Health Systems Strengthening Evaluation Collaborative
National Stakeholder Analysis

July 2022

Working Group 2: Priority 2

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Introduction

The Health Systems Strengthening Evaluation Collaborative (HSSEC) brings stakeholders together to think differently about how they approach HSS evaluation and work collectively to build and execute a shared agenda to improve this work. The Collaborative is based on the belief that to move HSS evaluation beyond its current fragmented form, leadership and commitment for advancing and changing ways of working must come at least partially from the joint action of three key groups of stakeholders: (i) country-level stakeholders, including governments, practitioners, and communities, (ii) donors that fund HSS and HSS evaluation, and (iii) evaluators and academics who are involved in HSS evaluation.

The HSSEC convened a working group to look at HSS evaluations from a national perspective and identify lessons learnt and opportunities for further strengthening HSS evaluations. The group conducted a national stakeholder analysis to gain national perspectives on HSS, ideas on how evaluation processes might better address country needs, and build on the findings from the Global Stakeholder Analysis.

Objectives and key questions

The primary objective of the national stakeholder analysis was to examine the interests and needs of HSS evaluation among national stakeholders and identify opportunities to better meet these needs through HSS evaluations commissioned by global donors.

The specific objectives of this work were to examine national stakeholder perspectives on:

- The relative priority given to HSS in comparison to other global health priorities
- The evidence interests and needs of national stakeholders, in particular, policymakers and donor representatives
- Linkages between evaluation capacities and policymakers, and opportunities to further strengthen linkages

Key research questions:

- What types of evidence do policymakers want or need from HSS evaluations?
- How are health systems routinely assessed or evaluated?
- How do country stakeholders experience the commissioning of HSS evaluation by external development partners? What are their perceptions of the evaluations and the evidence generated?
- Are there lessons for how HSS evaluation can be more useful for all parties?

Methodology

This review utilised a cross-country approach and included stakeholders from multiple countries to build a broad understanding of the interests and needs around evidence from HSS evaluations. An interview guide was developed drawing on the instruments designed for the global stakeholder analysis, led by Veena Sriram at the University of British Columbia.

Nine interviews were conducted with stakeholders from across six countries. Purposive sampling was used to identify respondents for this work. Working group members were consulted to help identify stakeholders in the following categories (i) national policymakers with interest in the evidence generated by HSS evaluations (ii) academic and/or research institutions working in the HSS evaluation space (iii) private sector organisations or civil society organisations involved in HSS evaluations and (iv) donor/development partner country-representatives/stakeholders. Following the development of a broad list of respondents, a narrow and final list of stakeholders was selected based on respondents' familiarity with the HSS ecosystem within their country.

Audio recordings from the interviews were transcribed using Otter.ai. Themes were developed around the overarching research questions, and interim findings were shared and discussed with the research team and members of the Working Group.

Key findings

Findings from our analysis are presented in six main sections. Section 1 offers perspectives around the relative priority for HSS versus other global health agendas. Section 2 describes HSS evidence policies, priorities, and the policy environment for health systems research. Section 3 highlights key examples of existing efforts to monitor and evaluate health system performance that emerged from our interviews. Sections 5 and 6 reflect on the ways in which there are linkages between various actors of the HSS evaluation ecosystem and how evidence from HSS evaluations is used in decision-making.

1. Relative priority for HSS in comparison to other global health priorities

Respondents widely agreed that there has been increased attention and interest in HSS in the last several decades. The ongoing COVID-19 pandemic has brought the opportunity to make the case for HSS investments and HSS evaluations stronger. However, respondents also noted that HSS is still perceived as secondary to other global health priorities and often as a means to an end for organisational outcomes of interest in a particular disease area.

> *"…often health systems strengthening becomes a secondary consideration. On top of that, sort of when they figure out that they can solve their problem without doing something to the health system, then health systems strengthening comes in." (IDI 1)*

> *"… it's always a means to an end. An end which is often described in terms of diseases or in terms of other things, [such as] the condition, specific population. Health system strengthening itself is hardly ever the primary thing." (IDI 1)*

> *"There have been some investments that are going into health system strengthening, but most of them are riding on particular results that need to be addressed. And then to be very small select set of results, many time globally defined or donor defined. And they seem to deliver those has become the defining definition of what the health system should look like. (IDI 8)*

> *"…COVID really exposed the health systems we have in this country, and it's very clear going forward, there has to be a deliberate effort to fund systems-related component" (IDI 6)*

One respondent noted that the global health security agenda risked taking attention away from HSS, given the complexity and longer-term investments needed for HSS.

