

Health Data Collaborative (HDC) External Evaluation

World Health Organization

13 October 2023



FINAL REPORT

Important notice

This document was prepared by Cambridge Economic Policy Associates Ltd (trading as CEPA) for the exclusive use of the recipient(s) named herein on the terms agreed in our contract with the recipient(s).

CEPA does not accept or assume any responsibility or liability in respect of the document to any readers of it (third parties), other than the recipient(s) named in the document. Should any third parties choose to rely on the document, then they do so at their own risk.

The information contained in this document has been compiled by CEPA and may include material from third parties which is believed to be reliable but has not been verified or audited by CEPA. No representation or warranty, express or implied, is given and no responsibility or liability is or will be accepted by or on behalf of CEPA or by any of its directors, members, employees, agents or any other person as to the accuracy, completeness or correctness of the material from third parties contained in this document and any such liability is expressly excluded.

The findings enclosed in this document may contain predictions based on current data and historical trends. Any such predictions are subject to inherent risks and uncertainties.

The opinions expressed in this document are valid only for the purpose stated herein and as of the date stated. No obligation is assumed to revise this document to reflect changes, events or conditions, which occur subsequent to the date hereof.

The content contained within this document is the copyright of the recipient(s) named herein, or CEPA has licensed its copyright to recipient(s) named herein. The recipient(s) or any third parties may not reproduce or pass on this document, directly or indirectly, to any other person in whole or in part, for any other purpose than stated herein, without our prior approval.

Contents

ACRONYMS	I
EXECUTIVE SUMMARY	II
1. INTRODUCTION	1
1.1. Background to the HDC	1
1.2. Evaluation objectives	1
1.3. Evaluation framework and methodology.....	2
1.4. Structure of the report	4
2. KEY FINDINGS	6
2.1. Relevance and coherence	6
2.2. Efficiency	15
2.3. Effectiveness, sustainability and impact	22
3. SUMMARY FINDINGS AND CONCLUSIONS	38
4. RECOMMENDATIONS	40
4.1. Strategic recommendations	40
4.2. Operational recommendations.....	43
APPENDIX A BIBLIOGRAPHY	47
APPENDIX B LIST OF INCEPTION AND CORE PHASE CONSULTATIONS	49
APPENDIX C INTERVIEW GUIDES	53
APPENDIX D E-SURVEY QUESTIONNAIRE AND RESULTS	57
APPENDIX E SUMMARY OF HDC GOVERNANCE STRUCTURE	66
APPENDIX F REVIEW OF HDC OPERATIONAL WORKPLAN AND PROGRESS REPORTING	69
APPENDIX G WORKING GROUP SUMMARY	78
APPENDIX H COMPARATIVE REVIEW OF GLOBAL HEALTH AND HIS ORGANISATIONS	84
APPENDIX I ANALYSIS OF HDC MEMBER BASE	88
APPENDIX J HDC THEORY OF CHANGE	90

ACRONYMS

Acronym	Full description
BHDC	Botswana Health Data Collaborative
CDC	Centers for Disease Control and Prevention (USA)
CHDC	Cameroon Health Data Collaborative
CRVS	Civil Registration and Vital Statistics
CSO	Civil Society Organisation
D&DG WG	Data & Digital Governance Working Group
DHIS2	District Health Information Software
DH&I WG	Digital Health & Interoperability Working Group
GPG	Global Partners Group
GPM	Global Partners Meeting
HDC	Health Data Collaborative
HIS	Health Information Systems
M&E	Monitoring & Evaluation
MHDC	Malawi Health Data Collaborative
PHC	Primary health care
PHI WG	Public Health Intelligence Working Group
RHIS WG	Routine Health Information Systems Working Group
SDGs	Sustainable Development Goals
SRG	Stakeholder Representatives Group
TOC	Theory of Change
TWG	Technical Working Group
UHC	Universal health coverage
UNFPA	United Nations Population Fund
UNICEF	United Nations Children's Fund
WG	Working Group
WHO	World Health Organization
WHO AFRO	World Health Organization Regional Office for Africa
WHO CO	World Health Organization Country Office
WHO EMRO	World Health Organization Regional Office for the Eastern Mediterranean
WHO SEARO	World Health Organization Regional Office for South-East Asia

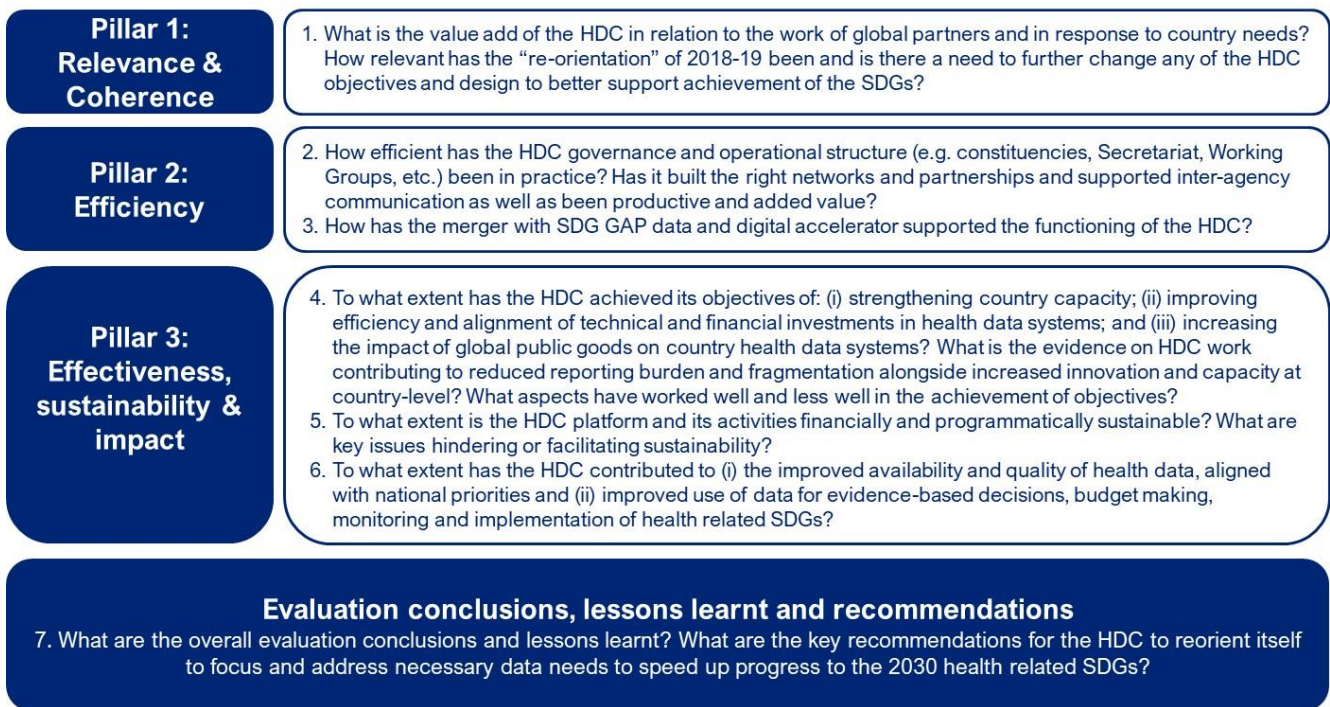
EXECUTIVE SUMMARY

Evaluation objectives and methodology

Cambridge Economic Policy Associates (CEPA) was appointed by the Health Data Collaborative (HDC) hosted by the World Health Organization (WHO) to undertake an external independent evaluation of the HDC. This evaluation was undertaken in 2023, recognising this is the midpoint of the 2015-2030 Sustainable Development Goals (SDGs), and covered the period between June 2015 and December 2022. The objective of the evaluation was to help the HDC to reorientate itself to focus and address necessary data needs to speed up progress to the 2030 health-related SDGs.

A framework for evaluating the HDC was developed adapting the six OECD evaluation criteria grouped in the following pillars: (i) relevance and coherence; (ii) efficiency; and (iii) effectiveness, sustainability and impact. Focused evaluation questions were developed under each pillar, reflecting the objectives of the evaluation and the context of the HDC. The evaluation framework is presented in Figure E.1. below.

E.1: Evaluation framework and questions



A theory-based approach was envisaged for the evaluation but could not be implemented due to inconsistency and lack of comprehensiveness in the HDC Theory of Change (TOC) and wide-ranging stakeholder views on the HDC objectives and scope of work (and therefore a TOC could not be retrospectively developed for the evaluation). A mixed methods approach was employed mainly focusing on the following methods: (i) document review; (ii) stakeholder consultations entailing semi-structured interviews with 64 stakeholders (iii) an e-survey to solicit views from a wider range of stakeholders than covered through the consultations; and (iv) six country case studies (including a mix of countries where the HDC has been active, recently disengaged, and not yet active).

Key findings

Key findings by evaluation pillar are presented below (bold text reflects key area/ aspect reviewed within each pillar).

Key findings
Relevance & Coherence
1. The HDC objectives are relevant and seek to address gaps within the current Health Information System (HIS) landscape, reflecting key priorities and country needs. However, in their current form they are too broad, unclear to stakeholders and too ambitious in relation to the current structure and resources of the HDC.

Key findings

2. There is lack of clarity on what specifically the HDC is doing in support of its objectives. The view is that the HDC has a lack of focus and is conducting a wide array of **activities** that do not together present an integrated plan towards its objectives.
3. The current **HDC model** requires considerable reform to deliver on its mandate and objectives especially with regard to improving country impact. This is because:
 - (i) although the multi-stakeholder partner base of the HDC lies at the heart of its added value, the HDC has not been able to meaningfully engage partners in support of its mandate and delivery of workplans beyond some positive working by select Working Groups;
 - (ii) despite the reorientation of the HDC emphasising country impact, there is no focused approach or functioning mechanisms for country engagement; and
 - (iii) the governance structure of the HDC is too complicated for its size and budget and does not sufficiently support adequate strategic direction and accountability.
4. Apart from its multi-stakeholder partner base, the HDC has struggled to articulate its **value-add** proposition to partner and country stakeholders which has limited stakeholder engagement.

Efficiency

5. The **governance structure** of the HDC is complex and heavy-handed, especially given limited human and financial resources to manage the network. The constituency structure in particular was critiqued by stakeholders as burdensome and adding limited value. The communication flow between the different HDC governance structures is not functioning optimally, resulting in a lack of effective decision-making, transparency and coordination.
6. The diversity of the HDC **membership base** is widely regarded as a strength, but only a small percentage of members are actively engaged.
7. Although the **SDG GAP D+D Accelerator and HDC merger** has led to some efficiencies in terms of aligning processes and reducing duplication of efforts, implementation has not been done in the most strategic or transparent way and visibility of the merger amongst stakeholders is low.

Effectiveness, sustainability and Impact

8. The **HDC TOC** is not well-defined and is rarely used and poorly understood by stakeholders as a result. The lack of a relevant and appropriate **M&E framework** is a significant weakness, resulting in unclear progress reporting.
9. There has been limited **progress** to date by the HDC against its three objectives – partly due to the range of challenges the HDC faces with its structure and design and partly due to external challenges outside of its direct control, including the COVID-19 pandemic.
10. Despite an increased focus in recent years on **HDC's knowledge brokering and advocacy roles**, there remain many challenges in reaching country stakeholders effectively, and the HDC has had limited success in increasing **technical and financial alignment across partners** with individual donor priorities continuing to shape the HIS agenda.
11. The **achievements of the Working Groups (WGs)** with regard to the production of global public goods, country capacity building and technical alignment across their respective areas has been mixed. Key facilitators of most productive WGs (such as Community Data, Digital Health & Interoperability, and Routine Health Information Systems) include strong leadership from Co-Chairs, accountability and ownership from partners, and stable resourcing. All WGs struggle to effectively show contributions to change at the country level.
12. There have been limited tangible achievements of the **HDC at the country level** – including (i) limited success in supporting the design and maintenance of effective country coordination mechanisms for HIS, and (ii) limited effectiveness of country missions and support for costed priority plans for HIS strengthening due to the lack of clear follow-up actions, which in some cases has had negative unintended consequences due to a mismatch in expectations especially with regards to funding.
13. It is difficult to clearly communicate **impact** at the country-level given the lack of a clear M&E framework and small scale of HDC support compared to investments from other partners, however gathered evidence suggests that only limited impact at the country level can be linked to the HDC.

Key findings

14. At the global level, a key risk to the **sustainability** of the HDC is the inadequate human and financial resources. This leads to sustainability challenges at the country level, as activities implemented by the HDC platform lack linkages to clear follow-up actions and funding.

Summary findings and conclusions

Overall, this evaluation finds that the results and achievements of the HDC have been limited to-date due to the range of challenges the HDC faces with its structure and design and partly due to external challenges outside of its direct control, including the COVID-19 pandemic. The reorientation of the HDC in 2019-20 tried to address a number of similar challenges to that identified in this evaluation in 2023. Fundamentally therefore, the HDC has not been able to re-boot itself based on the reorientation of 2019-20, and in fact, this evaluation finds that several of the changes introduced with the reorientation have not worked effectively since 2021.

The HDC is therefore at an important crossroads – with half the time to the SDGs elapsed and a critical need to ensure it delivers in the rest of the years in the run up the SDGs in 2030. Importantly, there were almost unanimous views from this evaluation that the HDC should not be disbanded but re-oriented and reformed. Even when stakeholders were not fully aware of the HDC concept and construct, when explained, were of the view that there is a definite space for a collaboration like the HDC to support better data and measurement for countries.

As such, the challenges for the HDC are many, and some longstanding, and there is an urgent need to address these challenges and support the better and more efficient functioning of the HDC. A re-boot 2.0 is in order, and several recommendations in this regard are provided in the next section.

Recommendations

An essential list of recommendations has been proposed to re-boot the HDC, without which it cannot be assumed that it can improve in its efficacy. Recommendations have been discussed in a workshop of HDC stakeholders held in September 2023.

<p>Strategic recommendations</p>	<p>Recommendation 1: Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage, and develop a supporting Theory of Change, work plan and M&E framework.</p> <p>Recommendation 2: Simplify and improve the effectiveness of the HDC governance by creating a small Board comprising senior level decision-makers from key donors of HIS alongside individual representation from other stakeholders (countries, CSOs, technical) that provides strategic direction to the HDC and remove the constituency-focused arrangements.</p>
<p>Operational recommendations</p>	<p>Recommendation 3: Improve the engagement with countries by developing a clear country engagement strategy that is well communicated and understood by stakeholders and especially countries, and does not focus on a preselected list of countries. Ensure that everything the HDC does is based on country needs and priorities and considers the added value for countries.</p> <p>Recommendation 4: Implement a number of actions to enhance the effectiveness of the Working Groups and ensure their outputs are directly relevant for countries.</p> <p>Recommendation 5: Ensure streamlined and focused communications that are tailored to different audiences (e.g. governance, learning) and stakeholders (e.g. global, country) and carefully consider the value add of these communications for respective stakeholders.</p>

1. INTRODUCTION

Cambridge Economic Policy Associates (CEPA) was appointed by the Health Data Collaborative (HDC) hosted by the World Health Organization (WHO) to undertake an external independent evaluation of the HDC. This report presents the evaluation findings, conclusions and recommendations.

The introduction section provides a background to the HDC (Section 1.1), evaluation objectives (Section 1.2), evaluation framework and methodology (Section 1.3) and the structure of the rest of the report (Section 1.4).

1.1. BACKGROUND TO THE HDC

As all countries work towards implementing and delivering on the 2030 Sustainable Development Goals (SDGs), robust and comprehensive data is required to monitor progress and guide decision-making and policies. However, there are still significant gaps in the way that health care data is collected, collated, used and analysed globally, regionally and nationally e.g., low quality and inconsistent programmes of Civil Registration and Vital Statistics (CRVS) and Health Information Systems (HIS), interoperability issues of digital health systems used by global partners and country health ministries, and HIS/M&E systems supported by development partners which are poorly aligned with national health priorities. Weak and fragmented health data systems undermine the effective use of data to address health-related threats, develop evidence-based policy and efficient resource allocation.¹

The HDC was launched in March 2016, following a 2015 high-level summit on Measurement and Accountability for Results in Health, endorsement in a 2015 Roadmap for Health Measurement and Accountability and a 5-Point Call to action. The HDC is a UHC 2030 related initiative, supporting partnership approaches contributing to improving data for strengthening primary health care (PHC) and universal health coverage (UHC). The HDC provides a platform for joint effort by global, regional and country partners to improve the availability, quality and use of data.

The HDC became operational between 2016 and early 2019 and supported coordination of multi-partner approaches to produce several global public goods and engaged with many countries. However, in 2019, due to changes in several agencies' leadership and the HDC Secretariat, together with WHO's new transformation agenda, there was a temporary hiatus in its work. Between October 2019 and March 2020, based on stakeholder feedback, the HDC governance was reorientated and modified (to constituency-based representation and more focused working groups) and with aims for more emphasis to be placed on country impact and alignment and for there to be stronger links between technical work and political will.

A more detailed background and history of the HDC is presented in Section 2.1.1 to support the assessment of the relevance of the HDC.

1.2. EVALUATION OBJECTIVES

This is an external independent evaluation of the HDC between June 2015 and December 2022. The evaluation is being undertaken in 2023, recognising this is the midpoint of the 2015-2030 SDGs. The evaluation objective is to help the HDC to reorientate itself to focus and address necessary data needs to speed up progress to the 2030 health-related SDGs. One of the main aims of the evaluation is to provide 3-5 clear, actionable recommendations to enable the HDC to be in a better position to have an impact at country level for accelerating the SDGs in terms of data.

The evaluation had the following tasks:

1. Develop a framework for evaluating the HDC's efforts from June 2015 to December 2022 that is based on adapting and using the six OECD evaluation criteria and principles.
2. Use the framework to comprehensively evaluate the HDC 2015-2022 based on the following three methods:
 - A desk review of HDC background, impact and materials 2015-2022;

¹ HDC (2021), Progress Report 2020 -21

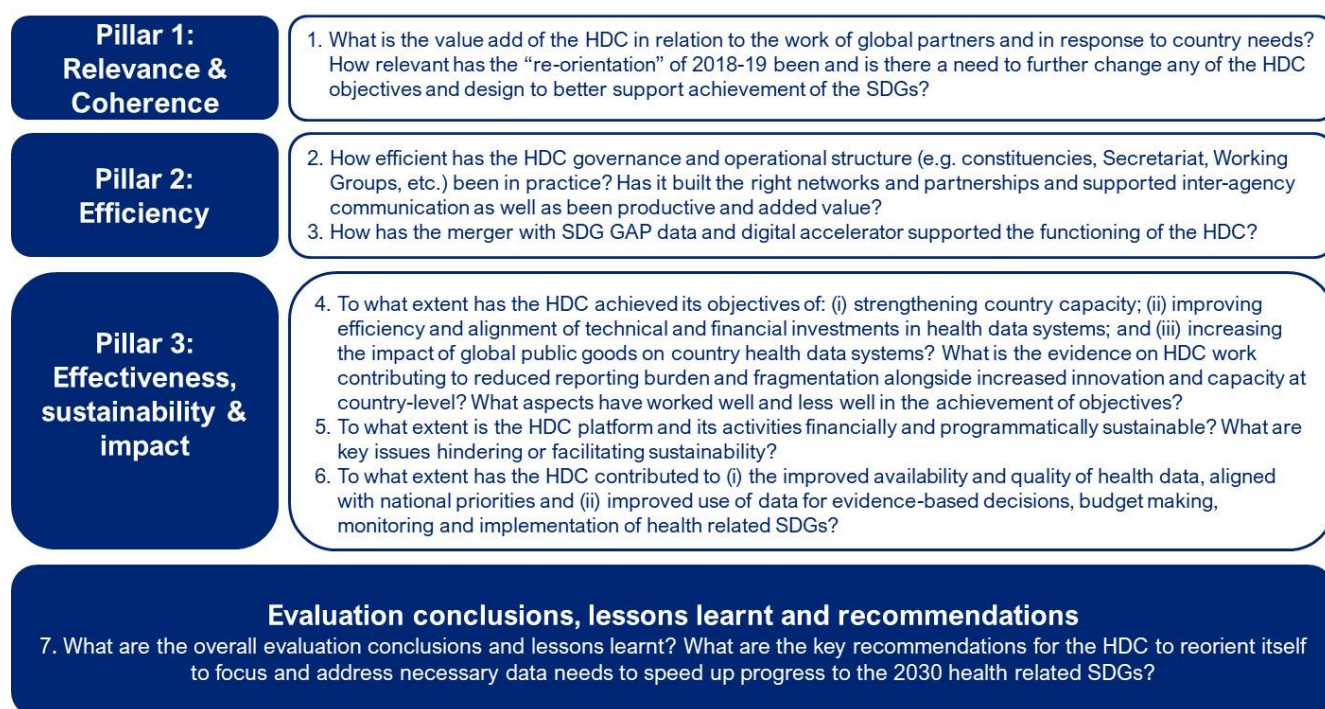
- HDC stakeholder interviews from all seven HDC constituencies (technical and leadership levels), all seven HDC working groups and the Secretariat, with emphasis on country and regional levels; and
 - Evaluation in up to six country-specific contexts of HDC country-level efforts.
3. Submit an evaluation report inclusive of the methodology, analysis, findings, and recommendations to the HDC to reorientate focus to accelerate the attainment of the 2030 health-related SDGs and disseminate the evaluation findings and recommendations at the end of the evaluation.

1.3. EVALUATION FRAMEWORK AND METHODOLOGY

Review questions and approach

Figure 1.1 presents the evaluation framework which is structured around the OECD DAC evaluation criteria, grouped in the following pillars: (i) relevance and coherence; (ii) efficiency; and (iii) effectiveness, sustainability and impact. Focused evaluation questions have been developed under each pillar, which reflect the objectives of the evaluation and the context of the HDC.

Figure 1.1: Evaluation framework and questions



The evaluation sought to be theory-based, in that it would draw on the Theory of Change (TOC) for the HDC, however during the course of the evaluation it was viewed by the evaluation team that this would not be an appropriate approach for this evaluation. This is because:

- There has been inconsistency between different documents describing the objectives and scope of the HDC and the TOC and there have been multiple versions of the TOC (the two key versions are included in Appendix J for reference).
 - The TOC version developed in 2019 (and included in the TORs for this evaluation) identified HDC activities in three main areas with associated outputs and outcomes: (i) coordination and alignment; (ii) innovation and new technology and (iii) capacity building. However, our review under this evaluation has indicated that these buckets of activities do not fully align with the areas of work of the HDC. In particular, the TOC missed the work regarding the contextualisation of global public goods and instead overemphasised the work on innovation and new technology.
 - An updated TOC shared after the completion of the analysis for this evaluation (and therefore not incorporated in this review) is viewed as an improvement over the last TOC in that it is better aligned

with the HDC governance documents, but continues to have some unclear aspects (e.g. reference to financial resources, how the HDC is supporting country autonomy and reduced fragmentation on data).

- In addition, and importantly, any attempt to “retro-fit” a TOC for the HDC in support of this evaluation faced challenges due to wide-ranging stakeholder understanding of the goals, objectives and activities of the HDC, with no common agreed understanding of the HDC.

In sum, the successive TOCs over time do not clearly represent HDC activities/ priorities and their linkages to the objectives and do not demonstrate how the HDC is affecting needed change. Our review under this evaluation has indicated that there continues to be considerable uncertainty on how HDC activities align with the HDC objectives and that many stakeholders were either unaware of the TOCs and/or had different interpretation and understanding of the HDC objectives. This is likely also due to the use of different TOCs across HDC documents, for example the “HDC One-Pager” on the HDC website still refers to the outdated TOC. Overall, there is limited clarity amongst HDC stakeholders on the scope and priorities of the HDC, an aspect which is discussed in depth in Section 2.

Evaluation methods and limitations

A mixed methods approach was employed covering the following methods: (i) document review; (ii) data analysis on the HDC member base²; (iii) stakeholder consultations entailing semi-structured interviews with 64 stakeholders including: HDC constituency groups (donors, countries, multilaterals and intergovernmental organisations, global health initiatives, research, academia and technical networks, civil society and private sector), HDC SRG members including HDC Co-Chairs, HDC Working Group Co-Chairs (Community Data, CRVS, Digital Health & Interoperability, Data and Digital Governance, LMIS, RHIS, Public Health Intelligence), HDC Secretariat, UHC2030 and SDG GAP Secretariat, WHO; (iv) an e-survey to solicit a wider range of stakeholders; (v) six country case studies (including a mix of countries where the HDC has been active (Botswana, Cameroon, Malawi and Nepal), recently disengaged (Tanzania) and not yet active (Pakistan); and (vi) limited analysis of other WHO partnerships for guidance on best practice and any learnings.

Appendix A contains a list of references used for the document review and data analysis, Appendix B contains a list of stakeholder consultations, Appendix C contains interview guides, and Appendix D presents the e-survey questionnaire and results. Appendices E-J presents document review summaries. A separate document is also provided with country case study reports.

Table 1.1 below includes key limitations of the evaluation, alongside mitigating measures taken to address them.

Table 1.1: Key limitations and mitigating measures

Main limitations	Mitigating measures
Document review: Availability of several draft documents on the HDC and inconsistency between documents.	Clarifications with the HDC Secretariat on access to any finalised documents and corroboration with stakeholder interviews
Consultations (global and country) and e-survey: Challenge in engaging stakeholders across the evaluation, reflected in difficulty in obtaining consultations (global and country) and low response rate to the e-survey (overall 3.3% of all official HDC members participated. See Appendix D for further information)	Close engagement with the HDC Secretariat to follow-up with stakeholders and identify replacements Multiple follow-ups to increase participation rate to the e-survey Careful triangulation based on available evidence base
Consultations (global and country): Limited stakeholder awareness and knowledge of the HDC implied lack of exact and accurate information from some interviews	Close engagement with the HDC Secretariat to identify the most relevant stakeholders (including stakeholders involved at the conception of the HDC)

² Other data analysis was planned on HDC funding and results, but historical information is not available on the former and progress reporting is not quantitative.

Main limitations	Mitigating measures
	Triangulation with document review and across consultations
Consultations (global and country) and results assessment: Limited ability of stakeholders to identify achievements of the HDC given limited overall lack of knowledge of the HDC and challenge in attributing specific results given the partnership structure of the HDC	Careful triangulation based on available evidence base
Progress assessment: Challenges assessing progress and impact given lack of consistent reporting against workplan particularly at the outcome and impact level, quantitative indicators, and limited financial data	Analysed as much information as possible from available documentation Triangulation with other evidence, including consultations, country case studies, and the e-survey
Survey: Response rate to the survey was low, despite multiple attempts at follow-up (suggestive overall of limited engagement of HDC members, reflected in report findings.)	The survey results have been triangulated with the findings from the other evaluation methods and the low survey response rate was considered when assessing the robustness of findings. In most instances, the survey results closely matched and supported findings generated from the other evaluation methods and, thus, have been included in the report,

Assessing strength of findings

In line with good evaluation practice, we have assessed the strength of the evidence by evaluating both the quantity (i.e. triangulation) and quality of evidence. Table 1.2 presents the robustness rating assessment scale for the findings. Note that all robustness rankings are *relative* robustness rankings, based on careful consideration and are ultimately judgement-based, and rely on the strong expertise of the evaluation team. The low response rate for the survey meant that survey responses were weighted less when assessing the strength of evidence.

Table 1.2: Robustness rating for findings

Rating	Assessment of the findings by strength of evidence
Strong	<ul style="list-style-type: none"> The finding is supported by data and/or documentation which is categorised as being of good quality by the evaluators; and The finding is supported by majority of consultations (global and country), with relevant consultee base for specific issues at hand and minimal indication of bias; and The finding is well supported through the e-survey responses.
Good	<ul style="list-style-type: none"> The finding is supported by majority of the data and /or documentation with a mix of good and poor quality; and/or The finding is supported by majority of the consultation responses (global and country); and/or The finding is reasonably well supported through the e-survey responses.
Limited	<ul style="list-style-type: none"> The finding is supported by some data and/or documentation which is categorised as being of weaker quality; or The finding is supported by some consultations (global and country) as well as a few sources being used for comparison (i.e., documentation); or The finding is partially supported through the e-survey responses.

1.4. STRUCTURE OF THE REPORT

The rest of the report is structured as follows:

- Section 2 presents key findings organised by the three pillars of the evaluation framework: Relevance & Coherence (Section 2.1), Efficiency (Section 2.2), and Effectiveness, Sustainability and Impact (Section 2.3).

- Section 3 presents the evaluation conclusions.
- Section 4 presents recommendations. Recommendations have been discussed in a workshop of HDC stakeholders held in September 2023.

The report is supported by the following appendices: Appendix A presents the bibliography; Appendix B presents the list of inception and core phase consultations; Appendix C presents interview guides; Appendix D presents the e-survey questionnaire and results; Appendix E presents a summary of the HDC governance structure, Appendix F presents a review of the HDC Operational Workplan (2020-2023) and progress reporting, Appendix G presents a summary of the Working Group objectives, composition and achievements, Appendix H presents a comparative review of other global health and HIS organisations, Appendix I presents an analysis of the HDC's membership base, and Appendix J presents HDC TOCs over time.

2. KEY FINDINGS

This section presents key findings organised by the three pillars of the evaluation framework: Relevance & Coherence (Section 2.1), Efficiency (Section 2.2), and Effectiveness, Sustainability and Impact (Section 2.3).

2.1. RELEVANCE AND COHERENCE

The first pillar of the evaluation framework is on an assessment of the OECD DAC evaluation criteria of relevance and coherence i.e. the extent to which HDC objectives and design respond to beneficiary, global, country and partner/institution needs and priorities (relevance) and compatibility of the HDC with other interventions (coherence).³

The evaluation question is as follows:

Review Question 1: What is the value-add of the HDC in relation to the work of global partners and in response to country needs? How relevant has the “reorientation” of 2018-19 been and is there a need to further change any of the HDC objectives and design to better support achievement of the SDGs?

Key findings – Relevance & Coherence	Robustness rating
1. The HDC objectives are relevant and seek to address gaps within the current HIS landscape, reflecting key priorities and country needs. However, in their current form they are too broad, unclear to stakeholders and too ambitious in relation to the current structure and resources of the HDC.	Strong
2. There is lack of clarity on what specifically the HDC is doing in support of its objectives. The view is that the HDC has a lack of focus and is conducting a wide array of activities that do not together present an integrated plan towards its objectives.	Good
3. The current HDC model requires considerable reform to deliver on its mandate and objectives especially with regard to improving country impact. This is because: (i) although the multi-stakeholder partner base of the HDC lies at the heart of its added value, the HDC has not been able to meaningfully engage partners in support of its mandate and delivery of workplans beyond some positive working by select Working Groups; (ii) despite the reorientation of the HDC emphasising country impact, there is no focused approach or functioning mechanisms for country engagement; and (iii) the governance structure of the HDC is too complicated for its size and budget and does not sufficiently support adequate strategic direction and accountability.	Strong
4. Apart from its multi-stakeholder partner base, the HDC has struggled to articulate its value-add proposition to partner and country stakeholders which has limited stakeholder engagement.	Good
5. The increase in the number of organisations with similar mandates to the HDC at the global and regional level will require the HDC to re-evaluate its value-add and role in relation to others, but it continues to fill a gap in the changing HIS/M&E landscape.	Good

Our assessment is presented as follows:

- Section 2.1.1 provides a background to the HDC creation in 2016, events impacting its initial years of work and the reorientation from 2021
- Section 2.1.2 presents an assessment of the HDC objectives and scope of work
- Section 2.1.3 presents an assessment of the HDC model, including challenges with its approach to working with partners as well as country engagement approach

³ <https://www.oecd.org/dac/evaluation/daccriteriaforevaluatingdevelopmentassistance.htm>

- Finally, Section 2.1.4 looks at the added value of the HDC, based on stakeholder feedback and comparative advantage vis a vis other global level data-focused initiatives highlighted by stakeholders during our consultations.

2.1.1. HDC launch and reorientation

The HDC was launched in 2016 as a result of the political commitment following the Measurement and Accountability for Results in Health Summit of 2015 which was convened by USAID, the World Bank Group and WHO. The goal of the Summit was to construct a common agenda to improve and sustain country measurement and accountability systems for health results in the post 2015 era. The summit built on lessons from Millenium Development Goals (MDG) era and past commitments such as the principles of the International Health Partners and related initiatives (IHP+), data driven approaches to strengthening services and programmes (PEPFAR 3.0), increased use of online, transparent systems of accountability, work done to rationalise indicators, a CRVS investment plan launched in 2014, and ongoing efforts to strengthen health information systems. The “5-point Call to Action” that was endorsed at the Summit identified five priority actions for health measurement and accountability post 2015 in LMICs, as follows:⁴

1. Increase the level and efficiency of investments by governments and development partners to strengthen country health information system
2. Strengthen country institutions capacity to collect, compile, share, disaggregate, analyse, disseminate and use data at all levels of the health system
3. Ensure that countries have well-functioning sources for generating population health data, including civil registration and vital statistics systems, censuses, and health services tailored to country needs, in line with international standards
4. Maximise effective use of the data revolution, based on open standards, to improve health facility and community information systems
5. Promote country and global governance with citizen and community participation for accountability through monitoring and regular, inclusive review of progress and performance at facility, subnational, national, regional and global levels, linked to health-related SDGs

The “Roadmap for Health Measurement and Accountability” identified a number of strategic actions, with corresponding country and global level actions, that drove the initial concept of the HDC (e.g. “investing in strengthening data sources and capabilities”, “generate global public goods”, “donor behavior coordination”).⁵ The Roadmap refers to an implementation approach including “a global collaboration involving WHO, the World Bank, and investing partners....responsible for facilitating international support for implementation of the Roadmap in countries...” which helped lay the foundation for the HDC.

