Contents

1.0. Executive summary

Background: EVIPNet was created to address the phenomenon of failure to use research findings in making decisions about programs, policies and legislation. EVIPNet Americas was formally launched in 2007. Currently, the countries in which it is active have multidisciplinary teams based in their health ministries. The teams' structures differ, as do the local modalities of knowledge transfer. In other words, the policy issues addressed or the time that it takes to address the issues vary from country to country. Some teams function autonomously, while others are still in need of consolidation. As of August 2010, the initiative was operative in one form or another in Brazil and Paraguay, at the US-Mexico border, and in Trinidad and Tobago, and both Brazil and Paraguay had produced policy papers.

Objective of this report: To provide an account of the management of the EVIPNet initiative in the Americas, its structure, the activities that have taken place, and their significant results and impact. The report covers the initiative's work from August 2010 to December 2013.

Framework of the evaluation: The evaluation drew on some methodological elements of a frame of reference known as the *payback framework*.

Results: As of December 2013, 12 countries are implementing the initiative, and 10 have finalized policy papers. There have also been deliberative dialogues on how to facilitate local implementation.

Processes/capacities: Between August 2010 and December 2013, 21 EVIPNet workshops were held, 700 people, mostly decision makers or researchers, participating.

Products: Between August 2010 and December 2013, 14 evidence briefs for policy were produced, and 10 deliberative dialogues were completed. Some of the documents generated are still in the process of publication, review, or translation.

Other products: It was necessary to develop evidence for policy-making on issues involving the environment, sustainable development, and indigenous peoples. The Pan American Sanitary Bureau of PAHO served as the nerve center of this process. Five regional syntheses for policy-making were completed, and two are in process. Steps were also taken to make the information more broadly known and published.

Impact: Various impacts are discernible in macro-level, subregional, national, and municipal policy scenarios.

Conclusion: Evidence-informed policies can be formulated and generate measurable impact at all levels. Decision and commitment to carrying out the policies are required, as are solid country structures and committed teams that can facilitate the processes of knowledge transfer and exchange among decision makers, researchers, and the society more broadly.

2.0. Background

In 2004, when the ministers of health of all the countries met in Mexico, it was observed that major obstacles to achieving the MDGs persist in many low- and middle-income countries; that research has a decisive, though insufficiently recognized, role in strengthening health systems; that solid national health systems must be in place to provide the health care interventions needed to achieve these health-related objectives; and that high-quality research is facilitated when each country has a solid, transparent, and sustainable national system for health research.[1,2]

Following the Mexico summit, the WHO world report on knowledge to improve health suggested putting greater emphasis on translating knowledge into action to actually improve public health – in other words, reducing the gap between what we know and what we do.[3] It also mentioned poorly based policy-making as one of the reasons that coverage is lacking for the neediest, as a reason partially explaining why health indicators are beyond levels that ought to be expected, and as the reason that many low-income countries fail to meet the targets of the health-related Millennium Development Goals (MDGs) as well as falling short of priority national health goals.[2]

It was in response to these shortcomings that the Evidence-Informed Policy Network (EVIPNet) was formed – at the global level in 2005 and in the Americas in 2007.

The research policy of the Pan American Health Organization (PAHO) was approved in 2009 as a means of strengthening these initiatives. It explicitly stresses the importance of the Organization's continuing to be knowledge-based, and it aims to ensure that solid and sustainable health research systems are in place at the national level in all the countries of the Americas, and that research data constitute a cornerstone of all activities undertaken to optimize health, equity, and development.[4] In 2010, the World Health Assembly approved the WHO strategy for health research, and declared that one of its objectives should be to intensify the connections between policy, practice, and research findings.[5]

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[1] Mexico statement on health research. Knowledge for better health: strengthening health systems. Ministerial Summit on Health Research, Mexico City, 16-20 November 2004.
[2] Hamid M, Bustamante-Manaog T, Truong VD, Akkhavong K, Fu H, Ma Y, Zhong X, Salmela R, Panisset U, Pang T. EVIPNet: translating the spirit of Mexico. Lancet. 19 Nov 2005; 366(9499):1758-60.
[3] WHO. World Report on knowledge for better health. Strengthening health systems. Geneva, 2004.
[4] PAHO policy on research for health. 2009. Online: http://www.paho.org/hq/index.php?option=com_content&view=article&id=1414&Itemid=931&lang=en. Accessed 14 December 2013.
[5] WHO's role and responsibilities in health research. 63rd World Health Assembly. A63/22, Item 11.19 of the provisional agenda of 25 March 2010. Online: http://apps.who.int/gb/ebwha/pdf_files/WHA63/A63_22-en.pdf. Accessed 14 December 2013.