> *"…and so (global health security) been the priority predominantly, while health system strengthening, because of its complexity and necessity for long-term, slow investment, tends to be the poor cousin. [Most] of the donor community are reluctant or unable, due to their sort of accountability systems, to invest in that sort of long-term slow burn. And all the benefits are under the radar, for [the] long-term type of initiatives that are required for health system strengthening." (IDI 3)*

How HSS is perceived and understood influences how investments in HSS are made and the expectations of the financial resources allocated to HSS. Some respondents also noted that the lack of earmarked funding for HSS and HSS evaluations remains a key weakness in some countries. Still, some donors are perceived as making deliberate efforts to contribute to HSS activities nationally.

"Unfortunately, we do struggle by [the] mere fact we do not have [funding] earmarked as health systems. However, in the last two, three years, there's been a deliberate effort by both mission management and team management to ensure that all teams contribute to help systems-related activities because ideally, they support activities across all these other service platforms. So, we do not have our own funding , but there are deliberate efforts to ensure that there are funds that are apportioned towards HSS-specific activities, that support all the service platforms" (IDI 6)

"The way in which the funding arrangement flows is, you know, it's fairly verticalised, and that creates a whole range of challenges for programme managers and policymakers, of course, who have, especially in South Africa, where we've taken the decision to integrate programming." (IDI 5)

In addition, short, programmatic-focused donor funding cycles are perceived as a barrier to doing HSS and HSS evaluations well, as they often require longer durations of funding and/or longer commitments to funding. Some respondents identified particular donors, including the World Bank, USAID, and more recently the Global Fund, as an exception to this.

"So, you know, some donors get it, you know, with respect to HSS, that it's not a quick fix, you've got to be in it for the long haul. Don't expect results, you know, soon. But other donors, you know, [are] looking for short term interventions and short-term results." (IDI 5)

"I think most of the partners are interested in supporting areas where they are interested in outputs." (IDI 6)

"It's only Global Fund (and USAID) that's literally coming in with a lot of interest in systems-related activities. Not a lot of these other donors." (IDI 6)

HSS Evaluation policies, priorities, and the policy Environment

Across our interviews, there were no identified formal policies around HSS evaluations**.** The lack of formal policies for HSS evaluations was identified as a barrier to improving accountability with the HS and tracking progress of policy reforms for HSS, even in contexts with progressive HSS policies such as prioritising the universal health care (UHC) agenda.

"Number one in Kenya, we do not have a policy that obligates government to review health system performance, which is rather unfortunate, and there is no legal requirement currently as it is that obligates the policyholders within the health system to do performance and to give account to somebody. So, in terms of health system performance, even if we wanted to do it, we do not have an obligation to give that report to anybody." (IDI 9)

Respondents also noted the diversity in understanding HSS and the definitions of HSS among national stakeholders. The lack of an agreed classification system on HSS interventions and investments leads to challenges in implementing a systematic approach to monitoring health systems progress.

"This is where, in Kenya, we have gotten the biggest disconnect. Everybody, from the policyholders to the politicians to the healthcare workers to the citizens, agree that the health system has to work. But then, unfortunately, we do not have a common understanding from the functions of the health system. Even as we are rolling out UHC, my understanding is that each person at the policy level understands the health system differently." (IDI 9)

Respondents noted that HSS evaluation priorities of governments were often those that donor partners drove and focused on the vertical health priorities of global health initiatives. The lack of,

or limited, domestic funding for HSS evaluations was pointed to as one of the reasons that government needs were not prioritised.

"Most of the priorities that the government has [are] those that are being pushed by donors, they're probably paying a little bit of attention. But because they don't have specific funding streams, they sometimes can push them." (IDI 6)

"I see currently no one wants to look at how that leveraging sometimes also creates constraints in the broader system, because you get the whole workforce incentivised to get the HIV results done, the few TB results done, and maybe some immunisation results. But the rest of the results are some going in the negative direction. Yeah, and that may not even be a concern of the global metrics or how systems should be assessed." (IDI 8)

"I think the way PEPFAR defines, Global Fund defines, GAVI defines health systems has kind of driven us in the programmatic limits of those results. And so, there's been a lot of interest in evaluating systems from that angle. And many times, to the detriment of the broader understanding that a national level should have at least from a country level." (IDI 8)

Ongoing Efforts to measure HS Performance

Despite the lack of formal evaluation policies, there are a number of mechanisms through which health systems are routinely monitored. Some of these are government-led, while others utilise donor-supported data systems. Routine mechanisms identified are presented in Box 1 and include examples from South Africa and Uganda.