With this context, the HDC was launched in 2016, with the original aims to:⁶

- support alignment and increase efficiency of investments for country data,
- increase country capacity to effectively use data to plan, budget and implement for better health outcomes,
- support monitoring of the health-related SDGs and, where possible,
- provide collaborative approaches to address gaps in technical support.

The HDC was set up as a UHC 2030 health-related initiative with a common commitment to promote the principles of the UHC2030 Global Compact for progress towards UHC and common approaches to strengthening health systems.⁷

⁴ World Bank Group, USAID and WHO, 2015, Health measurement and Accountability Post 2015: Five-Point Call to Action

⁵ World Bank Group, USAID, World Health Organization, 2015, The Roadmap for Health Measurement and Accountability

⁶ HDC, 2020, Mission, Objectives, Principles and Governance

⁷www.uhc2030.org/fileadmin/uploads/uhc2030/Documents/About_UHC2030/Related_Initiatives/UHC2030_Related_Initiatives_FINAL_April_2020.pdf

Over its first couple of years, the HDC followed an approach of identifying “pathfinder countries” (i.e. a few countries where the HDC would focus its efforts by way of catalysing progress with regards to data related challenges) and also supported the development of global goods and tools through multi-agency working groups (see Section 2.3.2/ Appendix G for details).

Soon after, however, the HDC reached a temporary hiatus in its work on account of changes in key agency leadership along with the wider WHO transformation agenda. A stakeholder feedback exercise was held over 2019 and 2020 that identified a number of challenges with the HDC including the following:⁸

- Need for greater clarity and communication of HDC mission, added value and objectives;
- Need for global tools and goods produced to be contextualised and adapted to country and sub national contexts;
- Need for more streamlined and constituency-based HDC representation, decision-making and WG functioning, recognising the increasing governance burden (# Working Groups (WGs), # of calls and # of participants on calls);
- Need for more demand-driven approaches, led by communities and countries (rather than partners) to highlight prioritised gaps in data collection, storage, analysis and use - with coordinated HDC partner approaches to respond to these in countries;
- Need for clear deliverables and ToRs for the WGs, along with stronger links between WGs;
- Need for the HDC Secretariat to play more of a convening, curating and facilitating function for data, WGs and countries and a clearer and more explicit role for WHO.

The overall stakeholder recommendations were to reboot HDC governance and Secretariat (to a structure that is discussed further below in Section 2.2), increase focus on countries and build political capital. These aspects have defined the “re-oriented” HDC that has been in operation since 2021. The HDC maintained its informal collaborative arrangement and refined its objectives as follows:⁹

- To strengthen country capacity to plan, implement, monitor and review progress through application of standardised processes for data collection, availability, analysis and use to achieve national health-related targets (and therefore eventual SDG health targets);
- To improve efficiency and alignment of technical and financial investments in health data systems through collective actions;
- To increase the impact of global public goods and tools on country health data systems through increased sharing, learning and country engagement.

A fourth governance-specific objective of the HDC is to ensure that it has governance processes and structures in place to provide transparent accountability mechanisms to all countries and partners, communications to all stakeholders and advocacy to strengthen political capital.

Over the period since its reorientation to date, further strategic shifts have been highlighted including: increasing the representation and diversity of HDC members with a focus on countries, increasing HDC’s knowledge brokering and communications advocacy role, and scaling up country work.¹⁰

⁸ HDC, October 2019-March 2020, Stakeholder feedback summary

⁹ HDC, 2020-2023 Workplan Narrative

¹⁰ HDC, September 2022, Progress Report

2.1.2. Relevance and appropriateness of HDC objectives and scope of work

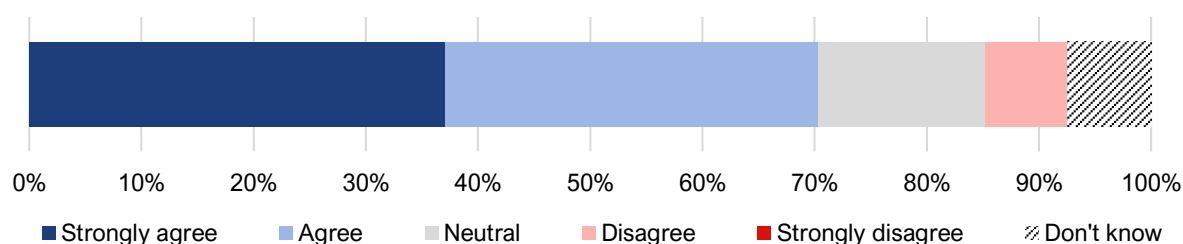
The evaluation has assessed the relevance and appropriateness of HDC's re-oriented objectives, mandate and scope of work by soliciting stakeholder views – both global and country stakeholders, through interviews and the e-survey. Main findings are as follows:

The HDC objectives are relevant and seek to address gaps within the current HIS landscape, reflecting key priorities and country needs. However, in their current form they are too broad, unclear to stakeholders and too ambitious in relation to the current structure and resources of the HDC.

As noted above, the three objectives of the re-oriented HDC are (i) strengthening country capacity; (ii) improving efficiency and alignment of technical and financial investments in data systems and (iii) increasing the impact of global public good and tools on country health data systems. Stakeholder feedback, and in particular country level feedback solicited during the country case studies indicates that:

- **The three objectives seek to address key gaps in the HIS landscape and are aligned with country priorities and country needs.** In general, the three objectives were considered to cover important aims that would help address gaps in the current HIS landscape. This was a largely unanimous view in our global-level stakeholder consultations and across the six country case studies. This has been supported through the e-survey where over 70% of respondents strongly agreed or agreed that the objectives are relevant and aligned to country needs (see Figure 2.1 below and Appendix D for more details). Not all global and country stakeholders could recall the HDC objectives in detail, but when prompted, agreed that these are important objectives that add value within the current HIS landscape.

Figure 2.1: Percentage of e-survey respondents who agreed that objectives are relevant and aligned to country needs



- **The objectives in their current form are not appropriate as they are too broad, leading to lack of clarity and understanding amongst stakeholders and are too ambitious to match the current HDC resources.** While there was support across stakeholders on the relevance of the objectives, there was also alignment in the view that in their current form they are too broad and unspecific. Thus for example, it is not clear to stakeholders how HDC seeks to affect its first objective on strengthening country capacity. As a result, there are many different interpretations on the objectives and priorities of the HDC and this has proved to be challenging for the operationalisation and communication of the HDC. The second critique is more fundamental and considers the objectives as being too ambitious for the HDC, both in terms of being unrealistic for the HDC to affect given the context of the global aid architecture (e.g. alignment of investments in data) and in relation to the limited resource base of the HDC.¹¹ This is leading to the HDC overstressing its existing resources, resulting in stakeholder frustrations as the HDC cannot deliver against its aims.

There is lack of clarity on what specifically the HDC is doing in support of its objectives. The view is that the HDC has a lack of focus and is conducting a wide array of activities that do not together present an integrated plan towards its objectives.

¹¹ The evaluation sought to collate information on the overall funding to the HDC from its inception however this data was not available to be provided to us by the HDC Secretariat.

In line with the criticism outlined above on the HDC objectives, there is a lack of focus in the HDC's work. The HDC tries to conduct too many different activities impacting on the robustness and effectiveness of conducted activities. In particular:

- While the HDC Secretariat developed a detailed workplan for 2020-23 (see Appendix F for a review) aligned to the three objectives, it has had limited use in practice with regard to planning activities, developing priorities and following-up on conducted activities. We understand that the HDC Secretariat has tried to engage the SRG on this workplan, but partners have not been adequately engaged. Indeed during the consultations for this evaluation, many stakeholders reported to being unaware of an HDC workplan (with some stakeholders in fact advocating for the creation of a workplan) and not being clear on its focus or priorities.
- Several activities have been conducted without having clear actions and follow-up activities planned leading to the impression that some meetings and events are reduced to a “tick-box” exercise without clear outputs (see the effectiveness section for a detailed discussion and specific examples on this point).
- Additionally, stakeholders considered that while activities largely fit under the three objectives, there is no strong link on the expected outputs and outcomes and no detailed assignment of responsibility and accountability.

2.1.3. Relevance of the HDC model, including approach to working with partners as well as country engagement approach

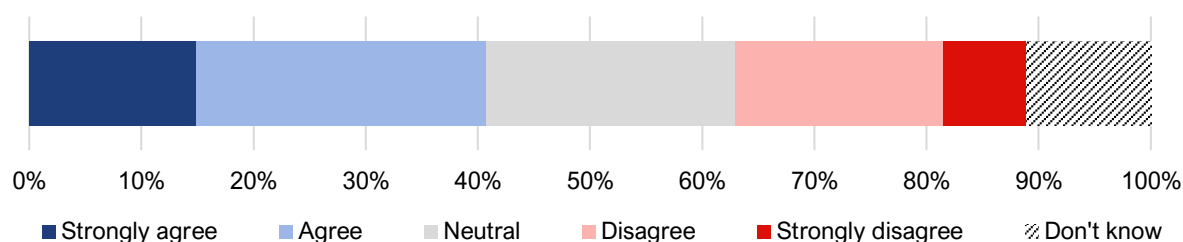
The HDC design or model is not clearly articulated in any HDC documentation. While the TOC and other HDC documentation describe governance structures as well as objectives, there is no discussion of the design and model of the HDC in terms of the approach taken to achieve objectives. In our evaluation, we have identified the following aspects as characterising the HDC model and present an assessment of what works well and less well for each in turn below:

- The HDC structure as an informal collaborative rather than a formalised legal entity
- WHO hosting of the HDC Secretariat and relationship with the WHO
- The overall structure of the HDC in terms of the different components/ structures that comprise its governance and delivery
- HDC approach to working with partners
- HDC country engagement approach

The overall finding across these aspects is as follows:

The current HDC model requires considerable reform to deliver on its mandate and objectives especially with regard to improving country impact. As part of the HDC reorientation, there have been some changes to the HDC structure and model including setting up of a constituency-based structure, development of several components to its governance structure, and better definition of the WGs functioning (see Section 2.2.1 and Appendix E on a detailed assessment and overview of the HDC governance structure). While some of these changes have been positive, overall, stakeholders have commented that the current model and governance structure require considerable reform to deliver especially against the pivot towards increasing country impact. This was also reflected in the mixed response of the e-survey in which just under 60% of participants disagreed or were unsure as to whether the HDC was well set up to respond to its mandate (see Figure 2.2 below and Appendix D for details). The strongest point of feedback was on the HDC's country engagement approach, discussed further below.

Figure 2.2: Percentage of survey respondents who think the HDC is well set up to respond to its mandate



HDC as an informal collaborative

There is good support for the HDC to be structured as an informal collaborative.

Stakeholders were supportive of the HDC set-up as an informal collaborative. They viewed this structure as being suitable for its mandate and role, recognising that its strength is in collaborating and coordinating with partners and a loose rather than formalised approach is sufficient and has worked well. Changing to a formalised approach would reduce its flexibility and impact its multi-sectoral partner collaborative approach.

An issue however is that at times, the HDC is misunderstood by stakeholders as an entity in its own right (e.g. stakeholders refer to certain global public goods as an “HDC product”). This goes against the grain of how the HDC is structured i.e. a collaborative that facilitates the work of its partners rather than originates/ develops work on its own right.

WHO hosting of Secretariat and relationship with WHO

There were some mixed views on the differentiation between the work of the HDC and WHO and that the HDC was WHO dominated, however overall WHO’s role was viewed as appropriate.

The difference between WHO’s role as hosting the HDC and as a partner was unclear to some stakeholders. Some considered that the line between the WHO and HDC was distinct enough, similar to how other WHO partnerships and collaborations function. Others felt that although the distinction was unclear, the fact that the WHO hosts the HDC as well as its normative and convening role justifies its leading role within the HDC. Some stakeholders argued, however, that the HDC Secretariat should move towards becoming more multi-institutional, particularly the Secretariat, as organisations outside of WHO are committing substantial time and funding including UNICEF and the CDC. Stakeholders voiced the perception that the HDC is WHO dominated, given that the HDC Secretariat is hosted by the WHO and predominately made up of WHO staff. It was noted that initially, WHO staff were somewhat discouraged from joining the HDC to avoid the perception of it being a WHO- dominated network, but this is no longer the case. Further, WHO is the most represented organisation at close to 10% of HDC membership.

HDC structures and governance

The governance structure of the HDC is too complicated for its size and budget and does not sufficiently support adequate strategic direction and accountability.

The current HDC structures is considered too layered and complex in relation to its mandate and given its size/ resources. The Stakeholder Representative Group (SRG) set up to provide strategic direction and guidance does not function as such and there is limited/ no accountability between the different structures of the HDC (Global Partners Group, SRG, Working Groups). The several challenges with the HDC governance structure and its functioning are described below in Section 2.2.1 on the efficiency assessment.

Approach to partner collaboration

Although the multi-stakeholder partner base of the HDC lies at the heart of its added value, the HDC has not been able to meaningfully engage partners in support of its mandate and delivery of workplans beyond some positive working by select Working Groups.

Section 2.2.1 on the efficiency assessment highlights the considerable growth in the partner membership base of the HDC over time, including membership from multiple constituencies. There are some positives with regards to its

current membership base (e.g. large numbers, multi-constituency representation, view that some of the best technical expertise on data systems is involved with the HDC, etc.), but also some issues (e.g. limited representation from countries, limited engagement of CSOs and private sector, lack of some key global health organisations being active members such as Global Fund and the World Bank, etc.). Section 2.2.1 also discusses these aspects in more detail.

However fundamentally the challenge with the HDC is that it has not managed to adequately engage its partners in support of its mandate and partners lack ownership over activities and interventions (apart from some successful Working Groups, discussed in more detail in Section 2.3.2). This is on account of a number of reasons, including:

- *Lack of clarity of the HDC objectives and mandate* – as outlined above – with partners largely unsure of the added value of the HDC and what benefit they can receive from being a member and engaging with the HDC.
- *Lack of clarity on the role and value of participating in various HDC structures and meetings/ activities.* As discussed in more detail on Section 2.2.1 on efficiency, most stakeholders were unclear of their role in the various HDC structures and the exact roles and responsibilities of these structures. Thus they have not been able to engage adequately with the HDC through these governance structures. In addition, several stakeholders have voiced lack of clarity in their participation and presentation at HDC events (including especially country stakeholders – see Section 2.3.2 on effectiveness), which has impacted partner incentives and engagement with the HDC.
- *Dissonance between the HDC workplan and partner workplans* – partners reported limited involvement in developing successive HDC workplans. Although the most recent workplan of 2022-23 was presented to the SRG, it was reportedly mainly developed by the HDC Secretariat with limited feedback from partners and some partners were even unaware of its existence. The HDC governance structures have also not facilitated joint/ coordinated workplanning, with the SRG for example not delivering on its strategic guidance role (as mentioned above and discussed in more detail in Section 2.2.1 below).
- *Limited funding available to the HDC* – Partners are disincentivised from engaging and taking responsibility for workplan activities and interventions, given the lack of funding to support activities.
- *Disengagement of some partners and lack of high-level leadership support in recent years.* Key global health funders such as the World Bank and the Global Fund are no longer actively engaging with the HDC. Additionally, engagement with high-level leadership amongst partner organisations is very low. This lack of higher level buy-in presents an obstacle to members spending time and resources on HDC facilitated activities.

Country engagement approach

Despite the reorientation of the HDC emphasising country impact, there is no focused approach or functioning mechanisms for country engagement.

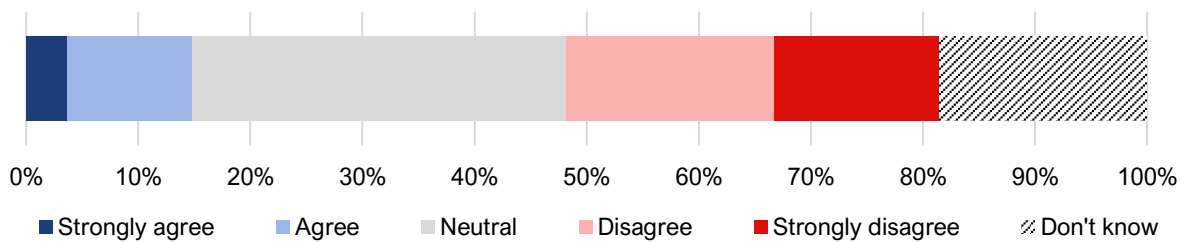
Document review identified the HDC “Country Engagement Approach” which outlines three principles of engagement: (1) Country engagement should occur by invitation rather than selection with strong country stewardship and country initiation; (2) Country engagement should be opportunistic where collective technical support and joint investments have been identified; and (3) Country engagement should be aligned at the global and regional level and either a reaction to country requests based on identified needs or proactive to demonstrate the value of an aligned partner response.¹² In addition, the types of engagement identified by the HDC include: (1) Strategic request for collective action to support extensive M&E activities (for example, strengthen M&E and/or HIS plan, determine priorities for investment, develop a common investment framework, or provision of technical support for implementation of the plan); (2) Focused request for collective action to support a specific M&E activity; (3) Specific agency request for technical support; and (4) Knowledge sharing for ongoing in-country coordination of

¹² HDC, 2022, Country Engagement Approach

partner work. Our assessment is that this delineation is not clear and specific enough, and pretty much allows for any approach or strategy to be followed by the HDC.

Indeed, consultations with stakeholders (interviews at the global level and interviews at the country level through the country case studies) have indicated that they are not aware on how HDC would engage and support countries. The messaging regarding increased country impact is welcomed but it is not clear to stakeholders how this has been translated into the operationalisation of the HDC. Many stakeholders were also not aware of this change to country focus and were unclear how this has been translated specifically into HDC objectives and activities. In particular, this shift has not been felt strongly with some in-country stakeholders. Less than 15% of stakeholders who responded to the e-survey felt that the HDC was able to deliver against its reorientation to focus on country impact (see Figure 2.3 below and Appendix D).

Figure 2.3: Percentage of survey respondents who felt that the HDC is able to deliver against its reorientation to focus on country impact



Country engagement has also been affected by misaligned expectations with regards to funding and direct technical support. The HDC's Country Engagement Framework specifies that it is not a funding mechanism, but that catalytic funding can be sought in support of country priorities. Some stakeholders also highlighted that provision of catalytic funding, or at the very least, support in mobilising resources through advocacy, would be welcome from the HDC and would serve as an important incentive for country engagement. However, in most cases evidence from country case studies demonstrate that the HDC is not able to mobilise in support of country activities. Further, countries have developed a list of prioritised activities for M&E/ HIS strengthening or investment frameworks for example, sometimes with direct HDC engagement virtually or through missions, with the expectation that funding would be made available to support identified needs. This has not occurred, leading to disappointment from country stakeholders and the perception that these exercises are purely academic and somewhat of a burden on country resources. There is a need for expectations around the HDC's role in mobilising funding to be addressed clearly in order to improve country engagement.

The mechanisms for country engagement are also not suitable and/ or nonfunctioning:

- *Ineffectual country engagement through governance structures:* Changes made as part of the reorientation of the HDC include encouraging countries to join the SRG and WGs meetings and to select country stakeholders as Co-Chairs. However, in practice, countries have not engaged much due to lack of clarity and adequate sensitisation of the HDC objectives and work, as well as ability of country stakeholders to dedicate time to the initiative (without a clear value-add in return).
- *HDC events have been focusing on increasing country participation at meetings, but country feedback indicates that they do not see a strong value-add in joining these.* Country stakeholders have mainly participated in global HDC meetings (GPM, SRG, WGs, and leadership events) in an ad-hoc manner, or when requested by the Secretariat to present. However, stakeholders did not identify a strong direct value-add from these presentations. They reported that presentations were somewhat duplicative with those given to other partners, and they were disappointed by the lack of follow-up after global meetings. They also expressed that when not explicitly asked to present, their role in meetings was unclear. Stakeholders felt that they would benefit more strongly from meeting formats which encourage active participation from country stakeholders- including time for discussions between country representatives, for feedback related to specific in-country challenges. Additionally, in person meetings in Geneva have been critiqued for being exclusive to country stakeholders. Late communication of invitations has resulted in-country stakeholders being unable to procure visas and flights in time for events.

- *Lack of processes to support a “bottom-up” approach for countries to reach out to the HDC to receive technical support and guidance.* Stakeholders have pointed to a few examples where countries have submitted requests for technical support to the HDC but where there were no mechanisms in place to respond to the request in a timely and organised way. It was noted that the HDC lacks an approach and supporting tool to record country requests and assign responsibilities to support countries leading to an ad-hoc and haphazard approach. At the country level, many stakeholders expressed uncertainty about the processes by which they could request support from the HDC. In contrast to what is proposed by the HDC’s country engagement framework, the HDC has been critiqued for having a “top-down” approach to selecting countries to receive technical assistance. There remains a perception amongst some stakeholders that countries are being ‘selected’ for membership in the HDC, and that criteria for this is opaque. Certain high-burden or high-need countries have been neglected.
- *Country stakeholders have emphasised the lack of country presence or at least regular engagement with a HDC Secretariat focal point as a challenge.* In Malawi for example, the HDC was most active, engaged and visible in terms of both the global and country platform from 2015-2018. During this period, a programme officer within the HDC Secretariat coordinated closely with the M&E TWG at the Ministry of Health to understand the overall strategy and vision, priorities, and identify priority areas for TA and where global public goods could be integrated. However, since 2018, stakeholders noted a drop-off in support and a lack of clarity on how they could access technical support from the global platform in large due to the constrained resources of the HDC Secretariat. Additionally, stakeholders emphasised that more support could be provided through country counterparts of partners, including engagement with the WHO Regional and Country offices, is also deemed necessary. The recent pivot towards a regional focus has been welcomed and could offer a compromise with regard to country engagement given limited resource availability. This includes the use of regional advisors that have a strong understanding of the country and regional contexts as well as attempts to closer coordinate with regional offices (especially WHO, as well as UNICEF, UNFPA, and regional development banks). It was indicated that the HDC needs to further strengthen regional engagement with some engagement in the past seen as ad-hoc and without long-term follow-up (e.g., the HDC engaged with the KEMRI Institute and Institut Pasteur de Dakar to lead a virtual GPM meeting as regional partner institutes but there have not been any further engagement or follow-up since then).

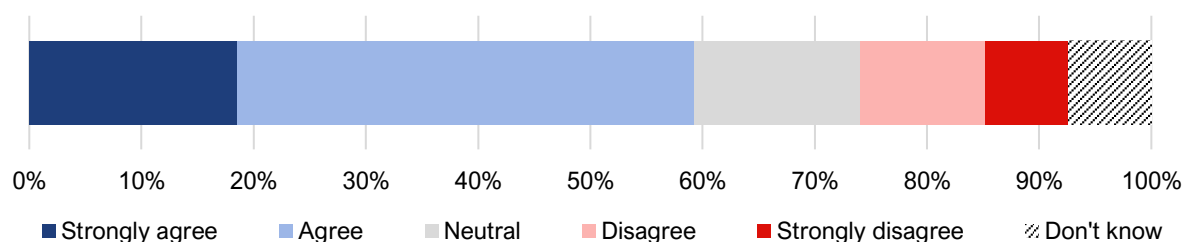
2.1.4. Added value of the HDC

Stakeholder perceptions – global and country

Apart from its multi-stakeholder partner base, the HDC has struggled to articulate its value-add proposition to partner and country stakeholders which has limited stakeholder engagement. Stakeholders see definite value in a collaborating and coordinating body to support partner work in data systems. It was highlighted that no other collaborative convenes such a broad range of stakeholders. The collaborative working through the Working Groups were considered the greatest value-add (*“It’s a place where partners can come together to identify gaps, work actively work with people and workshop things with different partners and perspectives”*). However, the several challenges highlighted above has reduced its added value. It is important to note however that stakeholders are not keen to disband the HDC; rather, they see value in re-orienting the HDC and making it work more efficiently and effectively.

This was corroborated by e-survey results. Nearly 60% of e-survey respondents agreed or strongly agreed that the HDC adds value to the work of other partners working on country HIS (see Figure 2.4 below and Appendix D for more details). Amongst stakeholders who provided greater detail, the key value-add identified was in providing a forum for interested partners to meet and fostering global coordination. One stakeholder noted that *“While I don’t agree with everything the HDC does, I think the absence of such an organization would revert back to the “old ways” of donors building competing systems with little to no coordination between each other.”*

Figure 2:4: Percentage of survey respondents who believe that HDC adds value to the work of global and regional partners and other data coordination bodies working on country health information systems



Country stakeholder feedback through the country case studies was more critical. During country case studies, stakeholders questioned the comparative advantage of the HDC in its current form and structure to deliver against its objectives. In particular, the HDC was considered to lack (i) funding or at least the ability to effectively coordinate and support access to funding from HDC partners; (ii) country presence, or at the very least regular and close engagement with country stakeholders, to ensure that technical assistance is targeted, aligned with country priorities and sustainable with regard to follow-up activities; and (iii) mechanisms by which to ensure technical expertise and global public goods developed through WGs are appropriately tailored to country needs and disseminated in a contextualised and digestible manner. Given these limitations it was not clear to country stakeholders what the added benefit would be of approaching the HDC for country capacity-strengthening support for example, over partners acting individually or through joint interventions.

Comparative advantage of HDC compared to other global data initiatives

The increase in the number of organisations with similar mandates to the HDC at the global and regional level (e.g. TransformHealth, Digital Square, and the WHO Hub for Pandemic and Epidemic Intelligence) will require the HDC to re-evaluate its value-add and role in relation to others, but the overall view is that the HDC continues to fill a gap in the changing HIS/M&E landscape.

Appendix H summarises these different initiatives. A desk review of these three organisations shows that:

- The degree of overlap with the HDC is fairly limited and the current mandate of the HDC is broader than all three. TransformHealth and Digital Square focus exclusively on digital health, and the WHO Hub for Pandemic and Epidemic Intelligence on disease surveillance.
- The HDC’s technical focus is also more inclusive- for example, stakeholders highlighted that the HDC CRVS WG is the only forum convening stakeholders working on CRVS globally. The HDC also has a wider membership base covering country stakeholders, multilateral and intergovernmental organisations, donors, global health initiatives, research, academic and technical networks, the private sector and civil society. In comparison, TransformHealth for example does not include multilateral and intergovernmental organisations, bilateral or multilateral donors, or national government stakeholders.

As such overall it was viewed that the HDC is filling a crucial gap by convening stakeholders working across HIS strengthening with a focus on advancing the SDGs. However, stakeholders also highlighted that the increase in the number of organisations working in the HIS space necessitates that the HDC re-evaluate its role, assessing and articulating its relation to these other organisations and its continued value-add.

2.2. EFFICIENCY

The second pillar of the evaluation framework is on the OECD DAC evaluation criteria of efficiency and covers the following evaluation questions:

- **Review Question 2: How efficient has the HDC governance and operational structure (e.g. constituencies, Secretariat, Working Groups, etc.) been in practice? Has it built the right networks and partnerships and supported inter-agency communication as well as been productive and added value?**

- **Review Question 3: How has the merger with the SDG GAP data and digital accelerator supported the functioning of the HDC?**

Key findings – Efficiency	Robustness rating
1. The governance structure of the HDC is complex and heavy-handed, especially given limited human and financial resources to manage the network. The constituency structure in particular was critiqued by stakeholders as burdensome and adding limited value.	Strong
2. The communication flow between the different HDC governance structures is not functioning optimally, resulting in a lack of effective decision-making, transparency and coordination.	Strong
3. The diversity of the HDC membership base is widely regarded as a strength, but only a small percentage of members are actively engaged.	Good
4. Although the SDG GAP D+D Accelerator and HDC merger has led to some efficiencies in terms of aligning processes and reducing duplication of efforts, implementation has not been done in the most strategic or transparent way and visibility of the merger amongst stakeholders is low.	Good

Section 2.2.1 below considers the review question 2 and Section 2.2.2 considers review question 3.

2.2.1. Efficiency of HDC governance and operational structure

Following a background to the HDC governance structure, the analysis of review question 2 is organised as follows: 1) Cross-cutting issues across global governance structures and 2) key findings organised by global governance structure.

Background

As noted previously, the HDC conducted a stakeholder feedback exercise from October 2019 to March 2020 to support its reorientation, wherein HDC stakeholders recommended that the governance structure be overhauled and relaunched. The new iteration of the HDC, developed with input and iterative feedback from members, was designed with the intention of improving the streamlining and transparency of decision-making, as well as communication and coordination between partners, countries and working groups. Four key changes were made: i) the establishment of a Global Partners Group (GPG) comprised of seven constituencies, ii) the establishment of the Stakeholder Representative Group to serve as a decision-making body with membership representative of the constituencies, iii) an overhaul and dissolution of inactive WGs (reducing the number of WGs from twelve to five in 2020) as well as clear criteria for the establishment of new WGs, and iv) emphasis on maintenance of a functional Secretariat and a clear outline of its responsibilities in response to its inactivity for nearly twelve months in 2018/2019.

A brief summary of the HDC’s current governance structure in terms of roles and responsibilities, composition and working modality is presented in Table 2.1 below, and a full summary of is available in Appendix E.

Table 2.1: Description of HDC governance structures¹³

Governance structure	Brief description
Global Partners Group (GPG) and Constituencies	<ul style="list-style-type: none"> • The Global Partners Group is inclusive of any member, entity or working group committed to the HDC mission, objectives and principles. It is a loose network of entities engaging in health data and digital efforts. • GPG members are affiliated to seven Constituency Groups; i) countries, (ii) multilaterals and intergovernmental organisations, (iii) donors and philanthropic foundations, (iv) global health initiatives, (v) research, academia and technical networks, (vi) civil society and (vii) the private sector. Quarterly calls are planned in 2023 for each Constituency Group.

¹³ HDC, 2021, Overview of HDC Governance

Governance structure	Brief description
	<ul style="list-style-type: none"> • There are GPG meetings twice annually, in March and September. The Secretariat regularly manages communication with the GPG through website updates, webinars, newsletters, emails, etc.
Stakeholder Representative Group (SRG)	<ul style="list-style-type: none"> • The SRG provides the HDC with technical direction and strategic oversight and promotes accountability of all members to the HDC mission and objectives, working in close collaboration with the Secretariat. • There are thirteen SRG members, representing the seven GPG constituencies. There are also three permanent Co-Chairs, from the i) country constituency, ii) WHO, and iii) multilateral or donor constituency. • SRG members participate in two annual face-to-face meetings, and monthly virtual ones. They are voted in for a two-year time frame. Decisions are made by consensus or voting if necessary.
Working Groups (WG)	<ul style="list-style-type: none"> • WGs are tasked with activities such as production of global goods, monitoring HDC efforts or responding to specific country requests. • Currently, there are six functional WGs, with membership varying from around fifteen people to several hundred. The six WGs are: Civil Registration and Vital Statistics, Community Data, Data and Digital Governance, Digital Health and Interoperability, Logistics Management Information Systems, Routine Health Information Systems (recently expanded to include the Public Health Intelligence WG). A Geographic Information System (GIS) WG is in the process of being launched. • Some WGs are existing entities or groups, which benefit from being part of the WGs. • WGs usually meet virtually on a monthly basis.
HDC Secretariat	<ul style="list-style-type: none"> • The Secretariat convenes the HDC, SRG, and WG meetings, leads advocacy and communication efforts, coordinates provision of technical support to countries, provides communication and coordination support to strengthen functional relationships/ facilitate information exchange and alignment of resources among stakeholders, manages and tracks implementation of workplan, provides reports on progress, undertakes strategic planning, monitoring and reporting. • Comprised of four part-time members currently, equating to approximately 2.5 full-time employees well as two regional consultants. • Hosted by the WHO and accountable to the SRG.

Cross-cutting issues across global governance structures

The restructuring of the HDC governance structures to promote streamlined and transparent decision-making and improve coordination and communication between stakeholders has not achieved its intended purpose. Current governance structures are faced with a number of efficiency challenges as follows:

The governance structure of the HDC is complex and heavy-handed, especially given limited resources to manage the network. Stakeholders through the consultations and e-survey cited the need to ‘strip the fat’ from governance structures and ensure that all layers are serving their intended purpose. In particular, stakeholders recommended i) reconsidering and potentially sunseting the constituency structures, ii) re-examining and strengthening the purpose of the SRG, and iii) reviewing the WGs to ensure that all are functional and needed. Members are engaging with HDC on a volunteer basis and report struggling to participate in frequent meetings (estimated anecdotally by the Secretariat at 100 per year between WGs, the SRG, GPG meetings, and constituency group meetings). The purpose of the constituency group meetings, which are being organised sporadically if at all, was particularly unclear to members.