In 2012, the EVIPNet Global Steering Group approved the strategic plan that will guide the work of the network until 2015.[6]

In 2013, the World Health Organization published "Research for universal health coverage," a report that again emphasized the role of research (both its execution and its utilization) for improving health as well as for the broader objective of human development.[7]

3.0. What is EVIPNet and how is it structured?

EVIPNet is a social network made up of and directed by people and institutions around the globe. It operates at three different but closely linked levels. [6]

First of all, there are teams in the countries formed of key actors, including political authorities and health system administrators, researchers, and civil society. A variety of activities and programs are included in the teams' missions. Their work basically consists of defining priority problems for their country or locality, and preparing evidence briefs for policy. The briefs are designed in user-friendly format and describe all the relevant evidence on governance arrangements, delivery of services, and financial arrangements that are needed for the policy options proposed, as well as considerations that need to be taken into account for implementation. The second important activity of these teams is to initiate deliberative dialogues on the briefs that they produce. The dialogue process is designed to ensure that scientific evidence will not be stressed to the exclusion of the tacit knowledge, opinions, and experiences of those who will be involved in or affected by the decisions that are made. [6]

Secondly, at the regional level these country teams interact with their counterparts from other nations, discussing their experiences, processes, and policy papers, as well as sharing ideas on a basic level regarding the development of innovative methodologies and new approaches. In the Americas, these interactions occur through workshops with groups of countries, and through mechanisms like internships involving international exchanges of personnel. The EVIPNet regions include sub-Saharan Africa, the Americas, Asia, the Eastern Mediterranean, and, as of this year, Europe.

Thirdly, the network has global headquarters in Geneva to harmonize and support the work of countries at the regional level. The key role of this central entity is to oversee the network's governance, and to coordinate the Global Steering Group and the resource group, in both of which the Americas participate.[6]

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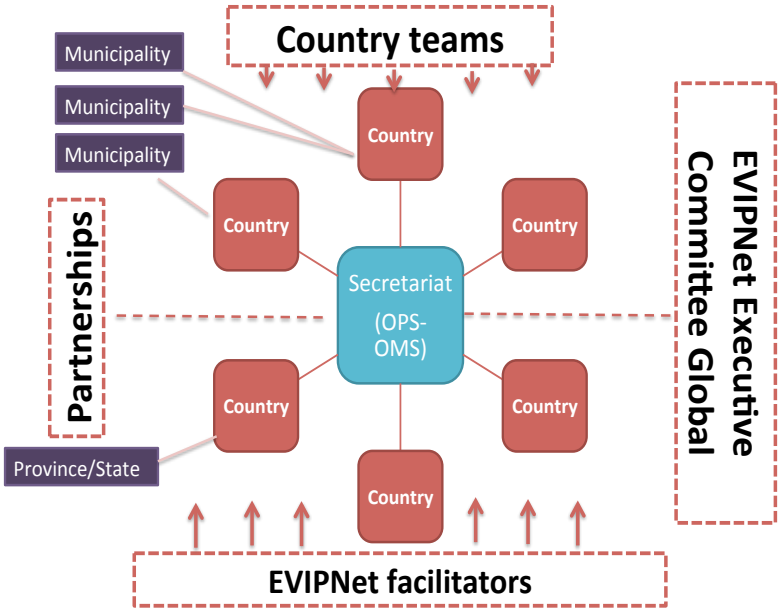
[6] WHO. EVIPNet Strategic plan 2012-2015. Online: http://www.who.int/evidence/OMSEVIPNetStratPlan.pdf. Accessed 14 December 2013.

[7] Research for universal health coverage. WHO. Online: http://apps.who.int/iris/bitstream/10665/85761/2/9789240690837_eng.pdf. Accessed 14 December 2013.

