SYNTHESIS REPORT

Evaluation of ESAR Institutional Strengthening Support Initiative on Decentralized Programme Monitoring and Response

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Abbreviations and Initialisms

BNA  Bottle Neck Analysis
CA  Causal Analysis
iCHIS  Integrated Community Health Information System
eCMIS  Electronic Client Management Information System
CO  Country Office
DFID  United Kingdom Development Agency
DFNC  District Food and Nutrition Committee
ESAR  East and Southern Africa Region
ESARO  East and Southern Africa Regional Office
FNC  Food and Nutrition Committee
HMIS  Health Management Information System
HQ  Headquarters
ICT  Information and Communication Technologies
ISG  International Solutions Group
IT  Information Technology
KE  Knowledge Exchange
MOH  Ministry of Health
MSC  Most Significant Change
MSCBARS  Multisectoral Community–based Approach for Reduction of Stunting
NRT  Near Real Time
NRTM  Near Real Time Monitoring
NRTMS  Near Real Time Monitoring System
ODK  Open Data Kit
PMR  Programme Monitoring and Response
RHMT  Regional Health Management Team
RMNCAH  Reproductive, maternal, newborn, child and adolescent health
SMS  Short Message Service
TOR  Terms of Reference
UN  United Nations
UNEG  United Nations Evaluation Group
UNICEF  United Nations Children’s Fund
VFNC  Village Food and Nutrition Committee
WASH  Water and Sanitation
Executive Summary

In 2014, UNICEF headquarters, in collaboration with its East and Southern Africa Regional Office (ESARO), took the decision to address certain issues related to the health of women and children by implementing a regional institutional strengthening support initiative to improve the Programme Monitoring and Response (PMR) capacity of the centralized government decision-making bodies and communities in four countries (Kenya, Swaziland, Uganda and Zimbabwe).

The ESAR PMR was designed as a learning initiative with the following goals:

- Improve service provision and program performance during implementation through improved monitoring of intermediate results, establishment of citizen feedback loops, and the use of monitoring and feedback data to adjust strategies as needed in a timely manner; and
- Identify and promote those promising practices of programme monitoring in response, tested and proven by early adopter districts, through the development of national scale-up plans within participating countries and the establishment of knowledge exchange platforms.

Four countries were selected for participation in the PMR Initiative (Malawi, Swaziland, Uganda and Zimbabwe). As the programme began, Malawi elected to drop out because of a national floods emergency and was replaced by Kenya. While the PMR Initiative was designed with an umbrella results framework for the region, each implementing country customized and localized the actual implementation of the Initiative.

The evaluation was carried out between 27 MAR 17 and 31 MAY 17. Field work was completed between 15 April 17 and 10 May 17.

This report is a synthesis of findings, conclusions and recommendations in the four country reports that accompany it. As such, in general, for greater detail about country-specific findings, please refer to the country reports.

Findings

The PMR Initiative has its genesis in an understanding of the continued evolution of ICT4D innovations in ESAR and how these innovations have contributed to building a culture of management using data in the health sector. Because of this, the PMR Initiative has been a response that can be localized and contextualized to specific country needs, priorities, and capacity. The PMR Initiative has established or enhanced platforms that produce reliable, quality and more real time data in all four countries. However, the emphasis of the initiative has been on data use. The evaluation cannot determine if UNICEF has a comparative advantage in the production of technology-based solutions. However, UNICEF appears to currently enjoy a significant competitive advantage, but one that needs to be carefully articulated and defended.

The PMR Initiative has not resulted in a process for incorporating citizen feedback that rivals or eliminates traditional, or established, community and government structures. The evaluation cannot determine if UNICEF has a comparative advantage in community engagement. However, UNICEF’s citizen engagement tools offer an opportunity for competitive advantage, but one that needs to be established and validated.

A significant achievement of the PMR Initiative is its catalytic contribution to a “management using data” culture in the four implementation countries. By emphasizing data use, even with incomplete data sets, the PMR Initiative has contributed to a virtuous cycle of increased demand for more data and a desire for improved data quality.

UNICEF actively pursued the exchange of knowledge generated by the PMR Initiative through a variety of platforms and opportunities, with mixed results. At the country level, UNICEF staff and partners rely mainly on traditional or established methods of knowledge sharing.
The PMR Initiative has increased the potential for long term sustainability through the institutionalization of processes and protocols, such as the S/B/A process, but this increased potential is mixed across the four implementing countries. The potential for both sustainability and scalability are increased when UNICEF’s support focuses on enhancing existing national platforms and, to a lesser degree, developing online platforms. The PMR Initiative has seen the beginnings of a critical shift in organizational and professional culture in the implementing countries. This shift enhances sustainability by creating the professional expectation of using data for management planning and decision making. The sustainability and scalability of gains realized by the PMR Initiative could be further enhanced through greater government partner contribution and broadening the directionality of scale.

The PMR Initiative has created information products (i.e. dashboards) and processes (i.e. S/B/A process) outputs that can be replicated in other context with similar foundations. The evaluation cannot determine if UNICEF has a comparative advantage in replicating technology-based solutions. However, UNICEF’s programming across many sectors suggests a competitive advantage exists that could be exploited.

Conclusions

The conclusions below flow directly from the findings above:

While the availability of more real time data has played a key role in the PMR Initiative, a more critical outcome is the Initiative’s contribution to the development of a “management using data” culture in ESAR.

UNICEF’s competitive advantage lies in its strategic and long-term relationships with government partners and its ability to manage IT enabled programming. UNICEF comparative advantages, if any, related to implemented technology enabled programming remain unknown.

The PMR Initiative’s attempts to engage citizen feedback have produced positive results, but have not yet inspired a new norm for how citizen feedback is gathered, utilized and managed.

The PMR Initiative has realized typical results in terms of knowledge exchange and contributed to the development of new tools and channels for the same. However, there is still some distance to go to achieve a true paradigm shift within UNICEF for Knowledge Exchange.

The scalability and sustainability of programming gains remains a high-quality goal. The PMR Initiative offers three unique paths that can be used as models for both large scale releases and continued refinement of this topic within UNICEF.

The PMR Initiative has highlighted critical opportunities for innovation at the beginning and end of the feedback loop in health system strengthening.

Recommendations

The recommendations below flow directly from the conclusions above and are prioritized as presented:

Recommendation 1: Continue to invest in the “Management Using Data” culture in ESAR by leveraging UNICEF’s unique relationship with government partners for long-term investment plans and replicating gains within healthcare and in other sectors.

Undoubtedly, the clearest gains in all four countries made by the PMR Initiative are found in managers using collected data to understand how they, and their facilities, are performing. UNICEF, and its partners, should continue to support the building of a robust management culture where individuals not only demand data for their management decisions, but also one where trust in data is the norm and understanding of data is expected at all levels.
Potential directions that could be taken in subsequent programming include:

- **Build capacity around short, medium and long-term planning and strategy.** For managers to continue to be excited about data, tangible results from using data will need to happen in the short term. To that end, UNICEF should seek to work with managers to develop short, medium and longer-term planning and strategies that allow managers to have quick wins that roll up into greater gains over the long term.
- **Seek to incentivize individuals or teams around data use and analysis.** Similar to the scorecard approach for RMNCAH, there may be other opportunities for a competitive system that compares facility or district performance to continue feed into emotional attachment to data.
- **Provide simple and transparent means for managers to identify and report on data quality issues.** Make sure this system also includes clear owners with authority to take action, accountability, and a feedback mechanism that makes it easy to see what actions have been taken to remedy issues.
- **Establish a professional environment where failure is tolerated and expected, as long as learning and adaptation also happens – not every decision based on data will result in positive outcomes, or any tangible outcomes.**
- **Encourage customization and creative solutions from managers based on existing and future automated analytical tools.** As these unique solutions begin to emerge, facilitate a platform or method for sharing in the country, regionally and globally.
- **Seek ways to make digital analytical tools available to all levels of the health care system, especially non-technical managers.**
- **Provide opportunities for members of the health sector to demonstrate gains and outcomes to other sectors and to other areas of the health care system.**

**Recommendation 2: Bolster UNICEF’s competitive advantage as a manager of enabling ICT solutions by investing internally in skilled information managers.**

UNICEF has established itself as a leader in managing programs that rely upon ICT functionality to enable the realization of expected outcomes for children. However, this is not a unique advantage and one that is coveted by many other organizations across the social sector. UNICEF should continue to differentiate itself by investing in individuals who are skilled information managers. These individuals should be tasked with answering the question, “How could [insert programme name] be enhanced, made more efficient, scale or be more sustainable through better data and subsequent analysis?”

While an understanding of technical areas (e.g. Education, Protection, Health, WASH) are important, the existing skill sets of these individuals should first emphasize:

- **A passion about data, analytics and their ultimate usefulness in achieving better outcomes for children;**
- **An intrinsic understanding of ICTs and the willingness to play, bend, break and fix ICTs to understand their usefulness;**
- **A clear understanding of information management, including storage, accessibility, interoperability, systems integration and meta data;**
- **At least an appreciation for data science and how data can be pooled, dissected and used in unique ways;**
- **A proven ability to think across sectors and silos;**
- **A proven track record in charting long-term visions associated with clear, short term milestones that produce tangible benefit;**
- **A personality that is willing and able to connect and partner with the private sector;**
- **A personality who is able to forge new relationships, managing existing ones and build community around data sharing; and**
- **An individual that “gets” the open source movement.**

Importantly, while ICTs are often a part of the data-enabling conversation, the real key here is information management and the use of information for management decision making. Creating or including an ICT
component is not always necessary and should be approached with the same care as any other aspect during programme design.

Recommendation 3: Invest in establishing UNICEF’s comparative advantage to make the case that ICT investments are the best use of donor funds for achieving better health outcomes for children.

As noted in this report and the country reports, the evaluation team was unable to determine if UNICEF has a comparative advantage related to enabling ICT solutions, improving the incorporation of citizen feedback and scaling or replicating programming. While this is not an easy question to answer by any estimation, answering it is mostly a function of available time and data.

UNICEF should invest in answering the comparative advantage question for two important reasons: first, understanding the optimal way to spend donor funds to achieve better health outcomes for children directly supports UNICEF’s mandate. Second, if it is possible to establish that investing $1 USD in ICT enabled programming delivered by UNICEF results in better, more or broader health outcomes for children than other alternatives, knowing this would be a powerful competitive advantage for the organization.

Recommendation 4: Continue to invest in collecting and responding to citizen voice by iterating current solutions and seeking new solutions from a larger community of practice.

UNICEF has been a leading advocate and practitioner for including citizen voice in programme design and delivery for many years. However, the attempts to include citizen voice via ICT enabled solutions in the PMR initiative generally fell short of expectations, or in the case of Kenya, was not used.