The communication flow between the different HDC governance structures is not functioning optimally, resulting in a lack of effective decision-making, transparency and coordination. Communication within constituency groups is virtually non-existent. The process by which SRG representatives gather feedback from their

constituency prior to making decisions is also not occurring. This is partly because by the time SRG meeting agenda points are shared, SRG representatives struggle to have sufficient time to share agenda points with constituents for feedback. Additionally, given the number of commitments of HDC members (including other HDC meetings), there is limited appetite amongst HDC members to attend constituency meetings when convened and attendance is low. There was an attempt to offset this by opening up SRG meetings to all HDC members as observers, but the majority do not join. Decision-making processes are therefore perceived as somewhat opaque. Additionally, WGs have limited visibility on the activities of other WGs. The 2020-2023 workplan assigns particular tasks to different governance structure, for example, activity 1.1.3 on identifying best practices for collecting and using community-generated data was meant to be advanced by the CSO constituency with support from the HDC Secretariat and SRG. However, it is not clear how the constituency group could achieve this activity without facilitation from specific partner organisations.

The lack of human and financial resources is a fundamental limitation of the HDC.

- For 2016-2019, the HDC had been pledged US\$7.75m from partner organisations although it is not clear if these pledges were paid out.¹⁴ From 2019-2022 the HDC received US\$1.2m from the CDC. Meanwhile, the 2022-2023 Workplan is costed at US\$1.45m excluding core staff costs.
- It was envisaged in the 2016-2019 workplan that in addition to the HDC Secretariat consisting of three full-time employees, a core team of a further nine focal points with dedicated capacity within key partner organisations would facilitate the work of the HDC.¹⁵ This never happened however, given limited recruitment resources. The Secretariat is currently made up of WHO staff at 0.5 FTE and one full-time consultant since 2020 with ad hoc support from other consultants (including two regional part-time regional consultants since 2022 with a country focus) forming the equivalent of 2.5 FTE, with some members noting that they are being pulled towards other priorities.
- Engagement of WG and SRG members is also limited by competing priorities, given that members are full-time employees of partner institutions. The lack of human and financial resources negatively impacts the efficiency of governance structures within the HDC, and progress against the HDC workplan as activities such as WG deliverables and technical support to countries cannot be delivered without committed staff and resources. For example, the RHIS WG put together a database of documents and tools for country beneficiaries with the support of a consultant from USAID. Currently however, there is no staff support to maintain the database actively. Coordination and communication amongst partners, countries and WGs is also negatively affected by the lack of human and financial resources, and the Secretariat being overburdened.

Key findings by global governance and operational structure

Global Partners Group:

- **The diversity of HDC membership is widely regarded as a strength.** The HDC has grown in terms of membership from 43 partners in 2016 to 904 individual members in April 2023 representing over 200 institutions. The majority of consultations highlighted the diversity and inclusiveness of the HDC as a strength. Stakeholders also felt that the 'right' players in the data and digital health space have been engaged. HDC is the only platform that has managed to bring together such a diverse range of stakeholders, including major multilateral initiatives and donors, which is a key value-add of the platform.
- **Although the 'right' players in HIS have been engaged, representation by nationality and constituency group is unbalanced amongst the membership base.** Analysis of the HDC membership database shows that the majority of members (just under 400 and close to 50%) are based in the US. The majority of HDC members are from high-income countries with only 30% of members based in low- and middle-income countries. This imbalance was highlighted by stakeholder consultations. Additionally, as highlighted above the WHO is by far the most represented organisation within the HDC, making up 10% of the membership

¹⁴ HDC, 2016-2017 Operational Workplan

¹⁵ HDC, 2016-2017 Operational Workplan

base. With regards to the balance between the seven constituency groups, membership of the country constituency, private sector constituency, and civil society constituency remains very low in comparison to the rest (60 members are considered country representatives for example, compared to 203 members from research, academia and technical networks). Although there have been recent efforts to improve country representation on the SRG and WGs, the lack of representation from country stakeholders was noted as being particularly problematic multiple times in consultations and through the e-survey, especially given HDC's aim to be a more country-driven initiative and network. Limited country engagement is discussed in more detail below.

- **Despite a large and expanding membership base, only a small percentage of members are actively engaged in the HDC.** The HDC Secretariat is responsible for communicating with the GPG as a whole, through the website, newsletter, email updates, etc. However, anecdotal information from the Secretariat indicates that less than half of members engage with communication materials shared by the HDC Secretariat. Even members involved in the SRG and WG meetings struggle to maintain regular participation, given competing professional commitments and the large number of meetings organised through the HDC. Continuous and active participation in the HDC reportedly relies on personal commitment, as well as buy-in from within partner organisations who approve and legitimise staff members spending time and resources attending HDC events. That being said, GPG meetings are well attended by several hundred members virtually. A few stakeholders also reflected on the challenges posed by the COVID-19 pandemic with regard to engaging with the membership and key partners through in-person events and stipulated that this may have contributed to lower engagement of members.
- **The purpose of the constituency group meetings was not clear to HDC members.** Efforts to make constituency groups into functional 'units' with regular meetings have been ineffectual. Few constituency groups are meeting regularly according to the planned schedule, meetings are poorly attended, and members who attend did not see the use of these meetings. The lack of purpose of constituency meetings is partly because of a breakdown in communication between the SRG and constituency groups, discussed further below. Because of this breakdown, constituency group meetings are not feeding into SRG decision-making processes.

Stakeholder Representative Group

The SRG lacks clarity in process as well as the leadership to serve as an effective decision-making body, due to i) weak member engagement and attendance, ii) confusion regarding the purpose and procedures of SRG meetings, and iii) a breakdown in communication between SRG representatives and constituency groups.

- Interviews confirm that SRG members have variable understanding of their role. While engagement among this group is higher than across the general HDC membership base, most attend only a subset of meetings. A review of SRG meeting minutes shows that attendance from all members is inconsistent. As with other HDC governance structures, membership on the SRG is done on a voluntary basis.
- A review of SRG meeting minutes and consultations suggest that a strength of the SRG is that it serves as an open forum for dialogue, where members feel comfortable discussing strategic issues frankly and openly. However, the exact purpose of meetings is unclear. There has been some criticism from stakeholders of the use of the SRG forum for ad-hoc presentations on technical issues, which while interesting, is perhaps not the most appropriate use of the forum meant to provide strategic and technical direction for the HDC. Additionally, there are a few examples of the SRG endorsing documents but otherwise limited indications of formalised decision-making processes (e.g. How are documents endorsed and when should the HDC endorse a document? How should voting work?). While HDC governance documents do outline roles and responsibilities of the SRG, as well as voting processes (although notably discussion on endorsement of deliverables is missing), consultations with SRG members suggests that these are not implemented clearly in practice. Discussion points are raised within SRG meetings without planned follow-up in terms of activities and outputs from SRG representatives. Instead, the Secretariat is tasked with the follow-up for most action points coming out of meetings. In the end, without any real mechanisms for making decisions or following-

up on decisions, the SRG has been relegated to passively endorsing outputs of the Secretariat rather than actively making decisions. This also places a heavy workload on the Secretariat.

- A further breakdown in the legitimacy and process of the SRG is that there is limited communication from SRG representatives to constituencies they represent, as noted above. The process by which SRG representatives get feedback from their constituencies prior to SRG meetings is non-existent. In part, this is because agenda items and documents are sent out too late for constituency engagement to be possible, and as discussed previously constituencies are not meeting in practice. Previously, SRG meetings were open to all HDC members, whereas now HDC members and WG chairs are encouraged to join but as observers rather than participants. In practice, attendance of observers is low. While this effectively limits meeting attendance to a more manageable size, stakeholders have commented on the fact that it cuts off communication to the broader base of HDC members and lessens transparency.

Key decisions made recently regarding the technical and strategic direction of the HDC, such as the merger with the SDG GAP D+D and the decision to organise joint missions in Nepal, Pakistan and Malawi, were perceived as having been made without appropriate stakeholder and partner engagement.

Working Groups

There is significant variation in the structure of WGs, primarily in terms of the i) the level of independence of the WG from the HDC Secretariat and ii) the purpose and objectives of the WG. This causes some confusion amongst stakeholders on the role of the WGs and also impacts extent of delivery and accountability. Some WGs were explicitly created under the HDC umbrella following its inception and have a closer working relationship with the HDC, relying on the Secretariat to support communication and coordination. This includes the CRVS WG, Community Data WG, Data and Digital Governance WG, and RHIS WG. On the other hand, both the LMIS WG and Digital Health & Interoperability WG predate the HDC and operate semi-independently. Additionally, while certain WGs such as the RHIS WG are very output and deliverable focused, the LMIS WG for example is intended to act as a forum for open discussion and information-sharing on some of the challenges affecting coordination. However, most stakeholders agreed that rather than operating as semi-permanent structures, WGs should be reviewed and disbanded if no longer serving a direct purpose or working towards specific deliverables.

Recently in response to feedback that the WGs lacked clarity in direction, there have been attempts by the HDC Secretariat to encourage strong workplanning from the WGs with clear deliverables, timelines, and accountability established. However, given that not all WGs have similar aims and objectives, this one-size-fits-all approach to strengthening and standardising the approach of WGs has not been successful.

Coordination of the WGs has proved to be a major challenge. WG workplanning is done independently of the HDC workplan, and vice versa (even amongst WGs which are more heavily interdependent with the HDC Secretariat). Among more independent WGs such as DH&I for example, other than providing progress updates to the Secretariat there is little engagement and alignment between the WG and other global structures of the HDC. In a similar vein, coordination between WGs has been largely unsuccessful. Most WG members report being unaware of the activities being carried out by other WGs. This is seen as a missed opportunity for reducing HIS fragmentation and advancing a more holistic approach to HIS. Further information regarding key challenges and barriers to the effectiveness of WGs, as well as facilitators of success is presented in Box 2.3 in Section 2.3.2 on Effectiveness.

HDC Secretariat

The HDC Secretariat is highly constrained in its staff resources and is increasingly having to drive the work of the HDC given limited partner engagement, which is not the intended approach for a collaboration.

As noted above, limited FTE at the Secretariat implies it is stretched too thin. Some of the recent developments in enhancing capacity such as hiring of the regional advisors is welcome and could seek to improve effectiveness.

Further, limited engagement of partners and dysfunctionality of the SRG has resulted in the Secretariat having to play a particularly involved role in coordination and decision-making for the collaborative, which goes against the intended partnership/ collaboration nature of the HDC. Limited partner/ SRG engagement has also resulted in many aspects put forward by the Secretariat not gaining traction (e.g. the workplan commented upon previously, a draft communication strategy that has not been finalised, etc.).

2.2.2. SDG GAP data and digital accelerator merger

This section presents key findings relevant to the merger of the HDC and the SDG GAP Data and Digital Accelerator.

The SDG3 Global Action Plan was launched in September 2019 at the UN General Assembly, with the goal of accelerating progress towards the health-related SDGs through a partnership of thirteen multilateral agencies. Accelerator working groups were created to support country-level activities and develop global goods in support of those efforts, including a Data and Digital Health accelerator working group co-led by UNFPA and WHO.¹⁶ In 2021, the HDC and SDG3 GAP data and digital health accelerator agreed to fully align work, linking multilateral efforts and increasing efficiency. The priorities of SDG3 GAP Data and Digital Health accelerator's collaboration with the HDC are CRVS and GIS, and specifically work in Pakistan, Malawi, and Nepal.¹⁷ In 2021, UNFPA, Co-Chair of the SDG3 GAP Data and Digital Health accelerator working group, joined the governance mechanism of HDC as a third multilateral representative. Since November 2021, monthly HDC SRG calls have included SDG GAP D+D members. The three main areas of collaboration are:

- Synergies between the HDC and SDG GAP Secretariats to provide support as needed;
- Promoting closer collaboration between the data and digital health accelerator as well as the primary health care accelerator of the SDG GAP with HDC WGs and actions;
- Driving joint country action and missions.

The SDG GAP D+D Accelerator and HDC merger has led to some efficiencies in terms of aligning processes and resources, strengthening the overall approach of both initiatives and reducing duplication of efforts.

The merger was responsive to feedback regarding the overlap in membership and mandate of the SDG GAP D+D Accelerator and the HDC. The merger was successful in streamlining the number of meetings people were attending and reducing the burden on members involved in both networks. Additionally, efficiencies have been created in avoiding duplication of efforts when rolling out support from the HDC and SDG3 Gap in countries. The merger has facilitated two joint missions in Nepal and Malawi, and demonstrates considerable effort to bring together WHO, UNFPA, and UNICEF at the country and global level. Stakeholders highlighted that this was an important achievement and efficiency gain of the merger, as joint missions are generally difficult to coordinate. Country stakeholders reported that the joint mission enhanced information sharing and promoted an alignment of messages from the three actors – in addition to reducing duplication of efforts and resources.

There has been limited visibility of the merger amongst stakeholders, and implementation has not been done in the most strategic or transparent way.

Despite verbal commitments to coordinate and align the two initiatives, communication from the SDG3 GAP and HDC Secretariat as well as technical coordination meetings remain separate. Aside from joint missions on CRVS and GIS in Malawi and Nepal which involved the HDC CRVS WG and SDG3 GAP D+D Accelerator, there has been no technical collaboration between other HDC WGs or SDG3 GAP Accelerators (such as the Primary Health Accelerator) which was proposed as a potential value-add of the merger. The two Secretariats continue to be supported by different donors but with somewhat overlapping mandates. Indeed, some key stakeholders expressed confusion as to the differences between the SDG3 GAP and HDC from the perspective of donors, funding, goals, operational approaches, priority countries, plans and timelines. Stakeholders, even those who are most engaged, have reported little communication or transparency about the strategy or context of the merger as well as its consequences in practice for the respective activities of the two initiatives. Confusion around the merger is exacerbated by a lack of full strategic and technical alignment between the SDG GAP D&D accelerator and HDC. The HDC's membership base is much broader than the thirteen multilateral organisations who form the SDG3-GAP and focuses on data issues outside of

¹⁶ For context, the Data and Digital Health Accelerator is one of seven SDG3GAP Accelerator Working Groups including (i) sustainable financing, (ii) frontline health systems/ primary health care, (iii) community and civil society engagement, (iv) determinants of health, (v) R&D, innovation and access, and (vi) innovative programming in fragile and vulnerable states and for disease outbreak response.

¹⁷ HDC Progress Report, 2021

CRVS and GIS. Additionally, the HDC works with more focus countries than Malawi, Nepal and Pakistan. How the HDC and SDG GAP D+D Accelerator expect to coordinate and align despite these differences, has not been made clear. Finally, given that the SDG GAP D+D Accelerator is managed at the Executive Level, stakeholders felt that an opportunity to leverage this link in order to build political support for the HDC has been missed.

2.3. EFFECTIVENESS, SUSTAINABILITY AND IMPACT

The final pillar of the evaluation framework is on the OECD DAC evaluation criteria of effectiveness, sustainability and impact – grouped together for a “results” focused assessment.

The following evaluation questions are considered:

Review Question 4: To what extent has the HDC achieved its objectives of: (i) strengthening country capacity; (ii) improving efficiency and alignment of technical and financial investments in health data systems; and (iii) increasing the impact of global public goods on country health data systems? What is the evidence on HDC work contributing to reduced reporting burden and fragmentation alongside increased innovation and capacity at country-level? What aspects have worked well and less well in the achievement of objectives?

Review Question 5: To what extent is the HDC platform and its activities financially and programmatically sustainable? What are key issues hindering or facilitating sustainability?

Review Question 6: To what extent has the HDC contributed to (i) the improved availability and quality of health data, aligned with national priorities and (ii) improved use of data for evidence-based decisions, budget making, monitoring and implementation of health-related SDGs?

The questions on effectiveness and impact in particular (i.e. Review Questions 4 and 6 respectively) were designed in the inception phase based on the HDC Theory of Change and the level of results highlighted within this. However the analysis during the core evaluation work has highlighted the several challenges with the TOC (mentioned in Section 1 and also detailed below) and as such it has not been possible to systematically assess these different levels of results for the HDC. More details on our approach and findings are presented below.

Key findings – Effectiveness and Impact	Robustness rating
1. The HDC TOC is not well-defined and is rarely used and poorly understood by stakeholders as a result. The lack of a relevant and appropriate M&E framework is a significant weakness, resulting in unclear progress reporting.	Strong
2. There has been limited progress to date by the HDC against its three objectives – partly due to the range of challenges the HDC faces with its structure and design and partly due to external challenges outside of its direct control, including the COVID-19 pandemic.	Good
3. Despite an increased focus in recent years on HDC’s knowledge brokering and advocacy roles, there remain many challenges in reaching country stakeholders effectively, and the HDC has had limited success in increasing technical and financial alignment across partners with individual donor priorities continuing to shape the HIS agenda.	Good
4. The achievements of the WGs with regard to the production of global public goods, country capacity building and technical alignment across their respective areas has been mixed. Key facilitators of most productive WGs (such as Community Data, DH&I, and RHIS) include strong leadership from Co-Chairs, accountability and ownership from partners, and stable resourcing. All WGs struggle to effectively show contributions to change at the country level.	Strong
5. There have been limited tangible achievements of the HDC at the country level – including (i) limited success in supporting the design and maintenance of effective country coordination mechanisms for HIS, and (ii) limited effectiveness of country missions and support for costed priority plans for HIS strengthening due to the lack of clear follow-up actions, which in some cases has had negative unintended consequences due to a mismatch in expectations especially with regards to funding.	Good

6. It is difficult to clearly communicate impact at the country-level given the lack of a clear M&E framework and small scale of HDC support compared to investments from other partners, however gathered evidence suggests that only limited impact at the country level can be linked to the HDC.	Good
7. At the global level, a key risk to the sustainability of the HDC is the inadequate human and financial resources. This leads to sustainability challenges at the country level, as activities implemented by the HDC platform lack linkages to clear follow-up actions and funding.	Good

As a precursor to the analysis of these Review Questions, Section 2.3.1 provides an assessment of the TOC and measurement and reporting framework of the HDC. Thereafter, Review Question 4 on effectiveness is discussed through Sections 2.3.2 on assessment of achievements against the three HDC objectives, and specific areas of progress and issues with regards to HDC’s work on knowledge brokering, advocacy and political will building, the work of the Working Groups, and country level activities and related outcomes. Review Question 6 on impact is a natural follow-on to this analysis and is presented in Section 2.3.3. Finally, Review Question 5 on sustainability is considered in Section 2.3.4.

2.3.1. Assessment of TOC and Measurement & Reporting Framework

The starting point for our analysis of the progress and results facilitated through the HDC has been a critical review of its TOC, M&E framework and progress reporting over time. Our review suggests several challenges, which fundamentally impact the measurement of results of the HDC. In particular:

The HDC TOC is not well-defined and as a result is rarely used and poorly understood by stakeholders.

As outlined in Section 1.3, there are a number of challenges with the TOC developed in 2019. In particular:

- The TOC does not align well with the HDC objectives and activities (e.g. the TOC does not make reference to the production and dissemination of global public goods, there is reference to improve innovation and new technology in the TOC which has not been highlighted in documents or by stakeholders as a particular area of focus of the HDC, etc.).
- The TOC also does not represent HDC activities and does not demonstrate how the HDC is affecting needed change. As such, the TOC does not clearly demonstrate the value-add of the HDC or areas of comparative advantage, thereby not serving as a useful communication tool for stakeholders (one of the core uses of a TOC).

The updated TOC clarifies the alignment issue with the HDC objectives. However, few stakeholders were aware of this updated version and/or continued to be unsure on the specific scope and priorities of the HDC. Moreover, there are multiple versions of the TOC across HDC documents and websites contributing to considerable stakeholder confusion.

The lack of a relevant and appropriate M&E framework for the HDC platform (including specifically for the Working Groups) is a significant weakness.

The HDC Secretariat developed a workplan for 2020-23 with supporting indicators, which was aligned to its three objectives (see Appendix F for an overview of the workplan and its key indicators). However, the majority of indicators provided in the workplan have not been used and are not systematically reported against. There is also limited knowledge of the workplan among stakeholders reflecting their limited input into the design and the lack of its use to guide activities and reporting.

The identified indicators in the workplan were not clearly linked to HDC activities and it is not clear what is expected to be achieved through the HDC platform and what is expected to be achieved through the work of partners. Some of the provided indicators also are at the activity level – e.g., they are more a “tick box exercise” such as counting the number of events that have taken place rather than focusing on specific outputs or outcomes achieved through the work of the HDC. For other indicators, it is not clear how these link directly to activities from the HDC platform or whether they are just more widely reflecting work from HDC partners (e.g., number of countries using SCORE).

There has also been a lack of an M&E framework for the Working Groups, which has hampered planning and timeliness of activities, division of responsibilities amongst partners, and accountability. The HDC Secretariat has recently started to work with Co-Chairs of the WGs to develop workplans, which has largely been welcomed although stakeholders cautioned that workplans and the wider M&E framework need to reflect that WGs are based on voluntary membership and have differing objectives.

Progress reporting is ad hoc and there is no clear reporting of the main achievements of the HDC. Overall, stakeholders have commented that they are not aware of what the HDC has helped achieve.

Progress reports on the HDC that are available are largely focused on activities. There is some progress reporting at SRG meetings, but this is also activity focused and ad hoc in terms of what is presented over different meetings.

The majority of global stakeholders interviewed indicated that they are not aware of the achievements of the HDC and emphasised the need to clearly communicate the outcomes and impact at country level to members and partners. Stakeholders commented that the lack of understanding of the progress and achievements facilitated through the HDC at the country level is a key barrier to strengthening partner engagement and strengthening political buy-in from decision-makers.

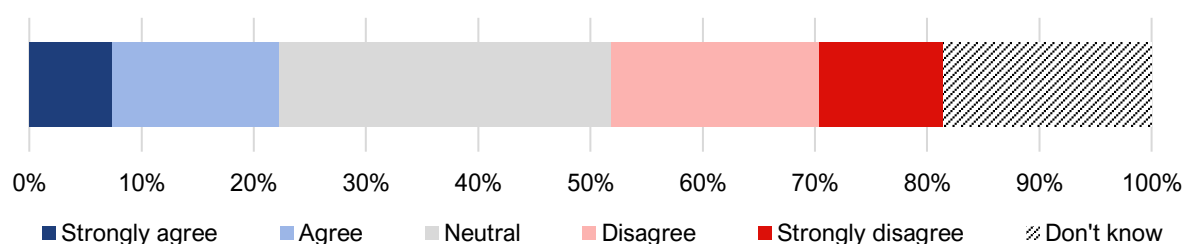
2.3.2. Effectiveness assessment

Achievements against three objectives

The lack of a functioning M&E framework and regular reporting makes it difficult to systematically assess the progress and achievements of the HDC. As outlined above, the lack of a well-functioning M&E framework and regular detailed reporting makes it difficult to clearly assess the progress made by the HDC, especially with regard to its outcome and impact at the country level. As result, this evaluation relied predominantly on the qualitative evidence from the consultations, e-survey and country case studies to inform an opinion on the progress made to-date.

There has been limited progress to date by the HDC against its three objectives – partly due to the range of challenges the HDC faces with its structure and design and the long periods of hiatus and low Secretariat functioning. This evaluation finds that overall progress facilitated by the HDC against its three objectives to date has been limited – a view which was supported through stakeholder consultations, country case studies (see country section below) and the e-survey (see Figure 2.5 below) which showed more participants (30%) disagreed that there has been substantial progress than agreed (22%). Other respondents were neutral (30%) or felt they did not have enough information to answer the question (18%).

Figure 2.5: Percentage of survey respondents who feel the HDC has made substantial progress on its objective since inception



There are a number of reasons for this limited track record including internal issues that could be addressed by the HDC as well as external factors which lie outside of HDC's direct control. This is presented in Table 2.2 below:

Table 2.2: Key factors responsible for the limited track record of the HDC

Internal factors	External factors (high-level/ sample)
<ul style="list-style-type: none"> • Mismatch of low resources and broad objectives • Hiatus in 2018-19 and low HDC Secretariat resources • Lack of an accountability mechanism, reporting and clear follow-up of activities 	<ul style="list-style-type: none"> • Global aid architecture which perpetrates vertical programmes and vertical data systems • Complexity of country data systems, with multi-sectoral (e.g., CRVS) and multi-stakeholder (e.g. government and non government) components

Internal factors

- Lack of high-level leadership buy-in, especially after 2018
- Lack of communicating clear value-add to country stakeholders

External factors (high-level/ sample)

- Changing landscape through digitalisation which is an attractive area for investment, but it is not always clear how practical/ beneficial these investments are
- COVID-19 pandemic impacted on the priorities of countries and the ability to coordinate in-person meetings

The COVID-19 pandemic was a challenging factor for successful implementation in 2020-2022 but also offers opportunities in the future as it highlighted the need for robust data systems for decision-making. One of the main ways in which the COVID-19 pandemic challenged the effectiveness of HDC activities has been through changing priorities of country stakeholders and partners away from routine healthcare and routine data collection on HIS. For example, country stakeholders reported that COVID-19 disrupted some of their efforts for stronger in-country coordination on HIS (e.g., Botswana, Malawi) and a few global stakeholders reflected on competing demands on their time during the pandemic. Additionally, the pandemic also required a change in working arrangement moving away from in-person meetings. However, many stakeholders considered that this effect was more limited on the HDC as many working arrangements took routinely place online in any case. Importantly, while COVID-19 was considered a contributing factor to the limited track record more recently, the vast majority of stakeholders considered it not to be the driving issue and instead pointed also to internal factors in direct control of the HDC. With regard to COVID-19, many stakeholders also emphasised the chances that it offered to the HDC and the HIS community at large by illustrating the need for strong data as well as providing impetus for increased innovation especially around the digitalisation of data systems.

Specific findings regarding HDC's effectiveness and achievements and how they relate to internal and external hindering factors are presented across four categories: (i) HDC knowledge brokering role; (ii) advocacy, communications and political will building; (iii) technical working groups and (iv) in-country activities and outcomes at the country-level. These are not comprehensive of the HDC's work nor mutually exclusive but represent the main categories of HDC's work as intimated through stakeholder consultations.

HDC knowledge brokering

Despite an increased focus in recent years by the HDC on knowledge brokering, there remain many challenges to reaching country stakeholders effectively. There have been mixed views on whether the HDC effectively conducted its knowledge brokering role (e.g., sharing best practices from countries and partners, and disseminating information through the website, regular member/ stakeholder calls, publications, and webinars). In the e-survey 33% of participants agreed or strongly agreed that the HDC was conducting its knowledge brokering role well whereas 26% disagreed or strongly disagreed (and the balance were neutral).

Specific insights across specific knowledge sharing activities include:

- *The website revamp was considered an improvement but is not easily navigable by country stakeholders to access guidance and tools.* While the new HDC website represents an improvement in explaining the nature and role of the HDC, no country stakeholders interviewed across the six country case studies indicated that they have used the HDC website to locate guidance or tools. The website was considered to focus on communicating the workings of the HDC rather than to communicate guidance, best practice and tools for countries in the HIS space.
- *Although hosting webinars has the potential to be a key value-add of the HDC, implementation requires significant strengthening.* At the global level, some stakeholders were appreciative of opportunities to participate in country-led webinars which highlighted specific activities and progress at the national level. However, generally the selection of webinar topics was critiqued as being ad-hoc and lacking clear purpose and follow-up activities. Additionally, some country stakeholders described these webinars as extra work, in which they were asked to present on their progress and approaches but did not receive any tangible input in return (e.g., sufficient time to discuss and receive feedback on their challenges), speaking to the need to adjust the structure of country-focused webinars in order to better serve stakeholders. Despite efforts to

increase the number and reach of HDC-hosted webinars, the majority of stakeholders at the regional and country level felt that visibility and engagement with these resources at the country level was weak. Overall, webinars are seen as an opportunity for value-add by the HDC but themes and topics require better targeting, particularly to respond to the needs of country stakeholders.

- *The effectiveness of HDC events was reduced due to the need for follow-up and enhancing country utility and value.* The HDC has organised several large summits which were well-attended by a mix of global, regional and country stakeholders. These events can be considered under the scope of both HDC's knowledge brokering and advocacy role. Some stakeholders spoke positively about these events as indicative of the HDC's capacity to convene a wide range of relevant stakeholders and spotlight key issues in HIS. Stakeholders also emphasised however the large resources they take, and the lack of connection to specific objectives and results which limits effectiveness of events for both knowledge brokering and advocacy purposes. Additionally, as events are largely Geneva-based some stakeholders have faced difficulties in attending. Country stakeholders also emphasised that there is a strong appetite for south-south collaboration and learning directly from country stakeholders in other countries which is not being met by the current structure of HDC events. This was considered an opportunity for the HDC given its wide membership base and mandate and something that could be more strongly supported through an increase in regional events. The HDC Secretariat was able to address some of these concerns through the 2023 Better Data for Better Health event, with efforts made to maintain momentum from the event and develop clear next steps following its conclusions and to allow for both virtual and in-person participation (See Box 2.1 below for more details).

Box 2.1: Summary of recent HDC events and views on their efficacy

HDC Leadership Event (2020): Two hundred people joined this virtual leadership event, where partners were invited to renew political commitments to data for action and country impact. The event showcased partnership as key to building on the COVID-19 response and accelerating support to drive the SDGs, as well as strengthening HIS to produce data for action. The event also served to advance the conclusions of the 2020 Stakeholder Report regarding recommended shifts for the HDC. Although stakeholders generally welcomed the event, there was no reported evidence that the event has led to renewed partner commitments.

Health Data Governance Summit (2021): The Health Data Governance Summit was organised by the WHO with contributions from the HDC. The summit provided an overview of the health data landscape, made the case for data as a global public good, and identified aspects of data maturity and good data governance practices. The resulting summit statement advocated for i) a global data governance framework with good data principles and ii) collective leadership and resources from multi-stakeholder and multisector data communities for stronger systems. The summit provides an interesting model for the HDC, as supporting partner events may limit resource constraints caused by planning and hosting large events which was highlighted as a key concern.

Better Data for Better Health (2023): HDC and partners co-hosted event in May 2023 to promote health data as a global good by (i) identifying and promoting good country health data governance practices (supported by the Data and Digital Governance WG); and (ii) promoting investment in HIS, guided by SCORE as an approach to investment, especially in Least Developed Countries. The event was organised to allow virtual and in-person participation, with several hundred people joining representing a diverse set of organisations and countries. Building on the momentum from the event, clear next steps towards a global health Data Governance Framework and investment in HIS were identified in the event report. Accountability and responsibility for these actions items have not been assigned however, and the Data and Digital Governance Working Group has indicated that their role in the development of a framework is on hold because of a lack of resourcing.

- *HDC specific knowledge products (i.e. in addition to those led by the WGs) are largely considered helpful but there is a need to ensure their practical application and use.* Recently, the HDC has engaged in the production of knowledge products to serve as useful aids for country stakeholders (outside of what was already being implemented and developed by the WGs which is discussed in detail below). Knowledge products include studies in five HDC countries examining partner alignment, the RHIS Investment Case commissioned by HDC and led externally by the Swiss Tropical and Public Health Institute, and most recently, a mapping of partner investments in the SCORE areas amongst countries engaging with the HDC by regional consultants. Stakeholders considered these to be useful additions but urged that knowledge products need to be effectively disseminated and practically applied rather than becoming purely interesting thought pieces.

The Nepal Alignment Study for example, was not disseminated widely to country stakeholders including those who participated in stakeholder interviews, and most were unaware that it had been finalised.

- *Some global public goods are used in countries but are often not linked to the HDC platform.* There are examples of countries using global public goods that have been supported or reviewed by the HDC (see Box 2.2) but in many instances this was considered to be driven directly by HDC partners and not by the HDC platform. Stakeholders generally thought that the HDC could play a valuable role with regard to knowledge brokering and with regard to dissemination and tailoring global public goods to country context. However, despite this being a focus under the reorientation of the HDC, there have been little examples where this has been done effectively and led to changes at the country-level.

Box 2.2 below highlights specific achievements of the HDC's knowledge sharing activities at the country level (note that there is a degree of overlap between this discussion, and the discussion of WG effectiveness continued below.)

Box 2.2: Achievements of HDC knowledge sharing activities & global public goods

Botswana: The Botswana HDC (BHDC) was established in 2020 to act as the country coordinating platform for HIS and M&E strengthening, guided by a Roadmap spelling out objectives and prioritised activities. The BHDC was established without direct involvement of the HDC/ HDC Secretariat but referred to global HDC documents and strategies in the development of the BHDC Roadmap. However, stakeholders commented that more country-adapted tools and guidance would have been useful. Since 2020, country stakeholders have participated in global HDC meetings (GPM, SRG and WGs) facilitated recently through the role of the Deputy Permanent Secretary as SRG Co-Chair. The focus of many meetings was perceived by stakeholders to be on delivering presentations on country best practices. However, stakeholders did not identify a strong direct value-add from these presentations. Stakeholders felt that they would benefit more from meeting formats encouraging active engagement with other country stakeholders, peer-to-peer learning and more open discussion around country challenges with space for feedback.

Cameroon: The Cameroon HDC (CHDC, established in 2016 as the coordinating platform for HIS and M&E strengthening) received technical support to adapt the WHO's reference list of 100 key health indicators to the Cameroonian context in 2017. However, this was viewed as having been supported by the WHO with no strong facilitating role of the HDC highlighted.

Malawi: Stakeholders involved in the development of government strategies from 2015-2018 pointed to the use of some global public goods, including WHO's Reference List of 100 Health Indicators, WHO's harmonised Data Quality Review, and WHO's Global Strategy on Digital Health. However, the majority of stakeholders identified multiple barriers impeding the use of global public goods. Stakeholders were unsure as to how to access global goods and technical expertise available through the global HDC platform and WGs. In particular, global public goods were considered not to be contextualised sufficiently to country specific contexts through the HDC or partners. Country stakeholders in Malawi also participated in several meetings through the global HDC platform on an ad-hoc basis, and similar to stakeholders in Botswana advocated for meeting formats which allowed for more active engagement with other countries and encouraged more concrete follow-up action.

