

Developing an indicator framework for monitoring and evaluating the institutionalization of evidence informed policymaking in health organizations

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Abstract

Background

The institutionalization of evidence-informed policymaking (EIP) is increasingly recognized as essential for strengthening health systems and improving decision-making processes. However, despite advances in implementation science and knowledge translation, monitoring and evaluation approaches for assessing the institutionalization of evidence-informed decision-making (EIDM) remain fragmented, heterogeneous, and insufficiently systematized. This study aimed to develop a framework of indicators for monitoring and evaluating the institutionalization of EIP in health organizations.

Methods

This methodological study was based on secondary sources and critical interpretive analysis. The study drew on a previous evidence synthesis focused on dimensions and indicators related to EIDM implementation in public health organizations. Studies addressing monitoring, evaluation, knowledge translation, organizational capacity, and implementation-related indicators were critically analyzed. Identified indicators were synthesized and organized into analytical dimensions associated with EIP institutionalization. Based on this synthesis, a framework composed of criteria, parameters, and indicators was developed.

Results

Six studies directly addressing indicators for EIDM institutionalization were identified in the underlying evidence synthesis. Existing approaches predominantly used qualitative and process-oriented indicators, with limited use of structured or composite measures. The proposed framework organized indicators across six implementation-related dimensions: governance; standardized and routinized processes; leadership and commitment; resources; partnerships, collective action and support; and organizational culture. The framework integrates criteria, parameters, and indicators intended to support both monitoring and evaluation activities while maintaining flexibility for adaptation across different institutional and health system contexts.

Conclusions

This study contributes to implementation science by proposing a context-sensitive framework for monitoring and evaluating the institutionalization of EIP in health organizations. The framework addresses an important gap in the literature by offering a structured yet adaptable approach capable of supporting organizational learning, reflective evaluation, and the sustainability of evidence-informed practices. Further empirical studies are needed to test the applicability, feasibility, and sensitivity of the proposed indicators across diverse health system settings.

Background

From a sociological standpoint, institutionalization is the process of establishing an institution and sustaining it over time. During this process, the institution acquires its own structure and culture. Berger and Luckmann [1] define institutionalization as the process by which human actions become habitual and compulsory. These patterns are imposed on members of a society or social group. In their view, institutionalization is also a legitimation process.

Through legitimation, an institution becomes socially accepted and respected. This process can help produce social order, but also constrain individual freedom by reinforcing existing power structures.

According to the literature, Koon et al. [2] note three dimensions underpinning institutionalization in health. These are the regulatory dimension, which concerns rules governing the use of knowledge in health policymaking; the normative dimension, which covers value judgments that ensure appropriate knowledge use in health policymaking; and the cultural-cognitive dimension, which includes routines, language, protocols, and shared beliefs about knowledge in policymaking. The authors state these dimensions show the multifaceted nature of institutions, as emphasized in multiple disciplines.

Within the field of evidence-informed policies (EIP) and evidence-informed decision-making (EIDM), institutionalization may be understood as a set of activities that becomes an integral and sustainable part of a formal system. These activities unfold through a sequence of events in which new practices become standard practice [3]. To this end, as evidence becomes a legitimate component of an institution, grounded in collective values and sustained by organizational resources, one can speak of the institutionalization of EIP [4]. The use of evidence, therefore, ceases to be a one-off effort and instead becomes a continuous practice embedded in organizational processes.

Ensuring the institutionalization of EIP requires developing and implementing monitoring and evaluation strategies. These terms cover several approaches, methods, and tools. Monitoring includes activities conducted during policy or program implementation. Evaluation occurs at the end, or sometimes midway, to assess whether objectives were achieved. The phrase monitoring and evaluation (M&E) often refers to assessing policies, programs, or recommendations in terms of their processes or outcomes, aiming to improve them [5].