Citizen feedback is essential for success in development programming. To that end, as noted above in Recommendation 1, results from the PMR Initiative should be seen as a moment of reflection for UNICEF in order to learn and iterate, so that the next programming cycle might attempt something new. In the spirit of working together to create greater efficiencies collecting and responding to citizen voice, UNICEF should shy away from going it alone. One immediate opportunity would be to engage FeedbackLabs, in one of their LabStorms, and use this community of more than 300 organizations as a catalyst for cracking the code to gathering and engaging with feedback from rural communities.

As an aside, at the time of this evaluation, the citizen feedback component in Zimbabwe was only just beginning to gain traction. UNICEF should monitor this process (based on U Report) as it is different than those used in the other three countries. There may be additional successes and challenges that can be learned.

Recommendation 5: Continue to evolve knowledge exchange at UNICEF through changes in organizational structure, professional culture and leadership buy in.

The evaluation found that the PMR Initiative fell short in terms of finding new, unique or scalable means for sharing knowledge. However, gains were made and, similar to citizen voice above, this should be seen as an opportunity for reflection, iteration and new design. Three areas UNICEF can concentrate on in the near term to improve its Knowledge Exchange practice are:

**Organizational structure:** UNICEF’s decentralized organizational structure creates natural boundaries between COs, within regions and globally. These physical boundaries are further compounded through the division of UNICEF’s work into separate sectors. While it is beyond the scope of this evaluation, it is clear that this structure provides little to no incentive for UNICEF staff or teams to regularly and reliably share information. When funding streams are added to this equation, incentives are reduced further. UNICEF should seek to find incentive options to break these barriers.

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1 See http://www.feedbacklabs.org
**Professional culture:** UNICEF’s professional culture does not currently reliably reward risk taking. UNICEF should pursue messaging and a clear incentive structure that rewards risk taking with regard to information sharing in order to establish a new norm regarding expectations about what happens with the lessoned learned in each CO.

**Leadership:** Underlying both of the above is the need for clear, strong, consistent and sustained leadership on knowledge exchange. If the organization and its staff do not perceive that KE is a high priority, with incentives for good performance and limitations for poor performance, change will not happen. This leadership position should come from the highest level possible and be tied to one or two, simple, clear goals. Communication about leadership expectations should be communicated at every opportunity and over a sustained period (2-3 years) in order for the message to become a part of the UNICEF culture.

Recommendation 6: Seek to shift UNICEF staff and partner mindsets about transferability of ICT enabled programming, and knowledge exchange, from “plug and play” to “customization.”

There are clear opportunities for gains made in the PMR Initiative to be replicated in other context, in both the health sector and other sectors. UNICEF should ensure that the following two criteria are present in any new context for replication to be successful.

First, ensure any receiving context has a minimum enabling environment. This environment includes:

1. National ownership and leadership of the system(s) that will receive the intervention;
2. National systems that are owned and operated by the government that can be enhanced;
3. The ability to partner with government and civil society;
4. The ability to foster development and improvement of infrastructure and policy;
5. The ability to align programmatic goals with accountability frameworks, incentives and actions;
6. Expertise that can be systematic about adopting and scaling innovations that are effective;
7. The ability to invest in adequate ICT capacity;
8. A long-term vision that allows sufficient time and investment for action and impact; and
9. The ability to focus on short term milestones along a longer-term road map.

Second, ensure that UNICEF staff and partners understand that replication of any ICT enabled process or system will, by its nature, require customization. As noted in the Uganda country report, there is a tendency for non-technical UNICEF staff and partners to desire systems and processes that are transferrable as “plug and play.” However, even systems that are built on a widely used, open source platform such as DHIS2 will require customization. As an example, consider the RMNCAH scorecard. While the underlying methodology for producing this scorecard remains the same across all context, at a minimum, the indicators chosen and their respective criteria (e.g. denominator) will need to be changed. And, therefore, the functionality of the ICT system will need adaptation.

Developing the capacity to establish an enabling environment and then offer the customized ICT enabled solution for that environment offer another opportunity for greater competitiveness at UNICEF.

Adopting a customization mindset also applies to the Knowledge Exchange approach at UNICEF. For example, while setting a single standard cap for the group sizes would be unrealistic, UNICEF should consider smaller group sizes in Yammer that target more specific populations. By so doing, UNICEF could create groups that are more manageable in terms of engagement by focus on a particular result area or competency. Slack is one example of a successful application of this paradigm where users have the ability to set up channels as necessary for almost any particular topic and invite users as necessary.

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2 For example, as of 28/05/2017, the size of the RTM CoP was 144.
Further customization for KE could be employed with Sharepoint. This repository should have a requirement for all information to have associated meta data that enables faster and more accurate searching.

**Recommendation 7:** Use ICT enabled programming as a bridge for multisectoral programming and scaling vertically.

The implementation of the PMR Initiative in Zimbabwe was clearly unique, as compared to Kenya, Swaziland and Uganda, and this has led to its own set of outcomes. One clearly positive gain from the Zimbabwe experience is the multisectoral nature of the implementation, which is in contrast to the health sector only implementation of the other three countries. UNICEF should continue to pursue similar opportunities where ICT enabled programming can overcome barriers, break silos or bridge gaps between sectors for a more holistic and integrated approach to achieving better outcomes for children.

In a similar vein, UNICEF should seek to leverage its success in vertically scaling the programming of the PMR Initiative to achieve the same horizontally.

**Recommendation 8:** Capitalize on opportunities exposed by the success of the PMR Initiative in closing the feedback loop to address the “no available resource” challenge and ensuring data collection is sustainable.

UNICEF should immediately seek to capitalize on the two major challenges exposed by the success of the PMR Initiative: Closing the feedback loop to address the “no available resource” challenge and ensuring data collection is sustainable. As with other areas mentioned above, “solving” these problems could create significant competitive advantages for UNICEF.

One option for closing the feedback loop could be the creation of a basket of funds that can be used to target identified problem areas in partnership with local governments. To ensure sustainability of data collection, UNICEF could work with partners to establish processes for data collection that offers a sustainable and worthwhile system of incentives.
Introduction

Background and Context

The twenty-one countries of UNICEF’s Eastern and Southern Africa region (ESAR) collectively bear a significant proportion of global under-five mortality, malnutrition and HIV despite notable improvements made in recent years. To further accelerate improvements in child health and nutrition outcomes, there is an increasing trend within ESAR countries to decentralize responsibility for planning and delivery of essential child survival and development services as a means to bring public decision-makers closer to local communities and needs, build local capacity and improve accountability.

Concurrently, the has been an observation from past UNICEF and other UN agencies’ work that, for most service delivery systems at decentralized levels, the traditional model of input-output monitoring and occasional impact monitoring (at the end of a multi-year period) is not addressing data gaps related to the achievement of intermediate results. This means there is a lack of ‘early warning’ data, as well as feedback loops, to signal whether services are likely to be effective or not; implementation bottlenecks and barriers need to be removed; and mid-course programme adjustments need to be made. The detrimental effects of an absence of intermediate results monitoring and more real-time response are many. These include ineffective planning and budgeting, inefficient use of material and human resources, and continued existence of large underserved populations of children.

Further, although high-impact, evidence-based and affordable child survival interventions are known, a number of global studies have highlighted the poor institutional capacity within decentralized health and health-related systems in developing countries and the constraints faced by district management teams in the implementation of health and health-related services. These include a lack of reliable, timely and strategically-selected and presented local data; insufficient emphasis on results; lack of identification of bottlenecks impeding effective coverage; failure to involve communities as active proponents in helping overcome obstacles to high coverage; and a lack of analytic and prioritization capacity which is particularly needed within the context of chronic resource constraints faced by sub-national management teams. As a result, innovative and sustainable strategies are needed to strengthen district and other sub-national monitoring systems, including citizen/community monitoring and social accountability feedback mechanisms, and data use practices in the health and/or health related sectors as a means to achieve improved and more equitable delivery of quality services and outcomes for children and women.

Overview: the PMR Initiative

In 2014, UNICEF headquarters, in collaboration with ESARO, took the decision to address the issues enumerated above, related to the health of women and children by implementing a regional institutional strengthening support initiative to improve the Programme Monitoring and Response (PMR) capacity of the centralized government decision-making bodies and communities in four countries (Kenya, Swaziland, Uganda and Zimbabwe).

The ESAR PMR was designed as a learning initiative with the following goals:

- Improve service provision and programme performance during implementation through improved monitoring of intermediate results, establishment of citizen feedback loops, and the use of monitoring and feedback data to adjust strategies as needed in a timely manner; and
- Identify and promote those promising practices of programme monitoring in response, tested and proven by early adopter districts, through the development of national scale-up plans within participating countries and the establishment of knowledge exchange platforms.

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3The text in this section has been taken from the TOR of this evaluation assignment.
4This section was adapted from the TOR for this evaluation assignment. For a detailed overview of the PMR Initiative see: Case Study: UNICEF harnesses use of near real-time data to support maternal, newborn and child health in Eastern and Southern Africa (2017)
The PMR Initiative Theory of Change

The hypothesis underlying the PMR initiative is that, if decentralized management and/or front line health worker decisions and responses are timelier and evidence-based, and if citizen feedback loops and social accountability structures are established, then over time improvements will be seen in:

- Sector service provision/program performance (i.e. coverage and quality of services);
- Communities’ commitment to invest in their own health and well-being; and
- The health and well-being of vulnerable and previously underserved children and women, thereby improving equity of health outcomes.

To operationalize this Theory of Change, UNICEF designed the Initiative’s institutional support across five programmatic pillars. The Initiative’s activities have supported:

1. The development of reliable and quality (more) real-time data availability at the sub-national level for identifying and addressing barriers and bottlenecks to the delivery of health and/or health related services (Nutrition, HIV, WASH);
2. The provision of feedback by citizens/youth groups on the delivery of health and/or health related services;
3. The review of performance by decentralized decision-making bodies using data from real-time monitoring and citizen feedback on a quarterly basis and the development of action plans;
4. The dissemination of knowledge among UNICEF and relevant government staff in ESAR countries on the use of real-time monitoring data for decision-making in the delivery of health and/or health-related services; and
5. The development of evidence-informed national plans of action within the four countries for scaling up models for decentralized PMR.

Because of the short time frame of the PMR Initiative and the timing of this evaluation (i.e. performed while many outputs were still in progress), the evaluation is unable to properly test the logic of the design and whether it “worked.” However, there are promising preliminary findings (see below) that indicate the support provided by the PMR Initiative is resulting in improved sector performance, at a minimum.