Nepal: In 2021, HDC/UNICEF developed a case study on partner alignment on HIS in Nepal, however country stakeholders noted that there was little dissemination of this study to the country. A few stakeholders, who had contributed to that study as respondents, seemed unaware of the final findings and recommendations. While the report is available on the HDC website, country stakeholders have not been made aware of this. Stakeholders did not refer to any other global public goods where they thought the HDC may have played a facilitating role.

Advocacy, communications and political will building

At the global level, the HDC has had limited success in advocating for increased technical and financial alignment across partners with individual donor priorities continuing to shape the HIS agenda. Stakeholders commented that it was a tall ask to significantly change the approach to HIS financing at the global level and pointed to some of the underlying challenges innate in the global health donor landscape. The influence of the HDC in that regard was considered to be quite low with many of the key funding mechanism not closely engaged (e.g., Global Fund, Gavi, World Bank etc.) and also reportedly the perception that there has low support and engagement across senior leadership positions within HDC partners, especially after the HDC hiatus in 2018-19. As a result, any progress that has been made is often taking place exclusively at the technical level (e.g., through engagement of technical people in HDC working group and events) but lacks a strong linkage to political decision-makers in HDC partner organisations and the linkages to funding. This is also supported by the fact that only around 26% of respondents to

the e-survey felt that the HDC had performed well in terms of the creation of stronger links between technical work and political will with regards to HIS.

Several activities with regards to advocacy and political will building have been viewed to lack long-term strategic vision and follow through. As described above, a critique of HDC's larger leadership events and summits is that they have lacked the needed follow-through and emphasis on country utility that would have yielded clear results. In addition to these larger leadership events and summits, the main avenue by which the HDC has sought to build political will at the global and regional level is through participation in global fora and direct relationship building. For example, the HDC has forged relationships with UHC2030, the Countdown to 2030 Initiative, and SDG GAP. However, as noted previously in Section 2.2.2, the merger with the SDG GAP is viewed as incomplete and lacking strategic vision. Further at the regional level, the HDC has connected with the KEMRI Wellcome Trust and Institut Pasteur de Dakar who hosted the GPM in December 2021, however this engagement was one-off and viewed as lacking follow through and further relationship building.

At the country level, the HDC has sought to build political will and momentum around the concepts of the HDC and the creation or strengthening of country coordinating platforms for data, but country stakeholders highlighted that this is an area that needs further strengthening. The majority of country stakeholders were vocal in saying that they valued advocacy from the HDC and attempts to improve alignment, as well as the principles and approaches. For some countries such as Malawi and Botswana, the principles and concepts were one of the key value-adds of the HDC and led to the establishment or strengthening of country coordinating platforms, strategies and policies. However, an important finding from country case studies is that stakeholders had limited awareness and visibility of the HDC even within 'HDC countries'. Stakeholders emphasized the need to strengthen communication and advocacy efforts to improve in-country knowledge and awareness of the HDC. Stakeholders also suggested that regional and country offices of the WHO and other partners have not been appropriately leveraged in order to strengthen advocacy in countries. These regional and country counterparts to HDC partners have the potential to play an important role in advocating for the HDC approach and ensuring the buy-in of country stakeholders given their contextual knowledge and understanding. In Botswana, the regional and country WHO office played a crucial role in the development of the HDC approach, but this connection has been underutilized in the majority of countries. Additionally, stakeholders at the global and regional level stressed that thus far the message of the HDC has reached very few countries despite its potential reach given connection to the WHO. More on this is discussed below on country-level activities.

Communications and advocacy has been identified as a 2022-2025 strategic priority¹⁸, and a draft strategy has been developed¹⁹ but has not yet been implemented due to the need for resources. In the short term, the goal of the HDC Communications & Advocacy strategy is to increase general awareness of the HDC through increased website traffic and development of a core set of assets, including social media channels, where members can share key strategic opportunities such as findings from recent missions and global public goods from partners and WGs. In the long-term, the goal of the strategy is to advocate for data and health information systems strengthening and the alignment of partners resources with country data and digital priorities. The aim is to strengthen the link between HDC's technical work, and political leadership in countries and at the global level. The strategy will be supported by development of a stakeholder mapping exercise, key messaging architecture, a methodological approach, and a workplan. The draft strategy is an important first step towards strengthening the HDC's communication and advocacy approach, however has not yet been finalised or implemented although it is understood that this is planned for 2023.

Working groups

The achievements of the WGs with regard to the production of global public goods, country capacity building and technical alignment across their respective areas has varied by WG. An overview of the Working Group performance across the three HDC objectives is outlined below. It is based on consultations with all WG Co-Chairs, document review of progress reports and specific WG updates, and input from WG coordinators within the HDC

¹⁸ HDC, 2021, GPM Presentation: 2020-2021 Review, 2022-2023 Milestones

¹⁹ HDC, 2023, Communications & Advocacy Strategy (draft)

Secretariat. WG updates in the progress reports were not very extensive, and tracking of progress was not done systematically, and therefore it was challenging to get a complete picture of WG deliverables.

There are six active WGs and one inactive WG at present, including the CRVS WG, Community Data WG, Data and Digital Governance (D&DG) WG, Digital Health and Interoperability (DH&I) WG, Logistics Management & Information Systems (LMIS) WG, Routine Health Information Systems (RHIS) WG, and Public Health Intelligence (PHI) WG (now inactive and incorporated into RHIS).

- With regards to the production, review and sense-checking of global public goods which is arguably the key value-add of the WGs, the most productive WGs have been the Community Data WG and DH&I WG. Numerous global goods have been co-created through the forum of both WGs (please see Table 2.3 below for key examples). The Public Health Intelligence WG (now inactive), RHIS WG, and Data and Digital Governance WG have been moderately successful, making key contributions to one to two global public goods each, including landscaping and a compilation of resources and tools available at the global level to support RHIS. The LMIS and CRVS WGs have supported the dissemination of global public goods developed by partners, but do not act as fora for the production, review or sense-checking of global public goods currently.
- With regards to strengthening country capacity in HIS, the CRVS WG and Community Data WG have been the most active in terms of direct country engagement through visits and missions. The Community Data WG and DH&I WG have also been involved in the development of knowledge-sharing tools to strengthen country capacity, including trainings and webinars.
- It is most difficult to map out WG achievements against the HDC's objective to align technical and financial resources, however stakeholders pointed to moderate progress made against this achievement by the LMIS WG, Community Data WG, D&DG and CRVS WG. Although somewhat intangible, the key value-add of the LMIS WG highlighted by stakeholders is that it serves as an informal collaborative network which increases the visibility of partner activities in the space, and therefore contributes to harmonisation of approach across stakeholders. The Community Data WG has organised joint missions funded by UNICEF and USAID. Additionally, in certain instances and on an opportunistic basis, they have been able to align technical and financial resources at the country level. For example, in Liberia the WG contributed to a review of the community health system strategy and data system and were able to mobilise Global Fund malaria programming funding in support of community data strengthening. The CRVS WG and D&DG WG have mainly contributed to financial and technical alignment around their respective technical areas through high level advocacy at events.

Both the Community Data WG and DH&I WG have performed relatively well against the three objectives and were cited as effective and productive in terms of the development of global public goods and knowledge-sharing. It was highlighted however that for the DH&I WG, in terms of "HDC attribution" it operates fairly independently from the HDC and receives substantial resources through PATH (including staff support). While the LMIS WG has been the least active in terms of concrete deliverables, its purpose and value-add are in serving as a discussion and information-sharing forum and it also operates independently from the HDC as an informal network.

Table 2.3 below highlights the key achievements of each WG in more detail.

Table 2.3: Key working group achievements (**Sources:** consultations, progress reports, WG updates and 2022-2023 deliverable tracker)

WG	Years active	Key achievements
CRVS	2020-present	Mission and engagement with CRVS stakeholders in Kenya, Malawi and Nepal. Advocacy around the importance of CRVS through attendance and support of the of the CRVS Partners Meetings, UNSCAP Ministerial Conference, UNECA, and related ICD11 meetings. Support for dissemination of WHO CRVS Strategic Implementation Plan and WHO-UNICEF Health Sector Contributions towards improving CRVS in Low-Income Countries.
Community data	2018-present	Development of global public goods ²⁰ , with input and endorsement from multiple HDC partners, led knowledge-sharing activities including the Community Health Information System/ DHIS2 System Design Academy in Dakar, the Community Health Measurements and Planning Tools webinar, and sessions and country consultations on community data at the Institutionalizing Community Health Conference in 2021. USAID/ UNICEF have funded missions to Liberia, Nepal and Malawi (WG Co-Chairs supported in review of community health system strategy and community data system in Liberia and were able to opportunistically align with Global Fund resourcing connected to malaria programming).
Data & Digital Governance	2020-present	Coordinated development of Health Data Governance Principles with substantial support from TransformHealth, since adopted by 190 organisations. Developed HDC webinar on Health Data Governance in May 2022. Presented at HDC Data Governance Leadership Event in May 2023. In the process of developing Health Data Governance Framework.
Digital Health & Interoperability	2014-present	Development of global public goods ²¹ and knowledge sharing products such as Digital Health Planning National Systems training, Digital Health Convergence toolkit workshops, AI & Machine Learning language processing brief and guest speakers, and Digital Health Applied Leadership Programme at the University of Global Health Equity in Rwanda.
Logistics Management & Information Systems	2016-present	Mainly serves as an information sharing-network. Disseminates the many products produced by implementing partners, but it is acknowledged that these are developed and published by the individual partners.
Public Health Intelligence	2021-2022	Carried out a landscaping of the resources/ tools available in the PHI space. Active from 2021-2022, before being folded into RHIS.
Routine Health Information Systems	2020-present	Developed compilation of RHIS standards, best practices, and tools at the global level, stored in an online repository and accessible through the HDC website (work implemented by USAID consultant). Similar compilation of tools at the country level ongoing. Contributed to WHO RHIS Strategy. Workstream developed to reflect on the integration of public health and emergency surveillance reporting into RHIS with the aim of developing comprehensive guidance and document country case study examples. Connected to development of RHIS Investment Case (but work being led externally team at Swiss Institute of Hygiene and Tropical Medicine). Participated in introductory HDC trip in Pakistan.

An important impediment to the effectiveness of the WGs is the lack of strong and sustained country engagement, with limited evidence on country impact to date. A welcome improvement is that there have been attempts to strengthen country stakeholder participation on WGs, with country stakeholders invited to act as Co-Chairs. However generally, country engagement and the dissemination and tailoring of public goods has not been sufficiently strengthened despite the reorientation of the HDC towards country impact. Barriers include:

- Even the most productive WGs with regards to the development of global public goods are struggling to link outputs to impact at the country level. For instance, members of the RHIS WG were uncertain as to whether the compiled tools, resources and guidance documents made available through the HDC website are being accessed by users in countries. Many country stakeholders interviewed for this evaluation could not identify an instance of having used a global public good produced, reviewed or disseminated through the HDC WGs,

(including when asked about specific products flagged in Table 2.3 above) although a few could give examples of global public goods produced by partners such as the WHO. Evidence suggests that the current HDC website and WGs are not conducive to identifying priority global public goods and disseminating them to country stakeholders.

- Despite recent attempts to improve this, multiple stakeholders during consultations and through the e-survey noted that participation of country stakeholders in WGs at the global level remained weak and ad hoc. Presentations given to WGs are at times considered to be additional work for country stakeholders, without results in terms of feedback and concrete follow-up (further details in Section 2.1.3 above on Relevance and Coherence).
- The HDC model is not adequately set up to leverage technical expertise within WGs and link them to country requests for support. The ad hoc mechanism by which countries engage with technical support from WGs has caused several issues. Reportedly for example, a country draft report requiring review from WG members was publicly shared despite the country not having officially launched it.
- Country-capacity strengthening, particularly missions, were highlighted by WG members and by country stakeholders as unsustainable given inconsistent engagement. For example, recent CRVS/ GIS missions in Nepal and Malawi with CRVS WG members are not viewed to have contributed to any changes in terms of country policy or approach due to a lack of concrete follow-up actions.

Box 2.3 below highlights other key challenges and barriers to the effectiveness of the WGs, as well as facilitators of success.

Box 2.3: Facilitators and barriers to WG effectiveness

Facilitators of WG effectiveness:

The most important facilitators of WG effectiveness are strong leadership from Co-Chairs, accountability and ownership by partners, and stable resourcing if possible. The Community Data WG, RHIS WG and the DH&I WG have benefitted from strong technical leadership from Co-Chairs, which is particularly important given the heavy burden but voluntary nature of the position. Additionally, deliverables of the three WGs were led and pushed forward by a specific partner in collaboration with others. This type of ownership of activities and interventions within the workplan generates accountability, but also provides an avenue for aligning activities with financial resources from partners. The Data and Digital Governance Principles were similarly led and financed by a partner with staff support (TransformHealth). The DH&I WG, as mentioned above is financed and supported by PATH amongst other partners which stakeholders highlighted as a major facilitator of its effectiveness. Multiple WG members and Co-Chairs also noted that support from the Secretariat in alleviating some of the administrative burden of running the WGs has led to increased effectiveness, giving Co-Chairs the space to focus on technical aspects. Notably, all active WGs are successfully meeting on a regular basis although attendance is inconsistent (see section on challenges below).

Some of the key challenges and barriers to WG effectiveness include:

- The extent to which WG deliverables are partner-owned or attributable to the HDC is often disputed. The ownership of deliverables varies substantially by WG. For example, certain groups such as the Community Data WG co-produce global goods relatively frequently, whereas the LMIS WG, RHIS WG, and CRVS WG have mainly contributed to the review and dissemination of partner-owned products. Partner ownership of deliverables was highlighted as a success factor for WG effectiveness above with regards to accelerating progress and ensuring funding, however, also calls into question the extent to which the HDC itself adds value to the work of partners. This lack of clarity regarding ownership leads to difficulties in establishing accountability for products and later in the branding of WG products, causing bottlenecks in the development of WG deliverables.
- The voluntary nature of WG participation which leads to inconsistent attendance of members, difficulty in advancing deliverables, and sometimes, periods of inactivity especially if WG Co-Chairs are busy. This led to the eventual dissolution of the PHI WG for example.

- Progress stalling due to a lack of available human and financial resources- this has led to delays in the RHIS compilation of country-level tools and guidance documents, and the Data and Digital Governance framework for example as the WGs are having to seek means of funding Workplan deliverables.
- A lack of collaboration between the WGs, creating missed opportunities for more holistic HIS strengthening (for example, only CRVS WG members were involved in recent missions to Nepal and Malawi despite data governance challenges being raised during the mission in both contexts which technical experts were unable to fully address.)
- Processes around the review and endorsement of WG deliverables are not clear. The Data & Digital Governance WG for example sought SRG endorsement of the Data & Digital Governance Principles but found the process to be challenging. This was due to perceptions that the WHO should have been more heavily involved in normative processes and that the HDC should not be a forum for formal endorsement.

Country level activities and country-level outcomes

There have been limited tangible achievements of the HDC at the country level – this applies to the translation of global level activities to the country level as well as HDC supported country activities. Findings related to the effectiveness of HDC knowledge brokering at the country level have been discussed in detail above and here we focus on findings in relation to two areas: (i) support for the development of in-country data coordination mechanisms (“country HDC”); and (ii) in-country missions and support for development of plans. The findings are supported predominately by the insights of the six country case studies provided in the Supporting Country Case Study Appendix.

(i) Support for the development of country HDCs

There has been limited success in supporting the design and maintenance of effective country coordination mechanisms for HIS. A key aspect of the HDC, especially between 2016-18, was to support countries in creating and/ or strengthening a country-led data coordination mechanism. This included advocacy support in countries through missions in the wake of the 2015 “5 point call to action” and technical support in setting up the mechanism. Review across the six country case studies under this evaluation has indicated the following:

- *At the national level, governance structures for an in-country HDC vary but are considered to be more sustainable when adapted to the local context and leverage existing structures.* The results of creating/ strengthening an in-country HIS coordination mechanism have been mixed across countries, but overall stakeholders have emphasised the need to ensure that any such mechanism is tailored to the country context and strengthens existing structures rather than building parallel systems. This was reportedly the case in Tanzania which led to the in-country HDC coordination body not being successful and ultimately leading to a system without a strong coordination body for HIS (see Box 2.4). In Kenya, a country-level HDC was created in the absence of any coordination due to delays in establishing the Interagency Coordinating Committee (ICC). However, following the ICC’s recent legal establishment the country HDC is viewed to no longer add value, and was eventually folded into the ICC. The use of existing government mechanisms was also considered to ensure buy-in and improve sustainability – an aspect particularly important given that the HDC (global) does not have any funding to support any country level mechanisms. That said, the creation of a separate country HDC can be warranted if there is an absence of an existing coordination that could be leveraged. This was the case in Botswana which successfully designed a coordination mechanism based on the HDC principles (see Box 2.4), although this was achieved without direct support from the HDC platform.
- *Among the countries where an in-depth case study was conducted and which have established national coordinating mechanisms for HIS, multiple challenges threaten their effective operationalisation.* In Botswana, disruptions due to COVID-19, staff turnover amongst leadership and BHDC TWGs, and competing priorities amongst BHDC TWG members who are volunteering their time has led to infrequent meetings and a derailment of progress. Similarly in Cameroon, staff turnover and low motivation amongst CHDC TWG members and a lack of financial resources has led to stalling of meetings. The Malawi HDC structure has also been weakened somewhat over the years, due to internal political shifts and a movement of resources away from the M&E TWG (see Box 2.4 below).

- *HDC is not set-up to effectively provide support to in-country coordinating mechanism or to drive the alignment agenda in-country however it could play a role with regard to advocacy of the HDC principles:* The insights from the country case studies suggests that the HDC is not well positioned to support countries with their coordinating mechanisms given the lack of direct funding as well as the lack of in-country presence (or regular contact with a focal point at the HDC Secretariat or nominated partner). Instead, stakeholders suggested that the HDC value-add could lie more within an advocacy role for the HDC principles of creating country-led coordination which is then taken forward and driven by country stakeholders. Stakeholders emphasised the role that regional and country counterparts of the global partners can play here. In particular, the role of WHO Regional and Country Office was emphasised. This has worked well in the case of Botswana (although the specific country circumstances around political leadership and higher domestic resources need to be taken into account). Similarly, the importance of sensitising country offices of other partners to work with and support government country-led coordination was seen as key (e.g., with some donors for example instructing their implementors to attend and work with country coordination mechanisms).

Box 2.4: Case study country achievements with regard to an HIS country coordination mechanisms (country HDC)

Malawi: A strength of HDC engagement was that the pre-existing CMED (Central M&E Division) led M&E TWG was leveraged as a coordination mechanism to serve as ‘Malawi HDC’. CMED was also strengthened through HDC engagement and TA seconded by partners. Although this model of embedding the HDC within existing government structures decreased its visibility as a separate structure, it ensured that coordination with stakeholders as well as development of tools and strategies was government-led and avoided duplication and fragmentation. Internal political shifts, COVID-19 and available resources has recently led to a stalling of momentum with regards to alignment and coordination through HDC supported structures however.

Botswana: There was no government structure in place to coordinate stakeholders working on HIS/ M&E Strengthening prior to 2019. A new Botswana HDC was therefore established, but it was embedded within the Departments of HIS, M&E, and Quality Assessment (DHSMEQA). The BHDC Roadmap now acts to an extent as the workplan for DHSMEQA and is aligned with and subsumed into DHSMEQA tasks encouraging government ownership of HIS/ M&E and alignment of partners around government priorities. However, despite a strong start and substantial political will as well as momentum, the BHDC does not appear to be achieving its full potential due to operationalisation challenges including COVID-19 disruptions, staff turnover, and competing priorities.

Tanzania: A parallel time-limited HDC coordinating mechanism was established rather than reviving and strengthening the M&E TWG within the Tanzanian government. The parallel HDC structure was not successful and unsustainable in the long-run resulting in a system in which no central coordination is taking place and HIS sits predominately within disease specific teams at the MoH.

Cameroon: There was no government structure to coordinate stakeholders working on HIS/ M&E strengthening until the establishment of the Cameroon HDC (CHDC) in 2016. Establishment of the CHDC was a considered a key value-add, as it brought together stakeholders involved in health data production for the first time around a shared vision. Besides the initial moment around the establishment of the CHDC, there was limited support from the HDC with regard to in-country coordination. Despite progress, challenges remain including limitations on CHDC effectiveness due to lack of funding and continued misalignment between some partners.

Nepal: Nepal has a strong government-led coordination mechanism on a technical level for HIS (TWGS) as well as strong coordination of development partners through Sector Wide Approaches (SWAp). All in-country HDC partners support Nepal’s health sector within the SWAp framework. Stakeholders raised doubts as to whether the HDC had brought about any change or impact towards improving coordination and alignment for health data strengthening, beyond what was already happening through SWAp in Nepal.

(ii) in-country missions and support for development of plans

Country missions and support for costed priority plans for HIS strengthening have had some benefits such as increasing the visibility of HIS and identifying key issues with regards to data in the country. However, the overall effectiveness of this work remains limited due to the lack of clear follow-up actions and in some cases has had negative unintended consequences due to a mismatch in expectations especially with regards to funding. There have been mixed views on whether the HDC should actively support country missions for specific topics for HIS. There are benefits of conducting joint missions across different HDC partners. For example, the mission on CRVS in Malawi reportedly increased the visibility of CRVS, strengthening in-country coordination and alignment

and allowed for the identification of key priorities and areas for improvement (see Box 2.5). Additionally, it was also seen as an opportunity to strengthen collaboration of the HDC with the SDG GAP and improve the coordination across HDC partners such as WHO UNICEF and UNFPA. Similarly, in-country stakeholders generally considered produced outputs (e.g., mission reports, white papers, costing priority plans etc.) to be of good quality and as helping to progress thinking around key issues in the space. However, there have been a range of challenges with regard to country missions and costing plans facilitated through the HDC, including:

- *Misunderstanding on the expectations of missions and costed priority plans especially with regard to funding available.* Country stakeholders in Tanzania and Malawi emphasised that they had different expectations of the missions and costed priority plans especially with regard to the availability of funding from HDC partners. This included on the one side an underlying misunderstanding of the HDC platform and of the ability of the HDC to fund identified priorities and some stakeholders stated that these aspects were not clearly communicated through the HDC. More informed stakeholders that understood that the HDC platform does not have its own funding nevertheless criticised the HDC for not having done more with regard to raising funds from partners. For example, stakeholders stipulated that through more in-depth planning it should have been possible to at least raise partial funds from participating partners in the missions or help countries in scoping and applying for funds. This mismatch in expectations was also seen in Tanzania to contribute to the recent disengagement in the country.
- *Lack of planning for mission follow-up and delays in producing outputs.* Experiences in Malawi and Nepal have shown that the missions have been conducted without a detailed plan around deliverables, timelines and follow-up action. For example, in Malawi it took nearly one year to produce the white paper outlining recommendations and prioritised actions for strengthening CRVS/GIS and to receive ministry endorsement.²² While acknowledging the complexity of organising multiple stakeholders and organisations, the majority of stakeholders felt that as the white paper was the primary output of the mission, efforts should have been made to capitalise on momentum garnered through the mission by having clear timelines that aimed for a timely release of the white paper. Additionally, it was felt that a clear action plan on next steps (including raising funding and integrating result into government agenda) should have been part of the initial mission planning. Challenges around follow-up and delays were reportedly exacerbated due to the limited resources of the HDC Secretariat as well as limited time of WG members (especially where the mission was not strongly linked to their day-to-day activity).
- *Missions are perceived by some country stakeholders to be very top-down, not decided transparently with government stakeholders or partners at the country level.* In Malawi, some key stakeholders felt they were not given enough time to adequately prepare and felt that the mission was “top-down” and decided at the global level. This was aligned with some shared opinion from global stakeholders that described that mission planning was often “ad hoc” and opportunistic depending on what other partners were already doing and what WG members had available time.

Box 2.5: Achievements of country missions and costed priority plans

Malawi: the CRVS/ GIS mission in 2022 organised by the HDC/ SDG GAP was credited with improving engagement of stakeholders within the CRVS space and generating important insights but to-date these insights have not been translated to tangible policy or resource changes. Aspects in the planning and follow-up of the mission limited effectiveness including: (i) misunderstanding on funding available for identified CRVS priorities, (ii) delays in the output of the mission and insufficient planning to take generated insights forward in terms of a clear actions, and (iii) insufficient engagement with some country stakeholders prior to the mission.

Tanzania: Together with the MoH, HDC produced a comprehensive document “Data and Digital Priorities: Coordinated Monitoring and Evaluation for Health Systems Strengthening” (undated), a costed plan of action for the seven M&E priorities identifying key deliverables for each priority area. However, following the development of this plan there was no further support from the HDC to deliver against the priorities. This mismatch in expectations with country stakeholders reportedly led to disengagement. In contrast, the “Costed Investment Road Map to

²² This mission took place in June 2022 and the white paper was launched in April 2023 with ministry endorsement reportedly provided in July 2023.

Support the Digitisation of Health Data” developed by PLAN with support from the Bill and Melinda Gates Foundation was implemented and did lead to greater financial alignment for the digitisation of health data.

Nepal: In 2020, the HDC convened by the WHO CO virtually developed priority areas for intervention to strengthen HIS in Nepal. The process raised expectations of government stakeholders; however, the jointly developed priorities did not lead to alignment of partner resources and implementation was shelved. Subsequently in January 2023, the SDG GAP and HDC jointly carried out a country mission in Nepal, with a focus on CRVS/ GIS. The 2023 mission led to development of a white paper/ brief, however finalisation and dissemination of the brief as well as development of concrete follow-up actions have been slow to materials. Additionally, stakeholders have raised questions on the selection of the theme and priority for the mission (not aligned with agreed upon priorities in 2021). This has led to the perception that HDC interventions in Nepal are sporadic, rather than coherent and results-orientated.

Pakistan: The HDC participated in a mission organised by WHO EMRO on CRVS in March 2022. The mission established health data priorities for combined support from HDC and SDG GAP, and a costed joint workplan was developed for 2022-2023. The mission generated interest in the HDC among key government officials and helped identify priorities. However, the workplan has not been operationalised and there has been no follow-up from the HDC since the mission. This is mainly due to internal changes in the governance of CRVS.

Cameroon: The HDC (virtually) and WHO CO provided support to the CHDC in developing a costed workplan. However, the CHDC has been unable to implement the workplan due to lack of financing.

2.3.3. Impact at the country level

It is difficult to clearly communicate impact and outcome at country-level given the lack of clear M&E framework and small scale of the HDC support compared to investments from other partners. As outlined above, it is difficult to effectively measure the outcomes and impact of the HDC at the country level given the lack of an adequate M&E framework and progress reporting. Additionally, this challenge is exacerbated by the fact that many of the HDC upstream activities such as coordination and global-level technical alignment are very hard to measure at the country level.

Gathered evidence suggests that there is only a limited impact at the country level that can be linked to the HDC. This lack of tangible country impact was confirmed through stakeholder consultations who either thought that there is no strong country impact or asked for the HDC to more clearly communicate what they had achieved. Similarly, the e-survey results showed that only a minority of respondents (below 15%) agreed that the reorientation of the HDC had delivered in terms of increasing country impact. Most respondents felt that they had limited information as to the HDC's activities and impact at the country level or were neutral (~50%) and the rest disagreed that impact has been achieved.

Box 2.6 below confirms that message showing that HDC supported countries have made some progress with regard to the reduction in fragmentation of their data systems and improving the access and use of quality data, but there is only limited or no evidence that any improvements are closely linked to HDC's work. In Tanzania, Nepal and Pakistan, stakeholders did not identify an impact of the HDC's engagement in country (note that activity in Pakistan has been very limited, as it is a pre-engaged country). In some instances, it can be said that the HDC provided some limited contribution as in the case of Malawi and Cameroon primarily due to early support strengthening in-country coordination mechanisms. Additionally, in the case of Botswana it could be argued that some “early wins” through the Botswana HDC have been enabled in the wider sense through the HDC principles (though to note is the lack of the HDC platform in directly supporting the set-up of the BHDC). In all three of these contexts, there have been improvements in the availability, quality and use of data since the launch of the HDC however challenges related to fragmentation and coordination persist.

Box 2.6: Impact of the HDC at the country level

Botswana: The BHDC had a strong start with substantial political will after its launch in 2020, and early wins included development of a comprehensive Roadmap and progress on initiatives such as the Health Sector Indicator Handbook. However, recent challenges related to COVID-19 and competing priorities have halted early progress, and an internal review by the Botswana MoH identified persisting challenges related to inadequate stakeholder coordination and poor-quality data. Given the lack of recent progress reporting however, the impact of recent initiatives (including the Indicator Handbook) is difficult to assess. The HDC itself has provided limited support in Botswana, although arguably HDC principles were a factor in setting up the BHC and in enabling some early wins.

Malawi: Since 2015, there have been improvements in the availability and use of health data, although challenges limiting the quality of data persist including fragmented and vertical programming and M&E. Improvements in the availability and use of health data can be partly attributed to the HDC's early work strengthening leadership and governance in Malawi (an area that was considered to perform strongly in the 2023 CHISU/ USAID rapid assessment of Malawi HIS). However, the HDC was only one actor in a wider HIS landscape of increased technical and financial support for M&E/ HIS from partners after 2015.

Tanzania: Since the launch of HDC, a more enabling policy environment has been developed for data strengthening, and significant strides have been made with HMIS data harmonisation and standardisation. Advancements include the development of HIS and M&E policies and guidelines including a Digital Health Strategy, roll-out of standardised indicators and tools through DHIS2, and harmonised data quality assessments. However, there is no evidence that HDC activities have contributed to these advancements.

Nepal: The HDC has not impacted HIS strengthening in Nepal. This is due to (i) limited value-add to existing structures coordinated through SWAp; (ii) no obvious contribution to mobilisation or alignment of resources; (iii) isolated events and outputs (such as case studies and missions) not followed through or linked to concrete actions; (iv) no clear link of global engagement to policy/ funding changes in Nepal; and (v) limited guidance/support from global HDC and partners headquarters to country teams.

Pakistan: The HDC has yet to have impact in Pakistan, given limited engagement.

Cameroon: The CHDC has played a role in facilitating convening of HIS stakeholders, leading to improvements in data sharing and availability as well as strengthened coordination between different MoH units and involvement of actors. Since 2016 other improvements in the availability, quality and use of data include implementation of harmonised data tools, data quality reviews, joint health facility surveys and roll out of DHIS2 in Cameroon. The CHDC is seen by stakeholders as having played an advocacy role in these advancements, but the global HDC platform is not credited by stakeholders as having significantly contributed.

2.3.4. Sustainability

This section presents key findings relevant to sustainability of the global HDC platform and the sustainability of its activities at the country level. Key findings include:

- **The sustainability of the HDC and its activities are threatened by the lack of adequate human and financial resources and reliance only two key HDC partners for support.** The Secretariat is under resourced when compared to its objectives and mandate and spread too thin to effectively coordinate and implement its activities. The lack of resources impacts both on the medium and long-term planning and interferes with the effective implementation and follow-up of activities. Moreover, the concentration of support to a few HDC partners further threatens the sustainability of the HDC platform with current funding coming predominantly from the CDC and human resources being provided predominantly by the WHO.
- **Option to provide funding and long term-support for the operationalisation of country coordinating mechanisms is not considered feasible given the lack of HDC resources.** The country case studies illustrated that in-country HIS coordinating mechanisms experience sustainability risks over time and that long-term funding and technical support would be a key value-add to address any operationalisation challenges (see Box 2.4 above and the Country Case Study Appendix). These challenges are particular pronounced in countries in which HIS coordinating mechanisms are not leveraging on existing structures and/or secured buy-in from senior decision-makers. Global stakeholders understood that the HDC would not be in a strong position to provide this support directly given the lack of funding and no country presence. However, there were often misunderstandings regarding the ability of the HDC to provide funding at the

country level leading to disappointments and disengagement in some instances (e.g., Tanzania). As a result, some stakeholders suggested that the HDC should re-orient its workings to clarify on funding expectations and instead more heavily advocate that any HIS coordination leverages and strengthens existing structures and receives strong in-country leadership which can offer more long-term sustainability.

- **Many activities implemented by the HDC platform in countries face sustainability challenges due to a lack of linkages of activities to clear follow-up actions, sustainable long-term funding and/or existing initiatives and structures.** There are number of examples of HDC supported activities such as prioritisation exercises, costing plans or country missions which were conducted ad-hoc (and while some had value-add) they overall were considered to lack strong follow-up and linkage to financing making them unsustainable (see Box 2.5 above on country missions and costing plans).

3. SUMMARY FINDINGS AND CONCLUSIONS

The HDC was launched with heightened political commitment on increasing efficient and aligned investments in country data systems and strengthening country capacity on data collection and use, through the the USAID-World Bank-WHO convened Measurement and Accountability for Results in Health Summit of 2015 and the corresponding “5-point Call to Action” and “Roadmap for Health Measurement and Accountability”. The Summit and its outcomes helped lay the foundation for the HDC and contributed to its original set of objectives and design. As a result, in its initial years, the HDC received the political attention needed to advance its work, however very soon reached a temporary hiatus in its work on account of several changes in the external landscape, including the WHO transformation agenda. A reorientation of the HDC was sought over the next couple of years (2019-20), which identified a number of similar challenges to that identified in this evaluation in 2023. Fundamentally therefore, the HDC has not been able to re-boot itself based on the reorientation of 2019-20, and in fact, this evaluation finds that several of the changes introduced with the reorientation have not worked effectively since 2021.