Monitoring and evaluation are guided by these principles: (i) Monitoring and evaluation are not just for experts; they involve the perspectives of different stakeholders through negotiation. (ii) Professionals and groups involved must be aware of the constraints from institutions and contexts where actions occur, so they can respond better. (iii) Monitoring and evaluation should not be seen as a simple chain of cause and effect; participants need to engage with emergent processes of change [6].

Indicators – whether quantitative or qualitative, used for monitoring or evaluation – are decision-making tools for analyzing information about corporate processes. These tools help understand organizational performance [7]. In monitoring, indicators track performance against established objectives and goals, identify deviations, and guide corrective actions. In evaluation, indicators help analyze results, effects, changes, or impacts from implementation or decision-making.

Considering the synthesis of evidence on the institutionalization of evidence-informed policies in health organizations, conducted by Barreto et al. (7), we can infer that the discussion on M&E can still be further developed within the national and international literature. Thus, this article aims to propose a framework of monitoring and evaluation indicators for the institutionalization of EIP.

Methods

This is a methodological study based on secondary sources and critical interpretive analysis for the development of a monitoring and evaluation framework. This study used a methodological approach based on secondary sources and focused on critically analyzing an evidence synthesis about the institutionalization of EIP. The initial analysis drew on the evidence synthesis noted in the Introduction [7], which identified key factors for implementing EIP. That

synthesis asked: Which dimensions and indicators can monitor and evaluate progress and outcomes of evidence-informed decision-making in public health organizations?

Based on this guiding question, we selected articles addressing EIDM and indicators related to its implementation. These articles were examined using a critical approach that focused not only on the dimensions and indicators identified but also on the contextualization and applicability of these findings within public health settings. This analysis enabled a deeper examination of gaps in the literature, as well as the different interpretations of indicators across institutional contexts.

The authors synthesized the indicators, aiming to highlight variables most relevant to EIDM. These indicators were organized by their range, from process evaluation to outcome analysis, covering various aspects of EIP management.

Subsequently, a summary framework of indicators for monitoring and evaluating EIDM was developed. This framework comprises three main components: criteria, which describe the broad areas for evaluating EIDM; parameters, which provide measurement guidance for each criterion; and indicators, which represent the measurable variables to be observed and monitored. The critical interpretation of the findings was conducted to assess not only the validity of the identified indicators but also their feasibility across different contexts, thereby allowing flexible adaptation in different public health organizations. This process of categorization and critical analysis was essential for refining the understanding of best practices for monitoring EIDM and supporting the implementation of EIP within health systems.

Results

General characteristics of studies on indicators

Six of the 24 studies analyzed in the evidence synthesis [7] directly addressed indicators. These studies examined implementation, knowledge translation (KT) quality, KT networks, KT infrastructure and capacity building, information systems, and program implementation evaluation. Table 1 describes these six studies.

Table 1

Characteristics of the studies on monitoring and evaluation reported in the evidence synthesis by Barreto et al., 2025 [7]

Author, year	Design	Objective	Focus
Armstrong et al. (2013) [10]	Intervention study and implementation plan based on a theoretical and narrative literature review, a systematic review of KT strategy effects, including a survey of local governments and a qualitative study of decision-making processes in Victoria, Australia	To describe the design and implementation plan of a knowledge translation intervention for public health decision-making in local government.	Implementation indicators
Bhuiya et al. (2024) [9]	Scoping review (253 articles)	To identify quality indicators from existing tools that provide guidance on how to practice knowledge translation and implementation science (KT practice tools) across all KT domains (dissemination, implementation, sustainability, and scale-up).	KT quality indicators
Da Silva et al. (2022) [11]	Rapid review (2 articles)	To identify strategies for promoting the use of tools (dashboards, tabulators, databases, etc.) to disseminate information of interest for monitoring and evaluation in health systems and policies.	Critical factors and indicators for the use of dissemination tools
Delnord et al. (2020) [12]	Scoping review (79 articles)	To identify the essential KT mechanisms and determinants that could help monitor the impact of national health information systems.	Critical factors and indicators for national health information systems
Kuchenmuller et al. (2022) [4]	Four-phase mixed methods: A focused literature review of KT networks, activities, and indicators; two scoping reviews to refine the indicator set; reviews by international KT experts and an online consultation with experts; piloting.	To describe the development of a framework for monitoring and evaluating knowledge translation (KT) networks.	KT network indicators
Scarlett et al. (2020) [8]	Scoping review (32 articles)	To identify, synthesize, and assess indicators used to evaluate KT infrastructure and capacity-building activities in a health policy context in order to inform organizational knowledge brokers.	Indicators for evaluating KT infrastructure and capacity-building activities