Country Specific Implementations

Four countries were selected for participation in the PMR Initiative (Malawi, Swaziland, Uganda and Zimbabwe). As the programme began, Malawi elected to drop out because of a national floods emergency and was replaced by Kenya. While the PMR Initiative was designed with an umbrella results framework...
for the region, each implementing country customized and localized the actual implementation of the Initiative in the following ways:*

**Kenya**

UNICEF Kenya, in partnership with the School of Computing and Informatics at the University of Nairobi, has developed new county- and sub-county-level DHIS2-based Integrated County Health Information Mesh (iCHIM) dashboards which are used at routine quarterly performance review meetings alongside the recently rolled out Reproductive, Maternal, Newborn, Child and Adolescent Health (RMNCAH) scorecard. This is combined with qualitative community feedback made available through the newly developed Information and Communications Technology for Social Accountability, a digital means of receiving feedback from community dialogue to be entered into DHIS2 and shared with health management teams. UNICEF Kenya has also advanced mobile phone use by community health workers for faster entry of standard community health information directly into DHIS2.

**Swaziland**

UNICEF Swaziland has developed the country’s first health management information system (HMIS) health dashboards for use at the subnational level. The key focus of the initiative is ensuring that data from the newly piloted national electronic Client Management Information System (eCMIS) are used at decentralized levels by the Regional Health Management Teams and facilities. UNICEF’s SMS-based citizen engagement platform, U-Report, is also used to generate feedback from health facility clients and to promote public health messages.

**Uganda**

UNICEF Uganda is demonstrating the value of linking indicators to bottleneck analysis by fully automating the national RMNCAH scorecard within DHIS2 alongside a bottleneck analysis dashboard and two other Near Real Time Monitoring (NRTM) dashboards on data quality assurance and an action tracker. The new dashboard suite is complemented by U-Report citizen feedback, linked to a complaints hotline and facility-based community dialogues, to concurrently understand the demand-side of health service delivery.

**Zimbabwe**

UNICEF Zimbabwe has developed a community-based near real time monitoring system (NRTMS) to strengthen the evidence-base of the Multisectoral Community-based Approach for Reduction of Stunting (MSCBARS) Programme and to involve the community in creating solutions to nutrition challenges affecting their children. Data from households with pregnant women and children under two years of age are linked to ward-level action microplans and complemented by U-Report poll data to capture community feedback on nutrition and associated interventions.

**PMR Initiative Timeline**

The PMR Initiative began in October 2014 and was originally set for completion in September 2016. At the time of the evaluation, the Initiative had received a no-cost extension through July 2017.

**The Evaluation**

**Timeframe and Team**

The evaluation was carried out between 27 MAR 17 and 31 MAY 17. Field work was completed between 15 April 17 and 10 May 17. The evaluation was carried out by:

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*The umbrella PMR Initiative results framework is included as an Annex.

6 The text for this section was taken directly from: *Case Study: UNICEF harnesses use of near real-time data to support maternal, newborn and child health in Eastern and Southern Africa (2017)*
**Team Leader – Stephen Ladek**

Stephen Ladek, Principal of ISG, is a seasoned international development and humanitarian aid professional with more than 15 years of experience helping individuals and organisations improve the performance of how they deliver development and humanitarian aid programming through organisational development, results based management and independent evaluation. Mr. Ladek has overseen and directly implemented evaluations related to funding from numerous governments intergovernmental agencies international organisations, NGOs, private enterprises and community-based organisations in more than 35 countries. He holds a BS in Farm and Ranch Management from Colorado State University, a MA in International Peace and Conflict Resolution from American University in Washington, DC and an MBA from Central European University.

**Co-Evaluator – Mark Irura**

Mark Irura is a Kenyan national and Nairobi-based technical manager. His expertise is in designing systems and managing technical projects, with a track record of more than 10 years on successful projects with the Government of Kenya, the private sector and multinational organisations. He has developed several process-focused software systems and customer-facing applications, including a retail internet banking tool. He deeply understands what users need in technical tools for adoption into daily processes. He holds an MSc in Information Technology from Strathmore University, a BSc in Computer Science from University of Cape Town and is completing a PhD in Computer Science from the University of Eastern Finland.

**Purpose**

The purpose of the evaluation is to:

- Support the further national scale-up of documented, effective PMR institutional strengthening interventions in the four participating countries;
- Guide anticipated replication in other countries in which UNICEF operates;
- Add to the regional and global knowledge base by generating evidence on processes and outcomes related to strengthening decentralized PMR systems in the health and nutrition sectors; and
- Provide information on the extent to which the work undertaken in the four countries is applicable to other sectors beyond health and nutrition.

**Evaluation Objectives**

The objectives of the evaluation are to:

- Assess achievement towards the programme’s expected results (milestones, outputs, intermediate outcomes, and primary outcomes) as per the initiative’s Results Framework;
- Assess the extent to which the programme activities have changed how (more) real time data is collected, analysed, packaged, disseminated, and used (i.e. the extent of uptake by targeted decentralized decision making bodies);
- Assess whether, and how, mutual and ongoing learning on PMR is taking place across target decentralized government units and countries, as well as within target UNICEF offices;
- Understand and document the range of contextual/environmental factors that served as enablers/disablers to the results achieved, including programme design, implementation, management and coordination processes;
- Assess the programme’s relevance, effectiveness, sustainability, scalability, and replicability to determine if the package of support interventions and tools employed by UNICEF’s four participating COs can serve as applicable models for other UNICEF countries and stakeholders in similar context and sectors, and other social sectors;
- Determine if the four UNICEF COs can serve as ‘centres of excellence’ within UNICEF globally on decentralized PMR or specific aspects of decentralized PMR;
- Document best practices and lessons learned related to:
  - Effective PMR among decentralized public decision-making teams
Institutional support aimed at strengthening decentralized PMR mechanisms, processes and practices, and
Adaptive programming during implementation through the availability and use of real-time monitoring and citizen-feedback; and

- Recommend whether this type of institutional strengthening initiative focused on PMR should be continued within ESAR and/or other UNICEF regions as a programming strategy regardless of sector, and if yes, how it would best be placed within UNICEF’s organisational structure.

Scope

The evaluation covers the entire implementation period from November 2014 to the present. There are no comparators for assessment. The evaluation includes all activities carried out in Kenya, Swaziland, Uganda and Zimbabwe, ESARO and UNICEF’s New York Headquarters. In each country specifically:

- In Kenya, Homa bay and Siaya counties.
- In Swaziland, all four regions (Manzini, Hhohho, Lubombo and Shiselweni)
- In Uganda, the PMR initiative was initially piloted Moyo, Mukono and Butambala districts. Full initiative support was scaled to include Adjumani, Isngiro, Nebbi, Riibirizi and Yumbe Districts and the underlying scorecard, bottleneck analysis and action planning was scaled nationally.
- In Zimbabwe, Chipinge, Chiredzi, Mutasa and Mwenezi districts

Methodology

Guiding Principles

In addition to the evaluation being in accordance with the UNEG Norms and Standards for Review and the UNEG Ethical Guidelines for Review, ISG used a range of participatory methods to ensure that key stakeholders and partners were centrally involved in reflective and forward thinking processes. As it was carried out, the evaluation adhered to the following principles:

- Consultation with, and participation by, key stakeholders to ensure the evaluation is relevant to its users and stakeholders, and that the evidence and analysis are sound and factually accurate. Consultation was iterative, informing each stage of the assignment progressively.
- Methodological rigor to ensure that the most appropriate sources of evidence for answering the analytical framework were used in a technically appropriate manner. The evaluation team used different data sources and methods throughout the process of the study to corroborating findings to and ensure consistency.
- Technical expertise and expert knowledge to ensure the evaluation benefits from knowledge and experience relevant to effective decentralized programme monitoring and technological innovations in development and that it contributes to building the body of evidence around what works, what does not work, and why.
- Independence to ensure that the findings stand solely on an impartial and objective analysis of the evidence, without undue influence by any stakeholder group.

In this context, our approach incorporated best practice evaluation criteria and principles for effective development assistance as well as norms and standards of the OECD/DAC framework.

Data collection tools and purposes

The evaluation relied on a suite of action research methodologies that collect qualitative data. Specifically:

Document review

A document review formed the initial assessment of the PMR Initiative at the global, regional and national levels, identifying outputs, success and challenges related to the program. The project team used insights gained from the document review to inform the study, in general, and refine other tools.
Key informant interviews (Individual and group)

Semi-structured interviews with a selection of stakeholders are an ideal method for obtaining in-depth, qualitative information. A selection of key informants to be interviewed (either individually or in a group discussion format) at the global and country levels was developed in consultation with the evaluation manager (who also serves as the PMR Initiative Coordinator) and UNICEF PMR National Officers at the country-level. This list included UNICEF staff at global, regional and country levels, primary stakeholders in each country (e.g. staff from government partners), and external stakeholders (e.g. donors, implementing partners, other CSOs, iNGOs). Interview guides and a list of interviewees are located in the Annex.

Direct Observation (Field visits)

ISG undertook four field visits to Kenya, Swaziland, Uganda and Zimbabwe in April and May of 2017. In addition to administering interviews, ISG directly observed implementation of each country’s contextualized approach within the PMR Initiative.

Most Significant Change

ISG employed the Most Significant Change (MSC) method to collect stories from stakeholders about their perceptions of how the PMR Initiative has changed systems and processes in each of the four countries. While the original intention was to use the PMR programmatic pillars as the domains of change, because of the limited time for the assignment, only one, generalized domain was used with key informants. In addition, and again because of limited time, the MSC data was not filtered through multiple stakeholder levels to arrive at a single story for the PMR Initiative. Because of this, the evaluation team chose to use the entirety of collected MSC data as further evidence for the findings and conclusions below.

Ethical Principles and Practices

ISG adheres to international norms on research standards and ethics. For all interviews, ISG ensured explicit informed consent from individuals through verbal acceptance at the beginning of interviews. All individuals interviewed in this evaluation, to the best knowledge of the evaluation team, were of adult age.

Evaluation criteria

The evaluation was carried out using a limited selection of standard OECD/DAC Criteria that included: relevance, effectiveness, and sustainability. Efficiency and Impact were not included, as agreed in consultation with UNICEF, because of the intended foci of the evaluation and overall timing of the Initiative.