The HDC is therefore at an important crossroads – with half the time to the SDGs elapsed and a critical need to ensure it delivers in the rest of the years in the run up the SDGs in 2030. Importantly, there were almost unanimous views from this evaluation that the HDC should not be disbanded but re-oriented and reformed. Even when stakeholders were not fully aware of the HDC concept and construct, when explained, were of the view that there is a definite space for a collaboration like the HDC to support better data and measurement for countries. The HDC objectives on improving country capacity, efficiency and alignment of financial and technical investments in health data systems and increasing the impact of global public goods and tools on country health data systems were all viewed as very relevant in relation to country needs. The multi-partner structure of the HDC (comprising international organisations, countries, academia, civil society and the private sector) was viewed as critical and of added value, enabling a holistic approach and support for country data systems; an aspect not offered by any other data-focused initiative, and especially at the overall HIS and global level. Stakeholders also emphasised the important gap and potential to support knowledge brokering on data-related guidelines and tools, as well as advocacy for aligned and efficient data systems, aspects that would be best delivered through a structure like the HDC through its multi-partner and informal structure, backed with credibility through WHO hosting.

However, the challenges in relation to the HDC are with regards to:

- A very broad set of objectives, lacking specificity and too ambitious in relation to the HDC resource base – which currently has declined to funding by one donor only (the CDC) alongside limited staff resources through the WHO.
- Lack of clarity amongst stakeholders on what the HDC is set up to do, what it does in practice and how to engage with the HDC. The HDC is viewed to have facilitated a disparate set of activities to date (both at the global and country levels), with no cohesion/ integration and limited follow-up. In particular, there are mixed views on stakeholder meetings and events that are organised by the HDC, but country stakeholders particularly have not viewed a very strong benefit for their participation to date.
- A heavy-handed governance structure, that does not support strategic decision-making, transparency or accountability, and is poorly understood by the range of HDC stakeholders.
- As a result of the points above, limited partner engagement with the HDC, an aspect that has fostered dissonance between the partners and HDC Secretariat, with the latter taking on more of a principal role over time – and thereby fostering a cycle of further dissonance. While there are some good examples of partner engagement (e.g. through select Working Groups) and outputs (e.g. the HDC-UNICEF country alignment studies), these are not extensive within the rubric of the HDC.
- Most significantly, the reorientation of 2019-20 sought to make the HDC more country focused, with an intention to pivot its work towards country impact, but until the end of 2022 there was no focused approach or functioning mechanism to support country engagement. For example, country engagement has been sought through the various governance structures of the HDC, but countries are not adequately incentivised to engage and have fed back through this evaluation that they do not see the clear benefits. The HDC has

sought to engage directly with some countries to support their data needs, but this has left these countries frustrated for the most part due to the lack of an offer of funding from the HDC and limited follow-up of in-country missions and activities. Further, as noted above, several country stakeholders have fed back to this evaluation that they have not seen immense value from participating in HDC organised events and meetings. Finally, Working Group outputs are not making their way to countries for the needed/ intended impact. Fundamentally therefore, the HDC is not able to deliver against its country focused role, which by virtue of its ambitious objectives and existing set-up is not conducive to deliver on this role. Most recently in 2023, there have been some promising changes to the HDC approach in this regard including the move away of focusing only on a few select countries and the increased focus on the regional level to engage with countries including through two new regional consultant positions.

- The lack of funding and no country presence means that the HDC is not well placed to provide in-depth support to countries on the operationalisation of in-country HIS coordinating mechanisms. There have been some benefits in terms of improved alignment and leadership to which the HDC early 2015-18 work on strengthening country coordinating mechanism has contributed. However, the evaluation found that the HDC is overall not well placed to provide sustainable technical or financial support on the operationalisation of country coordination and should therefore rather focus its efforts on advocacy and knowledge brokering on this topic.
- Limited information and awareness of the progress and results facilitated by the HDC – not least because of the lack of a clear M&E framework and regular and robust progress reporting – but also because of the opacity in the work of the HDC and how it is seeking to make measurable impact. There has only been limited progress to date by the HDC against its three objectives and many of its conducted activities have not been delivered effectively to-date and there have only been limited tangible achievement that can be connected to the HDC at the country level. To some extent, this is also a function of the upstream and coordinating role of the HDC, where direct attribution is more challenging.
- There have always been key external factors which have hindered the effectiveness and achievement of the HDC. This included general challenges regarding the structure of the global aid architecture which perpetrates vertical programmes as well as the complexity of the HIS space. In 2020, the COVID-19 pandemic added an additional challenge especially by diverting country stakeholders and partner priorities away from routine HIS systems and, to a lesser degree, providing additional challenges for in-person meetings and coordination.

As such, the challenges for the HDC are many, and some longstanding, and there is an urgent need to address these challenges and support the better and more efficient functioning of the HDC. A re-boot 2.0 is in order, and several recommendations in this regard are provided in the next section.

4. RECOMMENDATIONS

The final section of the report presents recommendations for the HDC, based on the evaluation findings, conclusions and lessons learnt. **Recommendations have been discussed in a workshop of HDC stakeholders held in September 2023. An essential list of recommendations has been proposed to re-boot the HDC, without which it cannot be assumed that it can improve in its efficacy.**

Recommendations are both strategic and operational, as follows:

Strategic recommendations	<p>Recommendation 1: Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage, and develop a supporting Theory of Change, work plan and M&E framework.</p> <p>Recommendation 2: Simplify and improve the effectiveness of the HDC governance by creating a small Board comprising senior level decision-makers from key donors of HIS alongside individual representation from other stakeholders (countries, CSOs, technical) that provides strategic direction to the HDC and remove the constituency-focused arrangements.</p>
Operational recommendations	<p>Recommendation 3: Improve the engagement with countries by developing a clear country engagement strategy that is well communicated and understood by stakeholders and especially countries, and does not focus on a preselected list of countries. Ensure that everything the HDC does is based on country needs and priorities and considers the added value for countries.</p> <p>Recommendation 4: Implement a number of actions to enhance the effectiveness of the Working Groups and ensure their outputs are directly relevant for countries.</p> <p>Recommendation 5: Ensure streamlined and focused communications that are tailored to different audiences (e.g. governance, learning) and stakeholders (e.g. global, country) and carefully consider the value add of these communications for respective stakeholders.</p>

Each of these recommendations are described in detail below in terms of their content and actions, implementation responsibility (i.e. who would be responsible for implementing the recommendation) as well as timeline and capacity requirements.

Limited resources of the HDC (Secretariat and partners) is acknowledged, and hence recommendation 2 on setting up a new HDC Board is of priority. This would however need a “first push” by the HDC Secretariat, supported by its hosting agency WHO. Several recommendations are aimed at garnering partner traction and engagement – specifically recommendations 1, 2 and 5, which aim to redefine HDC and re-do its governance so is more engageable by partners.

The timelines for the strategic recommendations is immediate/ short term, recognising that no time should be wasted in re-booting the HDC.

4.1. STRATEGIC RECOMMENDATIONS

Recommendation 1: Reduce the scope of the HDC to focus on where it can add value and has a comparative advantage, and develop a supporting Theory of Change, work plan and M&E framework.	
Implementation responsibility	HDC Board comprising partners (see recommendation 2 below) and HDC Secretariat
Timelines & capacity requirements	<p>Timeline: Immediate/ Short Term</p> <p>Capacity requirements: Medium</p>

This recommendation has received widespread support from HDC stakeholders. The following is recommended:

- **Reduce the broad scope of the HDC and concentrate its resources on a smaller number of objectives and activities where it can add the most value and has a comparative advantage.** The lack of

understanding and communication of the HDC comparative advantage has been a barrier to effective partner and stakeholder engagement. Additionally, it has led to the ineffective delivery on certain activities which can be considered outside of the core comparative advantage of the HDC. A focusing of scope would ensure that available resources are not stretched too thin and allow for more effective planning, implementation, and follow-up. Additionally, it would sharpen the HDC profile and more clearly communicate HDC's value-add to partners and countries. The scope of the HDC should be adjusted to reflect engagement of partners and availability of committed human, financial and political resources over time. The renewed scope would also need to take account of any synergies with the SDG-GAP Data and Digital Accelerator merger. See Box 4.1 below for CEPA's view on areas where the HDC should and should not focus. A one-page document along these lines that clearly articulates what the HDC does and how, and specifically what it doesn't do, should be developed and shared with members to improve clarity on the HDC role.

- **Develop a supporting updated theory of change** which is closely aligned with the updated scope and provides clear linkage to HDC activities and their expected outputs, outcomes and impacts. The TOC should be able to provide stakeholders with a clear presentation of HDC priorities and an understanding of how the HDC is expected to facilitate progress/ achievements. A partner workshop could be organised to help flesh out the new TOC which resonates with all partners' understanding and requirements.
- **Develop a clear workplan which is closely linked with key partner priorities and workplans.** Recognising the big task that this could be an option could be for the HDC to review and engage with the plans and priorities of some of the biggest funders of data systems at the country level (recognising these are developed in discussion with countries and/ or are country-led) such as the US government, the World Bank, the Global Fund and Gavi, and seek to identify where it can add value to help further their plans. The developed workplan should assign responsibilities to partners and also clearly outline the role of the HDC Secretariat. The development of the workplans should be mindful of the existing resource with the focus being on accountability. A successful workplan in this regard would ultimately also depend on effective leadership by the HDC (through the proposed HDC Board described in recommendation 2 below, the WHO as host of the HDC and the HDC Secretariat).
- **Develop an updated M&E framework and provide regular reporting.** The M&E framework should focus on results rather than activities. It should also make clear the contribution of the HDC platform and should be regularly reported to the HDC Board and key HDC partners and stakeholders. The M&E framework should be "light-touch" and fit for purpose i.e. a few core indicators should be focused upon rather than a long list, use of qualitative case study approaches given the upstream nature of HDC's work, etc.
- **Build an investment case around the new HDC objectives and workplan and advocate for funding (whether financial or in-kind partner support).** The HDC should develop a compelling investment case for its work, to serve as both a communication and fundraising tool.²³ On the back of this investment case, the HDC should look at re-engaging key HDC partners with the objective to get additional resources – either financial or in the form of dedicated staff time from partners (i.e. in-kind funding). Resource raising should be aimed at ensuring that the HDC Secretariat comprises multi-partner staff/ consultants (i.e. beyond WHO). The investment case should be well socialised amongst partners, including countries.

²³ This should be aligned and build on work being conducted on the investment case for good data governance and HIS and the upcoming broader data dividend work being presented at the UN SDG summit in September.
<https://www.healthdatacollaborative.org/meetings-events/events/better-data-for-better-health/>

Box 4.1: Assessment of HDC role going forward

Based on stakeholder feedback and the overall findings for this review, as well as a deep consideration of: (i) the feasibility of different roles given current HDC positioning; (ii) resource requirements (and especially being cognizant of the limited financial resources of the HDC and informal set-up of members/ partners); and (iii) where greater and continuous engagement with countries would be required (noting that is not possible in the current set-up of the HDC), the following are this evaluations views on the potential role for the HDC going forward.

This assessment is based on the current context for the HDC, and should there be growth in its financial resources and greater partner engagement in the future, it could look to re-evaluate its role and scope of work.

There is a **core role for the HDC** in the following aspects, all of which are aimed at country impact:

1. **Knowledge brokering** – which means supporting the development of knowledge products and making them available to the intended users (i.e., countries). As such, there is a two-fold role here for the HDC including:
 - (i) *Supporting the development of knowledge products*, which would leverage on its wide-ranging technical expertise by virtue of its multi-stakeholder membership and Working Group structure. The role could encompass supporting a multi-stakeholder review of knowledge products to enhance their appropriateness and relevance, support for contextualising certain global products for country-specific needs, and (where there are resources) developing global-level knowledge products covering key gaps on HIS related knowledge.
 - (ii) *Dissemination* – which would include dissemination to countries through the HDC and partners, including through holding workshops and conferences.
2. **Supporting learning through workshops and conferences**, building on the knowledge brokering role described above, but also supporting country-to-country/ peer-to-peer engagement and learning on key topics of relevance on HIS, through global level and multi-country workshops and conferences.
3. **Advocacy and communication for more efficient and effective HIS**, covering a range of issues relevant for HIS and on the back of good data and tailored advocacy/ communication approaches by stakeholders. One of the key aspects emphasised by stakeholders is with regards to advocating for donor alignment and reduced fragmentation of data requirements in countries. HDC could play a strong centralised role to make stakeholders more aware of the benefits of coordination and the costs of fragmentation (e.g. HDC could advocate for the use of existing in-country coordination mechanisms and government structures, provide a set of principles for country coordination, compile data on areas of donor coordination and fragmentation and make this available more widely to advocate for the ensuing benefits and costs). Other aspects could include the importance of integrated data systems at the country level, digital interoperability of different data systems, importance of community-led monitoring alongside other forms of data collection, etc.

Areas where the HDC should not consider and/ or de-prioritise are the following:

- **The HDC as a funding entity for country HIS needs.** The current political and economic climate post COVID-19 where many large global health initiatives have not been able to meet their replenishment targets indicates limited possibility of extensive HDC fund raising. Feedback for this evaluation did not support the role of the HDC as a funding entity, also noting this would add to further donor fragmentation of funding.
- **“Direct support” for operationalisation of country coordination on HIS**, noting this role requires hands-on country engagement which the HDC is not able to provide. Previous attempts at playing this role have met with limited success to date in terms of attribution to HDC in particular. A high-level knowledge brokering and advocacy role is however an option for the HDC.
- **Wider capacity building through direct TA provision and a country-by-country approach.** Capacity building is a wide term and has caused confusion amongst HDC stakeholders as to the exact scope of the HDC offering. As described above, capacity building linked to knowledge products and peer-to-peer learning should be supported by the HDC, but direct TA provision to countries would require resources, a defined mechanism for country access and regular country contact that the HDC does not have. The HDC Secretariat also does not have the capacity to maintain a roster of TA providers and be adequately networked with countries and donors to support this role. In addition, the TA landscape is already scattered and HIS donors and technical partners (including WHO) are making considerable efforts to improve coordination and accountability (and so HDC role in this area would add to fragmentation).
- **More engaged work on affecting donor alignment and coordination beyond advocacy efforts**, given the limited “weight” of the HDC in directly affecting these alignment agendas and priorities amongst the key donors in the global aid architecture, as also this role requiring more resources and country engagement which the HDC does not have. It was also noted that key donors are involved in coordination

discussions which are not through the HDC. As described above, the HDC could however have a potential advocacy role, to highlight the challenges from vertical data systems.

Recommendation 2: Simplify and improve the effectiveness of the HDC governance by creating a small Board comprising senior level decision-makers from key donors of HIS alongside individual representation from other stakeholders (countries, CSOs, technical) that provides strategic direction to the HDC and remove the constituency-focused arrangements.

Implementation responsibility	HDC Secretariat with partner engagement
Timelines & capacity requirements	Timeline: Short term Capacity requirements: Low-Medium

The following is recommended:

- **Overall structure:** The HDC governance structure should be substantially simplified to comprise a small Board for strategic direction and guidance and a Secretariat for day-to-day delivery only that is accountable to the Board. **Simplification means to remove other governance structures and especially the constituency-based structures as these are viewed as time-consuming and ineffective by stakeholders.** The importance of a multi-constituency voice is recognised but in the face of challenges in engaging partners, it would be important to prioritise their engagement through the WGs rather than requiring their grouping by constituency and organising constituency meetings.
- **Board membership:**
 - The Board should include a small number of stakeholders, individuals/ organisations that can really engage with the HDC. **It should include the largest funders for HIS (e.g. USAID, Global Fund), select technical partners (including Working Group Chairs if relevant), and some other stakeholders to represent country and CSO voice. The overall membership will therefore represent the various constituencies of relevance for HIS, but fundamentally this needs to be a senior level decision-making Board rather than focus on representation of different groups.**
 - It should not be a political level Board – in that members do not need to advocate for the HDC, but should include senior members from representative organisations. It can include technical representation – but, again, in essence the Board needs to include senior representation that can take decisions regarding collaboration and coordination of different organisations in the HIS space.
 - Given the above, there will need to be a mix of institutional and individual membership i.e. institutional membership from the largest funders of HIS but individual membership from a limited number of technical parties.
- **Board role and size:** The Board should have the clear mandate to provide strategic direction to the HDC i.e. define its objectives and scope of work, review annual workplans, assess progress and needed course corrections over time, etc. A starting point for the Board would be to oversee the implementation of the evaluation recommendations. **Given the role, the Board should comprise 5-7 members.**

4.2. OPERATIONAL RECOMMENDATIONS

Recommendation 3: Improve the engagement with countries by developing a clear country engagement strategy that is well communicated and understood by stakeholders and especially countries, and does not focus on a preselected list of countries. Ensure that everything the HDC does is based on country needs and priorities and considers the added value for countries.

Implementation responsibility	HDC Secretariat, with support from partners and guidance from the Board
--------------------------------------	---

Timelines & capacity requirements**Timeline:** medium term**Capacity requirements:** Medium for the HDC Secretariat

The following is recommended:

- **The HDC country engagement strategy should be clearly communicated to partners and countries,** highlighting specifics on what it does and does not do in relation to countries (especially given the history of mis-aligned expectations). Box 4.1 above provides a start on providing a clear framework in terms of what the HDC does for countries and where it does not play a role. Effective communication of this strategy would rely on operational leadership from the HDC Secretariat.
- **Move away from a pre-selected list of HDC countries that are provided with more specific support.** The evidence in this report suggests that the HDC in its current form is not well placed to provide in-depth and long-term technical support to countries – for example, the HDC itself is not well placed to support countries with the operationalisation of their data coordinating mechanisms. Instead, the HDC should concentrate on activities that are more relevant for a wider number of LMICs that could benefit from the HDCs offering with regard to knowledge sharing and global public goods. **This does not suggest the HDC should spread itself thin, rather that there should be flexibility to respond to a demand-driven approach from countries.**
- **Strengthen country engagement and ensure a “bottom-up” / demand driven approach to its work on HIS.** The HDC could explore several options, in discussion with partners and based on the advice of the Board, including:
 - Rely on WHO (and other partner) regional and country offices to “feed-up” country priorities to the HDC (as well as other technical partners with country presence)
 - Engage with key donors funding data systems in countries and who have country presence and/ or existing structures to solicit country views (USAID, Gates, Gavi, Global Fund, etc.) to understand where HDC can contribute
 - Building up from country priorities set out in country HIS strategies and investment roadmaps
 - Work through the regional advisors of the HDC that have been recently instituted
 - Conduct an annual survey of countries to understand key needs and identify where HDC could play a supporting role
- **Re-orient events and meetings to ensure maximum utility for countries to support their engagement.** Meeting objectives and agendas need to be developed with country learning in mind. Greater South-South sharing of experiences and lessons needs to be facilitated.

Recommendation 4: Implement a number of actions to enhance the effectiveness of the Working Groups and ensure their outputs are directly relevant for countries.

Implementation responsibility

HDC Secretariat and WG leads

Timelines & capacity requirements**Timeline:** short term**Capacity requirements:** moderate

The HDC should continue to strengthen the workings of the WGs, including through the following:

- **Develop annual plans and support their use and follow-up.** The plans should be simply designed and include a list of deliverables and timelines. They should be practical and reflect the voluntary nature of the

HDC WGs. The HDC Secretariat should ensure that the plans are used to follow-up on key deliverables and that timelines are met.

- **Support country engagement of the WGs** – key aspects include: (i) increasing country stakeholder participation in WGs; (ii) making sure WGs have access to the country priorities solicited under Recommendation 3; and (iii) exploring ways for the WGs to tailor global public goods for specific country contexts.
- **Improve the connection and collaboration between WGs.** There are complementarities between the Working Groups which could be better leveraged. The HDC Secretariat could increase the collaboration between Working Groups through the annual plans, joint knowledge products / public goods, “touch points” for Working Group chairs based on opportunity, etc.
- **Secretariat to continue to support the coordination, agenda, and follow-up of WG meetings.** This was considered a key value-add offered by the HDC Secretariat for some WGs (especially the smaller and newer ones). This should be continued and done systematically ensuring that there is a value-add for each WG meeting and that activities are followed-up and clear action points are formulated after meetings. For example, the Secretariat should support the WGs by sending the agenda 2-5 days in advance and sharing meeting notes and follow-up actions. Where possible, action points should be clearly assigned to WG members with clear timelines on next steps.
- **Consider facilitating the access to HDC partner funding for WG activities.** The existing resources for the HDC make it unlikely that it can support the funding of WG activities itself. However, it could consider an intermediate role in which it provides some scoping and then guidance around HDC partner funding for unfunded WG activities in the workplan. This would be a key value-add for some WGs that have no large projects funded by HDC partners.

Recommendation 5: Ensure streamlined and focused communications that are tailored to different audiences (e.g. governance, learning) and stakeholders (e.g. global, country) and carefully consider the value add of these communications for respective stakeholders.

Implementation responsibility	HDC Secretariat
Timelines & capacity requirements	Timeline: short-to-medium term Capacity requirements: low- medium

The following is recommended:

- **Communication to HDC members should be tailored/ targeted** to ensure there is a clear value-add to the audience that is being reached. The HDC should map out the different types of information/communication needs, who the key audience for that is, and how best to reach them. For example, different from the experience with SRG meetings, the proposed Board would be a forum for strategic decision-making on the HDC and hence would not be a place for presentation on country HIS systems or Working Group research products. Wider events such as open webinars would be more appropriate for knowledge sharing and dissemination of research products. Even for these, the penchant of country stakeholders to learn from other countries (i.e. South-South learning) should be prioritised. Operational leadership on this aspect from the HDC Secretariat would be critical to ensure the success of communication efforts.
- **HDC meetings should become targeted with clear value-add for participants rather than being standing and formulised invites for constituencies and members.** To increase engagement with participants the HDC should consider a targeted approach to meetings that have a clear agenda and follow-up action points and offer specific value-adds for participants rather than having an overly complex structure supported by regular standing meetings that have low utility and add workload for the HDC Secretariat.

- **Improve the website to increase utility to country stakeholders and explore other collaboration tools.**
The current website works well for audiences seeking to find out about the HDC, however, it is less suited for country stakeholders that want to find knowledge products or global public goods supported by the HDC. Other collaborative tools such as online file sharing platforms may also be explored.

Appendix A **BIBLIOGRAPHY**

This Appendix presents the list of references used in document review during the core phase of the evaluation. Reference lists for the country case studies are presented in a separate annex.

HDC Documents

General/ Governance:

- HDC, March 2023, Members Database
- HDC, 2022, Communications and Advocacy Strategy 2022-2025 (*Draft*)
- HDC, 2022, Country Engagement Approach
- HDC, 2021, Governance
- HDC, 2020, Summary One-Pager
- HDC, 2020, Mission, Objectives & Principles
- HDC, 2019-2020, Stakeholder feedback summary
- World Bank Group, USAID, and WHO, 2015, The Roadmap for Health Measurement and Accountability
- World Bank Group, USAID, and WHO, 2015, Health Measurement and Accountability Post 2015: Five-Point Call to Action
- HDC, 2022, Constituency Summaries, Global Partners Meeting
- HDC, 2021, Regional Institutes for Data in Africa- Building Capacity, Concept Note
- HDC, 2020, Leadership Event Report
- HDC, 2021, HDC Global Partners Meeting Event Report (hosted by KEMRI Wellcome Trust and Institut Pasteur de Dakar)

Working group documents:

- HDC, Working Groups Terms of Reference (Consolidated), *no year*
- HDC, 2021, Working Group Update: GPM
- HDC, 2020-2023, Working Groups Product Tracker
- Community Data, D&DG RHIS WG, Members list (*no date*)
- Community Data WG, 2020, Update on Global Public Goods
- Data & Digital Governance WG, 2020, Concept note
- Digital Health & Interoperability WG, 2019, Interoperability Mapping Tool
- LMIS WG, 2016, Interagency Supply Chain Group
- HDC Working Groups, 2020-2023, meeting minutes and agendas
- RHIS, D&DG, CRVS WGs, 2023, Draft Workplans

Progress Reporting:

- HDC, 2022, Progress Report
- HDC, 2022, Workplan Tracker

- HDC, 2022, Presentation: Overview and Achievements 2022-2025
- HDC, 2022, Performance Report September 2021-August 2022
- HDC, 2021, Presentation: 2020-2021 Review and 2022-2023 Milestones
- HDC, 2021, Performance Report September 2019-August 2021
- HDC, 2019, Final Progress Report 2018-2019
- HDC, 2018, Progress Report 2016-2018

Workplans:

- HDC, 2022-2023, Workplan and resource estimates
- HDC, 2022-2023, Milestones and Workplan
- HDC, 2020-2023, Working Group Outputs and Deliverables
- HDC, 2020-2023, Workplan
- HDC, 2020, Operational Workplan 2020-2023
- HDC, 2016, Operational Workplan

Meeting notes and slides:

- HDC, 2020-2022, SRG Meeting minutes and slides 2020-2023
- HDC, 2020-2022, GPM Meeting minutes and slides

Constituencies:

- HDC, 2022, Constituency Summaries, Global Partners Meeting

Country documents:

- HDC and UNICEF, 2022, Country Case Studies on Alignment
- HDC, 2020, Country Positions
- WHO, 2020, SCORE Assessment Country Summaries

External documents:

- CEPA, 2020, External Evaluation of the Partnership for Maternal, Newborn and Child Health 2014-2019
- PMNCH Board Meeting, 2020, Harnessing the power of partnership in the digital era (2020)
- PMNCH, 2021, Proposed Governance Reform Transition Process
- Transformhealth, <https://transformhealthcoalition.org/about/>, accessed June 2023
- WHO, 2021, Germany open Hub for Pandemic and Epidemic Intelligence in Berlin
- WHO HUB, 2022, What does the WHO Hub for Pandemic and Epidemic Intelligence do?
- WHO, 2022, The WHO Hub for Pandemic and Epidemic Intelligence: Strategy Paper
- Morgan and Pebody, 2022, The WHO Hub for Pandemic and Epidemic Intelligence; supporting better preparedness for future health emergencies
- Digital Square, <https://digitalsquare.org/about>. Accessed June 2023

Appendix B LIST OF INCEPTION AND CORE PHASE CONSULTATIONS

This Appendix presents the stakeholders consulted during the inception and core phase of the evaluation, at the global and regional level. Consultee lists for country case studies are included separately in the Country Case Study Annex.

Table B.1: Stakeholders interviewed during the inception phase

Name	Organisation	Position
HDC Secretariat		
Craig Burgess	HDC Secretariat	HDC Secretariat
Mwenya Kasonde	HDC Secretariat	HDC Secretariat
Donors		
Rachel Lucas	USAID	Senior Data Advisor
Ernesto Lembcke	GIZ	Digital Health Advisor
Research, Academia and Technical Networks		
Chris Murrill	CDC	Epidemiologist, Global Health Centre
Kathy Gallagher	CDC	Epidemiologist, Global Health Centre

Table B.2 provides a list of consultees at the global and regional level interviewed for the core phase of the review.

Table B.2: List of stakeholders consulted in the core phase

Name	Organisation	Position
HDC Secretariat		
Craig Burgess	WHO/ HDC	Secretariat
Mwenya Kasonde	WHO/ HDC	Secretariat
Tashi Chozom	WHO/ HDC	Secretariat
Carolina Futuro	WHO/ HDC	Secretariat
Kathy O'Neill	WHO/ HDC (former)	Secretariat (former)
WHO/ UHC 2030		
Marjolaine Nicod	WHO/UHC2030	Joint Lead for the UHC2030 Secretariat
SDG GAP Secretariat		
Isadora Quick	SDG GAP Secretariat	SDG GAP Secretariat Co-Lead
Hendrick Schmitz	SDG GAP Secretariat	SDG GAP Secretariat Co-Lead
HDC Constituencies		
Bilateral donors, foundations and regional funding entities		
Austin Davies*	NORAD	Senior Adviser, Department for Human Development
Nicola Wardrop	FCDO	One Health Policy Lead and Statistics Advisor
Countries		
Helen Kiarie Wambui	Ministry of Health, Kenya	Head, M&E Division
Multilateral and Inter Governmental Institutions		
Benson Droti	WHO AFRO	Health Information System Team Lead

Name	Organisation	Position
Peter Ghys*	UNAIDS (former)	Director of the Data for Impact Department (former)
Samira Asma	WHO	Assistant Director General, DDI
Isabella Maina	WHO	Africa Regional Consultant, HDC
Pandula Siribaddana	WHO/ HDC	Asia Regional Consultant, HDC
Alastair Robb*	WHO	Senior Advisor, Global Malaria Programme
Global Health Initiatives		
Natalie Zorzi	The Global Fund	Head of Monitoring & Evaluation
Michelle Monroe	The Global Fund	Senior Specialist, M&E
Mark Landry	The Global Fund	Senior Specialist, Country Digital Health Information Systems
Research, Academia and Technical Networks		
Debra Jackson	London School of Hygiene and Tropical Medicine (LSHTM)	Deputy Director, MARCH Centre
Jennifer Requejo	UNICEF (formerly Johns Hopkins University)	Senior Advisor and Chief of Health and HIV Unit
Benjamin Tsofa	Kemri Wellcome	Health Systems and Health Policy Researcher
Cheikh Loucoubar	Institut Pasteur, Dakar	Head of Epidemiology Department
Private Sector		
Grace Kiwanuka	Uganda Healthcare Federation	Executive Director
SRG		
HDC Co-Chairs		
Stephen MacFeely	WHO	Director of Data and Analytics
Onalenna Seitio-Kgokgwe	Ministry of Health and Wellness, Botswana	Deputy Permanent Secretary
Countries		
Gunanidhi Sharma	Ministry of Health and Population Nepal	Senior Health Administrator, M&E Section
Multilateral and Inter Governmental Institutions		
Sam Mills	World Bank	Senior Health Specialist
Arash Rashidian	WHO EMRO (alternate)	Director of Information, Evidence and Research
Steve MacFeely	WHO	Director of Data and Analytics
Romesh Silva	UNFPA	Senior Technical Specialist
Priscilla Idele	UNFPA	Chief, Population and Development Branch
Sainan Zhang	UNFPA	Technical Specialist, Data Innovation and Analysis
Bilateral donors, foundations and regional funding entities		
Rachel Lucas	USAID	Senior Data Advisor, Global Health Bureau
Ernesto Lembcke	Deutsche Gesellschaft für Internationale Zusammenarbeit (GIZ)	Digital Health Advisor

Name	Organisation	Position
Global Health Initiatives		
Steve Ollis	Country Health Information Systems and Data Use (CHISU)	Project Director
Heidi Reynolds	Gavi	Senior Specialist, Evaluation and Learning
Research, Academia and Technical Networks		
Kathleen Gallagher	US Government- CDC	Epidemiologist, Global Health Center
Chris Murrill (alternate)	US Government- CDC	Epidemiologist, Global Health Center
Xen Santos	US Government- CDC	Associate Director for Informatics and Information Resources at Global Health Center
Alvin Marcelo	Asia eHealth Information Network (AeHIN) (alternate)	Executive Director
Laticha Walters	Council for Scientific and Industrial Research (alternate)	Digital Health Governance specialist
Civil Society		
Maxwell Antwi	PharmAccess	Country Director, Ghana
Private Sector		
Patricia Monthe	MEDx Care (Netherlands)	Founder and CEO
Ruchika Singhal	Medtronic (USA) (alternate)	President
HDC Working Groups		
Civil Registration and Vital Statistics		
Doris Ma Fat	WHO	Statistician, Department of Analytics
Bhaskar Mishra	UNICEF	Global Technical Lead on CRVS and Legal Identity
Public Health Intelligence		
Carrie Eggers	CDC	Epidemiologist
Digital Health and Interoperability		
Chilunga Puta	PATH, Digital Square	Senior Data and Immunisation Advisor
Carolyn Kamasaka	JSI	Digital Health Advisor
Manish Kumar	University of North Carolina	Adjunct Professor
Logistics Management and Information Systems		
Lisa Hedman	WHO	Group Lead, Supply and Access to Medicines
Lindabeth Doby	USAID	Senior Digital Supply Chain Advisor
Community Data		
Ana Scholl	USAID	Evaluation Branch Chief, Office of HIV/ AIDS
Remy Mwamba	UNICEF	Statistics, Monitoring & HIS Specialist
Routine Health Information Systems		
Jørn Braa	University of Oslo	Professor, Department of Informatics

Name	Organisation	Position
Rifat Houssain	WHO	Lead, Information, Policy & Governance, Programme for health and migration, Office of DDG
Ayub Many	Kenya Ministry of Health	Medical Epidemiologist
Jean-Pierre de Lamalle	RHINO	Medical Doctor
Eman Aly	EMRO/ WHO	Technical Officer of Health Information System and CRVS
Theresa Diaz	MCA/ WHO	Unit Chief for Monitoring and Evaluation MNCAH and Aging
Data and Digital Governance		
Marie Donaldson	CUNY	Postdoctoral Fellow
Vikas Dwivedi	Palladium	Senior Health information Systems Advisor
External Stakeholders		
Nebojsa Novcic	PMNCH	Team Lead, Governance and Operations
Country stakeholders (8-10 per case study)		
Included in separate Country Case Study Annex		

**Indicates HDC early involvement stakeholder*

Appendix C INTERVIEW GUIDES

This Appendix presents the interview guides that were used in the core phase of the evaluation, for global, regional and country-level stakeholder consultations. Three consultation guides were created for country case studies to differentiate between active, inactive, and pre-engaged HDC countries. Guides were further tailored to reflect the individual experiences and knowledge of each consultee.