[Table 1]

Overall, the studies examined KT monitoring and evaluation using qualitative parameters. One study [8] used both qualitative and quantitative data. In that study, the quantitative part focused on simple measures like frequencies or

rates. None of the studies featured composite indicators made up of combined variables to show whether a standard was achieved.

M&E indicators are often presented as groupings of aspects, ideas, or actions that share some affinity. Some authors combine these groupings to propose indicators. Bhuiya et al. [9], for example, listed indicators related to four categories (development, evaluation, adaptation, and knowledge-user engagement) and four KT domains (dissemination, implementation, sustainability, and scale-up). Another study [10] combined KT activities (customized organizational support, group training, guided communication, and evidence summaries) with EIDM levels (individual, organizational, and system).

Literature-based monitoring and evaluation indicators

The M&E indicators were grouped into six dimensions from Kuchenmuller et al. [4]: Governance; Standardized and routinized processes; Leadership and commitment; Resources; Partnerships, Collective action and support; and Culture. Table 2 shows EIDM M&E indicators by these dimensions. In Table 2, monitoring and evaluation indicators are not separated because studies in the review do not distinguish between them.

Table 2

Monitoring and evaluation indicators for evidence-informed decision-making aggregated by dimension, according to Kuchenmuller et al., 2022 [4]

Dimension	Indicators
Governance	- Applicability of research to decision-making [8] - Increased demand for, or value assigned to, KT products or knowledge by policymakers [8] - Context of evidence use [11] - Researcher feedback on alignment of the project with priorities [8] - Improved health status and equity resulting from EIDM [4] - Improvements in health systems policies resulting from EIDM [4] - Changes in policies or programs consistent with produced evidence and greater availability of research evidence – relevant and understandable – for policymakers [8] - Quality and frequency of the organization's demand for evidence [11] - Support at the individual level – support to increase staff confidence, skills, and access [10] - Organizational-level support to improve the culture of evidence-informed decision-making within the public health team and promote evidence use by the public health team [8, 10] - Use of participatory approaches [9]
Standardized and routinized processes	- Capacity to assess sustainability and/or scale-up potential of KT tools - adoption of any method to assess implementation, sustainability, and/or scale-up potential [9] - Capacity to identify stakeholders' information needs [9, 11, 12] - Capacity to identify equity considerations [9] - Capacity to monitor, evaluate, and communicate the results of evidence-use interventions [8, 11] - Capacity for systematic knowledge synthesis – conducting a non-systematic knowledge synthesis process as part of the development of a KT practice tool [9] - Targeted communication – sending materials such as recent scientific publications or reviews, and dissemination of upcoming conferences, events, and training opportunities [10] - Conducting iterative processes – processes for refining KT practice tools based on feedback and relevant information [9] - Specialized knowledge about KT practice tools [9] - Inclusion of reflexivity and/or critical reflection – a description of the developer's reflexivity and/or critical reflection that may affect KT development [9] - Number of projects that lead/are expected to lead to behavior change and the gradual elimination of external funding [8] - Percentage of works submitted for publication [8] - Use of theory to inform the creation of the KT practice tool [9]