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7 Complete details of the field visits can be found in the accompanying country reports.
Analytical Framework

An analytical framework was created, in consultation with UNICEF, to guide the content of the evaluation; that is, to focus what the evaluation will specifically investigate, and how ISG would do this. In summary, the evaluation sought to answer the following questions:

<table>
<thead>
<tr>
<th>RELEVANCE</th>
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</thead>
<tbody>
<tr>
<td>• Is UNICEF’s decentralized PMR institutional strengthening support an appropriate response to documented country needs, priorities, policy context, capacity; and within UNICEF’s purview (e.g. non-duplicative, within UNICEF’s mandate and capacity?)</td>
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<tr>
<th>EFFECTIVENESS / ACHIEVEMENT OF INTENDED RESULTS</th>
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<tbody>
<tr>
<td>• For Outcome 1.1</td>
</tr>
<tr>
<td>o Is reliable and quality real-time data available to districts for identifying and addressing barriers and bottlenecks to the delivery of health, nutrition, HIV and/or WASH services?</td>
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<td>o Was a monitoring platform(s) that produces reliable, quality and (more) real-time supply-side data established or enhanced through the initiative?</td>
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<td>o Are the new, improved or previously unutilized reports produced and presented from this platform useful to target decision-makers?</td>
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<tr>
<td>o To what extent does UNICEF have a comparative advantage in this outcome area? How would the comparative advantage be defined?</td>
</tr>
<tr>
<td>• For Outcome 1.2</td>
</tr>
<tr>
<td>o Was a citizen/ community feedback platform(s) that produces relevant, credible and (more) real-time demand-side information established or enhanced through the initiative?</td>
</tr>
<tr>
<td>o Were new or improved citizen/ community feedback data reports/ tools/ processes/ practices introduced?</td>
</tr>
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<td>o To what extent does UNICEF have a competitive advantage in this outcome area? How would the competitive advantage be defined?</td>
</tr>
<tr>
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<tr>
<td>o Are quarterly performance reviews conducted and acted upon by districts using data from real time monitoring and citizen feedback?</td>
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<td>o What is the value-added of the digital/ non-digital platform(s) and data reports that were developed or enhanced through this program?</td>
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<td>o Is data being demanded and used to a greater extent for decision-making by targeted decentralized bodies?</td>
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<td>o Has the use of data lead to evidence-based action by target decision-makers and greater accountability on the part of ‘duty bearers’?</td>
</tr>
<tr>
<td>• For Outcome 2.1</td>
</tr>
<tr>
<td>o Do staff of governments and UNICEF use platforms for cross-country learning about real time programme monitoring and response in ESAR?</td>
</tr>
<tr>
<td>o Have knowledge platforms, tools, products and/or learning opportunities on PMR been generated and exchanged through the initiative?</td>
</tr>
<tr>
<td>o What is the use, and feedback on the value, of the various in-country and cross-country KE platforms, tools, products and learning opportunities developed and rolled-out through the Initiative?</td>
</tr>
<tr>
<td>o What could be done in future by UNICEF to strengthen knowledge capture and sharing within a similar programme, within the region and more broadly?</td>
</tr>
<tr>
<td>• Outcome 2.2</td>
</tr>
<tr>
<td>o Have evidence-informed National Plans of Action for scaling-up models for decentralized programme monitoring been developed?</td>
</tr>
<tr>
<td>o Is there evidence to suggest that gains made through the Initiative will be sustained and/or scaled nationally?</td>
</tr>
<tr>
<td>o Does UNICEF have a comparative advantage relative to other stakeholders to replicate this type of institutional support in other countries? If yes, does it exist equally for all five of the programmatic pillars?</td>
</tr>
</tbody>
</table>

<table>
<thead>
<tr>
<th>SUSTAINABILITY AND SCALABILITY</th>
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<tbody>
<tr>
<td>• Were the intervention packages selected by the COs designed with sustainability and scalability in mind?</td>
</tr>
<tr>
<td>• Do national scale-up plans exist for the integrated PMR models tested, or those demonstrated-effective components of the models tested, within each of the four participating countries? Are these scale-up plans realistic and do they include realistic sustainability plans?</td>
</tr>
</tbody>
</table>
Limitations

This evaluation is focused on the processes of implementation. It is an exercise in independently validating the achievement of intermediate outcomes by the PMR Initiative in each of the four countries. As such, the evaluation team did not consider data within the HMIS systems of the four countries, nor did they seek to interview end beneficiaries in the targeted communities. In other words, long term results or Primary Outcomes\(^8\) intended through the PMR work were not considered by the evaluation.

The timing of the evaluation has also been a limiting factor in two important ways:

- The timeframe of the overall PMR Initiative was short, covering only 2 years. At the time of the evaluation, there were still outputs from each country pending delivery and, as such, the evaluation was not able to fully consider them during field visits and subsequent analysis.
- The time allotted for the evaluation exercise was minimal. Originally planned for 90 days, the evaluation was ultimately conducted over only a 60-day period due to administrative delays. This, in turn limited the amount of data collected and the depth and breadth of subsequent analysis.

How to use this report

This report is intended to be a synthesis of findings, conclusions and recommendations in the four country reports that accompany it. As such, in general, for greater detail about country-specific findings, please refer to these in the Annex.

\(^8\) See the umbrella PMR Initiative results framework, included as an Annex.
Findings

Relevance

Is the PMR initiative relevant to the local contexts in which it was implemented?

Sub-questions considered for this evaluation question:
- Is UNICEF’s decentralized PMR institutional strengthening support an appropriate response to documented country needs, priorities, policy context, capacity; and within UNICEF’s purview (e.g. non-duplicative, within UNICEF’s mandate and capacity?)

Finding 1: The PMR Initiative has its genesis in an understanding of the continued evolution of ICT4D innovations in ESAR and how these innovations have contributed to building a culture of management using data in the health sector. Because of this, the PMR Initiative has been a response that can be localized and contextualized to specific country needs, priorities, and capacity.

The focus and structure of the PMR Initiative did not originate from a specific demand in any one of the four countries of implementation. Rather, as described by interviewees at UNICEF, the overall concept for the initiative was conceived by leadership in both UNICEF HQ and ESARO. However, this is not to say that the initiative is prescriptive. In fact, the evaluation finds quite the opposite is true. The PMR Initiative is a recognition that, in ESAR, the digitization of health systems has matured to a point where there was a critical need to move beyond data collection and aggregation to data analysis and application – especially at the district management level.

Said another way, through its focus on data use, the PMR Initiative captures the intangible need for managers to become “emotional” about the data available to them. The power of this emotional response was seen several times during the evaluation. As two brief examples:
- The overwhelming response and immediate demand for training from staff in Uganda from a non-intervention district after demonstrating the automated RMNCAH scorecard to them for the first time;
- The immediate group response and focus related to a unique scorecard produced by this evaluation (based on country implementation of the initiative – see below in the Effectiveness section) as presented at the Final Partner Meeting in Uganda.

In sum, the PMR Initiative has found a way for data to have immediate meaning to non-technical staff at all levels in a way that allows them to identify poorly performing indicators and devise specific plans to address the same.

The PMR Initiative has an umbrella results framework with five pillars. Paraphrased, these pillars are:
1. Developing the availability of more, timelier data;
2. The incorporation of more, timelier citizen feedback into management processes;
3. Instigating regular management reviews of reported data;
4. Greater sharing of knowledge locally, regionally and globally; and
5. Determining how scaling, sustaining and replicating of existing systems can be accomplished.

While each country works under these five pillars, each country made individual choices about how to implement the initiative locally. Specifically:

Getting Emotional about Data:

“You can make a very good and complex system, and if it cannot be easily and quickly understood, it is useless. There is a three-step process around the scorecard. You just need three steps to create a scorecard. You only need three colours to see how you are doing. So, you are able to look at the most complex health informatics problem, in just three steps. That's all you need. Also, it's more of a localized concept. It has been a combination of people and ideas. Putting it in the DHIS2 means it's not just Ugandans, but Tanzanians, Malawians. I think it has the power to change lives. It has the power to change programmes.”

– Ugandan respondent
Kenya

The Kenya health sector strategic plan 2014 – 2018 prioritizes capacity building in monitoring and evaluation (M&E) at different levels of the healthcare system. Also, the Kenya Health Data Collaborative9 roadmap singled out data analytics at both national and subnational level as vital activities that would accelerate achieving expected results in the health sector. As such, the PMR Initiative was well aligned to existing national plans already established by the MOH.

More specifically, like many countries in Africa, DHIS2 is the primary centralized repository of data in Kenya and all initiatives in health must be aligned to this tool and framework. The PMR initiative focused on the development of annual work plans, in the implementation counties, that are truly data driven by supporting the RMNCAH scorecard and digitization of previously paper based tools (i.e. MOH 513, 514, 515 and 51610).

Uganda

UNICEF has partnered with and supported the MOH the for almost a decade in Uganda. Much of this support has been focused on strengthening MOH systems through digitization and technology implementation.

DHIS2 is the foundation for the country’s HMIS, and this provides access health data across the country for districts. However, data availability remains constricted because of access bottlenecks (e.g. in practice only the district biostatistician has true data access) and analysis of data requires data extraction and hand coded analysis.

The PMR Initiative was used as an opportunity to continue to support the MOH in its evolution of the HMIS system by implementing an automated RMNCAH scorecard and supporting work planning with capacity building around bottleneck analysis and causal analysis.

Swaziland

Swaziland is currently transitioning its existing HMIS to a Microsoft-based Client Management Information System (CMIS). This transition includes the upgrade of health facilities infrastructure to support automated recording of data throughout the range of services delivered from point to point within the facility. The upgrade initiative falls within the goals of the MoH that aid to fulfil the larger government 2022 vision11 where the CMIS is a known project that will ride on the gains of the National ICT Infrastructure Policy.12

As such, while the PMR Initiative was not able to map onto a DHIS2 based system, as in other countries, it has focused on building capacity to use dashboards that are created from the existing HMIS, and new CMIS. Because of the facility transitions, data ownership is very high because the CMIS is becoming the standard way of doing business in these pilot facilities. Dashboards created under the PMR initiative, and their associated training, are being rolled out in every facility in tandem with CMIS.

Zimbabwe

Zimbabwe is an outlier in the PMR Initiative, in that, the UNICEF CO took the decision to support an existing country programme focused on addressing stunting (MSCBARS) through the provision of more, 9 See one of the priorities of the Kenya Health Data Collaborative as outlined in the roadmap – Goal A.1 - https://www.healthdatacollaborative.org/fileadmin/uploads/hdc/Documents/KENYA_THE_ROADMAP__Kenya__Health_Data_Collaborative__K_H_D_C.pdf
10 Read more in the Kenya Country Report
11 This is outlined in the GoS national vision 2022 that seeks to http://www.govsz/
12 The National ICT Policy states that GoS is broadly committed to implementation of ICT which will facilitate...sectoral development plans and projects which have an ICT component including the formulation of appropriate policies, strategies and plans for the implementation of e-applications e.g. electronic government and governance, e-health, electronic commerce. (http://www.ellipsis.co.za/wp-content/uploads/2016/07/Swaziland.pdf)
real time, cross sector data. The PMR Initiative was used to build a bespoke online platform to receive, analyse, report and offer admin tools.

Effectiveness

The evaluation team created the “scorecard” below to quickly communicate the findings for the effectiveness of the PMR Initiative in a format that was immediately familiar to all programme participants. The format mimics the RMNCAH scorecard used in three of the four implementation countries. The colour coding was used in all four countries. Green indicates “good,” yellow indicates “improvements are needed” and red indicates “critical attention needed.”