C.1. GLOBAL/ REGIONAL CONSULTEE

1. How relevant has the “reorientation” of the HDC in 2018-19 been and is there a need to further change any of the HDC **objectives** including (i) strengthening country capacity, (ii) improving efficiency and alignment of technical and financial investments in data systems, and (iii) increasing the impact of global public good and tools on country health data systems? Is the mandate of the HDC too broad and/ or irrelevant in relation to priority country needs? Was the reorientation along the right tracks or are there aspects of the rationale to the launch of the HDC that are more relevant?
2. Is the current **design** of the HDC in terms of: (i) the overall governance structure; (ii) how it works with its partners/ members; (iii) approach to country engagement; and (iv) balance between technical and political engagement fit-for-purpose to support achievement of its objectives? What might be areas for improvement?
3. What do you view as the **added value** of the HDC in relation to the work of global partners and other data coordination initiatives? How do stakeholders view the work of HDC as additional to that of WHO as well as contributing to the UHC2030 and SDG GAP agenda?
4. Given **limited financial resources** made available to the HDC to date, how best can it **position itself for impact**?
5. Is there **adequate stakeholder clarity** on the objectives, work and added value of the HDC? Do you consider there to be adequate communication and engagement as well as advocacy in relation to the HDC and what might be areas for improvement?
6. How **efficient** has the HDC **governance and operational structure** (e.g. constituencies, Secretariat, Working Groups, etc.) been in practice? Specifically: (i) is the membership base adequate and suitable engaged; (ii) is the role of the SRG clear and foster representation, accountability and transparency; (iii) what works well and less well with the Working Groups arrangement; (iv) is the Secretariat well performing and delivering on needed responsibilities; (v) is there adequate understanding, transparency and accountability in the overall governance structure; and (vi) how has the merger with SDG GAP data and digital accelerator supported the functioning of the HDC?
7. To what extent has the HDC **achieved its objectives** of: (i) strengthening country capacity; (ii) improving efficiency and alignment of technical and financial investments in health data systems; and (iii) increasing the impact of global public goods on country health data systems? What is the evidence on HDC work contributing to reduced reporting burden and fragmentation alongside increased innovation and capacity at country-level? Has the HDC contributed to the improved availability and quality of health data, aligned with national priorities and improved use of data for evidence-based decisions, budget making, monitoring and implementation of health-related SDGs?
 - a. Could you please cite specific examples of global level or country level work (e.g., knowledge sharing activities and products, technical working groups and their products, country level activities and advocacy and political will building) to support your assessment.
 - b. What aspects have worked well and less well in the achievement of objectives?
 - c. What is the likelihood of HDC supported work being taken forward by others in terms of additional financial resourcing and/ or political/ programmatic acceleration? Please give some examples.
8. What would be your **top 2-3 recommendations** for the HDC going forward? How can it better position itself to be a solid contributor to data challenges in support of achieving the SDGs?

C.2. COUNTRY CASE STUDY CONSULTATION- ACTIVE COUNTRY

1. What are the most significant challenges and achievements your country has experienced with regards to data systems for health in the past 5 years? (e.g. with regards to HMIS, surveys, CRVS, reviewing progress and performance, using data for policy and action, issues of coordination and alignment between donors and government with regards to data, community level data systems, etc)
2. To what extent are you aware of the HDC mandate and work and how have you, or other country stakeholders, engaged with the HDC in the past 5 years?
3. Could you describe the **key areas of support facilitated through the HDC** in your country? What is your view in terms of their contributions to improved data systems in your country? What aspects have worked particularly well and less well?
4. The HDC seeks to: (i) strengthen country capacity, (ii) improve efficiency and alignment of technical and financial investments in data systems, and (iii) increase the impact of global public good and tools on country health data systems, with the ultimate aim to reduce reporting burden and fragmentation alongside increased innovation and capacity at country-level. How valuable do you think these objectives are and **are they the right objectives or should it pursue less/ different objectives?**
5. What has been your **experience with the way in which the HDC has engaged with your country?** Has it worked with the right partners, in the right way and in an efficient manner? Has the HDC been able to support both technical improvements to data systems as well as garner political support?
6. What do you view as the **added value** of the HDC for countries in relation to the work of global partners and other data coordination initiatives? How do stakeholders view the work of HDC as additional to that of WHO as well as contributing to the UHC2030 and SDG GAP agenda?
7. The HDC is not a financing entity and it is not expected that the HDC will provide funding to countries for data systems strengthening in the future. It can however provide technical and coordination support. **How best can the HDC do this to support your country data needs?**
8. Do you consider there to be adequate **communication and engagement** (including around knowledge sharing) as well as advocacy in relation to the HDC and what might be areas for improvement?
9. *Question for country level stakeholders who are also part of the HDC:* How **efficient** has the HDC **governance and operational structure** (e.g. constituencies, Secretariat, Working Groups, etc.) been in practice? Specifically: (i) is the membership base adequate and suitable engaged; (ii) is the role of the SRG clear and foster representation, accountability and transparency; (iii) what works well and less well with the Working Groups arrangement; (iv) is the Secretariat well performing and delivering on needed responsibilities; (v) is there adequate understanding, transparency and accountability in the overall governance structure; and (vi) how has the merger with SDG GAP data and digital accelerator supported the functioning of the HDC?
10. Overall, in your country, **to what extent has the HDC supported the achievement of its objectives** of: (i) strengthening country capacity; (ii) improving efficiency and alignment of technical and financial investments in health data systems; and (iii) increasing the impact of global public goods on country health data systems? What is the evidence on **HDC work contributing to reduced reporting burden and fragmentation alongside increased innovation and capacity at country-level?** Has the HDC contributed to the improved availability and quality of health data, aligned with national priorities and improved use of data for evidence-based decisions, budget making, monitoring and implementation of health-related SDGs?
 - a. Could you please cite specific examples of country level work (e.g., knowledge sharing activities and products, technical working groups and their products, country level activities and advocacy and political will building) to support your assessment.
 - b. Are you aware of the work of the HDC Working Groups and have you used any of their supported products?
 - c. What aspects have worked well and less well in the achievement of objectives?

- d. What is the likelihood of HDC supported work being taken forward by others in terms of additional financial resourcing and/ or political/ programmatic acceleration? Please give some examples.
11. What would be your **top 2-3 recommendations** for the HDC going forward? How can it better position itself to be a solid contributor to data challenges at the country level in support of achieving the SDGs (at both the regional and country levels)?

C.3. COUNTRY CASE STUDY CONSULTATION- INACTIVE COUNTRY

1. What are the most significant challenges and achievements your country has experienced with regards to data systems for health in the past 5 years? (e.g. regards to HMIS, surveys, CRVS, reviewing progress and performance, using data for policy and action, issues of coordination and alignment between donors and government with regards to data, community level data systems, etc)
2. To what extent are you aware of the HDC and its mandate and work? If you are a member of the HDC, do you see value in being so?
3. The HDC seeks to: (i) strengthen country capacity, (ii) improve efficiency and alignment of technical and financial investments in data systems, and (iii) increase the impact of global public good and tools on country health data systems, with the ultimate aim to reduce reporting burden and fragmentation alongside increased innovation and capacity at country-level. How valuable do you think these objectives are and are they the right objectives or should it pursue less/ different objectives?
4. The HDC is coordinated through a Secretariat based at WHO Geneva and seeks to work through its partners (UN agencies, academic and research organisations, etc). Given the above noted objectives (or others you may view as relevant), how best do you think the HDC should set itself up for country support and impact?
5. The HDC is not a financing entity and it is not expected that the HDC will provide funding to countries for data systems strengthening in the future. It can however provide technical and coordination support. How best can the HDC do this to support your country data needs?
6. How do you think the HDC can add value over and above the work of other global partners and other data coordination initiatives? How do stakeholders view the work of HDC as additional to that of WHO as well as contributing to the UHC2030 and SDG GAP agenda?
7. How can the HDC ensure the best balance between providing technical and political level support for improved data systems and information in your country? How can the HDC capitalize more on political resources to strengthen links with technical components of data programmes?
8. Based on your understanding of the HDC (including through this interview), what would be your main **2-3 suggestions** on how the HDC should pivot itself to better support country data needs in the future (at both the country and regional levels)?

C.4. COUNTRY CASE STUDY CONSULTATION- PRE-ENGAGED COUNTRY

1. What are the most significant challenges and achievements your country has experienced with regards to data systems for health in the past 5 years? (e.g. with regards to HMIS, surveys, CRVS, reviewing progress and performance, using data for policy and action, issues of coordination and alignment between donors and government with regards to data, community level data systems, etc)
2. To what extent are you aware of the HDC mandate and work and how have you, or other country stakeholders, engaged with the HDC in the past 5 years?
3. What do you consider to be the biggest area of need for your country with regards to health data systems that the HDC might be able to support you on (e.g. technical documents, advisory support etc)? How do you think the HDC can add value over and above the work of other global partners and other data coordination initiatives?
4. The HDC's objectives include (i) strengthening country capacity, (ii) improving efficiency and alignment of technical and financial investments in data systems, and (iii) increasing the impact of global public good and tools

on country health data systems, with the ultimate aim to reduce reporting burden and fragmentation alongside increased innovation and capacity at country-level. How relevant are these to your country's needs? Should the HDC focus on specific objectives or have different objectives to better support country health data systems?

5. The HDC is not a financing entity and it is not expected that the HDC will provide funding to countries for data systems strengthening in the future. It can however provide technical and coordination support. How best can the HDC do this to support your country data needs?
6. If you have engaged with the HDC so far, what has been most helpful and what has been least helpful? How familiar are country stakeholders in terms of the work of the HDC?
7. What do you think the approach of the HDC should be scaling up in countries not yet currently engaged with the HDC (including at the regional and country level)?

Appendix D **E-SURVEY QUESTIONNAIRE AND RESULTS**

This Appendix presents the methods, questionnaire, and results of the conducted e-survey. The e-survey was designed to help quantify stakeholder views on HDC's progress and functioning (as well as gather recommendations for improvement) across a wider global, regional and country level stakeholder base than is feasible through consultations. The survey was designed in collaboration with the HDC Secretariat and was based off of the evaluation framework. The survey had two parts: Part 1 which "looks back" to assess HDC progress and issues; and Part 2 which "looks forward" to help design recommendations for the HDC. The survey was open for three weeks, from the 1st of June to the 23rd of June. In that time, an introduction and two follow-ups were sent out to the 827 members of the HDC listserv in order to increase response rate.

Appendix D.1 presents the questionnaire used. Appendix D.2 presents the e-survey results.

D.1. QUESTIONNAIRE

Respondent information

- Name (optional)
- Organisation (optional)
- Type of organisation (please select from one of the 7 HDC constituencies). If other, please indicate what type of organisation yours is.
- Have you engaged with the HDC in the past year: Yes/ No
- How long have you been engaged with the HDC? (Options: <1 year, 1-2 years, 2-3 years, >3 years)
- Please describe your role and engagement with the HDC [comment box]
- Country of location

Part 1: Assessing role and progress made by the HDC

1. I understand the role and mandate of the HDC well.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: Please provide any comments and recommendations in support of your answer.

2. The objectives of the HDC in terms of (i) strengthening country capacity, (ii) improving efficiency and alignment of technical and financial investments in health information systems, and (iii) increasing the impact of global public goods and tools on country health information systems are the most relevant in relation to the current priorities and country needs with regards to health information systems.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer, specifically if you'd like to share comments about one of these objectives, or additional and/ or different objectives that the HDC should pursue.

3. One of the key aspects of the reorientation of the HDC in early 2020 was to focus more on country impact. It has delivered well in line with this reorientation.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer.

4. The HDC reorientation in 2020 sought to create stronger links between technical work and political will with regards to health information systems. It has performed this well since.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: How could the HDC improve in this area?

5. The HDC adds value to the work of global and regional partners and other data coordination bodies working on country health information systems.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: Please provide any comments in support of your answer. If you tend to agree, please provide examples of how the HDC adds value and conversely if you tend not to agree then please provide examples of how the HDC does not add value.

6. The HDC is well set up to respond to its mandate (e.g. constituency-based structure with representative serving on a Stakeholder Representative Group, technical Working Groups, Secretariat hosted at WHO, in terms of the partners it engages with, linkages with countries, etc.)

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comments: Please provide comments on what aspects work well and not so well at HDC in support of its mandate.

7. The HDC governance and operational structure works well. It is efficient and promotes transparency and accountability.

- Strongly agree
 - Agree
 - Neutral
 - Disagree
 - Strongly disagree
-

- I don't have enough information to answer this question
Comments: What aspects of the governance and operational structure work well and less well? (e.g. Secretariat, working groups, SRG, constituency-based representation)

8. The HDC has made substantial progress on its objectives since its inception in terms of improving the efficiency and alignment of technical and financial investments in health information systems, strengthening country capacity and reducing reporting burden and fragmentation, thereby contributing well towards progress on the 2030 SDG goals.

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comment: Please provide examples of progress observed and the specific contribution of HDC.

9. The HDC fulfils its knowledge brokering role well (e.g. sharing best practices from countries and partners, and disseminating information through the website, regular member/ stakeholder calls, publications, and webinars).

- Strongly agree
- Agree
- Neutral
- Disagree
- Strongly disagree
- I don't have enough information to answer this question

Comment: Please provide any suggestions for improvement.

Part 2: Considering options for the HDC going forward

10. What are your top 3 recommendations for the HDC to maximise its impact to accelerate progress to the 2030 SDGs? Where should it focus/ prioritise its efforts in line with global, regional and country needs and what other organisations/ initiatives are already doing?

Please feel free to be creative in your recommendations, particularly if you are not happy with the status quo e.g. recommendations to sunset the HDC, or dramatically scale-up the role and function of the HDC so that it acts as a funding entity for countries. Equally, recommendations on specific aspects of HDC's structure and governance to enhance efficiency and effectiveness would be welcome.

(1) _____

(2) _____

(3) _____

11. As the HDC is an informal collaboration of partners, could you provide recommendations on how best it could mobilise action and alignment from partners in support of its objectives?

12. How can the HDC best contribute to reduce data fragmentation brought about by multiple partner and donor requirements and reporting systems?

13. How do you think the HDC should position and organise itself to have the maximum impact on countries, noting that it is not a funding entity, is organised through a small Geneva-based Secretariat housed at the WHO and the work is undertaken by partners? Do you have any practical suggestions on how the HDC can ensure greater reflection of country voice/ needs in its work and improve accountability to countries?

14. Do you have any specific recommendations on the HDC governance structure (e.g. Constituency-based representation, working group modalities, secretariat functioning and accountability to Stakeholder Representative Group)? How would you look to design the HDC to better respond to its mandate?

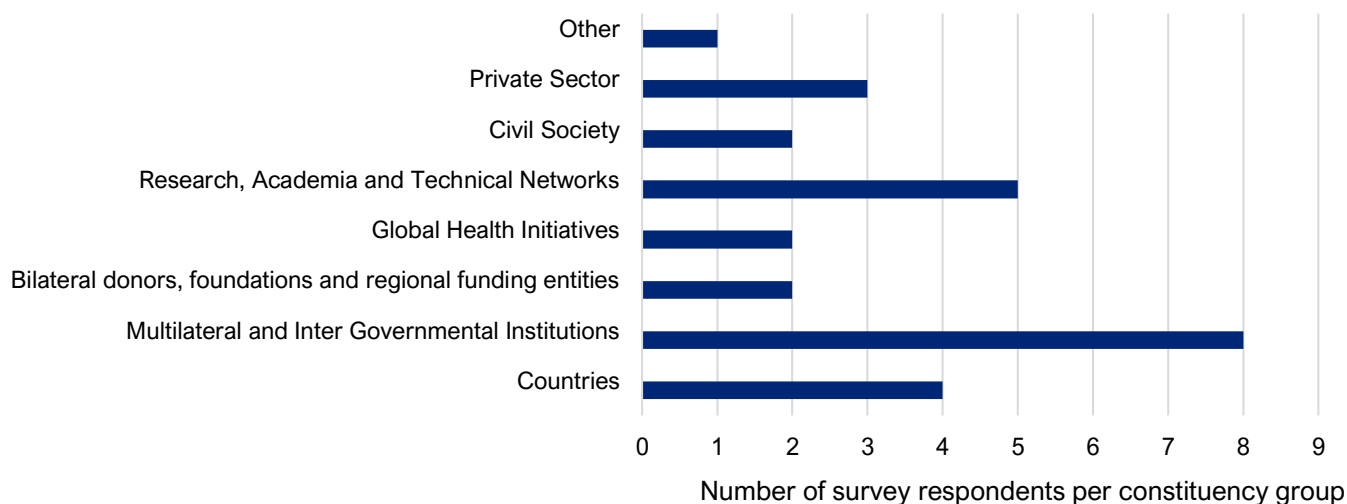
D.2. SURVEY RESULTS

D.2.1. Data on survey respondents

Around 280 recipients or 30% of members opened the survey link included in the HDC email, and of those 27 responded to the survey. This reflects overall a low response rate with 3.3% of all official HDC members participating and 9.6% of all HDC members that opened the email participating. Although the response rate was low, the e-survey did expand the reach of the evaluation beyond those who had already been interviewed.²⁴ 100% of respondents answered multiple-choice questions, and 30-52% answered open questions. Respondents represented all seven constituencies of the HDC. The greatest number of respondents came from Multilateral and intergovernmental institutes, followed by stakeholders from research, academia and technical networks and country stakeholders. Two-thirds of respondents had engaged with the HDC in the last year, and the majority had been engaged with the HDC for 1-2 years. Of the participants who gave information on location, fourteen out of the twenty-three survey respondents were based in the Global South.

Figures D.1-D.3 present data on survey respondents.

Figure D.1: Number of respondents per constituency group



²⁴ There was very limited overlap between e-survey respondents that provided their name and could be identified and stakeholders that participated in the global consultations.

Figure D.2: Percentage of respondents who engaged with the HDC in the past year

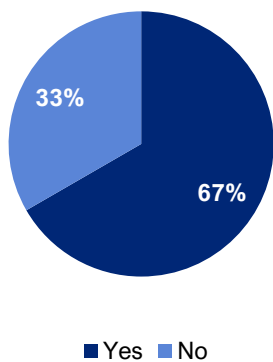
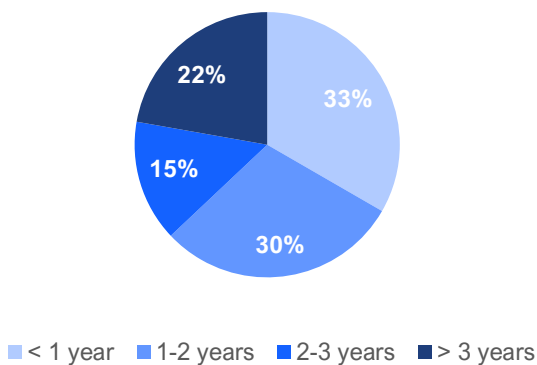


Figure D.3: Number of years respondents have been engaged with the HDC, by percentage

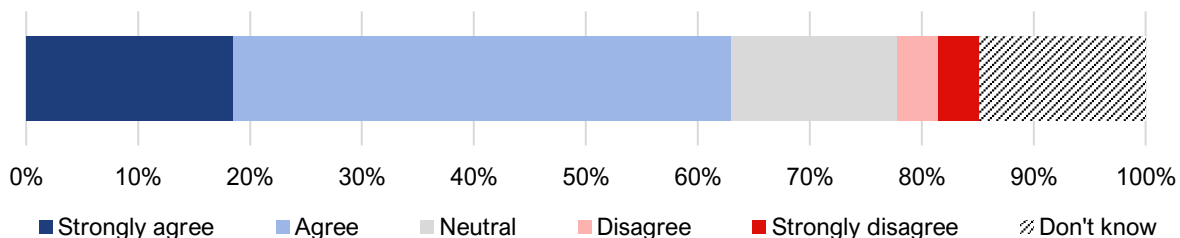


D.2.2. Results by survey question

This Section presents the results for Part 1 which assesses the role and progress made by the HDC to-date. Qualitative responses for Part 2 on recommendations going forward are not presented separately but have been directly considered as part of the recommendations in Section 4.

SQ1: I understand the role and mandate of the HDC well

Figure D.4: Responses to SQ1 by percentage



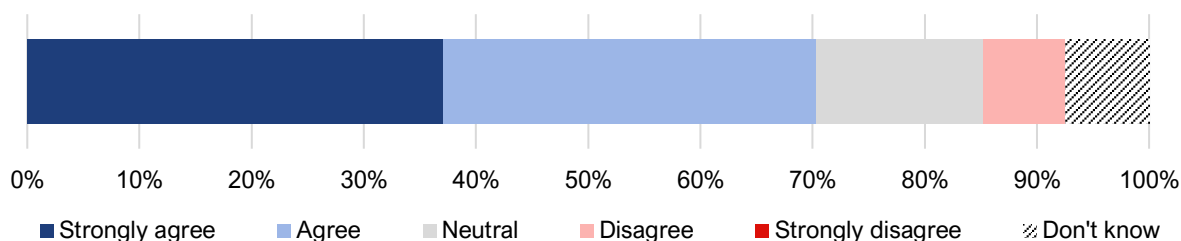
Quantitative results: The majority of respondents (63%) strongly agreed or agreed that they understood the role and mandate of the HDC.

Qualitative results: Of those who provided additional detail, points of strength included a clear definition of the HDC (particularly the HDC’s coordination role) communicated through presentations and meetings, the website, and governance documents such as the Working Group constitutions terms of references. Challenges raised included difficulties in distinguishing what an ‘HDC product’ is versus a partner products, a lack of clarity regarding the value

proposition of the HDC for focus countries as well as the role that partner organisations can usefully play, and a lack of clarity on how the HDC can realistically achieve its vision.

SQ2: The objectives of the HDC in terms of (i) strengthening country capacity, (ii) improving efficiency and alignment of technical and financial investments in health information systems, and (iii) increasing the impact of global public good and tools on country health information systems are the most relevant in relation to the current priorities and country needs with regards to health information systems.

Figure D.5: Responses to SQ2 by percentage

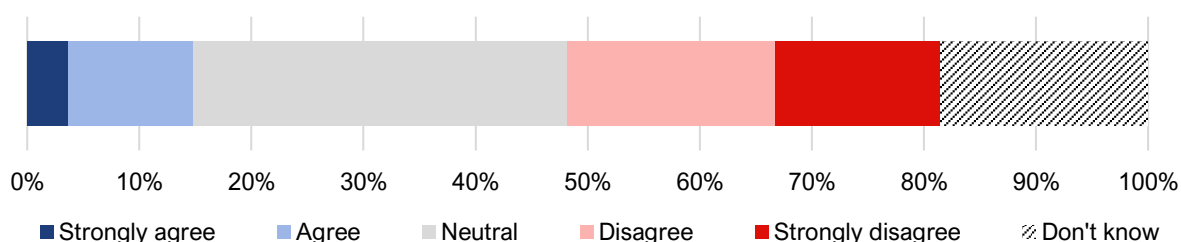


Quantitative results: The majority of respondents (70%) strongly agreed or agreed that the objectives of the HDC are most relevant in relation to current priorities and country needs. Across the survey, participants responded the most positively this question. No participants strongly disagreed with the objectives of the HDC.

Qualitative results: Qualitative responses show some disagreement as to the priorities of the HDC, however. For example, one respondent highlighted Objective 2 around improving efficiency and alignment of investments as being the core objective of the HDC, whereas others felt strengthening country capacity was most important (including in targeted areas such as innovation and technological advancement). Another respondent felt that the HDC should focus on using its normative power to institutionalise objectives in donor and country policies, which is a function that other organisation such as openHIE and Digital Square may have limited capacity to achieve. Another stakeholder also suggested that the focus within HDC on interoperability was perhaps overstated and not necessarily focused on user benefit with regards to the functionality of individual tools. Finally, a few respondents stressed that although objectives were relevant, progress towards operationalising these objectives was not visible.

SQ3: One of the key aspects of the reorientation of the HDC in early 2020 was to focus more on country impact. It has delivered well in line with this reorientation.

Figure D.6: Responses to SQ3 by percentage

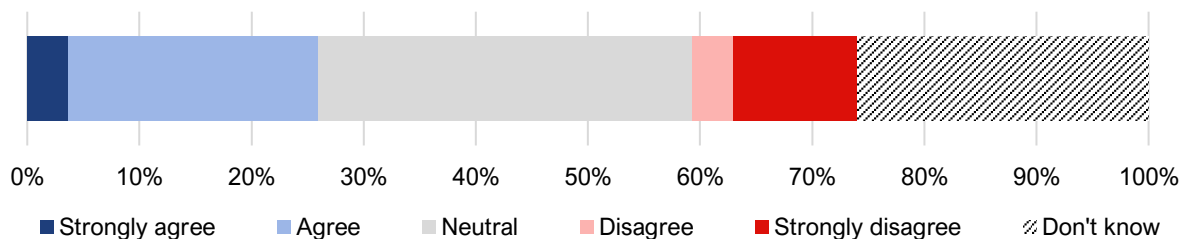


Quantitative results: A minority of respondents (15%) agreed that the reorientation of the HDC had delivered in terms of increasing country impact. 33% were neutral, 33% disagreed, and close to 20% did not have enough information to respond.

Qualitative results: Respondents felt that they had limited information as to HDC’s activities and impact at the country level. Some commented on the balance between technical and political work, feeling that the HDC needed to take a more technical approach. Additionally, a few commented that the HDC approach to technical assistance was not sustainable particularly the missions which were negatively impacted by poor alignment amongst leadership, and a lack of commitment to follow-up and an end-goal. Instead, one respondent suggested shifting from high-level partner missions to providing pragmatic support to a wider range of countries through regional and national resources. Additionally, one respondent noted a lack of participation in meetings from country stakeholders.

SQ4: The HDC reorientation in 2020 sought to create stronger links between technical work and political will with regards to health information systems. It has performed this well since.

Figure D.7: Responses to SQ4 by percentage

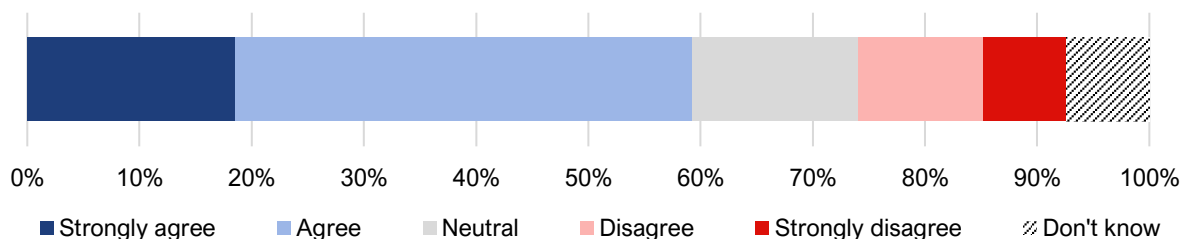


Quantitative results: Response was quite mixed to this question: 26% agreed or strongly agreed, 33% were neutral, 15% disagreed or strongly disagreed, and 26% did not have enough information to respond.

Qualitative results: At the country level, respondents suggested that the HDC should play a role in supporting countries to develop strategies and policies, provide technical assistance in improving advocacy efforts including for funding, engage more strongly with Ministries of Health at country level as well as civil society and academic institutions, and re-evaluate how the HDC works at the country and regional level particularly partner roles. At the global level, one respondent suggested that there is too strong a focus on high level leadership and political events which do not necessarily connect to specific objectives or results.

SQ5: The HDC adds value to the work of global and regional partners and other data coordination bodies working on country health information systems.

Figure D.8: Responses to SQ5 by percentage

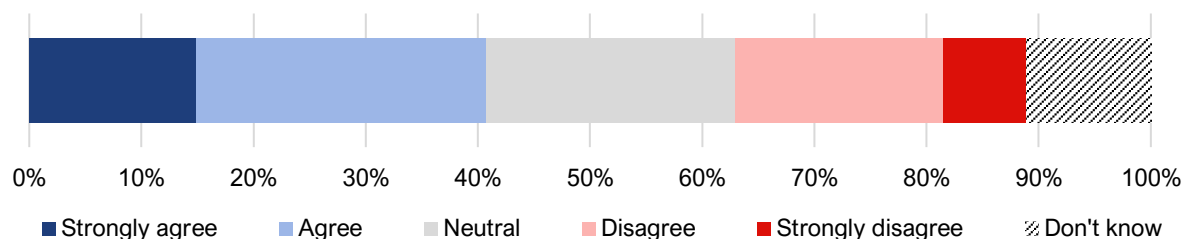


Quantitative results: Just under 60% of survey participants felt that the HDC does add value to the work of other partners working on country HIS. 15% were neutral, 18% disagreed or strongly disagreed that the HDC adds value, and only 7% did not know.

Qualitative results: The key value-add identified through qualitative responses was in providing a forum for interested partners to meet and fostering global coordination. One stakeholder noted that “While I don’t agree with everything the HDC does, I think the absence of such an organization would revert back to the “old ways” of donors building competing systems with little to no coordination between each other.” Potential strengths were in encouraging communication between country stakeholders and making use of the normative power of the WHO/HDC to support aligned investments. However, a few respondents felt that the HDC did not offer a clear comparative advantage and value-add relative to other efforts strengthening HIS in countries. One stakeholder clearly highlighted the lack of engagement with country stakeholders, particularly through WGs, as a missed opportunity.

SQ6: The HDC is well set up to respond to its mandate (e.g. constituency-based structure with representative serving on a Stakeholder Representative Group, technical Working Groups, Secretariat hosted at WHO, in terms of the partners it engages with, linkages with countries, etc.)

Figure D.10: Responses to SQ6 by percentage

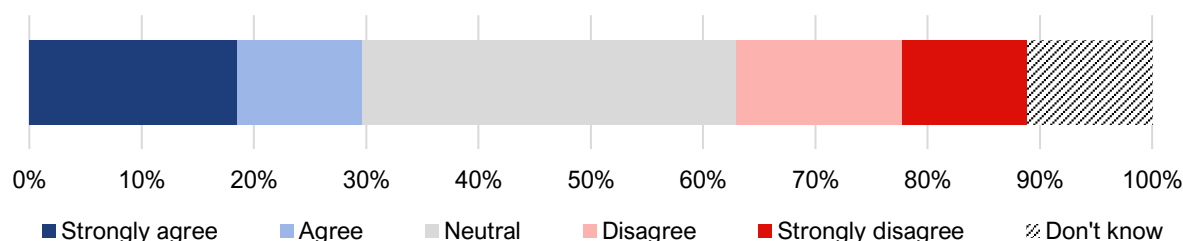


Quantitative results: Around 41% agreed or strongly agreed that the HDC is well-set up to respond to its mandate, 26% disagreed, 22% were neutral and 11% did not know.

Qualitative results: The three main points of feedback from the qualitative responses were that i) there are currently too many meetings without clear objectives- although the constituency-based structure is important the meetings themselves do not add value; ii) TWGs are struggling to gain momentum and produce deliverables; iii) linkages to countries needs to be significantly strengthened, including dissemination of global public goods (particularly in non-English speaking contexts).

SQ7: The HDC governance and operational structure works well. It is efficient and promotes transparency and accountability.

Figure D.11: Responses to SQ7 by percentage

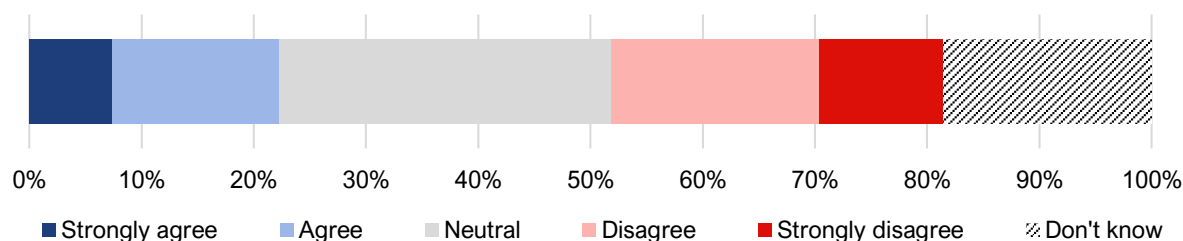


Quantitative analysis: The majority of respondents (33%) were neutral as to whether the HDC governance and operational structures were working efficiently and transparently. 30% agreed or strongly agreed, 26% disagreed or strongly disagreed, and 11% did not know.

Qualitative analysis: The main points of feedback were that i) stronger leadership and direction was needed particularly from the Secretariat; ii) representation from country colleagues was lacking; and iii) the objectives of the WGs, as well as the roles and contributions of participants within them was unclear.

SQ8: The HDC has made substantial progress on its objectives since its inception in terms of improving the efficiency and alignment of technical and financial investments in health information systems, strengthening country capacity and reducing reporting burden and fragmentation, thereby contributing well towards progress on the 2030 SDG goals.