Dimension	Indicators
Leadership and commitment	- Assessment of staff engagement with evidence [8] - Tailored organizational support – monthly program leader contact with collaborators by telephone [10]
Resources	- Increased capacity of national teams through activities [4] - Increased KT capacity among external stakeholders [4] - Increased KT practice and production/availability of products by national teams [4] - Percentage increase in pre/post skills scores following training and contribution to decision-making by partners and policymakers [8] - Capacity to assess determinants – use of qualitative or mixed methods approaches to assess determinants (barriers and facilitators) of KT use in a specific context [9] - Knowledge translation (KT) capacity and skills development [4] - Core competencies for data use [11] - Data availability [11] - Online availability of a website or evidence database [8] - Participant experience with evidence-based policymaking [8] - Input indicators: structure, financial resources, human resources, effective management, and technical assistance [4] - Changes in government-allocated funding [8] - Number/percentage of trainees reporting an intention to use the skills acquired [8] - Data quality/evidence quality [11, 12] - Periodic group training in a central location, using a modular approach to cover principles of evidence-informed public health, formulation of answerable questions, evidence searching, confidence, analysis of applicability, transferability, and evaluation; and activities designed to encourage networking among councils [10] - Use of KT products by national teams and external stakeholders [4] - Systematic and routine use of evidence in public policymaking [4]
Partnerships, collective action and support	- Acceptance and/or influence of evidence and financial and organizational support for knowledge transfer partnerships [8] - Application of a shared user-centered design process [9] - Increased trust and openness among partners [8] - Increased joint activity around the project [8] - Engagement of evidence users and producers [9, 11, 12] - Number/percentage of members present at activities and hiring of external consultants – contracting external organizations and/or teams [9] - Development of evidence syntheses in partnership with other institutions [10] - Feedback on network knowledge and perceptions and sustainability of built partnerships [8]

Dimension	Indicators
	- Identification of knowledge users for engagement [9] - Number of knowledge transfer partnerships [8] - Number of projects involving users [8] - Regular occurrence of policy dialogues on priority issues and KT activities considered beneficial for bringing stakeholders together and facilitating partnership development [8] - Partners' views on the use of research results [8] - Production of collaborative activities and stakeholders [4] - Production of research projects with policymakers [8] - Promotion of driving, engagement, exchange, and integrative efforts around KT [8] - Use of participatory approaches [9]
Culture	- Increased interest of national youth in research [8] - Increased use of evidence and EIDM values by policymakers, the media, and society [4, 8] - Organizational culture that promotes and uses research findings in decision-making [8] - Culture for promoting and using research findings in decision-making, and feedback on context/culture [8] - Sustainable institutionalization of EIDM [4] - Lessons learned from program evaluation – use of lessons learned or evaluation of previously implemented interventions, innovations, or programs to inform development – sustainability and scale-up [9] - Changes in policies or programs consistent with produced evidence [8] - Level of institutional commitment to EIDM [4] - Number of products related to organizational climate [8]

Proposed monitoring and evaluation indicators

Using the indicators in Table 2, a proposal was developed to evaluate EIP institutionalization in health organizations (Table 3). The synthesized indicators informed the development of the indicators, as well as the related criteria and parameters. The framework uses standardized wording for its components, since the original studies phrased indicators differently. The proposed framework is not limited to these criteria, parameters, and indicators. Other approaches may be developed to fit different organizations when monitoring and evaluating EIP institutionalization.

Table 3

Proposed monitoring/evaluation indicators for the institutionalization of evidence-informed policies (EIP) in health organizations

