with equity implications for low-income, socioeconomically disadvantaged families relying on PNAC to access healthy foods.
- **Desirable effects (benefits) of whole vs. reduced-fat:** Trivial or none. Based on available evidence and clinical experience, whole milk offers no distinct benefits over reduced-fat milk for this age

group. In the context of a healthy diet, reduced-fat milk may be more favourable for maintaining a healthy weight in most cases. Monitoring new studies was deemed important.

- **Undesirable effects (risks) of whole vs. reduced-fat:** Small. While observational evidence did not reveal distinct risks for whole milk versus reduced-fat milk, expert consensus (including paediatric cardiometabolic guidance) highlighted potential dyslipidaemia in susceptible individuals who consume whole milk, supporting caution.
- **Certainty of evidence:** Very low across critical outcomes (overweight/obesity, CVD risk, growth and development), necessitating reliance on expert knowledge and ongoing evidence surveillance.
- **Values and preferences:** Possibly important variability or uncertainty across families, though many would likely opt for reduced-fat milk, influenced by early introduction patterns and perceptions and by marketing labels that frames reduced-fat as “healthier”.
- **Balance of effects:** Probably favours reduced-fat milk, considering the above.
- **Resources (relative costs):** Varies. Price differentials (7.2% cheaper for whole milk) may not translate directly to public procurement. Fortification and packaging changes, shifts in demand, and supply agreements could help offset nominal differences.
- **Cost-effectiveness:** No studies found.
- **Equity:** Recommending whole milk would reduce equity, because vulnerable households have less physical and economic access to reduced-fat products. In this context, delivering reduced-fat milk through PNAC would improve equity by guaranteeing free access regardless of socioeconomic level.
- **Acceptability across stakeholders:** Probably not for whole milk. Clinicians and public health practitioners generally favour reduced-fat options, given the high prevalence of obesity. Families would likely accept either option, and the payer may prioritize a lower price. PNAC operations would be similar under either option.
- **Feasibility: Yes** (for either option). Both require similar implementation steps (industry engagement, norms, distribution, training, education). Whole milk might seem logistically simpler given the existing supply for <18 months, but retail availability also makes reduced-fat milk feasible.

Table 1. EtD table criteria and judgements

Criteria	Questions discussed by the panel	Evidence consulted by the panel	Judgements agreed by the panel
Priority	Is the problem a priority?	N/A	Yes
Benefits	What is the magnitude of the desirable effects (benefits) of whole milk compared to reduced-fat milk?	Evidence report on effectiveness (benefits and risks)	Trivial or none
Risks	What is the magnitude of the undesirable effects (risks) of whole milk compared to reduced-fat milk?	Evidence report on effectiveness (benefits and risks)	Small
Certainty of evidence	What is the overall level of certainty of the evidence?	Evidence report on effectiveness (benefits and risks)	Very low
Values and preferences	Is there variability or uncertainty regarding user preferences as to which alternative they would choose?	Evidence report on population values and preferences	There is possibly significant uncertainty or variability
Balance of risks and benefits	Does the balance of desirable and undesirable effects favour whole or reduced-fat milk?	Evidence report on effectiveness (benefits and risks)	Probably favours reduced-fat milk
Resources	What is the magnitude of the resources needed to deliver whole milk compared to delivering reduced-fat milk?	Reference price report	Varies
Cost-effectiveness	Which alternative is more cost-effective, whole or reduced-fat milk?	Evidence report on cost-effectiveness	No studies found
Equity	What impact would recommending whole milk have on health equity?	-	Reduce equity
Acceptability for stakeholders	Is whole milk acceptable to stakeholder groups? (compared to reduced-fat milk)	-	Probably not
Implementation	Is it feasible to implement whole milk?	Implementability report	Yes

4. Final recommendation and rationale

The official recommendation recorded by the MoH was:

“For children aged 24–71 months, the Ministry of Health *suggests* reduced-fat cow’s milk rather than whole cow’s milk. Strength: *Conditional.* Overall certainty (GRADE): *Very low.*”

The panel suggested additional considerations for the implementation of the recommendation, including:

1. Defining the exact fat content for the reduced-fat formulation, considering the requirements on fortification, acceptability, and stability of the milk formula.
2. Emphasizing that benefits of reduced-fat milk are greatest within a healthy diet.
3. Aligning nutritional profile and fortification with national dietary guidelines.
4. Preparing a comprehensive implementation plan which includes acceptability evaluations, workforce training, dissemination and marketing strategies, family education, industry coordination, and supply and distribution mechanisms.
5. Establishing monitoring and evaluation systems of this recommendation.
6. Periodic evidence review in light of evolving epidemiology and research.