Figure D.12: Responses to SQ8 by percentage

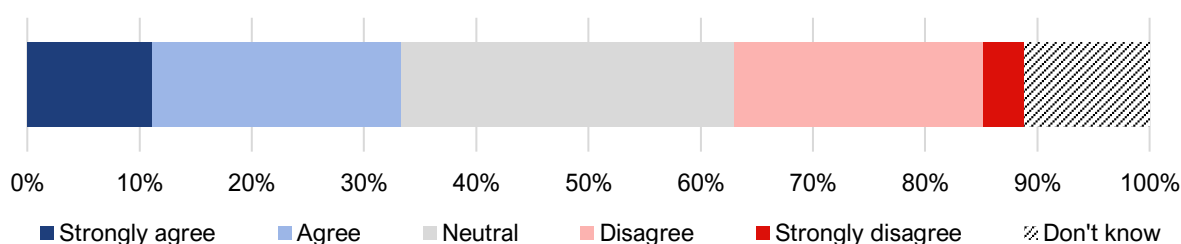


Quantitative results: More survey participants (30%) disagreed that the HDC had made substantial progress on its objectives since inception than agreed (22%), and many (30%) were neutral. A fairly high percentage (19%) also responded that they did not have enough information to answer the question, demonstrating a lack of visibility with regards to HDC activities and progress amongst stakeholders.

Qualitative results: The majority of qualitative responses highlighted that there was no visibility and evidence as to the impact and progress of the HDC, and a clearer results framework and reporting was needed. One stakeholder did suggest that donor projects have been stronger since the inception of the HDC, as organisations are *'forced to consider the broader impacts of the systems they are seeking to implement.'* Another stakeholder suggested that HDC support to countries was arbitrary and not designed for maximum impact.

SQ9: The HDC fulfils its knowledge brokering role well (e.g. sharing best practices from countries and partners, and disseminating information through the website, regular member/ stakeholder calls, publications, and webinars).

Figure D.13: Responses SQ9 by percentage



Quantitative results: Quantitative results were mixed. 33% of respondents agreed or strongly agreed that the HDC fulfils its knowledge brokering role well, 26% disagreed or strongly disagreed, 30% were neutral and 11.1% did not know.

Qualitative results: Feedback from qualitative responses suggested that this is an area where further strengthening is needed, particularly in ensuring that engagement with countries is as useful as possible. One respondent highlighted that engagement with francophone countries was weak, and another felt that the webinar topics were decided on an ad-hoc basis.

Appendix E SUMMARY OF HDC GOVERNANCE STRUCTURE

This Appendix provides a summary of the HDC governance structure after its reorientation in 2019.

Table E.1 provides information on the HDC governance structures including roles and responsibilities, composition, and operations based on the following documents: HDC Governance Document (January 2021), HDC Mission, Objectives, Principles and Governance (2020); and HDC Summary One-Pager (2020), as well as progress reports.

Table E.1: HDC Governance Structures

Governance structure	Roles and responsibilities	Composition	Operations
Global Partners Group (GPG)	<p>The GPG is a loose network of entities that engage with health data and digital efforts at the individual, community, regional and global level.</p> <ul style="list-style-type: none"> • Share experiences on ongoing data activities • Raise awareness of, suggest responses and align support in response to country requests for support • Participate in virtual or in-person dialogues to identify areas of collaboration • Review, comment and give advice on HDC strategy and operational plan • Participate in HDC meetings and contribute and share knowledge • Propose working groups based on needs of countries 	<p>Includes all HDC members. Open to any member, entity, or working group that can commit to the HDC mission, objectives and principles and can be affiliated with one of the seven constituencies.</p> <p>Constituencies include:</p> <ul style="list-style-type: none"> • Bilateral donors, foundations and regional funding entities • Global Health Initiatives • Research, Academia and Technical Networks • Civil Society • Private Sector • Multilateral and Intergovernmental organisations • Countries 	<p>Meets twice annually in March and September. Secretariat manages communications to the GPG through website updates, regular webinars, newsletters, emails, and informal social media mechanisms and groups.</p> <p>Constituency groups are expected to meet quarterly in 2023.</p>
Stakeholder Representative Group (SRG)	<p>The SRG provides the HDC technical direction and strategic oversight and promotes accountability of all HDC members to the HDC mission and objectives.</p> <p>SRG works in close collaboration with Secretariat to:</p> <ul style="list-style-type: none"> • Develop HDC milestones, workplan, budget and reports, and give periodic updates to the GPG • Support Secretariat functioning, contribute to staffing decisions 	<p>Thirteen members representing the seven GPG constituencies.</p> <ul style="list-style-type: none"> • 3 representatives from country governments in the HDC • 3 representatives of multilateral and intergovernmental organisations (1 representative of the WHO, 1 representing UN agencies, World Bank and OECD) • 2 representatives of donors (including bilateral, foundations, and regional funding entities) 	<p>SRG representatives are voted on by their constituency, for a two year time frame.</p> <p>The SRG participates in two annual face-to-face meetings, and monthly calls. The SRG is expected to seek views from other constituency members and communicate effectively back to the constituency on a regular basis, seeking inputs and giving updates. SRG decisions are to be made by consensus, and if necessary, by voting.</p>

Governance structure	Roles and responsibilities	Composition	Operations
	<ul style="list-style-type: none"> • Establish and agree upon HDC Working Groups (driven by country needs or gaps in data support) • Develop process to facilitate broad engagement of all HDC stakeholders • Oversee budget (Secretariat is accountable to SRG) • Develop, update and oversee HDC principles, Col statements, branding and communications strategy • Assess country level progress and agree country engagement/ strategic resource allocation • Measure and manage working group progress (mandating new WGs, closing existing WGs, and refining WG composition) • Identify opportunities for greater alignment/ efficiency • Establish strategies to build relationships with other bodies (SDG GAP, UHC 2030, EWEC, PMNCH) 	<ul style="list-style-type: none"> • 1 representative of CSOs • 2 representatives from research, academia and technical networks (1 one from the CDC) • 1 representative from Global Health initiatives • 1 representative from the private sector <p>There are three Permanent Co-Chairs of the HDC SRG- one from HDC country constituency, one from WHO, and one from either the multilateral or donor constituencies</p>	<p>SRG meetings may include observers from HDC and the data and digital accelerator of the SDG GAP. All Working Group Co-Chairs are invited every month to the SRG call to enhance collaboration and information sharing. WG Co-Chairs cannot vote on SRG issues, however.</p> <p>According to the 2021 Progress Report, all HDC members will be invited to SRG meetings moving forwards to increase awareness of HDC issues and to improve the process of gathering feedback from constituent members for input into the SRG.</p> <p>Since October 2021, the SDG GAP D+D) efforts (co-chaired by UNFPA and WHO) have merged with the HDC, as the SDG GAP is multilaterals and GHIs. One extra representative for the multilaterals has been created.</p>
Working Groups (WGs)	Tasked with various activities (such as production of global goods, monitoring HDC efforts or responding to country specific requests) or existing entities / groups who benefit from being part of the HDC.	<p>Previously, from 2016-2018 technical work was undertaken by 12 inter-agency working groups which included up to 350 technical experts and 60 organisations. However, it became apparent that some of the WGs were either non-functional or needed revising.</p> <p>Currently there are 6 active WGs. Membership varies from fifteen members to several hundred.</p> <p>WGs are:</p> <ul style="list-style-type: none"> • Civil Registration and Vital Statistics • Community data • Data and digital governance • Digital health and interoperability 	WGs usually meet virtually on a monthly basis. Some WGs receive support from the HDC Secretariat to coordinate membership and meetings, whereas others operate somewhat independently. More information is available on each WG in Appendix G.

Governance structure	Roles and responsibilities	Composition	Operations
HDC Secretariat	<p>The HDC Secretariat supports the day-to-day running and coordination of the HDC.</p> <ul style="list-style-type: none"> • Provide coordinated support to countries and facilitate communications, exchanges, and information sharing on country-led health data collaborative platforms, share country requests for collective action, communicate with countries and partners, provide country updates, disseminate lessons learned • Provide support to HDC WGs and SRGs by facilitating calls, minutes, agendas, strengthen communication and coordination • Implement advocacy, communication and branding strategy, coordinate development and dissemination of advocacy materials • Coordinate provision of HDC technical support to countries by facilitating coordinated technical and financial support and regular exchanges with country stakeholders • Liaise and maintain good relationships with other Global Health initiatives 	<ul style="list-style-type: none"> • Logistics management information systems • Public Health Intelligence – recently folded into RHIS • Routine Health Information Systems <p>Made up of four members currently but none are fulltime so it equates to approximately 2.5 FTE²⁵ as well as two regional consultants recently appointed.²⁵</p> <ul style="list-style-type: none"> • HDC Secretariat head is 30-50% of a full-time WHO position • One full time consultant manages the SRG and constituencies, as well as much of the country engagement. Has to take a contract break every 11 months. Currently funded by CDC, has been funded by UNICEF in the past. • One part-time consultant manages working groups and webinars/ platform for partners to share good practices • One part-time consultant provides general support to the HDC. Funded by the Young Professional programme. • Two full time regional consultants have recently been recruited. Contract duration is currently 6 months, have received funding support from regional resources and UNICEF. 	Currently hosted by the WHO and accountable to the SRG.

²⁵ Details on HDC Secretariat composition estimated by the Secretariat during consultations.

Appendix F REVIEW OF HDC OPERATIONAL WORKPLAN AND PROGRESS REPORTING

This Appendix presents a summary of HDC achievements from 2016 to 2022. Table F.1 presents the HDC's operational workplan for September 2020-December 2023, including objectives, activities and indicators. Table F.2 presents HDC achievements at the global/ regional level and country level based on a review of the HDC progress reports and presentations.

Table F.1: Operational workplan September 2020-December 2023

Objective	Activities	Indicators
To strengthen country capacity to plan, implement, monitor and review progress and standardised processes for data collection, availability, analysis and use to achieve national health-related targets (and therefore eventual SDG health targets)	<p>Global and regional:</p> <ul style="list-style-type: none"> Identify regional data and digital institutes who can support HDC objectives and engage with capacity building of regional and national data and digital issues One annual Africa regional meeting and one annual Asian regional meeting for HDC community to share best practices, stimulate peer learning to strengthen alignment with HDC objectives Consultancy support reviewing best practices of collecting and using community-generated data for tracking communities left behind Consultancy support for review of best practices electronic systems for real time reporting of health facilities <p>Country:</p> <ul style="list-style-type: none"> Identify data and digital 'champions' in each HDC country Support data and digital national champions to advocate, engage with partners and promote HDC objectives (social media and thought pieces) Identify national & sub national data and digital institutes supporting HDC objectives and support engagement in national HDC Consultancy support in each HDC country for collecting and using community generated data for tracking communities left behind 	<ul style="list-style-type: none"> HDC countries with national health strategy HDC countries with a health sector monitoring and evaluation plan M&E HDC countries with a Health Information System plan or policy Number of HDC countries with annual health strategic plan review process Number of HDC countries with established data quality assurance mechanisms Proportion of countries with functioning national disease surveillance systems Proportion of facilities having in place electronic systems for real-time reporting of health statistics in country (target is 80% of facilities)
To improve efficiency and alignment of technical and financial investments in health data systems through collective actions.	<p>Global and regional:</p> <ul style="list-style-type: none"> Consultancy support for review analysis of current status of alignment of HIS technical and financial investments in 9 HDC countries - initial results for Nov meet Convene HDC group to follow-up on actions strengthening alignment agenda from leadership meeting in November <p>Country:</p> <ul style="list-style-type: none"> MoH, HDC partner HDC data digital focal points identified in each HDC country Coordination mechanism identified for HIS / data M+E (strengthening existing) 	<ul style="list-style-type: none"> HDC countries with national Health Information System coordinating body Number of countries with established ministry of health led country platform for health information e.g. Integrated Health Situation Room in Malawi, Kenya Health Observatory Number of countries with civil society participation in drafting of national health strategy

Objective	Activities	Indicators
	<ul style="list-style-type: none"> • Landscape analysis of a) planning & budget cycle, b) strengths & challenges of HIS / M+E in health, c) prioritised issues and solutions that HDC partners could support addressing, consider applying Theory of Change, e) current investment landscape of investments in HIS in each country • Country specific HDC 2020-2023 plan developed and implemented focusing on HIS and digital investment (led by MoH with partner support) • Consultancy support for in country teams landscape analysis in HDC countries (technical and financial summaries with analysis on alignment), highlighting alignment with National Priorities. • Consultancy support for developing and implementing HDC plans in each HDC country • Identify national data and digital institutes who can support HDC objectives and support engagement in national HDC • Annual health systems review support for HIS / data quality in each HDC country 	<ul style="list-style-type: none"> • Number of countries with civil society participation in annual and midterm health strategy or other reviews • HDC countries with documented instances of data use in decision-making including programme design/planning/resource allocation/management/improvement or policy development & implementation/advocacy
<p>To increase the impact of global public goods and tools on country health data systems through increased sharing, learning and country engagement</p>	<p>Global and regional</p> <ul style="list-style-type: none"> • Review current WG membership, ToRs and workplans - strengthening diversity and potential support for WGs • Constitute 7 HDC WGs (RHIS, governance, epidemics, logistics, community, CRVS, DIO) • WGs identify gaps in current global tools or revise existing global tools, based on country feedback • Monthly WG updates with SRG highlighting progress, support and info dissemination <p>Country</p> <ul style="list-style-type: none"> • Consultancy support for reviewing appropriate use and adapt, where appropriate, existing tools (eg. Community, SCORE, HHFA, HEAT & others) for HDC country specific contexts • HDC partners support adaptation and promotion of HDC tools in country contexts 	<ul style="list-style-type: none"> • Proportion of countries with established MOH led central health data repository Access to repository • Number of countries with contextualised HDC global data tools • Proportion of countries using SCORE and digital maturity indices to assess progress
<p>To ensure HDC has governance processes and structures in place to provide transparent accountability mechanisms to all countries and partners, communications to all stakeholders and advocacy to strengthen political capital of HDC</p>	<p>Governance:</p> <ul style="list-style-type: none"> • Adequate staffing of HDC secretariat • Facilitating calls & follow-up with SRG, constituencies, HDC, WGs, UHC2030 • Convening HDC Global Partners meeting • Membership outreach and increasing # countries • Clear workplans, follow-up and links with WG outputs <p>M&E/ Accountability</p> <ul style="list-style-type: none"> • Six monthly review of workplan targets • SRG feedback to secretariat functioning (based on KPI & tracker) 	<ul style="list-style-type: none"> • Maintenance of global functioning secretariat • Quarterly HDC progress reports at global and national level • Number of HDC hosted event • Functioning HDC website which is updated at least monthly • Independently contracted evaluation planned and independent contractor sourced for evaluation

Objective	Activities	Indicators
	<ul style="list-style-type: none">• Designing 2023 Evaluation• Contracting, managing and implementing the evaluation• Dissemination of evaluation results• Incorporating evaluation results into 2024-2030 HDC plans <p>Advocacy and political leadership</p> <ul style="list-style-type: none">• Consultancy support for leadership event• Convening leadership event• Drafting and disseminating commitments• Six monthly advocacy with HoA on HDC progress <p>Communications</p> <ul style="list-style-type: none">• Website update and maintenance• HDC social media activities, blogs and thought pieces from HDC• HDC reg meets & contributions to UHC2030 Related Initiatives• Communicate and disseminate HDC tools• HDC reg meets and contributions to SDG GAP	

Table F.2: HDC progress reporting 2016-2022

Year	Global/ regional progress	Country progress
2016-2018 ²⁶	<ul style="list-style-type: none"> • Commitments made by 42 partners • HDC approach showcased at global, regional and national fora (including World Data Forum) • HDC linked with Asia eHealth Information Network, Countdown to 2030, and civil society groups to advocate for HDC approach, data use and accountability • 11 multi-stakeholder working groups have developed • Working Groups have reviewed and harmonised 29 health data-related global public goods, 23 of which are published or ready to be published <ul style="list-style-type: none"> ○ Global Reference List of 100 Core indicators updated to reflect recommended health-related indicators to measure SDGs ○ New Data Quality Review toolkit ○ Routine Health Information Systems curriculum ○ Master Facility list resource package ○ Community Health Information System Guidelines ○ Harmonised health facility survey modules ○ Core quality of care module, Inventory of quality of care domains and indicators ○ CRVS eLearning Course ○ Better Data for Women and Children: Strengthening CRVS across the Continuum of Care Report ○ Health Information Systems Interoperability Maturity Toolkit ○ Web-based technology registration system (Digital Health Atlas) ○ Handbook on National Health Workforce Accounts ○ A System of Health Accounts Implementation guidelines that support unified resources tracking for ○ SCORE technical package of key interventions to strengthen country data systems, accompanied by assessment tool to track progress, to be launched. Developed by WHO with inputs and contributions from HDC partners and a key deliverable of the HDC Operational Workplan 2016-2017 	<ul style="list-style-type: none"> • HDC approach adopted by Cameroon, Kenya, Malawi and Tanzania (pathfinder countries) with demand from DRC, Ethiopia, and Uganda (falls short of 5 country target) • Kenya: rallied partners behind 6 M&E priorities, conducted comprehensive analysis of health sector data to inform mid-term review of health sector strategic plan, strengthened CRVS capacity in 33 counties, mapped all current investments in HIS and M&E to support development of common framework to guide future investments, aligned funding for four separately planned health facility surveys. • Malawi- developing M&E framework of its second health sector strategic plan. Leveraging Global Reference List of 100 Core Health Indicators, Malawi reduced number of indicators from 195 to 82 reducing burden on health workers. This list was supported and agreed upon by the Bill & Melinda Gates Foundation, WHO, Bloomberg Data for Health Initiative, and the Malawi Ministry of Health supported by GIZ/ EPOS Health Management • Cameroon: conducted a joint SDI/SARA health facility survey with support from the Global Fund, World Bank and WHO. Also implemented newly developed Data Quality Review toolkit in 7 districts. • Tanzania: Tanzania's HDC is working to improve compatibility of digital health data systems. Tanzania HDC communique identifies 'addressing fragmentation of M&E and data systems' as the top priority for collective action

²⁶ HDC, 2016-2018, Progress Report

Year	Global/ regional progress	Country progress
	<ul style="list-style-type: none"> ○ New portal established for tracking health-related SDGs, including UHC and inequalities in health ○ Indicators developed for measuring country health information systems ● Fostered collaboration with UHC2030, Countdown to 2030, and Global Partnership for Sustainable Development Data- including through participation in joint meetings and forums ● Participated in UHC2030 retreat for health system related initiatives to explore areas of cooperation, including potential joint products, funding arrangements and information sharing ● Organised first workshop of the Countdown to 2030/ Health Data Collaborative regional initiative to generate evidence and strengthen country analytical capacity for women's, children's and adolescents' health organised by the African Population Health Research Centre in Nairobi in 2017. Involved 35 participants from 19 countries, who conducted in-depth analyses of household survey data and health facility data ● HDC and HDC partners have participated in a number of data forums organised by the Global Partnership for Sustainable Development Data, including the first UN World Data Forum in Jan 2017 and High Level Meeting on Data for Development in Africa in June 2017, to advocate for HDC approach to strengthening capacity 	
2018-2019 ²⁷	<ul style="list-style-type: none"> ● Strategic Planning Retreat held in January 2019 to discuss next phase of HDC, and outline HDC Operational Workplan 2019-2024 ● More than 350 technical experts from 60 organisations involved in WGs, have developed, reviewed and harmonised 33 global public goods, 25 of which are ready to be published (includes 29 global goods from 2016-2018) ● Challenges ● Delayed recruitment of HDC Secretariat Officer due to WHO Global Transformation Process limited ability of HDC secretariat to communicate and collaborate with partners, stalled updating of HDC governance structures and procedures, and finalisation of HDC 2019-2024 Operational Workplan 	<ul style="list-style-type: none"> ● See above ● National Stakeholder Workshops on Routine Health Facility Data Analysis and Use held in Malawi (Nov 2018), Zimbabwe (Nov 2018), Tanzania (January 2019), Uganda (Feb 2019), and Cameroon (April 2019)- workshops began the process of integrating recommended standards into national RHIS ● Number of countries interested in adopting HDC approach expanding- includes DRC, Ethiopia, Uganda, and Botswana
2019-2021 ²⁸	<ul style="list-style-type: none"> ● Data focal points have been identified in each country (MoH or NSO) 	<ul style="list-style-type: none"> ● HDC focus countries have increased from 4 pathfinder countries (Malawi, Cameroon, Kenya, and Tanzania) to 11 countries (Malawi, Cameroon, Kenya,

²⁷ HDC, 2018-2018, Final Progress Report (*Reporting to CDC*)

²⁸ HDC, September 2019-August 2021, Final Progress Report (*Reporting to CDC*)

Year	Global/ regional progress	Country progress
	<ul style="list-style-type: none"> • 344 resources and tools have been shared through the HDC website for partners and countries to use and adapt • Four HDC countries have outlined data and digital priorities, in the context of COVID 19, and called upon partner alignment toward technical and financial support in these catalytic activities in the next 2-3 years. • Private Sector Constituency formed • 7 WGs established with clear and updated TORs • HDC grew from 94 members in March 2020 to 307 members in August 2021 • 2 annual Global Partner Meetings • 3 HDC webinars with 290 attendees • HDC Leadership Event took place 16th December 2020- 200 people joined 2-hour leadership event showcasing partnerships as key to building on C19 response, accelerate sustainable support to drive SDGs, and strengthen HIS • Between November 2019 and March 2020, a survey of over 55 HDC members identified five strategic needs for the HDC. These laid the foundations for the HDC 2020-2021 workplan 	<p>Tanzania, Uganda, Botswana, Zambia, Nepal, Myanmar, Indonesia, and Bangladesh)</p> <ul style="list-style-type: none"> • Individual country updates • Botswana- launched HDC in 2020, and developed Botswana HDC Roadmap 2020-2025- The roadmap outlines the BHDC principles; the key priority areas for BHDC as well as the Governance structures. Additionally, the roadmap has spelt out an operational plan that shall guide the BHDC investments in the next one year (2020/21 FY). BHDC technical working groups were launched. A joint signed communique was issued. • Malawi- June 2020, SDG Gap & Digital Accelerator and HDC jointly initiated discussions with MoH to explore avenues for strengthening HIS. MOH identified key support needs in areas of digital health and data governance, infrastructure, and HCW capacity. Dec 2020 MoH, GAP, HDC and bilateral agencies agreed to develop a country-led roadmap on partner engagement for data and digital health
2020-2021 ²⁹	<ul style="list-style-type: none"> • Membership update <ul style="list-style-type: none"> ○ September 2019- 52 members/ 28 organisations ○ March 2020- 94 members, 54 organisations ○ December 2021- 224 members (plus 543 DGI WG)/ 80 organisations (plus 33 DGI WG) • Data Governance Summit June / September 2021- 800 registrants/ 394 organisation • Governance- constituencies being strengthened, and WG supported by Secretariat (although this was identified as a challenge), SRG has had calls since March 2020, SDG GAP D+D merged with HDC, HDC Secretariat expanded through two UNICEF funded regional consultants and a 2 full time consultants, private sector constituency created • Country engagement- 11 countries engaged with in 2021, with 7 having expressed interest. Challenge- although in 2021 five countries identified their data and digital priorities and budget estimates, partners have not aligned resources 	<ul style="list-style-type: none"> • Botswana- see above • Kenya- The Kenya HDC approach facilitated consolidated investments to achieve common goals on large scale activities that contributed to critical evidence generation for the health sector however temporarily dormant but will be re-launched in August 2021. Pegged and operationalised within the following existing mechanisms to avoid duplication – Kenya Health Sector Partnership Framework and launch of the HIS/ M&E Inter Agency Committee • Malawi- Challenges remain- There is a lack of sustainability of digital health products, inadequate coverage of digital health solutions, lack of interoperability between digital systems, lack of trust in data quality and lack of data use. Further, there is inadequate and unskilled workforce in digital health. MoH called on partners to align activities to National Digital Health Strategy, through the HDC. Year 1 activities are harmonised with the Digital Health Roadmap. • Tanzania- no activities/ achievements identified

²⁹ HDC, 2020-2021, Progress Report

Year	Global/ regional progress	Country progress
	<p>with country identified priorities and managing expectations has been challenging. Will require frank and open dialogue with partners.</p> <ul style="list-style-type: none"> Working Groups- The Logistics and Management Information Systems and Digital and Interoperability Working Groups are relatively autonomous and have their own ways of working, connected with broader logistics and digital efforts. In 2021 new TORs were developed for Routine Health Information Systems (RHIS), CRVS, Public Health Intelligence (functioning from early 2022) and Data and Digital Governance. Challenges in 2021 have included secretariat capacity to support WG functioning and diversifying WG Membership (especially country and CSO members) Communication and advocacy- HDC website redesigned in 2020. HDC Twitter account, youtube channel, and LinkedIn page were created. The HDC Leadership Event in November 2020, created momentum for political leadership and commitment for the HDC objectives, which has been captured in the 2021 Data Governance Summit and other data related activities (200 people joined). The political will galvanized during the Data Governance Summit relied on and used the HDC and SDG GAP platforms for partnership approaches to data for better health outcomes. HDC partners led 5 webinars. Partnership approach- HDC engaged with KEMRI Wellcome Trust and Institut Pasteur de Dakar, regional institutes that will host GPM in Dec 2021 and support national/ subnational data and digital institutes, HDC objectives and activities. Since November 2021, monthly HDC SRG calls have included SDG GAP D+D members- priorities include GIS, SCORE with a focus on Pakistan, Nepal and Malawi. Collaboration with UHC2030- The UHC 2030 Civil society engagement mechanism has played a key role in supporting the CSO constituency for the HDC 	<ul style="list-style-type: none"> Nepal- National Planning Commission and the Ministry of Health have developed a results framework of health-related SDG indicators including SDG-3 and nutrition related indicators of SDG-2 (HDC specific activities not identified)
2021-2022 ³⁰	<ul style="list-style-type: none"> In September 2022, HDC has 803 members and 226 organisations- only 18% are from LMICs or fragile contexts and country governments or representatives, civil society, and private sector are underrepresented HDC launched its communication and advocacy strategy, as well as the HDC website in September 2022. Also hosted 8 webinars. HDC conducted a desk review of alignment status of partner technical and financial investments in 5 countries Developed a new Theory of Change and Principles of Country Engagement 	<ul style="list-style-type: none"> Active engagement with 11 countries including renewed engagement with Indonesia, Bangladesh (2022 target was 12 impact countries). Major challenge is that secretariat capacity is low, and that countries are distracted by COVID 19 pandemic Data and digital priorities identified in 5 countries Kenya- focused on strengthening CRVS through improved collaboration. CRVS Kenya mission in 2021 led to Kenya requiring training in medical certification of cause of death as a requirement for health workers, and the Africa Medical

³⁰ Health Data Collaborative, Progress Report September 2022

Year	Global/ regional progress	Country progress
	<ul style="list-style-type: none"> • Development of an RHIS investment case, with work to continue until April 2023 by the winning bidder (Swiss Tropical and Public Health Institute) • In June and September 2021, HDC partners were engaged with the Health Data Governance Summit. Although this was convened by WHO it involved multiple HDC partners at different levels, significantly increased members of the HDC and has stimulated thinking in the Data and Digital Working Group to move issues forward on governance • COVID case study 	<p>Councils and Associations developing a protocol to set guidelines incorporating medical certification of cause of death.</p> <ul style="list-style-type: none"> • Uganda- MoH launched HDC technical working group with partners in January 2022 and has a road map for 2022-2023 • Pakistan- initial WHO led Pakistan mission established a need for mechanism like HDC, HDC/ SDG GAP Data and Digital Health Accelerator are currently planning for follow-up visit in 2022/2023 • Malawi- joint HDC/ SDG GAP mission led by UNFPA and WHO with multiple partners focused on CRVS and GIS generated a White Paper and road map with possible resources to tackle key gaps in CRVS and GIS plans, HDC partners following up in 2022 • Botswana- Botswana's HDC partners have been led by the MoH, coordination structures are in place and activities to strengthen digital health, CRVS and data for quality of care are continuously being reviewed and implemented • Cameroon- HDC advocated for domestic investments for HIS and made significant progress with multi-partner approach to data and leveraging partner resources for common objectives • Nepal- identified its top data and digital priorities in 2021 and convened a call with HDC partners to align resources. Unfortunately, this generated expectations and partners were unable to commit anything, so alternative ways of engaging partners is being sought • In 2021, Tanzania, Kenya, Uganda, Nepal and Malawi identified their data and digital priorities, complete with costed plans - however this did not translate to alignment of resources amongst partners
2022 ³¹	<ul style="list-style-type: none"> • September in-person meeting resulted in clear plans • 2022-2025 workplan approved- with refined milestones and metrics, as well as a 'lead member' for certain deliverables to foster ownership and create momentum • WG products • HIS investment case underway • HDC website relaunched • Communications & Advocacy strategy renewed 	<ul style="list-style-type: none"> • Malawi mission- white paper finalised and shared • Pakistan mission- March 2022 WHO EMRO effort, HDC made a presentation to government but no concrete response from govt about whether they want to actively engage with HDC

³¹ SRG Meeting Slides and Notes, December 2022

Year	Global/ regional progress	Country progress
	<ul style="list-style-type: none"> • Secretariat capacity increased- addition of Tashi and Carolina • Challenges: <ul style="list-style-type: none"> ○ Engagement in WGs and focus on deliverables ○ Managing country resource expectations ○ Demonstrating impact on alignment work ○ Secretariat capacity ○ Country engagement 	
<ul style="list-style-type: none"> • 2023³² 	<ul style="list-style-type: none"> • Priorities <ul style="list-style-type: none"> ○ HDC evaluation ○ Regional platforms (Africa and Asian regional consultations, institutes and regional offices) ○ Closer links to SDG3 GAP Primary Health Care accelerator ○ HIS investment case and leadership event 	<ul style="list-style-type: none"> • Priorities <ul style="list-style-type: none"> ○ Nepal/ Pakistan missions- Pakistan mission in March 2022 was led by WHO EMRO and another joint mission planned but no concrete response on whether they want to actively engage with HDC ○ Mapping partners and country efforts ○ Linking WG technical expertise with country needs ○ Increasing country engagement (particularly fragile countries, leveraging platforms in African and Asian regions) ○ National Health Data Conference planned in 2023 by HDC Cameroon to engage data producers and users in improvement of data for UHC and decision-making- meant to be a national and regional conference

³² SRG Meeting Slides and Notes, December 2022

Appendix G WORKING GROUP SUMMARY

Appendix G presents a table summarising the objectives, composition and achievements of each Working Group (WG) since its inception. It is based on document review of HDC progress reports, HDC WG Terms of Reference, Excel tracker of WG products (2020-2023), WG meeting minutes, WG member lists, presentations, and draft workplans under development (RHIS, D&DG, and CRVS WGs only). Information was corroborated and supplemented through key informant interviews.

Table G.1: WG Summary

Objectives	Composition	Achievements (since WG inception)
Civil Registration and Vital Statistics (CRVS) WG: founded in 2021		
<p>Strengthen national CRVS systems through coordination and collaboration at global, regional and national levels and exchange of information. The specific objectives are to:</p> <ul style="list-style-type: none"> • Support coordinated country-level engagement by respective institutions that is consistent with the WHO global CRVS strategy 2020-2023 and respective partner agendas. • Explore and leverage opportunities to accelerate the improvement of CRVS systems. • Promote the importance of CRVS in the global development agenda. • Act as liaison for information exchange between HDC and other global and regional entities supporting CRVS strengthening. 	<p>54 members (2021) from the Research, Academia and technical Networks constituency (CDC, LSHTM), country constituency (Zambia, Uganda, and Tanzania MoH and Zambia, Uganda and Tanzania WHO country offices), multilaterals (UN, WHO, World Bank), CSOs (SCOPE, the Pacific Community, and Vital Strategies).</p>	<ul style="list-style-type: none"> • WHO CRVS Strategic Implementation Plan publicly available • CRVS Stakeholder Workshop in Kenya • WHO-UNICEF Health Sector Contributions towards improving the Civil Registration of Births and Deaths in Low-Income Countries: guidance publicly available • Malawi and Kenya presented to the Working Group and specific support activities were planned • WG supported a global CRVS Partners Meeting on 9-10 November 2021 • WG members participated in the UNSCAP Ministerial Conference • Working Group members supported UNECA, UNESCAP, and related ICD11 meetings • Cross-cutting work with the Digital Health and Interoperability (DH&I) Working Group in 2021. A number of DH&I members shared their expertise during the CRVS Technical meeting to support the CRVS implementation in Kenya from 30 November to 4 December 2021 • Met with the Routine Health Information Systems (RHIS) Working Group and presented CRVS linkage with RHIS • Organised and participated in joint SDG3 GAP/ HDC mission to Malawi in June 2022 and Nepal in January 2023
Community Data WG: founded in 2018		
<ul style="list-style-type: none"> • Enhance alignment, coordination and collaboration across global and country stakeholders dedicated to improved generation and use of community data and systems for health. • Optimise, harmonise, and/or promote standards, guidance and tools that support integration of routine community 	<p>52 members (2021) including members from AKROS, USAID, ICF, CHWImpact, USAID, Global Fund, UNAIDS, Peace Corps, Palladium Group, UNICEF, JSI, University of Oslo.</p>	<ul style="list-style-type: none"> • In 2018 WG held its first in-person meeting in Washington DC, in December 2018 • WG also organised the Community Health Information System/ DHIS2 system design Academy in Dakar in 2018 • Developed conceptual framework to measure community health workforce performance, with a Community Health Worker indicator guide. Involved multiple HDC partners but led by Population Council. https://link.springer.com/content/pdf/10.1186/s12960-019-0422-0.pdf

Objectives	Composition	Achievements (since WG inception)
<p>data and data systems into broader HMIS and information ecosystem.</p> <ul style="list-style-type: none"> Learn from and build on country community data and systems efforts aimed at supporting frontline community health worker service delivery and enhancing population health. 		<ul style="list-style-type: none"> Guidance on minimum requirements for a CHW Master List hosted in a registry- led by Clinton led by the Clinton Health Initiative, Community Health Impact Coalition, the Global Fund, UNICEF and endorsed by the working group (https://www.unicef.org/documents/implementation-support-guide-development-national-georeferenced-community-health-worker) Guidance on strategic information and service monitoring publicly available (lays out a set of standardised indicators) publicly available (UNICEF lead in collaboration with WHO, Global Fund, UN Women, UNAIDS, Stop TB, Rockefeller Foundation, Gavi, Community Health Impact Coalition) https://www.healthdatacollaborative.org/our-response/working-groups/community-data/guidance-for-community-health-workers-strategic-information-and-service-monitoring/ Community health measurements and planning tools webinar is publicly available-organised by Population Council with substantial participation of the HDC US President's Malaria Initiative (PMI) launched Digital Community health Initiative (DCHI) to strengthen quality health delivery at community level by investing in scale-up of digitally enabled community health platforms. PMI has partnered with Digital Square to carry out assessments of digital landscapes and carry out assessments of current digital environment. (USAID PMI Lead) HDC Community Data WG led sessions and country consultations on community data and CHIS during the Institutionalising Community Health Conference 2021 (USAID, UNICEF, BMGF) Development of CHIS standard configuration package in DHIS2 is in progress Also input from some members resulted in the publishing of 'community-based health care, including outreach and campaigns in the context of the COVID-19 pandemic, interim guidance' (https://www.unicef.org/media/68811/file/Guidance-Community-based-Health-Care.pdf) and 'Monitoring health services during COVID-19 USAID/ UNICEF have funded missions to Liberia, Nepal and Malawi (WG Co-Chairs supported in review of community health system strategy and community data system, and were able to opportunistically align with Global Fund resourcing connected to malaria programming).