Criterion	Parameter	Indicator
1. Organizational culture	Assess the adoption of values and practices that support organizational change, such as openness to innovation, collaboration, and evidence use.	Percentage of professionals who report collaborative practices, evidence use, and openness to innovation within the organization.
2. Stakeholder engagement	Assess the degree of participation and commitment among the various professionals and groups involved in implementing EIP institutionalization processes.	Percentage of professionals from different sectors of the organization involved in implementing EIP institutionalization processes.
3. Satisfaction and engagement of involved stakeholders	Monitor the degree of acceptance and engagement of involved stakeholders every six months.	Percentage of professionals who report adherence to new practices and satisfaction with the changes.
4. Leadership and accountability	Assess leaders' commitment and support for institutional change at least 1 year after the start of EIP institutionalization.	Number of leadership actions and decisions that reflect support for change (such as creating new policies and allocating resources for implementation).
5. Policies and organizational structures that facilitate EIP institutionalization	Monitor changes in policies and structures that facilitate EIP institutionalization every six months.	Proportion of new or updated policies or guidelines created to institutionalize EIP (e.g., new quality policies or incentives for evidence use).
6. Use of evidence in decision-making	Assess improvement in the use of scientific evidence in decision-making at least 1 year after the start of EIP institutionalization.	Number of documented decisions that considered EIP processes.
7. Formalization of EIP actions	Assess – within the set of documents publicly released by the organization – the existence of principles, regulations, and/or plans aimed at EIP at least 1 year after the start of EIP institutionalization.	Proportion of new formal documents presenting principles, regulations, and/or plans for the institutionalization of EIP.
8. Use of information	Assess the usefulness of the information made available for decision-making at least 1 year after the start of EIP institutionalization.	Percentage of professionals who report usability of the information provided.
9. Capacity to search for evidence syntheses	Assess professionals' capacity to search for and use evidence syntheses at least 1 year after the start of EIP institutionalization.	Professionals' perceptions regarding the realization of evidence synthesis searches.
10. Training and competency development	Assess the impact of training and capacity-building activities carried out as part of the EIP institutionalization process.	Percentage of professionals who report having completed an EIP training course and feeling more confident in using evidence.
11. Collaborative processes	Assess the involvement/contribution of other organizations/groups/stakeholders in the decision-making process at least 1 year after the start of EIP institutionalization.	Perception of those involved in the collaborative process regarding the organization's decision-making.

Criterion	Parameter	Indicator
12. Impact on operational outcomes	Assess the impact of implementing EIP institutionalization across the organization as a whole.	Perceived change in the organization's processes and outcomes.

[Table 2]

[Table 3]

As noted, this proposal does not distinguish between monitoring and evaluation. The same indicator may serve both purposes. In other words, an indicator may function as a monitoring reference when progress in the implementation process is under consideration. Conversely, when the evaluative dimension is emphasized, the indicator serves as a reference for analyzing the results obtained at the end of the process to which it relates.

Although the dimensions used to classify the synthesized indicators are not explicitly presented in the proposal, they are reflected in the content of the criteria and parameters suggested for the indicators.

Finally, it should be noted that the methods for monitoring or evaluating each indicator are not described in the proposal. This is justified by two considerations. First, the way a given indicator is monitored or evaluated depends directly on the context in which it is intended to be applied. Second, for some of the indicators presented in Table 3, more than one methodological strategy may be adopted.

Discussion

The findings of this study indicate that monitoring and evaluation of the institutionalization of EIP remains a field under consolidation, marked by conceptual diversity, methodological heterogeneity, and a fragmented formulation of indicators [8, 13]. Critical analysis of the identified studies shows that, although recognition is growing regarding the importance of evaluating knowledge translation processes and evidence use, efforts have focused mainly on specific dimensions, such as capacity building, infrastructure, or networks, without a systemic articulation that reflects the complexity of institutionalizing EIDM in public health organizations, especially within universal public systems such as the Brazilian Unified Health System [14, 15].

A first important finding concerns the predominance of qualitative indicators, often formulated as broad analytical categories or thematic groupings, rather than as structured, composite, or performance-oriented indicators. This finding suggests that the field still operates more at an exploratory and descriptive level than at a properly evaluative one, which limits comparability across experiences, replicability of models, and the systematic use of indicators as management tools. At the same time, this predominance reflects the complex, relational, and contextual nature of EIP, whose institutionalization does not unfold linearly or lend itself exclusively to quantitative metrics.