Box 1. Examples of routine and ongoing efforts to monitor health systems performance

In South Africa, health system evaluation is related to monitoring processes, which are linked to statutory processes of planning. Annual performance plans are conducted at the provincial level, which then feeds into three- to five-year visions for the province. At the district level, health planning is linked to quarterly M&E processes, which document standardised indicators that are largely programmatic. Quarterly meetings are held to review and reflect on the data, highlighting progress and challenges in service delivery. There have been ongoing debates around the indicators routinely collected at the district level, as these are often set by the national department with provincial responsibility for collection.

Implications of data from the provinces are discussed and reviewed at the national level in the National Health Council (NHC) Technical Committee. The NHC holds regular meetings to review various health policy issues. The NHC is made up of the Minister of Health, members of the Executive Council for Health from the nine provinces, the South African Local Government Association, and the South African Military Health Services.

In Uganda, annual health sector reviews are conducted for each financial year, looking at results against health plans and highlighting progress, challenges, and lessons learned. These reports are publicly available, but the consistency of the data collected is variable, with a larger focus on indicators from programmatic areas and priorities.

Evidence interests and needs

Respondents noted that while there is strong evidence for high-impact interventions around service delivery, there are perceived gaps in evidence around key HSS domains, including governance and health financing**.**

"The thinking has been that we have a lot of evidence on high impact service delivery interventions that really work. But where we still need evidence is really in governance, and health financing, and how those components can really help improve, how do they contribute to improving key indicators, and sustainability of interventions." (IDI 7)

In evaluations commissioned by donor partners, respondents pointed out that there are often assumptions around the types of evidence and information needed by national governments. HSS evaluations were perceived as serving the information needs of those who commissioned the work and those who implement evaluations rather than serving the information needs of the local users. Limited utilisation of national research institutions to lead donor-commissioned HSS evaluations was seen to possibly influence policymaker willingness to manage or negotiate for their own evaluation/evidence needs. In addition, limited domestic funding for health systems and policy research further exacerbates the prioritisation of commissioner needs over national priorities.

"There's this standard expectation that what the country needs from evaluations is a yes or no answer. Did it work? Did it not work? And I think that that assumption runs so contrary to my experience in government. That when, if the World Bank comes in, they assume that we want to know whether a programme worked or not. But that's not what we really want to know." (IDI 1)

"And the reality is partners will fund the research which is in their interest. So, you will find that most of the research that is done, health research which is done in Kenya, has not been done for consumption within Kenya." (IDI 9)

Instead, respondents noted that governments want and need evidence around multiple dimensions, including (i) evidence around the impact and contribution of HSS investments on health outcomes; (ii) cost-effectiveness evidence to support prioritisation and decision-making in resource-constrained contexts; (iii) evidence to unpack complex causal chains between activities/outputs from programmes to improvements in health systems functions, (iv) evidence to support learning and adaptation; and (v) evidence that responds to the needs of non-health policy stakeholders.

i. Evidence around the impact/the contribution of HSS investments

"So I'd rather that we craft our evidence of investment, tagged on outcomes, rather than on the bits and pieces of activities within the system, we move away from process indicators in as much as they are important and output indicators to outcome indicators." (IDI 9)

"Currently as it is, the evaluation follows vertical programmes, which to me, is inefficient. Because these vertical programmes operate within a wider health system. Given a chance, I'd rather invest in the normative functions of the health system, in terms of strengthening the system by strengthening the governance and accountability of the health system, rather than evaluating the bits and pieces of activities within a programme. So, what I personally would have wished to see is outcome-based evaluation." (IDI 9)