<table>
<thead>
<tr>
<th>Country</th>
<th>Outcome 1.1 More Real Time Data Available</th>
<th>Outcome 1.2 Community feedback</th>
<th>Outcome 1.3 Quarterly performance reviews</th>
<th>Outcome 2.1 Knowledge exchange</th>
<th>Outcome 2.2 National Plans for Scale</th>
</tr>
</thead>
<tbody>
<tr>
<td>Kenya</td>
<td>Achieved</td>
<td>In process</td>
<td>Achieved</td>
<td>In process</td>
<td>Partially Achieved</td>
</tr>
<tr>
<td>Uganda</td>
<td>Partially achieved</td>
<td>In process</td>
<td>Achieved</td>
<td>Partially Achieved</td>
<td>Achieved</td>
</tr>
<tr>
<td>Swaziland</td>
<td>Achieved</td>
<td>In process</td>
<td>Achieved</td>
<td>In process</td>
<td>Achieved</td>
</tr>
<tr>
<td>Zimbabwe</td>
<td>Achieved</td>
<td>In process</td>
<td>Achieved</td>
<td>Partially Achieved</td>
<td>Partially Achieved</td>
</tr>
</tbody>
</table>

Each column of the scorecard is discussed in detail in the five intermediate outcome sections below.

Intermediate Outcome 1.1: Is reliable and quality more real-time data available to districts for identifying and addressing barriers and bottlenecks to the delivery of health, nutrition, HIV and/or WASH services?

Sub-questions considered for this evaluation question:

- Was a monitoring platform(s) that produces reliable, quality and (more) real-time supply-side data established or enhanced through the initiative?
- Are the new, improved or previously unutilized reports produced and presented from this platform useful to target decision-makers?
- To what extent does UNICEF have a comparative advantage in this outcome area? How would the comparative advantage be defined?

As described in more detail below, the evaluation finds that, while one of the pillars of the PMR Initiative is the increase of data availability, the real focus of the initiative was on using data flows that had already been established. The exception to this is the case of Zimbabwe, which created an entirely new data stream, and one that captures data across many sectors.

Finding 2: The PMR Initiative has established or enhanced platforms that produce reliable, quality and more real time data in all four countries. However, the emphasis of the initiative has been on data use.

In all four countries, funds from the PMR Initiative were used to build or enhance an existing data driven platform. Described in detail in each of the country reports associated with the evaluation, in summary, the PMR initiative:

- Kenya: Development of Community Health Information System (CHIS) targeting community health; automation of RMNCAH scorecard, community score cards as well as MoH tools (for example, the MoH 516).
Outcomes for women and children).

UNICEF, what is the most optimal use of UNICEF resources for the highest return (i.e. better health advantage, but one that needs to be carefully articulated and defended.

The limitations of the evaluation prevent the ability to determine, among the many options available to UNICEF, what is the most optimal use of UNICEF resources for the highest return (i.e. better health outcomes for women and children).

The evaluation finds, across the four countries a part of the study, that UNICEF enjoys a competitive advantage in the public health sector. This advantage stems from UNICEF’s association with the United Nations, in general, and UNICEF’s non-agenda partnership model, specifically. In each country, the evaluation team recorded appreciation for the fact that UNICEF operates differently than other implementing partners – ensuring that programming aligns with the goals of the local government and not with the goals of the partners (or funding stream). This sentiment was expressed at every level, perhaps most potently at district or county levels where respondents provided specific examples of how other implementing partners work, while helpful, does not address the needs of the local government structures.

Important, emphasis on aligning UNICEF’s support with government needs underscores the fact that the tools and

Communities Using Data For Decisions

“Previously, at community level, there was some planning taking place, but it was arbitrary from higher levels. With NRTMS communities are now planning on their own and taking action. This program is now beginning to influence the supply of services on the ground. If you check the data trends, you can see the number of people accessing services in health, agriculture, and more. And we are also seeing some behaviour changes in hand washing and other sanitation services.” – Zimbabwe respondent

“I did not expect that VHWs would be able to appreciate what computers can do for them. Now that they can see their own information is something I think that is making a change in the appreciation of how IT can directly benefit them.” – Zimbabwe respondent

More Efficient Management Decisions

“Dashboards. Because it’s an operationalization of an idea that people would talk about, but very few examples to show. The dashboards show the reality, rather than what people just ‘think’. It has also provided access. I can sit behind my desk [in the capital], open up my computer and see what’s happening in Chirezi. The alternative would have been that I get in my car, drive to that area, systematically combine and talking to many different people, then number crunching, etc. before I could ever see anything. This is powerful.” – Zimbabwe respondent

- Uganda: Development of automated RMNCAH scorecard, bottleneck analysis (forthcoming) and action tracker (forthcoming).
- Swaziland: Support to build dashboards that leverage new CMIS real-time data (and, to some extent, the old HMIS data where data is recorded after a month) and the requisite training.
- Zimbabwe: Design, development and implementation of a bespoke multi sectoral platform and associated analytics (i.e. dashboards, trend reporting).

Finding 3: The evaluation cannot determine if UNICEF has a comparative advantage in the production of technology-based solutions. However, UNICEF appears to currently enjoy a significant competitive advantage, but one that needs to be carefully articulated and defended.

The evaluation finds, across the four countries a part of the study, that UNICEF enjoys a competitive advantage in the public health sector. This advantage stems from UNICEF’s association with the United Nations, in general, and UNICEF’s non-agenda partnership model, specifically. In each country, the evaluation team recorded appreciation for the fact that UNICEF operates differently than other implementing partners – ensuring that programming aligns with the goals of the local government and not with the goals of the partners (or funding stream). This sentiment was expressed at every level, perhaps most potently at district or county levels where respondents provided specific examples of how other implementing partners work, while helpful, does not address the needs of the local government structures.

Importantly, emphasis on aligning UNICEF’s support with government needs underscores the fact that the tools and
processes created as a part of the PMR Initiative are not a unique offering. Indeed, in every case, local contractors are used to implement the technology solution. Rather, the emphasis on shifting government culture and behaviours towards “management using data” through the provision of analytical tools and subsequent planning processes are the areas of significance.

Intermediate Outcome 1.2: Is feedback from citizens/community groups about the delivery of health and/or health-related services collected and considered?

Sub-questions considered for this evaluation question:
- Was a citizen/community feedback platform(s) that produces relevant, credible and (more) real-time demand-side information established or enhanced through the initiative?
- Were new or improved citizen/community feedback data reports/tools/processes/practices introduced?
- To what extent does UNICEF have a competitive advantage in this outcome area? How would the competitive advantage be defined?

There is an understanding in all four countries that listening and responding to citizen feedback is essential to the ultimate success of the health sector. The evaluation team was presented a variety of methods in which this happens – from SMS applications on mobile devices to traditional community dialogue meetings. What is clear is that traditional structures for community engagement remain the norm, and therefore the default, for managers to interact with community voice and that an opportunity remains to find a more efficient alternative.

Finding 4: The PMR Initiative has not resulted in a process for incorporating citizen feedback that rivals or eliminates traditional, or established, community and government structures.

As described in detail in the associated country reports, the PMR Initiative has sought to implement technology based solutions for gathering and incorporating citizen feedback into data flows and management processes in three of the four countries. In brief:
- Kenya: Kenya has used the PMR Initiative as an opportunity to enhance established community dialogues.
- Uganda: U Report was used to gather data about citizen needs and mTRAC is used to collect “hotline” information about individual complaints and compliments.
- Swaziland: U Report has been implemented as end user monitoring system.
- Zimbabwe: U Report has been implemented to survey communities, via the VFNC, about programme performance.

As such, by design, in two of four cases (Kenya and Swaziland), mechanisms for feedback from the greater community remain untouched by the PMR Initiative. In Kenya, community dialogues remain the norm, and are considered a critical feature of the overall health system structure. In Swaziland, U Report is used to poll individuals about their satisfaction with services recently received at a health facility, and as such, is more akin got end user monitoring and does not constitute citizen feedback about broader health care issues.

In the other two cases (Uganda and Zimbabwe), a technological solution for receiving citizen feedback has been rolled out, but the results have been mixed. In Uganda, interviewees in UNICEF and at the district level stated that using U Report had been ineffective in capturing local needs. Not only was U Report seen as a “national level” system, but any data that was collected and disaggregated for local use took months to be received and did not align with data from DHIS2 or the RMNCAH scorecard. In Zimbabwe, U Report is used to poll VFNCs about community engagement in the community action planning process, community access to multisector support via implementation of micro plans and community satisfaction

13 Source: Presentation by Kenya Team at Final Partner Meeting in Uganda, May 2017.
with overall multisectoral support. As noted in the 2016 annual report, the Zimbabwe CO has yet to see traction of the U Report data in the greater programme.

In contrast, in each of the four countries, the evaluation clearly finds that establish community and government structures remain the norm for soliciting and receiving community feedback. As noted above, in Kenya this is intentional. However, in the remaining three countries technologies introduced have not established a new norm for citizen engagement. In Uganda, interviewees at the district levels regularly mentioned community dialogues, Barazas\(^{14}\) and other structures as methods for engagement. In Swaziland there were quarterly data reviews in all 4 regions (there are 3 facilities in each of the regions) by the Regional Health Management Teams. In Zimbabwe, the intensive structure of the FNCs are a natural feedback mechanism/structure that reach from national to village levels.

**Finding 5:** The evaluation cannot determine if UNICEF has a comparative advantage in community engagement. However, UNICEF’s citizen engagement tools offer an opportunity for competitive advantage, but one that needs to be established and validated.

As stated above, the limitations of the evaluation prevent the ability to determine, among the many options available to UNICEF, what is the most optimal use of UNICEF resources for the highest return (i.e. better health outcomes for women and children).

In terms of competitive advantage, UNICEF has not yet been able to show enough value at the individual level for technological options to replace traditional or established government feedback structures. This is not to say that U Report or mTRAC have not been valuable innovations. For example, as noted in a previous evaluation,\(^{15}\) in Uganda, U Report has contributed significantly to political and economic processes and mTRAC has been a key driver of accountability through its ‘hotline’ feature. However, at the time of this evaluation, citizens do not look to technology as their first means for communicating needs or wants with the health system.

**Intermediate Outcome 1.3:** Are quarterly performance reviews conducted and acted upon by districts using data from real time monitoring and citizen feedback?