In the global literature on monitoring and evaluation applied to knowledge translation and evidence use, many “indicators” emerge as qualitative inventories – domains, dimensions, categories, and checklists – that are useful for mapping capacities, functions, and processes, but are less well suited, when used in isolation, to standardizing performance, comparing units over time, or synthesizing progress into composite measures. The review by Bhuiya et al. [9] presents a broad landscape of candidate indicators derived from practice tools, reflecting substantial diversity in items and domains and reinforcing the extent to which the field still frequently operates at the level of dispersed descriptors and criteria rather than aggregated metrics oriented toward standards. In parallel, the framework

proposed by Kuchenmuller et al. [4] makes explicit the need to organize this repertoire into a results chain – a theory of change or logic model – and to propose sets of core and recommended indicators that can be selected according to stage of maturity, a typical movement of the transition from broad categories to more structured measurement systems, even though these remain dependent on contextual adaptation.

Another important finding concerns how the analyzed studies conceive the relationship between processes and outcomes. Many of the proposed indicators occupy an intermediate zone in which practices, capacities, and institutional arrangements are treated simultaneously as both means and ends of institutionalization. This blurs the classical distinction between monitoring and evaluation and reinforces the idea that, in the field of EIP, following the process itself already constitutes an evaluative judgment about the degree to which evidence has been incorporated into decision-making processes. This observation underpins the methodological choice adopted in this article not to rigidly separate monitoring indicators from evaluation indicators, while recognizing their hybrid and multifunctional nature.

Aligned with the global literature on evaluation in implementation and health systems, the predominance of qualitative indicators and broad analytical categories may be interpreted as evidence that the field is still maturing: when events are complex, multilevel, and strongly context dependent – as is the case with the institutionalization of EIP and EIDM – there is a tendency to operationalize monitoring and evaluation through descriptions of capacities, arrangements, and practices (e.g., governance, organizational culture, data infrastructure, and learning routines) that function simultaneously as means and markers of success.

Recent reviews show, on the one hand, that contemporary frameworks combine – and sometimes overlap – implementation and evaluation components, incorporating process evaluation and iterative cycles as part of the intervention itself, thereby shifting the classical boundary between monitoring and evaluative judgment [16]. On the other hand, when mapping strategies and performance measures in learning health systems – a useful international analogue for dialogue with institutionalization – strong concentration is observed in intermediate indicators, digital infrastructure, feedback mechanisms, and continuous improvement capacities, along with persistent gaps in measuring distal and comparable impacts (population outcomes, equity, and costs). This reinforces the idea that process tracking assumes evaluative centrality when final outcomes are diffuse, with long-latency, and influenced by multiple determinants [17].

Categorizing indicators according to structuring dimensions showed that the institutionalization of EIP is a systemic phenomenon that transcends the technical sphere of producing and using evidence. Dimensions such as organizational culture, leadership, governance, resources, and partnerships emerge as equally central, indicating that evidence use is sustained not only by the availability of high-quality information, but also by shared values, institutionalized routines, organizational incentives, and trust-based relationships among stakeholders. This interpretation reinforces the understanding that EIP should be analyzed as a social and organizational practice rather than solely as an individual or organizational competence.

International reviews on knowledge translation and implementation reveal that the institutionalization of evidence use is a systemic and relational situation, dependent on leadership, organizational culture, governance, and co-production between researchers and decision-makers, rather than merely on the technical availability of high-quality information [18, 19]. Scoping studies indicate that shared values, institutionalized routines, and collaborative arrangements are key to the sustained incorporation of evidence into decision-making processes [19]. In addition, methodological analyses emphasize that, in complex and context-mediated fields such as health policy, evaluation tends to privilege organizational and institutional dimensions while acknowledging the nonlinear relationship

between technical intervention and outcomes [20]. Reviews of communities of practice further reinforce that evidence use constitutes a social practice sustained by networks, relational capital, and collective learning [21].