4.0. EVIPNet in the Americas

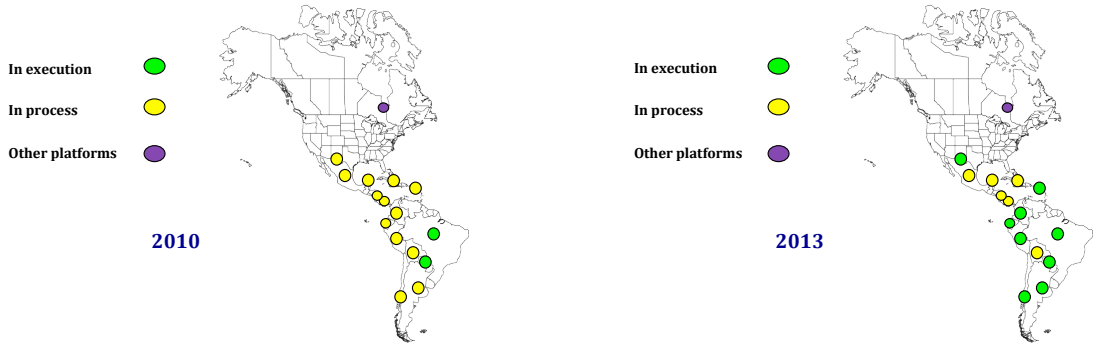
The network in the Americas has country teams with structures and processes for knowledge transfer that differ, either in terms of the policy issues that they address or in terms of the time that it takes to address the issues. Some countries, such as Brazil, are expanding the EVIPNet network domestically in a decentralized way by installing evidence centers in municipalities and states supported by EVIPNet and BIREME. Some teams function autonomously, while others are still in need of consolidation. Certain partners help strengthen EVIPNet in the Americas – notably McMaster University (Dr. John Lavis) and Catholic University of Chile (Dr. Tomás Pantoja). The resource group of EVIPNet in the Americas is very important as well. It consists of professionals who serve as facilitators at the network's capacity-developing workshops, and who provide peer review of the documents that are generated in connection with policies and deliberative dialogues. Some of them (us) also contribute to the development of the network in other WHO regions, EVIPNet Europe being a case in point. Finally, as mentioned above, the Region of the Americas is represented in the Global Steering Group, which is the breeding ground for the process of designing the principal strategic orientations (Figure 1).

Figure 1: Structure of EVIPNet Americas in 2013



EVIPNet is now in operation in 10 countries, some of which have more activity than others. Figure 2 provides additional perspective on the process, showing the network as it was in mid-2010 and as it is in December 2013.

Figure 2: Status of execution of EVIPNet in the Americas (2010/2013 comparison)



* "In process" means that interest in joining the network has been expressed, that there has been participation in training events on the EVIPNet methodology, or that evidence briefs for policy are in development. "In execution" means that the country has asked to join EVIPNet and has completed at least one evidence brief for policy.

5.0. How do we work?

We work mainly with processes for knowledge transfer, facilitating interaction between researchers and decision-makers and encouraging the use of research findings in the formulation of policies, programs, and legislation. EVIPNet is the entity that articulates this process of exchange, which is mutual and, we hope, sustained.

A basic step is to structure a solid country team, or a team at a subnational level, that includes representatives of direct stakeholders and actors that are key to the process, such as health authorities or their representatives, science and technology councils, the academic and research community, and civil society. The team should be led by the health ministry. Although it is anticipated that all EVIPNet teams will follow the established guidelines, the organizational model used in each country should be relevant in the context of that nation, and should be adapted to local needs and resources.

The planning phase takes 8 to 12 months. Each team proposes a work plan, for which the EVIPNet Secretariat at PAHO provides the necessary technical support. The work in the planning phase concentrates on three areas:

1. Forming the team: Appointing the appropriate members, and consolidating the interdisciplinary team.

2. Developing the project: Defining the objectives and creating a work plan that takes local interests into account.

3. Resources: Allocating the resources that are necessary or available for creating the proposed network.

The execution phase requires approximately 5 years. EVIPNet teams carry out the proposed activities, always drawing on the active assistance of the Secretariat at PAHO and on an international support group known as the EVIPNet resource group. This support is provided to teams until they develop their own abilities and become sustainable. During this phase, the hope is to develop capacities that facilitate interaction between researchers and decision makers through the processes of seeking, selecting, evaluating, adopting, and adapting evidence pertinent to the needs of decision makers and related to the problems that have been defined jointly as priorities for health policy design and implementation.

The processes that can be expected to occur when the EVIPNet strategy is adopted include prioritizing a problem that calls for a policy or program, writing a document to serve as a central tool in the process of knowledge transfer (the evidence brief for policy), conducting deliberative dialogues on the policy paper, implementing the policy or program, and following up with evaluation cycles.

As of August 2010, the initiative was in progress in one form or another in the following places: Brazil, Paraguay, the US/Mexico border, and Trinidad and Tobago. Policy documents had been completed only in Brazil and Paraguay.

6.0. Objective of the report

The objective of this report is to provide information on the EVIPNet initiative in the Americas: on how its structuring has unfolded, on the activities that have taken place, and on some incipient results and impacts, based on a specific evaluation framework. The period covered is August 2010 through December 2013.

7.0. Framework of the evaluation

Given that EVIPNet exists as a response to failures to use research for decision-making in programs, policy-making and legislation, and that its existence in the Americas dates from 2007, some results and impacts will presumably be visible. The period that was analyzed is August 2010 through December 2013.