"If a person is in finance, and they're influencing where a small budget will have to be shared, if you told them, this is a budget line for malaria drugs, then this is a budget line for a systems-related activity. There is no chance, especially for anybody outside health, that they will give a chance to anything to do with a systems focus. They will go with the immediate one. The pill is the most important benefit for them. They will want to pay for [the] salary of the health worker out there. They don't realise that the pill and the staff function within a system that has to be optimally well facilitated. They don't get that concept. But remember, they're in a key decision-making point, especially when we are in a resource-constrained environment." (IDI 6)

ii. Cost-effectiveness evidence

"In terms of RSSH [Resilient and Sustainable Systems for Health] or health systems strengthening – either doing this research or funding research within healthcare systems, this research should be geared towards improving health outcomes. Being innovative in terms of curing and getting more healthy outcomes, with less investment, coming up with innovative ways, how do we achieve the same with less money." (IDI 9)

"Our target should be this specific reduction in incidences of HIV, tied to a given amount of investment, the return to normal or near-normal life for the people who are living with HIV." (IDI 9)

iii. Evidence to unpack the complex causal chain between activities and outputs and a strengthened health system

"But if we measured the activities within a programme, it is near impossible to re-engineer them into the various normative functions of the health system." (IDI 9)

iv. Evidence to support learning and adaptation, including progressively improving health systems over time, would allow policymakers to use information in their prioritisation and routine decision-making.

"Whether the answer is yes or no doesn't change, what we're going to do, what we need to know is how to learn to make it better. Over time, progressively." (IDI 1)

"And I've often tried to make that point, that in many instances, in my experience, and many others, what a government really needs, sometimes it's not what they want, [what] the government really needs is a system that allows it to learn from itself by itself, about itself, to improve what it's doing on an ongoing basis. And a lot of evaluation is set up in a discrete time-bound form. And that just doesn't align with reality. You know, governments don't make decisions that way. And bureaucrats, ministry people, no one makes decisions that way." (IDI 1)

v. Evidence to address needs of stakeholders beyond health, including financing and planning departments. For non-health stakeholders, translating health outcomes and impacts into evidence on national and economic development is needed.

"But then planning and Treasury are key, our targeted outcomes and impact, we should be able to convert them to really grow in terms of national development. And the gap that we occasion by having skewed investment, we need to quantify it [as] a loss to the economy. In so doing, we will be able to influence planning and the Treasury to invest more in this system. We need to bring on board the parliamentarians because they are at the core of approving government policy." (IDI 9)

Linkages in the HSS evaluation ecosystem

Linkages between researchers and policymakers are varied, limited by the number of actors, and often opportunistic**.** While respondents noted the importance of strengthening linkages between actors in an HSS evaluation ecosystem, there was agreement around the barriers to doing so, including the limited availability of domestic funding for health systems research. Linkages between researchers and donor partners were perceived to be stronger than linkages between researchers and policymakers due to this limitation in domestic funding.

“But what we found is that, you know, there’s this dialectical relationship between the researchers and the policymakers, that works best. So, the closer the two are to each other, and, you know, chat to each other and all of that. And the extent to which there is respect between the two, even though respecting the autonomy of the researchers, of course, the better it works.” (IDI 5)

“First of all, the percentage of institutions in states that are capable of doing this is small. And then the government has, I wouldn’t call it favourites, but people they know and trust. So, they go back to them every time. So, then it’s you're not building new organisations, you're going back because nobody has the time to invest, right? Or the time or the resources, like they know how to do it, just give it to them and get them to do it. So, it's a very instrumental opportunistic kind of relationship right now.” (IDI 4)

Respondents identified a need for the HSS research community to better understand how governments operate and for the community to tell the HSS story better to strengthen linkages to policymakers, particularly to non-health actors involved in policymaking. This includes understanding the information needs of policymakers, providing focused and prioritised findings, and involving finance stakeholders early in the research process.

"The other thing is that researchers need to understand the way in which governments operate, including the decision-making processes as well as the resource allocation processes, often you would get a researcher coming up with really good results. But because the budget allocations have already been done, they have to wait another year or more before the output can be translated into implementation." (IDI 5)

"We need to tell a story, but I don't think we are still doing that. Most of the researchers, with all due respect all of us in that field, tell a story that makes them look like they're the experts, talking about graphs and that kind of stuff. The guys making decisions are not interested in that storytelling. Tell them something that will pique their attention and force them to make a decision that favours us in that space. Rather than telling the story from our technical expertise, we need to tell the story from the lens of the key decision-makers." (IDI 6)

Respondents identified a number of models, presented in Box 2, in which linkages between health systems evaluation actors and governments have been built over a number of years and from which wider lessons can be drawn.