5. From evidence to PNAC reformulation decisions

The recommendation directly informed the PNAC reformulation process for the 2021–2023 period for the 24–71-month age groups, as documented by the MoH in technical memorandum and presentation (17,18). These reports reflect concrete programmatic changes, including the transition from a dairy beverage to powdered milk, the introduction of reduced-fat milk for children aged 24–71 months, adjustments to micronutrient fortification, and updated packaging and labelling. Collectively, these documents illustrate how the EtD framework’s judgments on acceptability, feasibility, and equity were translated into procurement specifications and implementation planning.

Discussion

This study illustrates a real-world application of a decision-support framework originally designed to inform patient-level clinical recommendations (1,2), and later adapted for health system and public health decision-making (4). The experience of the Chilean MoH demonstrates how the GRADE EtD framework strengthens the transparency and credibility of the policymaking process, particularly in contexts where there is lack of consensus or is unclear which criterion should prevail when making the final recommendation.

Key findings from the EtD application

Several features of the process were important. First, the EtD framework structured deliberation beyond the interpretation of effect sizes. In clinical guideline development, randomized controlled trials (RCTs) and direct patient outcomes typically underpin recommendations. In this case, however, no RCTs were available, and the observational evidence was indirect, inconsistent, and of very low certainty for critical

outcomes. The EtD framework ensured that the panel's reasoning—across values and preferences, resources, equity, acceptability, and feasibility—was explicitly documented. This helped maintain a structured decision process and prevented judgments from becoming ad hoc in the face of limited evidence. Such an approach is consistent with the guidance developed in the DECIDE project for applying GRADE EtD in health systems and public health contexts, which emphasizes transparency and contextualization when moving from uncertain evidence to population-level decisions (4).

Second, the framework enabled the integration of program logistics and procurement realities into the deliberation. Public programmes must translate policy recommendations into operational specifications, including purchase contracts, fortification standards, labelling requirements, and distribution mechanisms. The EtD criteria addressing resources, acceptability, and feasibility allowed these practical constraints to be systematically assessed alongside the scientific evidence. Although whole milk showed a 7.2% lower reference price, this difference alone did not determine the recommendation. Equity in access to reduced-fat products, implications for programme implementation, and viability of regulatory adjustments were also considered. Therefore, the EtD process allowed economic considerations to be weighed together with equity and coverage objectives, rather than treated as a simple cost-minimization exercise.

Third, the process explicitly stressed equity and stakeholder perspectives. The panel argued that recommending whole milk could reinforce inequities, as reduced-fat options are less accessible to lower-income households. In contrast, supplying reduced-fat milk through PNAC would normalize access to healthier products among vulnerable populations. Evidence on social values and perceptions, and the expert knowledge, also highlighted the importance of cultural preferences and family experiences in shaping programme acceptability. These insights informed the recommendation to accompany implementation with targeted communication and education strategies.

Operational lessons from the process

The Chilean case also illustrates how GRADE can be adapted to enhance accountability in public health policymaking. The EtD framework for health systems and public health provides a validated structure for integrating diverse sources of evidence and judgement. It complements other public-health–oriented frameworks, such as WHO-INTEGRATE, which emphasize broader societal and system-level considerations and address how to evaluate certainty of complex non-randomized evidence (5,6). In this case, the Department of Food and Nutrition's decision to adopt the EtD framework created an opportunity to strengthen institutional accountability by documenting and publicly reporting how each decision criterion was assessed. Such transparency clarifies how recommendations are reached and ensures that contextual factors—such as feasibility, costs, and social values—are systematically incorporated into the deliberative process.

Reflections from PNAC's managers and expert panellists suggested that the EtD approach facilitated consensus-building and improved the documentation of decisions made under uncertainty. The provision of reduced-fat, fortified milk for children aged 24–71 months was considered operationally

feasible, with neutral to positive acceptability expected among families and frontline staff, given that product characteristics, preparation guidance, and training needs were adequately addressed. Stakeholders also emphasized the importance of embedding monitoring and evaluation within procurement and distribution processes. Suggested mechanisms included acceptability studies, periodic surveillance of programme indicators, and continuous scanning of emerging evidence. These considerations were consistent with the rapid evidence synthesis conducted for this process, which highlighted the need for careful monitoring and evaluation given the remaining uncertainty regarding body mass index (BMI) outcomes.

Contribution to the evidence-informed policymaking literature

The main contribution of this article is to document and critically reflect on the application of the GRADE EtD framework within a public policy decision. This experience is particularly relevant in institutional contexts where the integration of structured knowledge translation processes is not typically regarded as a priority or a mandatory component for policy formulation, nor systematically embedded in national public health or health system decision-making processes.

