VIGNETTE 4

Agenda and priority setting

Using the global living evidence map on evidence-informed policymaking (EIPM)

Use case

A cross-sector convenor, for example a regional evidence network or collective, is organising a dialogue to set a shared EIDM research and practice agenda, independent of any single funding or policy decision. The convenor uses the living evidence map to identify where research is concentrated, how coverage has changed since 2024 and which emerging patterns or evidence gaps warrant discussion. The aim is to inform a collective agenda rather than a specific funding or policy decision. This scenario is illustrative.

+64%
growth in the evidence base since 2024 (617 → 1 010 studies)

+130%
growth in Agreement (M2) evidence, the fastest-growing mechanism

12%
of studies now counterfactual, down from a 16% share in 2024

30%
of studies are from the WHO African Region (up from 28% in 2024)

> *All four figures are drawn from the live evidence-map dataset (November 2026 update, n=1 010), cross-checked against the 2024 World Health Organization (WHO) technical report (n=617) where a comparison is made. Geographical representation is calculated as a share of studies, rather than regional codes, to ensure comparability across the two periods.*

The decision

Which emerging research patterns, evidence gaps and questions about EIDM practice should be prioritised for discussion, and how can stakeholders use these findings to agree on a shared research and practice agenda?

Using the map

The convenor reads the map for shape and change, not just size:

1. **Read the map's growth over time.** The evidence base expanded from 617 studies in 2024 to 1 010 by November 2026, an increase of approximately 64%. While the search strategy remained consistent across updates, studies identified through external contributions also added to the evidence base. The increase therefore reflects growth in the mapped evidence base and should not be interpreted as an increase in newly published studies alone. Publication-year counts were approximately 45 studies per year in 2020–2023, rising to 92 in 2024 and 87 in 2025, suggesting higher publication output in recent years. These figures reflect publication years rather than the timing of additions to the map.

   > *What you would see in the map: filter by publication year, or use the growth-over-time view, to see the pace of growth, not just the running total.*

2. **Examine changes in mechanism coverage.** Agreement (M2) has grown much faster than the evidence base as a whole (109→251, more than doubling, raising its share from 18% to 25%). Access (M3) and Structure and process (M6) grew slightly slower than the base, so they make up a marginally smaller share, despite remaining large in absolute terms.

3. **Compare study designs and sector shape.** Counterfactual-based evaluations grew from 101 to 123, but rose slower than the overall evidence base, so their share fell from 16% to 12%). Health's share of sector-coded evidence declined from 75% to 63%, despite an increase in the number of health-related studies. These patterns indicate changes in the composition of mapped research, rather than necessarily reflecting changes in evaluation quality or sectoral priorities.

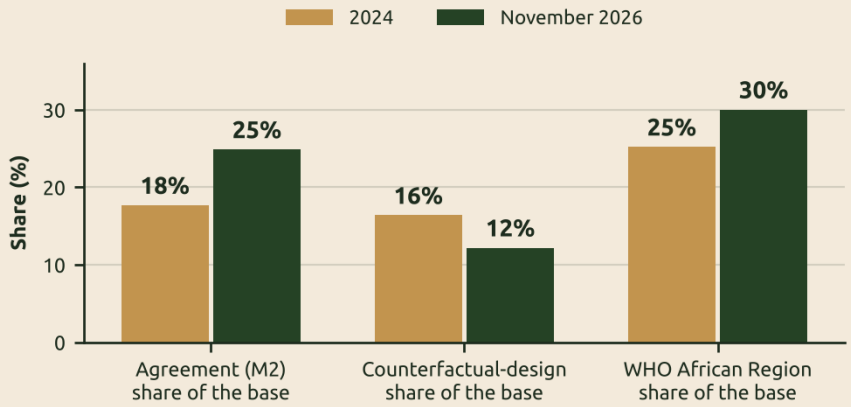


Figure 1. Share of the evidence base in 2024 (n=617) and in the November 2026 update (n=1 010): studies coding Agreement on evidence and policy needs (M2), studies using a counterfactual design, and the WHO African Region.

Full names: Agreement on evidence and policy needs (M2); Access to evidence (M3); Structure and process for EIDM (M6).

4. **Compare geographical representation**. On a comparable regional-code basis, the WHO African Region accounted for 25% of all regional codes in both 2024 and November 2026. The shares for the WHO South-East Asia and Eastern Mediterranean Regions increased from 3% each in 2024 to 7% and 5%, respectively, in November 2026.
5. **Funding source and cost-effectiveness reporting are two dimensions not covered in the 2024 analysis.** Their inclusion in the current evidence map expands the information being tracked, although coverage remains limited, with only 22 studies reporting cost-effectiveness. The convenor can use these findings to raise questions about the information needed to support future research and practice decisions.

What the map can reveal and what it cannot establish

The map can reveal	The map cannot establish
• How fast the base, and specific mechanisms, sectors, and regions, have grown or shrunk in relative share, not just absolute count. • Which parts of the field were thin in 2024 and have grown disproportionately fast since. • How the number and proportion of counterfactual studies have changed relative to the overall evidence base. Which dimensions the map's custodians have started tracking that were not part of the 2024 analysis at all.	• Whether this reshaping reflects deliberate agenda-setting by funders and researchers, or simply which studies happened to be published and found. • Whether increased research coverage represents improvements in study quality, policy relevance or evidence use. What today's shape will look like at the next update; the map is only a live snapshot. • Which institutions or funders contributed to particular changes, or how the evidence base will evolve in future updates.

Evidence gaps and what they mean

The share of counterfactual designs has not kept pace with the field's overall volume: it fell from 16% to 12% even as the base grew by almost 64%. This reflects a change in the composition of the

evidence base rather than necessarily indicating a decline in impact evaluation activity or research quality. For the convenor, the finding provides an opportunity to discuss whether the current mix of evaluation approaches adequately addresses the field's research and practice needs.

Practical takeaway

> *The convenor uses the map to identify potential discussion priorities, including the growing representation of agreement-focused interventions (M2), changes in geographical and sectoral coverage, and the declining proportion of counterfactual studies. These findings inform a stakeholder dialogue to agree on shared research and practice priorities, taking account of their relevance, importance and feasibility. Because the evidence base continues to evolve, the convenor also proposes periodic reviews of the agreed agenda, using future map updates to assess whether priorities should be maintained, revised or expanded.*

A note on sources and currency

This vignette is grounded in the interactive evidence map's underlying study dataset (November 2026 update, n=1 010) and the 2024 World Health Organization (WHO) technical report, which supplies the 2024 comparison figures used above. The search strategy remained consistent across updates, with studies identified through external contributions also added to the evidence base. The reported 64% increase therefore reflects growth in the mapped evidence base and should not be interpreted as an increase in newly published studies alone. Because this is a living map, updated periodically as new studies are added, later updates may show different figures.

References: World Health Organization (2024). *The art and science of promoting evidence-informed decision-making: a global living evidence map*. World Health Organization. https://iris.who.int/handle/10665/382279. License: CC BY-NC-SA 3.0 IGO

About

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 vignette

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

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