<table>
<thead>
<tr>
<th>Sub-questions considered for this evaluation question:</th>
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</thead>
<tbody>
<tr>
<td>• What is the value-added of the digital/ non-digital platform(s) and data reports that were developed or enhanced through this program?</td>
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<tr>
<td>• Is data being demanded and used to a greater extent for decision-making by targeted decentralized bodies?</td>
</tr>
<tr>
<td>• Has the use of data lead to evidence-based action by target decision-makers and greater accountability on the part of ‘duty bearers’?</td>
</tr>
</tbody>
</table>

Across all four countries, the evaluation team was presented with overwhelming evidence that management structures were understood, regular meetings held and that these meetings were used to review data from HMIS (Kenya, Swaziland and Uganda) or the NRTMS (Zimbabwe), identify poorly performing indicators and create specific plans of action to address them.

**Finding 6:** A significant achievement of the PMR Initiative is its catalytic contribution to a “management using data” culture in the four implementation countries.

Across the four countries involved in the PMR Initiative, the most significant outcome recorded by the evaluation team is recognition by managers at all levels that “managing using data” must become the norm. As expressed by interviewees, this desire is driven by the introduction of analytical tools (e.g. RMNCAH scorecard, NRTM dashboards, BNA and CA) that are accessible to non-technical managers. These tools provide the basis for management conversations about poorly performing indicators and the

\(^{14}\) For more on Barazas, see [http://www.monitor.co.ug/artsulture/Reviews/What-happens-at-a-Baraza-/691232-2009610-snj2h8/index.html](http://www.monitor.co.ug/artsulture/Reviews/What-happens-at-a-Baraza-/691232-2009610-snj2h8/index.html)

subsequent development of action planning. In the case of Zimbabwe, the nature of the NRTMS allows this process to extend beyond the health sector into education, WASH, agriculture and more. Specific examples from each country include:

**Kenya**

The PMR Initiative has contributed to the outcome of data from the iCHIS becoming a key agenda item for community dialogue visits, which are held quarterly. This data is then used to create action plans at various levels, because not all responsibility for action rests with the local health systems. Challenges identified have interventions planned by the most appropriate level of leadership. As examples, interviewees shared that low reporting rates led Siaya and Homa bay county governments to hire more volunteers and the fact that the cleanliness of a latrine would be actioned to the household level.

**Uganda**

The automatic scorecard has provided an option for managers and non-technical staff to dig in to analysis and use S/B/A process down to the facility level. This has led to evidence of local communities taking specific, individualized action. As one specific example, at a facility in Mokono District, the evaluation team was shown a BNA that indicated poor performance around antenatal drugs – pregnant women weren’t returning for the complete set of medications before birth. The facility took the decision to address this issue and created an action plan around it. Over a six-month period, the facility moved the results on this indicator locally to achieve their expected target.

**Swaziland**

Observations during in-country visits clearly indicated that dashboards, and their associated analytics, are used by the regional health management teams in the four pilot regions. It is clear from the in-country visit that not only did these meetings happen, but that attendees find value in them and are prioritizing indicators for additional dashboards to be developed. Below is an example of indicator and data use summary presented by Manzini Regional Health Team in a quarter 1 review meeting in 2017.

### Table: Manzini Region Health Management Team Presentation – Indicator tracking and data use.

<table>
<thead>
<tr>
<th>Indicator</th>
<th>Baseline</th>
<th>What might be the cause</th>
<th>What possible actions that can be taken</th>
</tr>
</thead>
</table>
| 1. Number of pregnant women who tested for the first time and received results | 100% | • Data capturing issues  
• Human resource  
• Laboratory not capturing results into system  
• Departmental differences | • Sister to talk to laboratory to make sure they enter all results  
• Nurses to check if all clients results are captured into system and assist |
| 2. Number of pregnant women re-testing for HIV for the first time during this pregnancy this period | 80% | • Data capturing issues  
• Women not retested | • Nurses to check if all clients results are captured into system and assist  
• Check if all eligible women are retested |
| 3. Number of exposed infants who tested for HIV using DNA PCR at 6-8 weeks and received results | 100% | • National Lab takes a long time to bring back results and the monthly report is submitted without the results. | • To engage the national lab to submit back results on time so that they are reported in the current month |

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**Changes in Management Culture**

“What captures it for me, is that for 10 years, we felt no need to revise our planning guidelines. And when we got the scorecard and bottleneck analysis, we found a reason to revise. So meaning, it’s like we had given up, saying ‘leave it that way.’ When we first saw [the S/B/A process], it was being piloted with reproductive health, but we said, ‘this directly applies to our system.’ So, the 2017 version [of the planning guidelines], is revising the 2007 version. Even we ourselves [as the planning office] have found a justification for planning.” – Ugandan respondent
The use of dashboards for decision making has been enabled by the capacity that has been built as well as the emphasis on the data use part – evident in the root cause analysis and actions to be taken. This is also captured better by this response from an interview at Piggspeak Government Hospital (Hhohho region),

**Zimbabwe**

Local communities are taking specific, individualized actions, when possible (i.e. when actions do not require external resources). For example, interviewed VHW's related they have seen improvements in facility use by pregnant women, the consistent measuring of child height and weight and improved exclusive breastfeeding practices. Responses from interviewees at all levels indicate there is clear leadership buy in for both the system and the culture of using data which it promotes.

**Finding 7:** By emphasizing data use, even with incomplete data sets, the PMR Initiative has contributed to a virtuous cycle of increased demand for more data and a desire for improved data quality.

While it could be argued that data availability was increased in each of the four countries, only the NRTMS in Zimbabwe has created a truly new stream of data (and a rich, multi-sectoral one at that). In Kenya, Swaziland and Uganda the PMR Initiative focused on using existing data flows via national HMIS systems to build out analytical capabilities. These systems have been built with the knowledge that they are likely relying upon incomplete data sets.

As such, the evaluation team recorded a consistent refrain from interviewees across the four countries for both more data and higher data quality. The evaluation did not find that these desires have led to a material change. However, it is important to note that managers recognize that both data availability and data quality directly affect their ability to have accurate analysis that will feed into their planning and decision making processes.

Several interviewees also expressed the view that emphasizing data use also automatically leads to an improvement in data quality in a (near) real-time fashion. Two examples from interviews focused on recognizing obvious data errors:

1. If an enumerator reported visiting 600 households in a village over a day but the village only has 300 households, there is clearly an error; and
2. If a report on disease detection shows a sudden spike, it can be quickly determined if this is an error or a true issue that needs immediate attention.

More nuanced discussions about data quality have resulted from the intensive conversations surrounding agreement on the indicators within the scorecard/dashboards themselves. As stakeholders have participated in these conversations, interviewees suggested that this has also contributed to a greater awareness about the data currently available and how it could be improved going forward.

A final example relates to the transformation of data from the enumerator or facility level through digitization into the HMIS system. In two of the four countries (Uganda and Zimbabwe) data originates in paper form and is then physically transported to a central office for digitization. Interviewees at the village/facility level and district levels in both countries expressed interest in finding ways to eliminate...
errors along this chain. Kenya and Swaziland may be good case studies for this going forward, as both countries have chosen to pursue options for data collection that is digital at the source.\footnote{In the case of Kenya, they have automated data collection tools at community health level – with CHAs going out with mobile devices to do this work. In Swaziland, the CMIS enables automated collection of data at different service points in the health facility}

Finding 8: The PMR Initiative has highlighted the need to ensure resource mobilization for identified health sector issues as paramount.

The PMR Initiative has successfully catalysed the conversation around managing using data in its areas of implementation. This shift has, in turn, lead to energy and excitement on the part of both managers and citizens about the possibility of change being realized in their communities. More specifically, the analytical tools developed by the PMR Initiative have allowed managers to identify poorly performing indicators and then plan and prioritize actions accordingly.

The evaluation team finds that, across all four countries, this process is quickly leading to a potential situation that could have important consequences. Initially, managers have been focusing planning and action on areas of improvement that require no, or very little, new resource inputs (e.g. improvement in breastfeeding practices or better inventory management skills). However, these types of interventions, by their nature, will be addressed relatively rapidly. This will, in turn, leave identified problem areas that require financial or other input to be addressed. While interacting with interviewees, especially at the village or community level, the evaluation team heard a need for these resource inputs. In some cases, the ask was small (e.g. materials for enumerators to help promote their work) but there are other, larger issues (e.g. the repair or construction of a facility). As the health sector continues to evolve in each of these countries, closing this loop to be able to address problem areas will become more and more critical.

Intermediate Outcome 2.1: Do the staff of governments and UNICEF use platforms for cross-country learning about real time programme monitoring and response in ESAR?

Sub-questions considered for this evaluation question:

- Have knowledge platforms, tools, products and/or learning opportunities on PMR been generated and exchanged through the initiative?
- What is the use, and feedback on the value, of the various in-country and cross-country KE platforms, tools, products and learning opportunities developed and rolled-out through the Initiative?
- What could be done in future by UNICEF to strengthen knowledge capture and sharing within a similar programme, within the region and more broadly?

Finding 9: UNICEF actively pursued the exchange of knowledge generated by the PMR Initiative through a variety of platforms and opportunities, with mixed results.

The PMR Initiative has engaged in a variety of activities to promote the exchange of knowledge about health systems strengthening across the PMR implementation countries and globally within UNICEF. These activities include:
Knowledge Exchange Toolbox: A Knowledge Exchange Toolbox\textsuperscript{17} was produced by UNICEF to provide staff and partners with options for how to share their learning. This toolbox is available online for free to the public. The evaluation did not collect data about its specific use within the PMR Initiative.

Yammer Social Network Platform: UNICEF has adopted Yammer\textsuperscript{18} as its enterprise social networking platform. A specific “channel” within Yammer was created for the PMR Initiative to facilitate and capture conversations between staff and partners. Globally, this platform has seen increased usage, with approximately 1000 users/month in early 2015 growing to approximately 3000 users/month by the end of 2016.\textsuperscript{19} While the Yammer platform has not seen extensive use for the PMR Initiative (see below), globally, UNICEF maintains at least eight channels that are highly active.

Sharepoint: UNICEF has utilized Microsoft Sharepoint as a content management and collaboration platform for the PMR Initiative. Similar to Yammer, the use of Sharepoint for the PMR Initiative has been limited, with most staff and partners choosing to collaborate through other, established platforms, such as email.

e-Discussions: The PMR Initiative held four, facilitated e-Discussions.

Webinars: The PMR Initiative hosted several webinars for the exchange of information and general knowledge sharing. In at least four cases, each country involved in the PMR hosted a webinar. This event was used as an opportunity to not only share information about the country’s implementation of PMR, but also to receive feedback from attendees. Across interviews with UNICEF country level staff, respondents perceived these webinars to be a high value sharing opportunity.

Quarterly Meetings: Over the two years of the PMR Initiative, four face to face meetings were convened, one in each of the implementing countries. Each of these meetings were opportunities for country teams and partners to share their experiences to date, learn from others’ implementation and discuss challenges. Because of their face to face nature, interviewees from UNICEF and partners found these meetings highly valuable. As noted by one respondent, peer reviews at regional meetings where countries compared implementations were seen to be especially effective because, not only did country teams share new ideas, but they also shared also lessons learned about what does and doesn't work from past experiences.