Box 2. Examples of models linking HSS evaluation actors and governments

The National Health Systems Resource Centre in India was established in 2007. Its mandate is to provide technical assistance in policy and strategy development to states and support capacity building of the Ministry of Health. It followed the establishment of the National Rural Health Mission in 2005, which was set up to strengthen health systems. NHSRC is an independent body with close linkages to the Ministry, and key leadership positions are held by Ministry and State representatives.

The KEMRI Wellcome Trust Research Programme aims to conduct research relevant to both national and international health policy. It also aims to build a cadre of Kenyan and African researchers to support long-term research development in Africa. KEMRI has established close partnerships with government stakeholders at the district and national levels and supports research training of government staff.

Health Systems Trust in South Africa was established in 1992 and focuses on ‘health systems strengthening, research, and strategic support to the implementation of priority health programmes.’

Western Cape Department for Health in South Africa. Provinces are responsible for implementing and managing health services. The Western Cape Department has built strong linkages with universities and importantly, has built its public health expertise by employing its own experts and through joint posts with universities.

The Ghana Health Service has fostered strong linkages to research institutions in Ghana. Policymakers may spend time at national universities, and there are a number of staff members who have worked both in the government and in academia.

Respondents also noted that long term investments in national institutions are needed to build domestic evaluative capacities, including prioritising partnerships with local institutions, building networks, and supporting early career researchers to develop key skills around conducting health policy and systems research. In addition, respondents highlighted the value of creating platforms for knowledge exchange and for policymakers to interact with researchers and identify policy-relevant research questions.

"They bring in international agencies like you all to evaluate a programme right and that's done to them because for them, that's the programme and its closed. But if they really want to strengthen evaluative capacity, they have to start off by institutional strengthening. They have to pick national and state-level institutions, build networks, build learning organisations. And that takes time. I only say that they've been in countries for so long. And they haven't done this, because they've been so keen on vertical programmes that they can show results. And you know, they have to show their own governments this, so that I can understand that. But even a fraction of what they spent the if they had invested in institutions, perhaps today, we'd be saying something different about how to strengthen these institutions." (IDI 4)

Use of evidence from HSS evaluations

In many contexts covered by this analysis, large amounts of programmatic data are collected and collated in national health management information systems. The challenges around evidence use include barriers to accessing and reviewing data from across systems, evidence for decision-making being largely understood in terms of epidemiological or programme-specific data, limited human resources and embedded capacities to use data for decision-making, and incomplete feedback loops to support decision-making at the sub-national level.

In addition, in some contexts, like in Uganda, a key barrier to building capacity to use evidence is the limitation of governments to fund and hire research and M&E skills, given external demand and far higher salaries offered by donor partners.

“The biggest challenge right now with our ministry is the fact that they can't hire the right staff for the jobs that are approved in the structure because most of IT staff or M&E sophisticated skills are paid very highly by the partners and the market out there. The government rates are not anywhere close. So, 90% of the folks running the M&E divisions of the ministry, are all staff that have been seconded by donors, specifically WHO and US government through USAID and CDC. The government has the positions, they have a budget line item, but unfortunately, M&E skills are very highly paid.” (IDI 6)

There were varying opinions on the lessons that can be drawn from the COVID-19 response. For some respondents, COVID-19 and national responses to the pandemic have resulted in large pushes for data and data-driven decision-making. For example, in Western Cape in South Africa, the Department for Health developed dashboards to track and monitor key COVID indicators to the sub-district level. The development of these dashboards has allowed the department to draw evidence into routine decision-making and bring different pieces of data from different systems together. For others, there was a recognition of the advantage of COVID data, which has required

investments and prioritisation of sectors beyond health. It remains unclear how much the health sector may be able to leverage these efforts.

> *"There is room for more system-level evaluation on a routine basis, where the service and the HR and the finance data could be more routinely brought together in decision-making. So, to some extent that seems to be happening now, because of COVID." (IDI 2)*

Despite routine data collected at the district level and reported up the data chain, there remain large feedback and response mechanisms gaps, with limited or no recommendations for actions shared back to the district level.