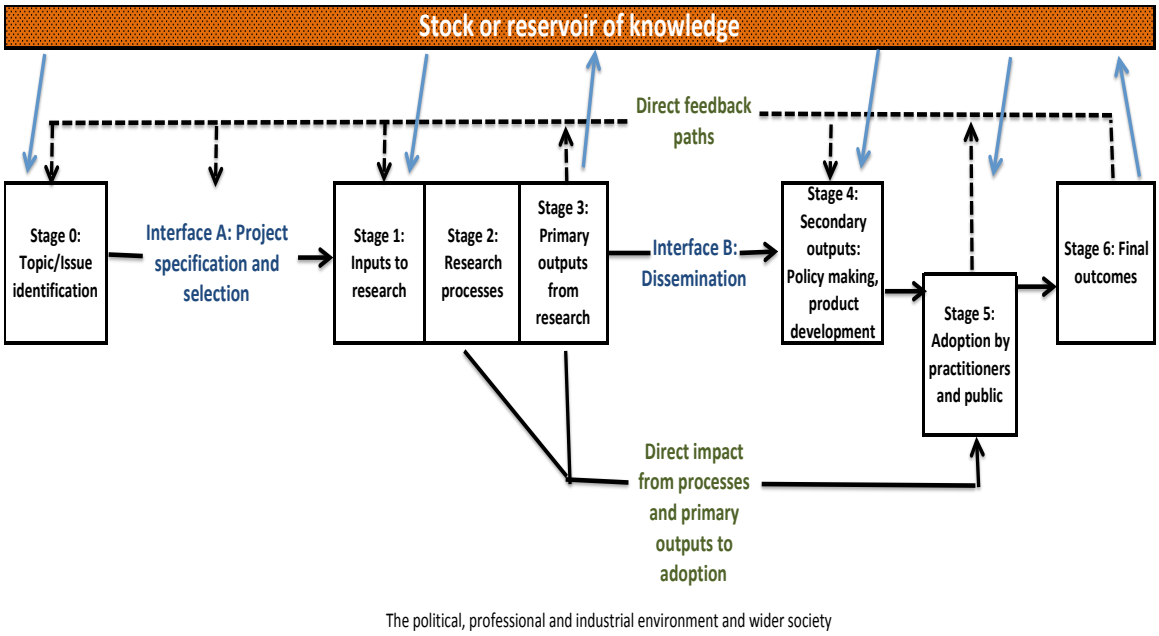
The evaluation made use of some methodological categories and elements of a frame of reference known as the *payback framework*.[8]

The *payback framework* is a tool for multidimensional analysis that applies a logical model to the processes of research, and that makes use of a system to classify the benefits of research (Figure 3). The logical model highlights the flow from research to products and results, while the categories throw light on how research has impacted knowledge, on research capacity, on decision-making,

[8] Hanney SR, Grant J, Wooding S, Buxton MJ. Proposed methods for reviewing the outcomes of health research: the impact of funding by the UK's Arthritis Research Campaign. Health Res Policy Syst. 2004 Jul 23; 2(1):4.

on health, and on socioeconomic benefits. The categories point the way from research to the transfer/translation of research for the society, and can highlight products that are of interest for different audiences. The use of the term "impact assessment" usually implies a specific attempt to determine whether observed changes in results can be attributed to a specific policy or program.

Figure 3: Payback framework model. Adapted from Hanney et al (2004).



Although EVIPNet Americas is young, and – even more significantly – despite the limited three-year evaluation period, there were processes to which, as a whole, results and impacts can be attributed. The basic features of the processes are capacity building and recognition of the need to conduct research for policy-making. This process included not only the EVIPNet teams in the countries but also key actors at the Pan American Sanitary Bureau (PASB) itself – primarily the EVIPNet Secretariat. On the assumption that impact assessments can be more informative if they include evaluation of processes, this evaluation reports on both fronts and provides some examples.

7.1. How does EVIPNet construe knowledge transfer?

It is important that there be clarity with regard to the concept of knowledge transfer in the EVIPNet framework. In this context, knowledge transfer consists of a dynamic and iterative process that includes synthesis, dissemination, exchange and ethically sound application of knowledge to provide more effective health services and products and strengthen the health system.[9,10] It should

[9] Straus S, Tetroe J, Graham I, eds. Knowledge Translation in Health Care. Moving Evidence to Practice. Wiley-Blackwell & BMJ Books: Chichester, 2009.

be said that this process involves a complex system of interactions between researchers and decision-makers, and that it can vary in intensity, complexity, and level of commitment, depending on the nature of the research findings and the needs of specific audiences. In addition, the community and civil society can also be part of the process, making it more participatory and representative of the interests of the groups involved in specific health policies. In particular, EVIPNet speaks of "knowledge translation platforms," where, in addition to the process of transfer and exchange between researchers and decision makers, deliberative dialogues are held to optimize the implementation of informed health policies.