Dedicated Knowledge Exchange Facilitator: The PMR Initiative benefited from the attention of a part time dedicate knowledge exchange facilitator, based in Nairobi. One of the key roles of the Knowledge Exchange Facilitator was to conduct training on usage of the document repository (Sharepoint) to share materials, webinar recordings, updates announcements and discussions for the real-time community of practice through the Yammer Platform (for discussions).

However more investments in training is still required (within CO’s and from ESARO) to continue to demonstrate to different communities the benefits of these communities of practice and the benefits of specific tools.

Importantly, across all knowledge exchange platforms and opportunities, UNICEF intentionally invited and coached government partners to participate. As related by interviewees at UNICEF, in general,

\textit{Investments In Training}

“If I were to invest money now... I would also invest money in moderating this contextual experience and provide sustained technical assistance in helping people utilize these dashboards for them to see value.” – Swaziland respondent

\textsuperscript{17} See the full toolbox at: https://www.unicef.org/knowledge-exchange/index_82053.html
\textsuperscript{18} For more information on Yammer see: https://products.office.com/en-us/yammer/yammer-overview
\textsuperscript{19} These approximations were provided during an interview with UNICEF staff.
partners did not actively engage in the knowledge sharing platforms, but were active in more traditional face to face opportunities.

Interviewees noted the following challenges related to UNICEF’s knowledge exchange efforts as a part of the PMR Initiative. These include:

- The knowledge exchange facilitator was only dedicated part time, which limited their engagement and promotion of the platforms;
- UNICEF introduced new technology and platforms (i.e. Yammer, Sharepoint) and adoption by staff and partners takes time;
- The PMR Initiative has a very short duration, which left little time for reflection and/or iteration related to what works (or not) related to knowledge exchange;
- New systems naturally competed with existing systems that staff were more comfortable with for knowledge sharing/storage. This could also be stated in another way – users (both internal and external) have existing sources of information for such knowledge and do not see enough value in the current platforms set up to replace these sources.

The evaluation team noted that several interviewees specifically noted UNICEF’s professional/organizational culture as a key limiter to the participation in new platforms, such as Yammer. Summarized, these interviewees described a general reticence to participate in an enterprise social network because of a fear of “looking stupid” to their peers. This contrasts with interacting on other platforms, such as Facebook or WhatsApp, where rapid, frequent and unguarded interactions are the norm.

Another limiting factor for adoption, expressed by interviewees from UNICEF, were internal UNICEF networks - a known phenomenon to all staff of any seniority. Staff tend to rely on these networks for a wide variety of information and knowledge sharing and, especially for those who use these networks successfully, there is little incentive to seek information elsewhere.

**Finding 10: At the country level, UNICEF staff and partners rely mainly on traditional or established methods of knowledge sharing.**

At the country level, the evaluation team found that interviewees from UNICEF had mixed awareness of the new platforms established for knowledge sharing related to the PMR Initiative. When prompted by the interviewer, all staff could identify the Yammer and Sharepoint platforms. However, universally, these were not seen as high value sharing resources, but rather low level professional responsibilities associated with the project. When interviewing partners, none of the interviewees mentioned these online platforms as knowledge sharing opportunities.

This does not mean that knowledge exchange did not happen in the project. Indeed, interviewees from both UNICEF staff and partners expressed their appreciation for opportunities to share with others during webinars, meetings and other, establish channels like email. This held true within the implementation of the initiative across the four countries. As the evaluation team interviewed individuals at the district/county and village levels, it was clear that knowledge sharing took place, but that traditional or establish means were the medium by which this happens.

A clear example of this comes from Zimbabwe. The NRTMS was built as a data source compliment to the MSCBARS programme. The MSCBARS programme established food and nutrition committees (FNCs) at the National, Provincial, District, Ward and Village levels. These councils were tasked with meeting regularly to review collected data and associated dashboard and then plan and create ‘microplans’ for execution. The councils also were tasked with reporting results and action plans upward, which provided ample opportunities for face to face interaction for knowledge sharing.
Intermediate Outcome 2.2: Have evidence-informed National Plans of Action for scaling-up models for decentralized programme monitoring been developed?

Sub-questions considered for this evaluation question:
- Were the intervention packages selected by the COs designed with sustainability and scalability in mind?
- Do national scale-up plans exist for the integrated PMR models tested, or those demonstrated-effective components of the models tested, within each of the four participating countries? Are these scale-up plans realistic and do they include realistic sustainability plans?

Finding 11: Interventions that focused on enhancing the existing national health system data platform (i.e. HMIS) are immediately scalable and have a higher potential for sustainability. National adoption remains mixed.

In Kenya, Swaziland and Uganda, the PMR Initiative focused on enhancing the existing HMIS in some way. Specifically:

Kenya

The S/B/A process has been incorporated into county integrated performance reviews and the annual work plan process of the county governments. Because the process is now baked into the HMIS, any other county has access to the associated dashboards, and several counties (such as Garissa, Lodwar, Turkana and Kisumu) have requested training to take the initiative forward. The S/B/A process has not been officially adopted nationally at the time of this evaluation.

Uganda

In terms of the sustainability of development interventions, the PMR initiative in Uganda has achieved a textbook development goal: incorporation of the S/B/A process into national planning guidelines with associated technology enhancements incorporated into the HMIS. At the time of the evaluation, the S/B/A process had been rolled out to all districts in the country.

Swaziland

Similar to Kenya, in Swaziland, the analytical tools created as part of the PMR Initiative are housed in the CMIS that is being rolled out to all health facilities. As such, national scale up is only a matter of time, especially given the fact that the government is including training on the dashboards with each new implementation of the CMIS in the country. Further, data from the dashboards features prominently in the quarterly regional review meetings by the RHMT’s.

Finding 12: The scalability of the NRTMS in Zimbabwe could be achieved immediately, however the sustainability of the MSCBARS management structure it supports is unlikely.

The NRTMS in Zimbabwe is an online platform build on ODK technology. As such, technically, it could be immediately used by any district, ward or village across Zimbabwe immediately, provided they had an internet connection. To that end, the only limiting factor for scaling the NRTMS is its connection to the MSCBARS programme. At the time of this evaluation, MSCBARS has received support to scale from four to 19 districts.

The NRTMS, as a technology, is lightweight – requiring only one server and limited additional infrastructure, such as tablets and feature phones. However, the management structure that it supports, via the MSCBARS, is heavy in its traditional face to face reporting and meetings from village to national FNCs. The unsustainability of this management/meeting process was noted in the Zimbabwe 2016 Annual Report for the programme.
Sustainability and Scalability

Finding 13: The PMR Initiative has increased the potential for long term sustainability through the institutionalization of processes and protocols, such as the S/B/A process, but this increased potential is mixed across the four implementing countries.

The sustainability of any change is underscored by the true adoption and long term commitment of individuals and organizational structures affected by the change. In the case of health systems strengthening, this can be measured in terms of government policy and resource allocation. Said another way, through institutionalization of the changes. In all four countries, to varying degrees, the evaluation finds that the seeds for long term sustainability have been sown. Specifically:

Kenya

As noted above, the successes seen through the PMR Initiative have stimulated hiring of more CHA’s to improve reporting rates, and non-implementing counties have begun to request access to training for the dashboards developed by the Initiative. However, interviewees at the MOH indicated it is important to craft proper incremental plans to detail which components developed through the Initiative the government GoK will take up, so that resources can be mobilized. Furthermore, in Kenya the enhanced system, as currently implemented, requires smartphones to support data entry and viewing.

Swaziland

The gains realized by the PMR Initiative have become a part of de-facto policy in Swaziland, as all new implementations of the CMIS will also include the dashboards and training related to the S/B/A process. The challenge here is that this roll out requires resources to be mobilized (and which are not yet fully secured) as of this evaluation, the MoH is still engaging with different partners for sustained roll out of the PMR initiative alongside CMIS roll-out.

Uganda

As noted above, gains from the PMR Initiative have been institutionalized in district planning guidelines as of 2016. Given that the last changes to these guidelines was 10 years earlier, there is a high likelihood that the S/B/A process will become the “norm” for planning and budgeting in the Ugandan health sector. The evaluation also recorded evidence of the S/B/A process resulting in facility level results and being used for targeted (and therefore more effective) resource mobilization at the district level, further promoting and embedding the process.

Zimbabwe

While recently receiving support from DFID to expand from four to 19 districts, the sustainability of the NRTMS in Zimbabwe is tentative, especially given UNICEF’s internal acknowledgement that the management structure/process it supports is too heavy and expensive to maintain for the long term. However, as related by one UNICEF staff member, the NRTMS is generating more local level policy level decisions. As examples:

- In Chiredzi District, a policy has been drafted that states all interventions

Multi-sector Support

“When we started, there was a resistance from sectors, saying ‘why stunting?’ As if its being dumped on them; it wasn’t on their agenda and why should they care. Now, we are at a stage where stunting has become glamorous and everyone wants to jump on the bandwagon, whether it is FAO or WFP or Ministry of Agriculture, or others. And, now, being led by [Office of the President and Cabinet]. Now, everyone wants to show what they have done in this area. This tells a story about how we’ve started to make a difference with NRTMS.” – Zimbabwe respondent
must use NRTMS generated data as their baseline (i.e. no other baseline work will be approved).

- At the village level, as related by several interviewees, the NRTMS implementation has spurred policy making by Chiefs related to giving birth at health facilities. Those that choose to give birth at home are fined (e.g. goat or chicken).
- As told by a UNICEF interviewee, a planning and review meeting by the Office of the President and Cabinet generated a commitment that the FNCs, which were created by the MSCBARS programme, should become a part of government mandated provincial development committees. This, in turn, creates a de-facto mandate for the NRTMS data to be used in decision making.

Finding 14: The potential for both sustainability and scalability are increased when UNICEF’s support focuses on enhancing existing national platforms and, to a lesser degree, developing online platforms.

A key focus of the PMR Initiative is to move from “piloting” innovations for health systems strengthening to that of true scale and sustainability. UNICEF has made good on this commitment by choosing to focus on interventions that enhance national platforms and an intervention that created an online platform.

Enhancing national platforms
In Kenya, Swaziland and Uganda, the PMR Initiative designed and developed enhancements that are embedded in each country’s established national HMIS. By so doing, all games realized by the initiative can be immediately scaled nationally to all users of the HMIS. In the best case, this is already being seen in Uganda, where the S/B/A process has been rolled out nationally. A similar potential exists in both Kenya and Swaziland.