> *"But feedback loops and effective feedback is not that is there, and is partly a resource, partly responsiveness. So, the culture is established, people just push the data up and expect nothing down. And that, for me, is rapid (data) can be there, but it is not going to change the people's experience of the service or anything on the ground unless there is an effective response mechanism. And that response mechanism is where government and its partners, not necessarily there, everybody is pursuing their own results." (IDI 8)*

Strengthening existing data systems at the national and sub-national level, building capacities to collate and use evidence from across systems, and investing in human resources to increase the number of staff able to monitor health systems progress were identified by respondents as being crucial to improving HSS evaluations. Several respondents also noted that strengthening Health Management Information Systems (HMIS) were key and provided the opportunity to respond to evidence needs of multiple stakeholders, including donors and governments.

Conclusions and recommendations

The national stakeholder analysis captures a series of perspectives on the interests and needs around HSS evidence of diverse actors involved in HSS evaluation and research at the national level. Despite increasing interest in HSS, and more recently around the resilience of health systems, global health security and the COVID-19 response, HSS is perceived to be a secondary interest to donor partners. Short timeframes for HSS interventions funded by donors have created a priority for evidence that can be captured in the three- to five-year funding cycle, a motivation to evaluate HSS from the programmatic angle, and a focus on the short-term measurable activities and outputs from the investments.

Donor funding cycles, in addition to the lack of or limited domestic funding for HSS evaluations, create a system in which donor/commissioner evidence needs are prioritised over the needs of national users, including policymakers. As a result, policymakers identified evidence from existing HSS evaluations to be of limited use to their own roles and their countries' needs. In addition, stakeholders identified that limited formal policies for HSS evaluations, and varying perspectives on definitions of HSS, contribute limited accountability and methodological challenges to monitoring health systems performance, even in contexts that have adopted universal health coverage agendas.

National stakeholders identified needing evidence to support their decision-making, often where trade-offs must be considered and where financial resources are limited. Five categories of evidence were identified through our review as being important to national stakeholders: (i) evidence around the impact of the HSS intervention (impact + outcomes), (ii) evidence around the cost-effectiveness of HSS interventions to support prioritisation of HSS investments in one area versus the other, (iii) evidence to unpack the complex causal chains between HSS activities and outputs and strengthened health systems, (iv) evidence to support learning and adaptation of programmes on a routine basis, and (v) evidence around the economic impact of HSS investments, to support the needs of non-health decision-makers, including planning and financing stakeholders.

Across our interviews, stakeholders pointed to the limited structural incentives in place to build linkages between actors involved in HSS evaluation at the national level, including limited domestic funding for health systems and policy research and the prioritisation of donor needs. Challenges around using data from HSS evaluations include fragmentation of data across systems, limited capacities, and limited human resources.

Recommendations

The national stakeholder analysis captures a series of perspectives on the interests and needs around evidence from HSS evaluations of actors involved in HSS evaluations. Key recommendations that come out of our findings are as follows:

- Strengthen understanding of how different government actors work, how decisions are made and identify opportunities to engage with non-health policy stakeholders.
- Draw lessons from the COVID-19 response, in particular around reviewing and analysing data from across systems to support broader evaluations of health systems.
- Develop tailored narratives for HSS to target and attract policymaker engagement with evidence from evaluations.
- Involve non-health stakeholders in consultations during an HSS design process to capture evidence needed by non-health decision-makers.
- Conduct mapping exercises to identify organisations and institutions conducting HSS research, monitoring, and evaluation.
- Prioritise investing in health information systems to support the evidence needs of multiple national stakeholders.

- Identify and share lessons around using evaluation methods that may be better suited to capture the complexity of HSS investments and respond to government evidence needs, including qualitative research methodologies.

Recommendations to donors

- Conduct a review of internal evaluation/research commissioning practises and guidelines to identify opportunities for more equitable partnerships with national evaluation capacities.
- In calls for evaluations, make explicit requests for research leadership from national researchers/institutions, playing a principal investigator (PI) or co-PI role.
- Earmark funding from HSS investments and/or HSS evaluations to support PhD/DrPH researchers from national institutions.
- Prioritise partnerships that support institutions/research models that build national capacities and strengthen linkages between research and policy institutions, where available.

Recommendations to the research/academic community

- Play an active role in clarifying user needs from HSS evaluations by stakeholder groups and managing expectations regarding what can and cannot be achieved in HSS evaluation designs and timeframes.
- Identify opportunities to build policy stakeholder evidence needs in routine programmatic evaluations.