Following the payback framework model, the processes, outputs, and results are shown first, and then the aspects that fall under "categories," including: impact on knowledge, research capacity, decision-making, health, and potential socioeconomic benefits (the latter too premature to measure at this stage). These categories point the way from research toward the transfer/translation of knowledge for the society, and can highlight products that are of interest to different audiences, as occurred, for example, in the case of the evidence brief for water and sanitation policy – a case that exemplifies the policy formulation process outlined in Figure 4.

8.0. Processes, products/results

8.1. Processes/capacities

Between August 2010 and December 2013, there were 21 EVIPNet workshops involving many countries, and 700 people (basically decision-makers and researchers) were trained or made more aware of the issue. The workshops lasted four days on average, and in most cases were developed and conducted by the EVIPNet coordination staff at the PASB. Table 1 provides details on the workshops and some links for information on the activities. Evaluations, which were conducted for most of the workshops, showed that the novelty of the methodology was a positive factor, and that it should be disseminated to encourage evidence-informed policy-making. Negative factors that came up in the evaluations were the short duration of the workshops and the need to acquire more tools.

Table 1. Activities: workshops

Site of workshop	Number of country teams participating	Participating decision makers and researchers	Date
Chile	8	35	mar-11
Ecuador	1	10	Aug-11
US/Mexico border	2	40	Dec-11
Colombia	1	29	feb-12
Mexico (the border)	1	45	mar-12

[10] Wilson MG, Lavis JN, Travers R, Rourke SB. Community-based knowledge transfer and exchange: helping community-based organizations link research to action. Implement Sci. 2010 Apr 27; 5:33.

Site of workshop	Number of country teams participating	Participating decision makers and researchers	Date
Chile	1	33	may-12
Brazil + OIPSS[a]	1	42	jun-12
Colombia	1	43	jun-12
Cartagena (Colombia) [b]	5	6	nov-12
Brasilia (Brazil)	1	35	Dec-12
El Paso (USA)	1	15	Dec-12
Costa Rica (COMISCA & Health Focus Project/GIZ)	5	40	Apr-13
Bolivia (International Meeting on Ethnic Groups, Indigenous Peoples and Evidence-building in Health)b	9	40	may-13
PAHO, Washington, DC (Workshop on systematic reviews and the use of evidence for practice and policy.)	PAHO Headquarters, Washington, DC	20	jun-13
Recife (Brazil)	1	30	jun-13
San José (Costa Rica)	1	30	jul-13
Bogotá (Colombia) Workshop to adjust food guidelines to be appropriate in the context of food for the Colombian population [c]	1	20	Aug-13
Brasilia (Brazil) [d]	1	90	oct-13
Brasilia (Brazil) (Strategic workshop)	1	24	nov-13
Buenos Aires (Argentina) (Workshop)[b]	1	43	nov-13
Belo Horizonte (Brazil) (EVIPNet seminar)[d]	1	30	Dec-13
	44[e]	**700**	

a) Ibero-American Observatory on Health Policy and Systems (Argentina, Colombia, Paraguay, Portugal, Spain, Peru, Uruguay, Chile); b) Workshop on creating awareness; c) Eight national, international, and governmental organizations; d) EVIPNet Secretariat (PAHO, Washington, DC) not present; e) Some countries are repeated.

8.2. Products/results

Between August 2010 and December 2013, 14 evidence briefs for policy were produced. Some of these are still in the publication, review, and/or translation stage. Some are already available online (Table 2).

Table 2. Products: evidence briefs for policy

Title	Country	Date
Atividade física e prevenção/controle da hipertensão arterial na Atenção Primária à Saúde (APS). Núcleo de Evidências em Saúde da SMS de Piripiri.	Brazil	2010
Perinatal mortality.	Brazil	2010
Management and Rehabilitation Services for Sexually abused young persons under 18 years old in Trinidad and Tobago.	Trinidad & Tobago	2011
Role of primary health care in the integrated management of chronic non-communicable diseases.	Paraguay	2011
Financing options for the treatment of rare diseases in Chile.	Chile	2011
Strategies to increase the distribution and adherence to micronutrient Powder in 6-36 month old children in Peru.	Peru	2011
Interventions targeted to reduce dropouts from tuberculosis treatment.	Peru	2011
Prevenção e controle da Dengue no espaço urbano. Núcleo de Evidências em Saúde da SMS de Piripiri.	Brazil	2011
Reduction of maternal mortality in Ecuador: Policy options to improve access to high-quality skilled maternal care.	Ecuador	2012
Reducing perinatal mortality in Brazil.	Brazil	2013
Policy options targeting drivers to prevent deaths and injuries from traffic accidents in Ciudad Juárez, Mexico.	US-MEX border. PAHO	2013
Policy options to improve access to mental health services by strengthening secondary care.	US-MEX border. PAHO	2013
Policy options to promote the inclusion of vulnerable young people in productive life in Ciudad Juárez	US-MEX border. PAHO	2013
Policy options to prevent school harassment in Ciudad Juárez.	US-MEX border. PAHO	2013

Ten deliberative dialogues were also held in this period (Table 3).