This gap becomes more evident when contrasted with other types of health-related decisions in which the Chilean state has established institutional mechanisms to systematically integrate structured processes for the production, mobilization, and use of evidence. For instance, since 2020 the National Cancer Law requires the periodic updating of clinical practice guidelines for different types of cancer every two years (19,20). Similarly, the Ricarte Soto Law mandates the use of health technology assessment processes to determine public coverage for high-cost treatments (21,22).

These examples illustrate that, while structured evidence-informed processes have been institutionalised in specific areas of the Chilean health system, their use remains uneven across different types of policy decisions. In this context, reporting the application of the EtD framework contributes to the EIPM discipline by providing an empirical example of how structured deliberative approaches can be applied to support transparency, accountability, and systematic consideration of evidence in public health decisions.

Limitations

The findings should be interpreted considering several limitations. Although the process drew on the best available evidence, the underlying evidence base was limited. The synthesis relied primarily on observational studies, some of which involved age groups that did not fully match the PNAC target population (e.g., cohorts including children aged 2–8 years). Several outcomes were also based on surrogate indicators, such as non-HDL cholesterol, and no formal economic evaluations were available to inform the assessment of costs and cost-effectiveness. These limitations justified the panel's conditional recommendation and highlight the importance of periodically updating the evidence base as new studies emerge.

Implications for policy and research

Despite these limitations, the Chilean experience suggests that structured decision frameworks such as GRADE EtD can support more transparent, accountable, and context-sensitive policymaking in public health. Future research could examine how different deliberative frameworks are adopted and adapted within policy institutions, particularly in settings where EIPM processes are still evolving. Comparative studies could help identify which frameworks best align with the organizational cultures and governance arrangements of health systems and under what conditions they are most effectively integrated into routine policymaking.

Conclusions

Using the GRADE EtD framework enabled Chile's MoH to make a transparent, equity-sensitive, and operationally grounded decision on milk fat content for the PNAC programme for children aged 24–71 months, despite very low certainty of evidence. The panel determined that whole milk offered no clear benefits over reduced-fat milk for critical outcomes and might pose small risks for susceptible children. While values and preferences were likely to vary, programmatic objectives and equity considerations favoured the provision of reduced-fat milk. Resource implications were uncertain and potentially offset by implementation needs; no cost-effectiveness evidence was available. The resulting conditional recommendation—reduced-fat milk over whole milk—was accompanied by concrete plans for implementation, monitoring, and periodic review of emerging evidence.

This article demonstrates how a systematic and rigorous deliberative approach can be applied to public health programming and procurement decisions. It also illustrates the flexibility of the GRADE EtD framework to incorporate multiple forms of evidence beyond scientific research, including contextual constraints and opportunities, expert judgement, and the perceptions and values of relevant stakeholders. In doing so, the approach supports the development of a defensible policy that prioritize equity and feasibility while acknowledging uncertainty and establishing mechanisms for learning and continuous improvement within the health system.

Abbreviations

BMI: Body Mass Index

CoI: Conflict of Interest

CVD: Cardiovascular disease

DECIDE Project: "Developing and Evaluating Communication strategies to support Informed Decisions and practice based on Evidence" Project

EIPM: Evidence-informed policymaking

EtD: Evidence to Decision

GRADE: Grading of Recommendations Assessment, Development and Evaluation

HDL: High-Density Lipoprotein

MoH: Ministry of Health

OR: Odds Ratio

PICO: Population, Intervention, Comparison, Outcomes

PNAC: Spanish acronym for National Complementary Food Programme

POCO: Population, Option, Comparison, Outcomes

RCT: Randomized Controlled Trial

SR: Systematic Review

UPSIE: Spanish acronym for Evidence-Informed Health Policy Unit

WHO: World Health Organization

Declarations

Ethics approval and consent to participate: Not applicable. This article documents and reflects on the application of a support-decision framework within a public policy process and did not involve the collection of personal data requiring ethical approval.

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Authors' contributions: LKB wrote the first draft of the manuscript. CIC served as methodological coordinator for the development of the EtD recommendation, while RBJ and LKB provided methodological support. CIC, RBJ, and LKB analysed and interpreted the effectiveness findings (benefits and risks). RBJ and CIC analysed and interpreted the values and preferences findings. CIC analysed and interpreted the reference cost findings. VHM analysed and interpreted the cost-effectiveness findings.

LKB synthesised the findings and prepared the discussion. All authors reviewed, edited, and approved the final manuscript.

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