Data and Digital Governance (D&DG) WG: founded in 2020		
<ul style="list-style-type: none"> To develop best practice principles, frameworks, and toolkits for data and digital health governance that can be adopted by national governments, alliances, and WG member organisations. 	<p>59 members (2021) from CSOs (Open Communities), Donors (USAID), Global Health Initiatives (PATH, Global Fund), Multilaterals (WHO), Private Sector (Helium</p>	<ul style="list-style-type: none"> Coordinated efforts to produce Health Data Governance Principles through a collaboration with Transform Health. The Principles were formally endorsed by the SRG. Work continues on advocacy at different levels and recent work in UNGA and a letter to the DG of WHO to place data governance on the agenda of the WHA.

Objectives	Composition	Achievements (since WG inception)
<p>To include a specific focus on ensuring accountability by global actors to host governments and beneficiary communities.</p> <ul style="list-style-type: none"> To support HDC secretariat in maintaining a repository that serves to support knowledge sharing in shared priority areas of the working group members; to include templates, model policies, and standards that community members can contribute to and use. To serve as an advocacy accelerator for the larger HDC, supporting translation of technical needs into recommendations, identifying and responding to global health priorities (e.g., COVID-19), building connections to digital and data governance leadership and venues in the global health community, and promoting the overarching priorities of the WG membership. 	<p>Health, Palladium, Bluesquare), Research, Academia and Technical Networks (CUNY)</p>	<ul style="list-style-type: none"> Working group TORs approved by HDC WG Co-Chairs Contributions to WHO Data Governance Summit publicly available- facilitated the break-out session for Data Sharing Policies – legal and ethical aspects Developed HDC webinar on Health Data Governance in May 2022. Compiled and presented good data governance practices in countries to the HDC leadership event on 18th May 2023 Development of Health Data Governance framework is ongoing

Digital Health & Interoperability (DH&I) WG: founded in 2014

<ul style="list-style-type: none"> Optimise the meaningful use and reuse of health information technology in low- and middle-income countries to support achievement of SDGs through the implementation of foundational digital health infrastructure. Actively promote the development, use, and long-term support of digital health ‘global public goods’. Increase, in a measurable way, the level and alignment of country and partner investments in support of Objectives 1 and 2. 	<p><i>543 members approximately (2021)- Co-Chairs in 2021 were representatives from USAID, Open Communities, WHO, and PATH</i> <i>543 members approximately (2021)- Co-Chairs in 2021 were representatives from USAID, Open Communities, WHO, and PATH. Made up of multiple sub-working groups.</i></p>	<ul style="list-style-type: none"> Held Digital Health & Interoperability 2021 virtual annual meeting Artificial Intelligence and Machine Learning Sub Working Group developed New Language Processing brief, monthly meetings hosted guest speaker, looking into data quality issues and achievements Business Value Proposition and Market shaping Sub Working Group with Vital Wave and Digital Square worked on market analytics with a focus on TCO working towards advocacy on procurement documentation Capacity building and curriculum sub working group launched Digital Health Applied Leadership Program in collaboration with the University of Global Health Equity in Rwanda Data Privacy and Security Standards Sub Working Group able to reach new audiences for disseminating frameworks and research findings, and developed new guidance Digital Health Planning National Systems training for 80 participants from WPRO Ministries of Health
---	--	---

Objectives	Composition	Achievements (since WG inception)
		<ul style="list-style-type: none"> • Digital Health Convergence Meeting Toolkit workshops held- for five countries in Asia under USAID, ADB, Asia eHealth Information Network, GIZ, and UNICEF • Global public goods developed include: • Brief on digital health systems used in 22 countries to address COVID-19 needs • Digital Health Capability models Navigator- a maturity model-based tools selection for specific context at national and sub-national level is publicly available (USAID funded) • Supply Chain Information System Maturity Model toolkit v2 • Map and Match Initiative, coordinated by PATH-Digital Square to look into the integration of existing ecosystem for the COVID-19 response
Logistics Management & Information Systems (LMIS): founded in 2016		
<ul style="list-style-type: none"> • Support member states with development of information systems policies and guidelines for health commodities [Policy] • Develop on a common framework, approach and principles for coordination of LMIS investments and technical support to countries. [Coordination] • Document learnings about open LMIS, private sector LMIS options, strategies to re design / reengineer LMIS based on experience from the field. [Strategy (Sustainability)] • Develop a global strategy to support digital health solutions for LMIS [Technical] • Agree and adopt information standards [Technical] 	<p>Led by RMNCH SCT (Convenor of the ISG), with focal points from all partner agencies (at global and country levels) engaging around specific countries of interest (Tanzania, Zambia, Myanmar, Senegal). One or multiple partners to take the lead for each country and global deliverable.</p> <p>Constituents include RMNCH SCT, BMGF, USAID, UNFPA, GFATM, HISP, VR, Dimagi, JSI, UNICEF.</p>	<p>LMIS Working Group and Global Health Supply Chain Program (GHSC) implementing partners have developed and published numerous global good documents to allow country programmes to jump start their LMIS, verification and traceability initiatives- living documents Global standards, policy papers, and working documents (non HDC) publicly available. Each output is in fact the work of a specific partner within the transport and supply chain environment (ISG) and they are not branded ISG or HDC.</p>
Public Health Intelligence (PHI) WG: active 2021-2022 (recently folded into RHIS WG)		
<ul style="list-style-type: none"> • Create opportunities for collaboration to foster improvement of investments in surveillance and health information systems for meeting International Health Regulations around outbreak detection and response. 	<p>About 16 members (2021) across multilateral and intergovernmental organisations (UNEP-WCMC, OIE, WHO, UNICEF, OIE/OHISS, FAO/ OHISS); Donors (FCDO UK, Rockefeller Foundation); Research, Academia and Technical Network</p>	<p>Carried out a landscaping of the resources/ tools available in the PHI space.</p>

Objectives	Composition	Achievements (since WG inception)
<ul style="list-style-type: none"> Develop specific strategies for coordinating resources towards building capacity for better use of data for responding to public health events at national and subnational levels. Contribute technical expertise in the areas of data standardization, data harmonization and interoperability of Health Information Systems/solutions to other global initiatives with the aim to merge information from multiple sources, including from human, animal and environmental health (One Health approach). 	<p>(CDC, NSAH UK/OHISS, Defra UK, IPD, UKHSA, IPD, SVA/OHISS, Africa CDC)</p>	

Routine Health Information System (RHIS) WG: founded in 2020

<ul style="list-style-type: none"> Global Goods: Review, define and harmonise standards for improved facility-based RHIS to improve health services and health system strengthening through: Collation of resources and tools for RHIS indicators, data quality, analyses, and use; Identification of ways in which investments in RHIS can be better aligned to ensure stronger, scaled and sustainable systems that reduce reporting burden, improve data quality and increase efficiency; Contextualization of protocols and standards for integrating disease surveillance, public health and humanitarian emergency data into RHIS and documentation of best practices for learning; Dissemination and promotion of standards for introducing information 	<p>43 members (2021) across Civil Society (JHPIEGO), Global Health Initiatives (GFATM), Multilaterals (WHO, UNAIDS, WHO EMRO, UNICEF), Private Sector (Helium Health), Research, Academia and Technical Networks (Health Information Systems Program, RHINO, LSHTM, UiO, Country Health Information Systems & Data Use(CHISU)/ JSI, University of Philippines)</p>	<ul style="list-style-type: none"> Successfully developed a compilation of RHIS standards, best practices, and tools at the global level, stored in an online repository and accessible through the HDC website. The documents were classified according to the chapters of the RHIS training curriculum developed with the support of the MEASURE evaluation project (USAID). Contributed to WHO RHIS Strategy- consultation on RHIS as an integral part of health and data use Initiation of the compilation of country-specific documentation stored in another section of the online repository. Discussion is ongoing to identify the best platform to make these resources accessible to countries. Initiation of the reflection on the integration of public health and humanitarian diseases and emergencies surveillance reporting into RHIS with the aim of developing comprehensive guiding notes, documenting country case example, identifying electronic systems – assessment and M&E tools and engaging partners to support integration Connected to development of RHIS Investment Case (but work being led externally team at Swiss Institute of Hygiene and Tropical Medicine) RHIS WG member participated in introductory HDC trip in Pakistan
---	--	---

Objectives

Composition

Achievements (since WG inception)

culture in country health systems, leading to improved use of data for improved service delivery at all levels of the health system, but particularly at district level and below.

- Country Support:
 - In collaboration with HDC partners and country governments, align support for achievement of a country's RHIS goals. RHIS technical assistance and project funding will be aligned and coordinated to support national plans for RHIS strengthening.
 - Ensure collaborative processes with country engagement and engagement with all relevant stakeholders including civil society and the private sector.
-

Appendix H **COMPARATIVE REVIEW OF GLOBAL HEALTH AND HIS ORGANISATIONS**

This Appendix has two subsections. Section H.1 includes a table reviewing the mandate and structure of three health data initiatives for comparison with the HDC, and Section H.2 presents lessons learned from the PMNCH's governance structure, which supported development of recommendations for the HDC.

H.1. DESK REVIEW OF HEALTH DATA INITIATIVES

Stakeholder feedback queried the need for the HDC in addition to other health data initiatives that have been established over the last few years, specifically Transform Health, the WHO Hub for Pandemic and Epidemic Intelligence and Digital Square. Table H.1 presents a high-level summary of the objectives, technical areas of focus, membership, structure and financing of these three health data initiatives which were raised in stakeholder consultations.

Table H.1: Desk review of TransformHealth, the WHO Hub for Pandemic and Epidemic Intelligence, and Digital Square

Key objectives	Technical areas of focus	Membership base	Key points of structure/ financing
Transformhealth			
<ul style="list-style-type: none"> • Recognition of the fundamental role of digital technologies and data use to transform and strengthen health systems to expand primary health care which is an essential foundation for achieving Universal Health Coverage (UHC) by 2030. • To allow for full beneficial, impactful, and responsible management of health data, while safeguarding data privacy, ownership, and security. • To strengthen digitally enabled primary health care systems in low- and middle-income countries to achieve UHC by 2030.³³ 	<ul style="list-style-type: none"> • Increasing coalition's membership and advancing objectives at national and regional level. • Establishing strategic partnerships with regional networks and groups like G7 and G20. • Focusing on digital transformation with initiatives like the Digital Health Week and launching the Case for Digital Health report. • Developing a conceptual framework for a full investment case on digital health for investment priorities and the necessary funding for digital health transformation. 	<ul style="list-style-type: none"> • 42 Organisations as of 2021- predominately civil society, academia, professional bodies, private sector, and grassroot organisations (partners do not appear to include multilateral organisations and key bilateral and multilateral donors) • 3 Regional Networks (Asia- AeHIN, LATAM- Recainsa NGO, West & Central Africa- Baobab Institute and Sprakup Africa) • 2 National Coalitions (Kenya ~24 organisations, Indonesia ~20 organisations) 4 more being set up in Mexico, India, Senegal, and Ecuador.³⁴ 	<ul style="list-style-type: none"> • There is an Investment and Resources Circle in the organisation structure which works convening investors and key stakeholders with the goal of increasing domestic and international investments for digital health transformation. • The organisation engages with select short-term working groups which complement the internal organisational circles and are open to all coalition partners to join. ³⁵

³³ Transformhealth, Objectives Available at: <https://transformhealthcoalition.org/about/>

³⁴ Transformhealth, Partners Available at: <https://transformhealthcoalition.org/partnerships/>

³⁵ Transformhealth, About Available at: <https://transformhealthcoalition.org/about/>

Key objectives	Technical areas of focus	Membership base	Key points of structure/ financing
	<ul style="list-style-type: none"> Establishing a Global Research Consortium (GRC) Developing a set of globally unifying, human rights-based Health Data Governance Principles. Creating a long-term strategy to drive the creation of a global health data governance framework, underpinned by these Principles. Consultative processes and events. 		

World Health Organization (WHO) Hub for Pandemic and Epidemic Intelligence			
<ul style="list-style-type: none"> Enhance methods for access to multiple data sources vital to generating signals and insights on disease emergence, evolution and impact. Develop state of the art tools to process, analyse and model data for detection, assessment and response. Provide WHO, Member States, and partners with these tools to underpin better, faster decisions on how to address outbreak signals and events. Connect and catalyse institutions and networks developing disease outbreak solutions for the present and future.³⁶ 	<ul style="list-style-type: none"> Connecting data, solutions, and communities of practice globally: Creating a multi-disciplinary collaborative intelligence environment and building a global system to connect data from a wide range of sources. This includes data across sectors, disciplines, and regions. It explores beyond traditional disease surveillance, including case data and laboratory data, embedding it with the essential contextual information about environmental, social, and economic factors. Facilitating development and wide availability of analytic tools and driving a global agenda for responsible research 	<ul style="list-style-type: none"> The organisation works with the all the Member States and partners with six of the WHO Regional Offices. The two foundational partners are the Robert Koch Institute and Charité – Universitätsmedizin Berlin³⁸ The Hub has several other global partnerships including the US CDC's Centre for Forecasting and Analytics which brings together 50 international modelling groups.³⁹ 44 Member States and 18 organisations and networks joined their Epidemic Intelligence from Open Sources (EIOS) initiative in 2022 	<ul style="list-style-type: none"> The Hub has received a funding of EUR 90 million from the Federal Republic of Germany. It forms and functions as a part of a new Division of Health Emergency Intelligence and Surveillance Systems, which is located within the WHO Headquarters Health Emergencies Programme⁴⁰

³⁶ WHO, (2021) WHO, Germany open Hub for Pandemic and Epidemic Intelligence in Berlin, September Available at: <https://www.who.int/news/item/01-09-2021-who-germany-open-hub-for-pandemic-and-epidemic-intelligence-in-berlin>

³⁸ WHO (2022) The WHO Hub for Pandemic and Epidemic Intelligence: Strategy Paper

³⁹ Morgan and Pebody (2022) The WHO Hub for Pandemic and Epidemic Intelligence; supporting better preparedness for future health emergencies, Eurosurveillance Available at: <https://www.eurosurveillance.org/content/10.2807/1560-7917.ES.2022.27.20.2200385;jsessionid=LQ27bB6l5teqpV2s4CAOwBMWeNTVPdLGHAJhTeUg.i-0b3d9850f4681504f-ecdclive>

⁴⁰ Morgan and Pebody (2022)

Key objectives	Technical areas of focus	Membership base	Key points of structure/ financing
	<p>and development in pandemic and epidemic intelligence.</p> <ul style="list-style-type: none"> Forecasting, detection, and assessment of health risks: Providing advisory, training, and capacity building services; and supporting timely, effective decision-making and policies.³⁷ 		
Digital Square			
<ul style="list-style-type: none"> Aims to strengthen country efforts to develop national digital health infrastructure, ensuring these efforts are supported by coordinated investments and a selection of high-quality digital health tools⁴¹ 	<ul style="list-style-type: none"> Helps identify investment opportunities and operational support for procurement. Promotes the development, adoption and reuse of digital health global goods and works on increasing their availability, adaptability and maturity. Working on a digital health capacity to help governments strengthen their digital health capacity with the Planning National Systems course and the Digital Health Applied Leadership Program.⁴² 	<ul style="list-style-type: none"> They support 4 regional networks (Asia eHealth Information Network, African Alliance of Digital Health Networks, Digital REACH and RECAINSA) Have over 120 partners in the digital health ecosystem.⁴³ 	<ul style="list-style-type: none"> They coordinate more than \$71 million from 14 digital health investors (includes the likes of Bill and Melinda Gates, Child Relief International Foundation, Microsoft, and more)

³⁷ WHO HUB (2022), What does the WHO Hub for Pandemic and Epidemic Intelligence do? December Available at: <https://pandemichub.who.int/news-room/questions-and-answers/frequently-asked-questions>

⁴¹ Digital Square, Mission Available at: <https://digitalsquare.org/about>

⁴² Digital Square, How we work? Available at: <https://digitalsquare.org/howwework>

⁴³ Digital Square, Partners and Funders Available at: <https://digitalsquare.org/partners>

H.2. LESSONS LEARNED FROM PMNCH'S GOVERNANCE RESTRUCTURING

A review of PMNCH's governance restructuring helped to inform recommendations developed for the HDC. Box H.1 below summarises key lessons learned.

Box H.1: Lessons learned from PMNCH governance structure

An evaluation of PMNCH from 2014-2019 found multiple governance challenges including an unwieldy structure, unsustainable workload for the Secretariat, perceived lack of transparency and efficiency in decision-making, and a small proportion of actively engagement members. A majority of informants suggested that governance structures and decision-making bodies needed to be reformed for greater efficiency and effectiveness. Subsequently in 2020 and 2021, PMNCH undertook a reform process to streamline its governance and make it more fit-for-purpose to deliver on the 2021-2025 Strategy. The following key changes were adopted, relevant to similar challenges faced by the HDC.

- **Country engagement.** Within the Executive Committee of PMNCH, there is a specific Partner Engagement in Countries Committee. This committee assesses partner engagement and alignment at the country level, liaises with the Strategic Advocacy Committee on advocacy needs, identifies synergies with other relevant platforms and campaigns, and provides guidance to and reviews progress of organisations benefitting from limited PMNCH grants. However, a recent proposed change envisions the PMNCH supporting multi-partner collaborative platforms in countries and building on existing collaborative efforts in countries. A country lead focal point will be identified amongst partners to coordinate in-country advocacy and actions. These platforms have not yet been implemented, therefore the success of the initiative remains to be seen.
- **Partner engagement.** In an effort to create a more partnership-centric approach, PMNCH will support partners in directly communicating, planning and working together, and monitoring progress through 'Communities of Practice' (CoP) which are essentially working groups or thematic hubs. Members themselves would create groups specific to need, forming and dissolving as needed with the Secretariat working only as a communications facilitator and connector of the CoP. In recent workplans, efforts have been made to identify lead partners for workplan deliverables and supporting mechanisms. Partners are expected to deliver processes and products, including through consultancy contracts. Additionally, partners are requested to choose the level of engagement they prefer to have with PMNCH so that resources, information and opportunities are appropriately tailored.
- **Constituency-based.** Like the HDC, constituencies are the core organising structure of the PMNCH. The constituency structure while somewhat unwieldy, provides legitimacy to the PMNCH. Notably, similar to the HDC, the number of members actively engaging within constituencies is extremely low. PMNCH has found that people are most likely to engage when there's a specific product on the table – for example a report, website, event, journal article, etc.
- **Secretariat structure and operations.** Adapting to the changes above and moving towards an increasingly virtual PMNCH, and towards a partner-led rather than Secretariat-led model has led to a reimagining of the role of the PMNCH Secretariat. Secretariat work is limited to five key areas: campaigns and outreach support, knowledge synthesis, digital communications, governance and partner engagement, and supporting operations of the PMNCH.

Sources: (i) CEPA, 2020, *External Evaluation of the Partnership for Maternal, Newborn and Child Health 2014-2019*; (ii) governance reform documents including PMNCH Board Meeting, *Harnessing the power of partnership in the digital era (2020)* & *Proposed Governance Reform Transition Process (2021)*

Appendix I ANALYSIS OF HDC MEMBER BASE

This Appendix presents the data analysis of the HDC membership base. Figure I.1-I.5 below provide an overview of the results. The key findings of the analysis include the following:

- HDC membership has increased from 43 partners in 2016 to 904 individual members in 2023 representing over 200 institutions. Despite growing membership however, only a subset of HDC members are actively engaged. This is discussed in Section 2.2 on Efficiency.
- The HDC membership base is roughly balanced between genders especially at the global level taking into account members from all regions. At the regional level however, men make up roughly two-thirds of membership from the AFRO, EMRO, and WPRO region and women make up two-thirds of membership from EURO, PAHO, and SEARO.
- WHO is the most represented organisation within the membership, with 91 members from WHO. USAID is second at 50 members, and Vital strategies is third at 41 members. From the AFRO and SEARO region, the majority of members work at Ministries of Health.
- The majority of members- 398- are from the US. Only around 30% of members are from low and middle income countries, the majority are from high income countries.
- Country representatives remain the smallest constituency of the HDC, whereas representatives from research, academia, and technical networks and multilateral and intergovernmental institutions make up over one-fifth of the membership each.

Figure I.1: Gender breakdown of HDC membership

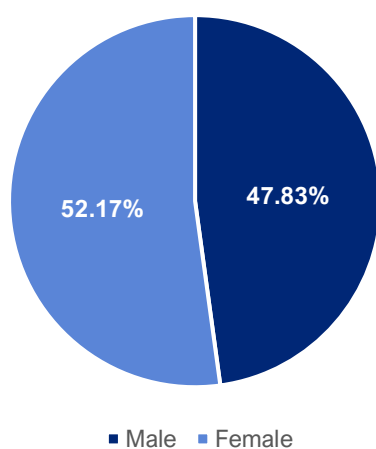


Figure I.2: Number of members by country (top 10)

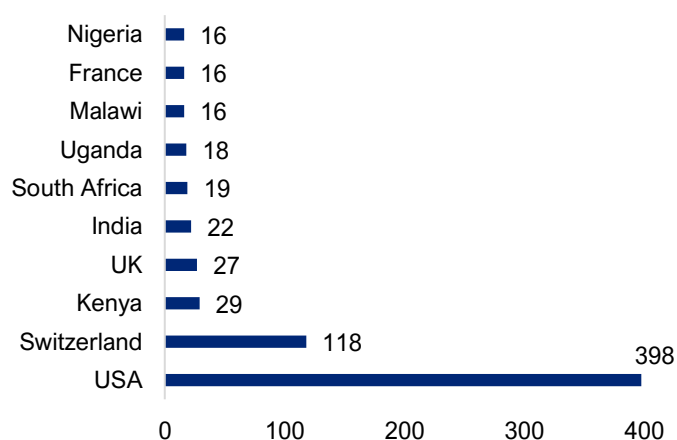


Figure I.3: Number of members by constituency

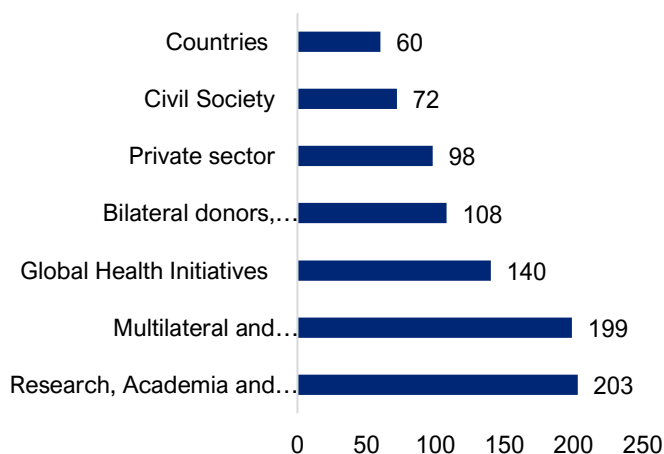


Figure I.4: Number of members by WHO region

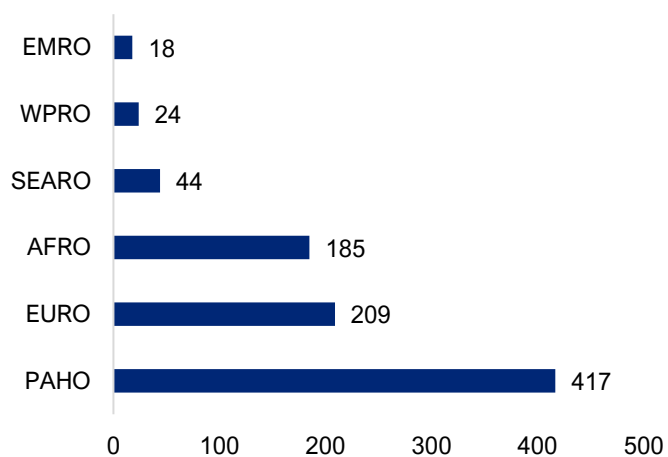
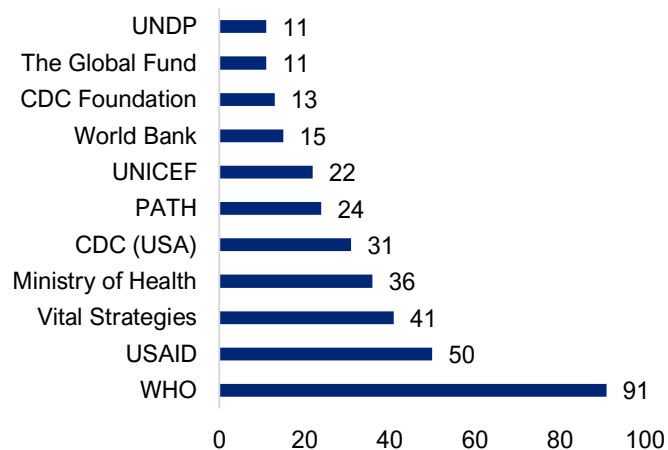


Figure I.5: Number of members by organisation (top 10)



Appendix J HDC THEORY OF CHANGE

Figure J.1: TOC developed in 2019

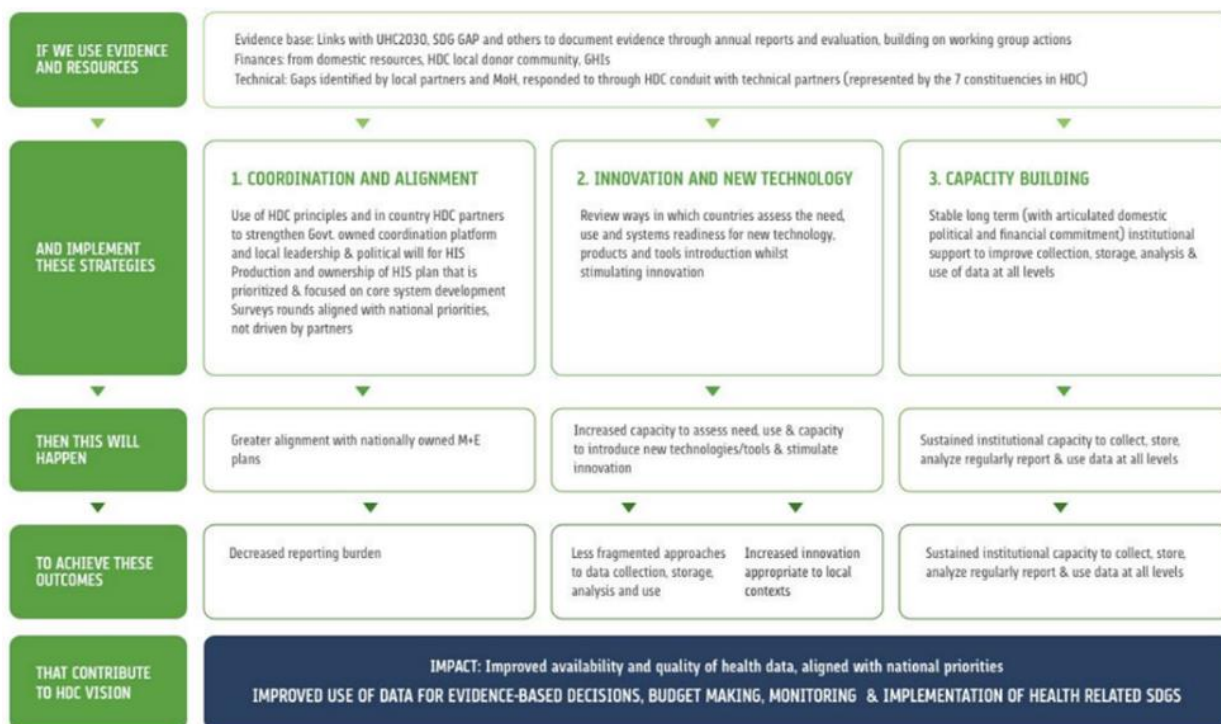
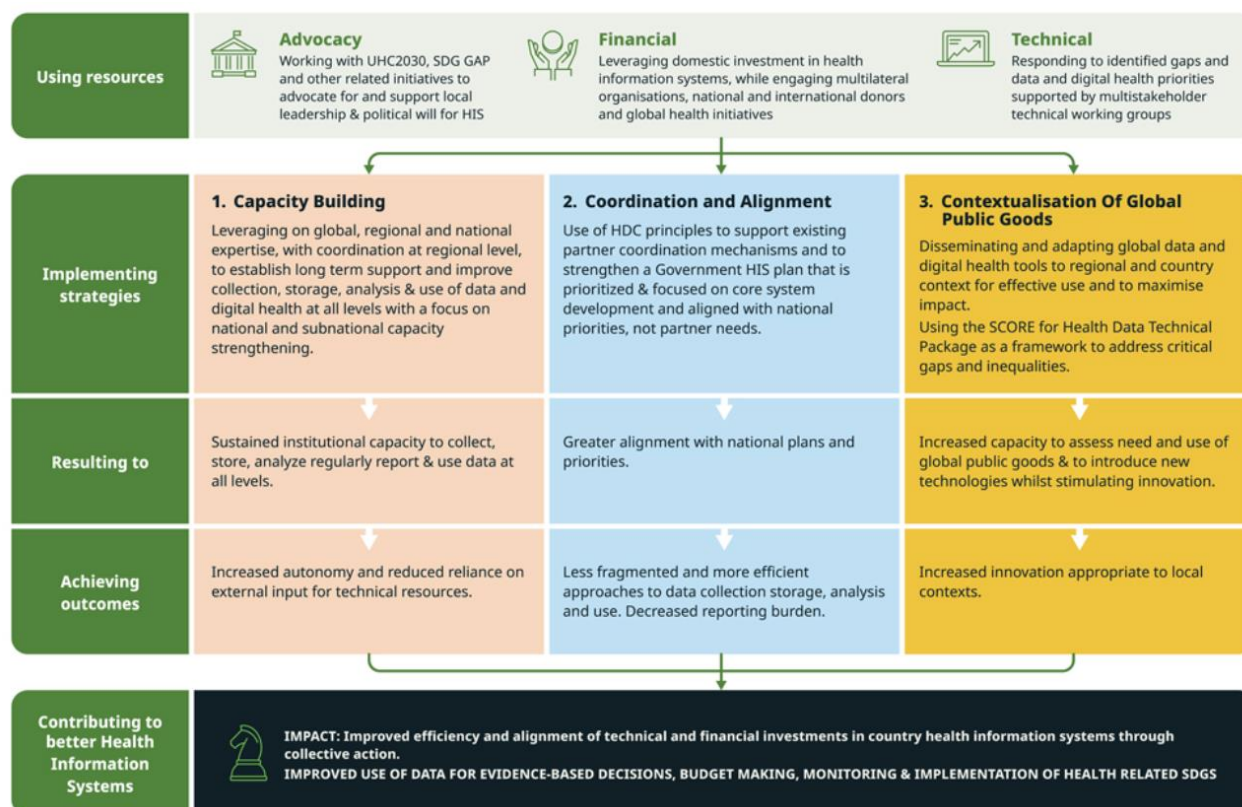


Figure J.2: Updated TOC





UK

Queens House

55-56 Lincoln's Inn Fields

London WC2A 3LJ

T. +44 (0)20 7269 0210

E. info@cepa.co.uk

www.cepa.co.uk

 [cepa-ltd](#)  [@cepald](#)