The indicator framework proposed in this study speaks directly to this broader understanding. By articulating criteria, parameters, and indicators, it seeks to overcome the fragmentation observed in the literature and to offer an analytical structure that can guide both reflective processes and operational decisions within health organizations. Rather than establishing a closed normative model, the proposed framework is intended to function as a guiding matrix that can be adapted to different institutional contexts, levels of organizational maturity, and governance arrangements.

A particularly relevant aspect of the proposal is its emphasis on the contextual interpretation of indicators. By not prescribing a single measurement methodology, the study acknowledges that the meanings attributed to indicators, and therefore their implications for management, depend on the concrete conditions in which they are applied. This choice reinforces a conception of monitoring and evaluation as reflective, negotiated, and situated practices, aligned with the dynamic nature of institutionalization processes and the diversity of health systems. Global reviews in implementation and evaluation in health indicate that indicators acquire meaning only when interpreted in light of the institutional, political, and organizational context in which they are applied, reinforcing evaluation as an adaptive and co-produced practice [16]. Contemporary frameworks further emphasize that the usefulness of indicators depends on their integration into local decision-making processes and iterative learning, rather than on rigid standardization [22].

Finally, we should acknowledge this study's limitations. The proposed indicators were based on the analysis of secondary sources and therefore reflect the biases, gaps, and predominant emphases of the literature analyzed, as well as the authors' own perceptions, which are linked to their prior knowledge of and experience with EIP and EIDM. Notable is also the fact that the lack of empirical testing of the proposed framework currently precludes any inference about its operational validity or its sensitivity to change over time. These limitations, however, do not diminish the relevance of our contribution; on the contrary, they point to a future agenda for research and practical application in which the framework can be tested, adjusted, and refined in real-world health management settings.

Conclusions

This study reinforces that the institutionalization of EIP is a complex, gradual process that depends heavily on organizational, cultural, and relational factors. Although important advances have been made in identifying dimensions and practices associated with evidence use, systematized monitoring and evaluation proposals capable of capturing, in an integrated manner, the multiple components of this process remain incipient. To this end, the indicator framework presented in this article seeks to address a relevant gap in the field of EIP institutionalization by coordinating criteria, parameters, and indicators that make it possible to observe not only the presence of evidence in decision-making processes, but above all the extent to which these practices become routine, legitimate, and sustainable within health organizations.

By proposing a flexible, context-sensitive set of indicators, this study may contribute to strengthening monitoring and evaluation approaches oriented toward institutional learning rather than performance control alone. The proposal does not aim to exhaust analytical possibilities or establish a universal normative model, but rather to offer a structuring basis that may support managers, policymakers, and researchers in critically reflecting on their own decision-making processes. Future studies are needed to empirically test the proposed framework, explore its

applicability at different levels of the health system, and delve deeper into its capacity to inform strategic adjustments, thereby contributing to the consolidation of effective, evidence-informed public policies.

Abbreviations

EIDM
Evidence—Informed Decision—Making
EIP
Evidence—Informed Policymaking
KT
Knowledge Translation
M&E
Monitoring and Evaluation

Declarations

Ethics approval and consent to participate

Not applicable, but all precepts of ethical conduct and integrity in research were rigorously observed in this study.

Consent for publication

Not applicable.

Data Availability Statement

Data sharing not applicable to this article as no datasets were generated or analysed during the current study.

Competing interests

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Authors' contribution

All authors designed the study. RG, JOMB, and TST conducted the analysis and developed the initial version of the monitoring and evaluation indicator framework. All authors contributed substantially to the interpretation of findings and to the conceptual refinement of the framework and its analytical dimensions. RG, JOMB, and TST drafted the first version of the manuscript and MLTM, RR, and SFS critically revised the manuscript for important intellectual

content and contributed to subsequent revisions. All authors reviewed and approved the final version of the manuscript.

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