Table 3. Products: deliberative dialogues

Deliberative dialogues on the following evidence briefs for policy	Year
Policies to provide water and sanitation, human rights, public health, and equity. Dominican Republic.	2010
Policies to provide water and sanitation, human rights, public health, and equity. Guatemala.	2011
Policies to provide water and sanitation, human rights, public health, and equity. Brazil	2012
Use of pesticides in public health for vector control of 5 diseases: Chagas disease, malaria, dengue, Leishmaniasis, and filariasis. Guatemala.	2011
Interventions to forestall injuries to motorcyclists. Washington, DC.	2011
Policies to improve adherence to tuberculosis treatment in Peru.	2011
Policies to improve adherence to micronutrient regimes in children under 2 in Peru.	2011
Management and Rehabilitation Services for Sexually abused clients under 18 years old in Trinidad.	2011
Policies regarding access to high-cost drugs for rare diseases.	2011
Policies on access to quality human resources for the care of pregnant women in rural Ecuador.	2011
Policy to reduce perinatal mortality in Brazil.	2013

8.3. Other products

It was also necessary to develop evidence when evidence was lacking in areas such as environmental and sustainable development policy, policies to improve access to health services for indigenous populations, and strategies to reduce the involvement of courts of law in health care in the Region. This interprogrammatic, horizontal work at the PASB translates into the following documents that provide syntheses for regional policy-making:

1) Water and sanitation from the standpoint of human rights, equity, and public health.

2) Use of pesticides in public health for vector control of 5 diseases.

3) Public policies to prevent motorcycle accidents.

4) Policies to prevent health damage from the consumption of illegal drugs.

9.0. Impact

9.1. Macro-level policy

As mentioned above, the processes of knowledge transfer (and exchange) include prioritizing problems that call for a policy or program, writing the document that will serve as a central tool in the process of knowledge transfer (the evidence brief for the policy), holding deliberative dialogues on the policy paper, implementing the policy or program, and following up with evaluation cycles – in all of which processes evidence plays a fundamental role. One example of this process is the policy brief mentioned above on water and sanitation, for which it was necessary to produce evidence from the standpoint of human rights, equity, and public health as support for policies; to conduct deliberative dialogues; and to take the issue to the highest possible levels. The document helped to create maximum impact, with the result that water and sanitation was defined as a health determinant at the 2011 meeting on the social determinants of health in Rio de Janeiro. It should be noted, too, that the document contributed to the creation of the coalition to eliminate cholera by improving water and sanitation on the island of Hispaniola in June 2012. This impact is reflected on the timeline shown in Figure 4.

Figure 4. Example of production and use of evidence for policy-making.

A recent example with COMISCA at an EVIPNet workshop in April 2013 shows how policies can be drafted for a problem common to several countries of a subregion. Several countries participating in the workshop pointed to chronic kidney disease (CKD) from nontraditional causes (CKDnTC) as a severe public health problem. This disease is affecting the countries in different ways, and though its etiology is not sufficiently known, the countries agreed that options must be developed to deal with it, and work began on a policy paper addressing the issue. One of the

options was to give the problem more visibility and put it on the highest-level subregional policy agenda. After the workshop, the EVIPNet Secretariat participated in an international conference on CKD in El Salvador, where there were presentations on various research projects being conducted in the Region's countries. At the end of the conference, a high-level meeting on CKDnTC issued the Declaration of San Salvador. Based on this, the Salvadoran Ministry of Health, representing the COMISCA countries, requested policy support from the Director of PAHO. A concept paper and a resolution to present to the 152nd Executive Committee in June 2013 were produced, and were approved by the 52nd Directing Council. Resolution CD52/R10 was adopted by the Member States in October 2013. The commitments assumed by the PASB are now being worked on, and an action plan is being developed by a task force. This is an example of how a subregional policy (an incipient one in this case) can be generated, with options that point the way to an approach (Figure 5).

Figure 5. Example of subregional policy-building based on shared problems.

9.2. Municipal policies

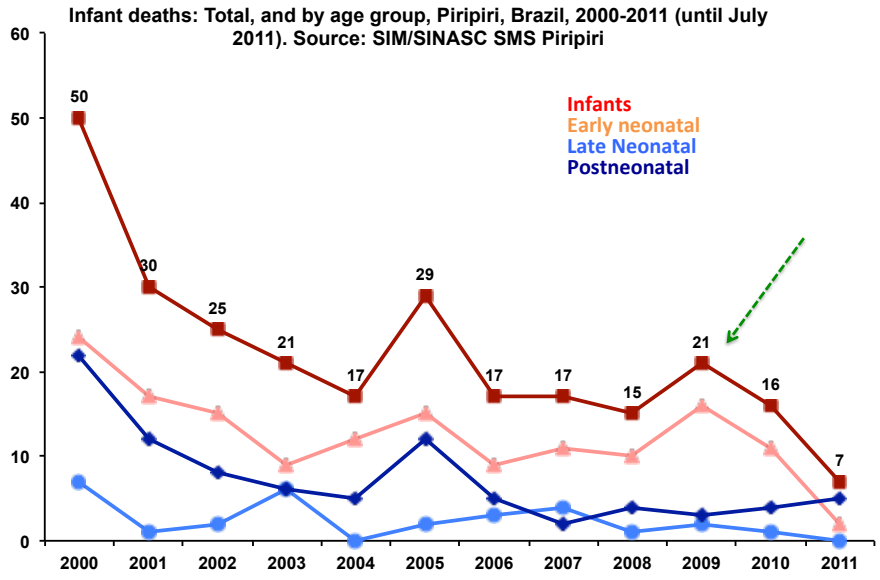
The case of the Municipality of Piripiri in Brazil is an excellent example of how scientific evidence can be used to develop local policy. The municipality had high rates of perinatal mortality. Its mortality indicators had been stagnant or rising between 2004 and 2009 (Figure 6).

Among the problems detected were poor childbirth care, human resources with little training, failure to use protocols and care guidelines, etc.

Action was taken to improve the provision of services, and a policy on perinatal care was put in place. There were multiple interventions, but those considered likely to have had the greatest impact were the incorporation of adequate human resources along with in-service training – most importantly around nursing care for the resuscitation of newborns. The municipality's plan is to

continue with the options that have been put into effect and to gradually implement the policy options that were described in its policy brief and discussed in deliberative dialogues.

Figure 6. Time at which the options were incorporated (green arrow). The numbers of child deaths (red line) are absolute quantities. Source: Municipality of Piripiri, Brazil.



Planning at the end of 2009

Implementation of policy options in 2010

Impact, 2011

The impact can be seen in more detail in Figure 6, which makes it clear that the reduction of infant mortality is basically due to a reduction in the number of neonatal deaths.

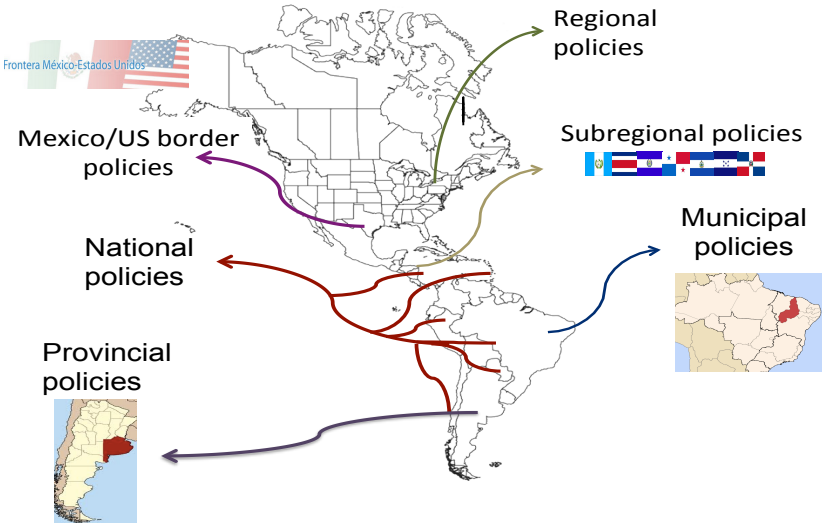
9.3. National policies

The use of response mechanisms by national teams is probably the first demonstrable impact at the level of national policy. Peru is one of the countries that have done the best work with this methodology. The country's former Minister of Health provides an eloquent demonstration in a video that is an example of a decision maker's using evidence to address critical and urgent problems such as the provision of emergency contraception. The other example is the discussion that took place on the introduction of genetically modified organisms (GMOs). Thanks to the fact that evidence was brought to the table in addressing this problem, the Peruvian Congress has placed a 10-year moratorium on introducing GMOs in Peru in consideration of their implications for agriculture, the environment, and public health. This policy decision was influenced not only by

social mobilization and by press releases from opinion makers, but also by the Ministry of Health itself, which took a position on the issue on the basis of a technical report by the EVIPNet team in Peru that dealt with the use of genetically modified foods and described the scientific evidence on the issue. Rapid response mechanisms are not the only area in which work has been conducted in Peru: the EVIPNet team has also formulated important long-term policies. Examples are the strategies to improve adherence to tuberculosis treatment and to improve adherence to multiple micronutrient powders regimes to reduce iron deficiency anemia in children under 2.

Figure 6 shows the diverse territorial scopes of evidence-informed policy-making scenarios. The challenge is not merely to formulate such policies, but also to follow and monitor them over time to measure their impact on health and make the processes involved more broadly known.

Figure 6: Different policy-making scenarios in the Region of the Americas reported through EVIPNet.



10.0. Other inputs

As the following list suggests, distribution and dissemination of information on EVIPNet during the period covered by this evaluation may have helped promote and strengthen the processes of knowledge transfer.

10.1. 2010-2011 period

Talks/seminars/conferences

1. Talk on EVIPNet. Honduras, September 2010.

2. Presentation of the Evidence-Informed Policy Network. Guatemala, 2011.

3. Central talk at International Seminar on Health ‘‘Innovation: challenges and opportunities” during Expouniversidad 2011 in Medellín, Colombia, on EVIPNet networks to support policy-making and decision-making.

4. Co-coordination of the workshop on EVIPNet at the Cochrane Collaboration Colloquium in Spain in 2011: “Using systematic reviews to inform policymaking: the experience of evidence-informed policy networks (EVIPNet) in the Americas.”

5. Participation in the meeting of the Advisory Committee on Health Research, with a presentation on the progress of EVIPNet in the Americas and a description of an innovative methodology for identifying gaps in research while prioritizing to reach MDG5 (2011).

Publications

6. Background article in PIE bulletin no. 5: Luis Cuervo and Evelina Chapman: La red de políticas informadas en evidencia en las Américas (EVIPNet Americas).

7. Production of and/or contribution to reports on EVIPNet workshops.

Media

8. Expouniversidad 2011 video in Medellín on the innovative aspects of EVIPNet and its contribution to solid policy-making in health. University of Antioquia – Expouniversidad: Evelina Chapman – YouTube.

9. Co-Production of EVIPNet videos (HSS & KMC) and interview with Peru’s Minister of Health.

10. Redesign of the EVIPNet website.

11. The formal EVIPNet presentation recorded and made into a PowerPoint.

12. Interview conducted with the global web coordinator for EVIPNet. Other interviews also conducted.

13. Interviews in Chile co-produced in 2011.

10.2. 2012-2013 period

Talks/seminars/conferences

Facilitator in Ethiopia at the International Forum on evidence-informed health policy for low- and middle-income countries.

In-person and virtual presentations on EVIPNet for countries in the Americas and other regions.

Other presentations disseminating information on EVIPNet, principally in the Americas (1, 2, 3, 4, 5, 6).

Publications

14. Contribution to the "Supporting the Uses of Research Evidence" (SURE) guides.

15. Contribution to the EVIPNet strategic plan.

16. Contribution to the generation of evidence through publications in indexed journals (publication1, publication 2, publication 3).

17. Contribution to the Region's evidence briefs for policy, in some cases through co-authorship (example), in others in a reviewing role (example).

18. EVIPNet Americas pamphlet.

19. Presentation of the EVIPNet Americas 2010-2012 report.

Resources

Contribution to the development of the EVIPNet Virtual Health Library.

11.0. Pending

The hope is to finish the following evidence briefs for policy in the course of 2014:

Table 4: Evidence briefs for policies that are to be completed/started (2013-2014).

Evidence briefs for policy	Country	Date
Policy options to develop life skills in children and young people in order to prevent violence in Ciudad Juárez.	US-Mexico border (for Ciudad Juárez)	2013
Evidence brief on the impact of using cigarette packages to advertise and promote the consumption of cigarettes in the general population.	Colombia	2013-14
Policies on food advertising that targets children in Colombia.	Colombia	2013-14
Policies on promotion, advertising, and sponsorship of tobacco consumption in Colombia.	Colombia	2013-14
Policy on healthy beverages for schoolchildren to prevent child obesity.	Colombia	2013-14
Clinical management; coordination of health network.	Chile	2012-13
Health care for people with chronic diseases.	Chile	2012-13
Allocation of resources for health care.	Chile	2012-13

Policy to diminish crack consumption in the Brazilian population.	Brazil	2013-14
Policy to reduce maternal deaths and "near misses".	Brazil	2013-14
Policy to reduce vitamin A deficiency.	Brazil	2013-14
Strategies for approaching chronic renal disease in Central America's agricultural communities.	COMISCA countries	2013-14

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13.0. Challenges

- Expand EVIPNet in the Region.
- Foster the sustainability of the coordination provided by PASB and that of the country teams.
- Continue to make use of different modalities to build capacities.
- Strengthen the regional work and the network's funding, and incorporate the EVIPNet strategy in other initiatives in which ministries use evidence in an articulated way, such as evaluations of health technologies, programs to produce guides, etc.
- Continue to evaluate EVIPNet.
- Bring the country teams together for a face-to-face meeting.

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