Online platforms
Hey similar potential for immediate scalability can be found in Zimbabwe. The NRT MS, as an online platform, is available across the entire country to anyone with an Internet connection. While the system is now becoming of the de facto information system for the FNC, it is the establishment of a new information system within the government. As such, the institutionalization and long term support for the NRTMS – at the government level – remains tentative at best.

Finding 15: The PMR Initiative has seen the beginnings of a critical shift in organizational and professional culture in the implementing countries. This shift enhances sustainability by creating the professional expectation of using data for management planning and decision making.

As noted above, and detailed in the four accompanying country reports, the evaluation finds that the PMR Initiative’s most important gains are found in its contribution to the organizational and professional culture shift in each of the four countries. This shift enhances sustainability by creating a professional expectation in managers of being able to use high quality, reliable data for planning and decision making. This expectation exists at every level in the health system, the further strengthening the potential for policy creation and resource mobilization where it is currently lacking (Kenya, Swaziland and Zimbabwe), and policy enforcement where it already exists (Uganda).

Finding 16: The sustainability and scalability of gains realized by the PMR Initiative could be further enhanced through greater government partner contribution and broadening the directionality of scale.

The PMR initiative has intentionally focused its efforts on decentralized bodies within the health system of the four implementing countries. By broadening the directionality of scale and increasing the contribution of government partners, UNICEF could further enhance the gains of a similar, future initiative.

Greater government partner contribution.
UNICEF is not an implementing organization, rather it works through partners for all programming like the PMR Initiative. The most critical partner is the government itself at all levels. As concepts have been proven and rolled out successfully, further sustainability and scale could be achieved through the government’s willingness to take on more risk for continued enhancement, development and depth.
On Scaling

"We know that resources are inadequate, but it will not be enough to just have one county working well... forever... doing the same thing. If it is doing well, then let's move and scale it up so that everybody else benefits... as long as results are too good to keep doing it... but then we need to have a meeting with the higher leadership to indicate where we started, where we have reached, the results..." – Kenya respondent

It is also important that resources can be secured for the current gains made by the PMR initiative to scale – within the existing pilot counties – but more importantly horizontally to other counties. At the time of writing, there are counties which have shown interest in the program (but admittedly whose state of funding is not fully known).

In Kenya PMR initiative it is currently working up in 2 out of 47 counties. In Swaziland, the initiative took place in 4 regions (12 out of 287 facilities countrywide). The above quote therefore points to the fact that despite the gains made, the results are would need more coverage. This still requires the expertise and skills of an organization like UNICEF to still provide leadership in a transition period during the scale up where it is able to partner with MoH particularly to demonstrate results to the Ministry of Finance. The key to success as indicated above is having a clearly documented and phased approach in transitioning components of the program to the government.

Directionality of scale.

UNICEF’s focus on scale, as it relates to the PMR Initiative, is essentially horizontal. That is, when a concept or enhancement is proven its value, the focus is on how that gain can be made available nationally to other regions (or even countries) through the organizational bodies and individuals who need access (e.g. the dashboards in HMIS) for success.

But this evaluation finds another dimension of scale which also needs to be addressed for future endeavours to be successful; how to also scale enhancements vertically within the health system.

Finding 17: The data for HMIS systems in ESAR originate from volunteer and/or low paid workers, which presents a risk to the overall data chain.

While not a defined portion of this assignment’s analytical framework, the evaluation team noted that in all four countries, data that was input into HMIS systems almost exclusively originated from the work of volunteer or low-paid workers. Specifically:

- Kenya: CHVs and CHAs are the origination point for HMIS data.
- Swaziland: Facilities are the origination point for HMIS data.
- Uganda: Facilities are the origination point for HMIS data.
- Zimbabwe: VHW’s are the origination point for the majority of NRTMS data.

It can be argued (as it was during the KIIIs with respondents from the University of Nairobi) that PMR in Siaya and Homa bay has addressed totally the first component of data availability especially for the health worker in the frontline. They are not paid properly and these are tools motivate them because they lessen reporting burden and make their work easier.

However, still, typically volunteer and low-wage workers have high turn-over rates and competing interests to data collection activities. Another problem witnessed (in Homa bay and Siaya, Kenya) is that private facilities (both privately owned or faith-based health institutions) often have higher staff turnover than in government owned facilities,20 and which impacts the flow of data into the national HMIS.

20 The Homa bay county government in Kenya seconded MoH staff to the 2 largest faith based institutions in the county to address problem of continuous data reporting.
While this assignment did not specifically study this point, interviewees at the community/village/facility level consistently used the interview opportunity to request more support and resources for their work. It also points to other challenges in the country health systems which might be requiring urgent attention from the MoH (and possibly competing for attention and intervention at the central MoH level because they are better articulated in terms of costs or otherwise).

Replicability

Sub-questions considered for this evaluation question:

- Does UNICEF have a comparative advantage relative to other stakeholders to replicate this type of institutional support in other countries?
- If yes, does it exist equally for all five of the programmatic pillars?

Finding 18: The PMR Initiative has created information products (i.e. dashboards) and processes (i.e. S/B/A process) outputs that can be replicated in other context with similar foundations.

An important part of the PMR Initiative seeks to generate solutions that are applicable beyond the countries of implementation and determine how UNICEF might replicate similar gains in other countries and in other sectors. The evaluation team finds three outputs from the PMR Initiative that could be transferred with varying degrees of difficulty.

**Dashboards built in DHIS2**

DHIS2 is currently used as the primary health information system in 47 countries across four continents (30 of these are in Africa).21 Because of its open source nature, any improvements to the DHIS2 system made by contributing member of the development community can be made available to the entire user base. This holds true for the development of the RMNCAH (and the forthcoming BNA and Action tracker) dashboards from the PMR Initiative. Customization of the dashboards would need to be performed on a case by case basis related to indicators, user access and other, minor, functionalities.

Other considerations that would need to be made in other countries relate to the collection and input of data necessary to run the analytical tools. For example, in Uganda, a paper based system of primary data collection is still used. This data is entered into the DHIS2 system by hand at the district level. In Kenya, however, a decision was taken to use phones to capture data digitally, eliminated the need for paper registers and physical transport, but adding in other considerations of physical devices and data connection costs.

In the case of Swaziland, dashboards developed for the Initiative are built into a CMIS that is based on a proprietary Microsoft technology platform. As such, these dashboards can only be transferred to another context that are using this platform.

**S/B/A Process**

The scorecard, bottleneck analysis and action planning process UNICEF has developed and used in tandem with technological enhancements is immediately transferrable to another context. Indeed, the S/B/A process is not technology, or system, dependent and, as such, can be transferred to any context with available data. This is not limited to other health systems and could be considered for other sectors, especially those that are data rich.

**Online NRTMS**

As stated earlier, the NRTMS is an online system build on open source technologies. As such, it not only can scale within Zimbabwe to anyone with an internet connection, but the system – as is - could be replicated without terrible difficulty in other countries that are experiencing stunting as a major issue.

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21 For the latest distribution figures see: https://www.dhis2.org/inaction
However, to be completely realistic, the NRTMS would need to be localized and contextualized for every new installation to account for organizational and political structures, sectors, indicators and more. More likely that transferring the technology itself is the possibility of transferring the know-how of building such a platform to other UNICEF COs.

**Finding 19:** The evaluation cannot determine if UNICEF has a comparative advantage in replicating technology-based solutions. However, UNICEF’s programming across many sectors suggests a competitive advantage exists that could be exploited.

The limitations of the evaluation prevent the ability to determine, among the many options available to UNICEF, what is the most optimal use of UNICEF resources for the highest return (i.e. better health outcomes for women and children).

The accompanying country reports provide case by case detail about the competitive advantage UNICEF currently enjoys in public healthcare technology development space. The responses of one interviewee capture well the general sentiment of government partners stating that UNICEF, as a part of the broader UN family, is a preferred partner because they, “are a development partner with whom we speak the same language,” they, “understand the government way of doing things,” and, “they are not so rigid, not focused on a particular organizational/programme outcome.” The way UNICEF worked in partnership with government has been contrasted with other development partners, who usually implement programming that is tied to a specific goal or agenda (e.g. HIV/AIDS, Malaria).

Regarding the S/B/A process, while UNICEF’s support has been well received across Kenya, Swaziland and Uganda, it is far from a unique offering. The evaluation team were presented with similar scorecards to the RMNCAH during field visits and district level staff from non-intervention areas were verse in their use for analysis and planning. This indicates that other implementing partner use and teach similar methods.

**Lessons Learned**

The following lessons to be learned from the PMR Initiative were identified during the evaluation process:

Leveraging existing national programmes, processes and systems (i.e. HIMS) improves buy in, accelerates development and adoption and enhances sustainability.

Software and technology are living processes. There is often an underlying or unspoken assumption that newly created or adopted technologies will offer a solution to a problem. The truth of the matter is that technology is only an enabler for solving an issue in a different, and often more efficient manner. As such technology should be adopted with the understanding that it is a long-term investment that will require constant care and feeding.

Using technology for feedback is a laudable goal and one that should be pursued given global trends in connectivity and affordability. At the same time, in regions such as ESAR, a culture of communication that is technology focused remains a significant hurdle to overcome and programming support for target populations should reflect this.

The PMR Initiative is already showing that better data and better management analysis of that data leads to identification of problems at the local level. However, this process must also include mechanisms for closing the feedback loop with articulated solutions from decision makers.

The management by data culture, encouraged explicitly by the PMR Initiative, is infectious because it empowers local managers in real ways and allows for individualized and nuanced funding needs proposals. However, future initiatives that adopt this type of support should ensure the management review/analysis process of data always results in clear, reasonable action items that are ultimately “owned” by one individual.
UNICEF’s existing corporate culture is deeply ingrained across a decentralized organization. This is powerful and requires time and clear, consistent leadership messaging to evolve, especially with regards to the sharing of information.

When developing national plans of action for adopting a technology-enabled solution, scale doesn't have to mean national or global. Technology is cheap enough that it can be localized for specific needs and still provide the return and efficiencies desired. The bigger hurdle for ICT4D initiatives is user adoption and a professional culture that expect technology to be at the centre of individual skills, roles and practices.

Conclusions
The conclusions below flow directly from the findings stated above:

Conclusion 1: While the availability of more real time data has played a key role in the PMR Initiative, a more critical outcome is the Initiative’s contribution to the development of a “management using data” culture in ESAR. (Based on findings 1, 2, 6, 7, 9, 14 and 15)

At the core of the PMR Initiative was the desire to ensure that managers in decentralized structures data available to them. With the exception of Zimbabwe, which built an information management system from scratch, this appears to have already been true prior to the Initiative via existing HMIS/CIMS. As such, the evaluation concludes that UNICEF COs rightly emphasized data use in their contextualized implementations. This is notable especially given the fact, in all cases, managers were working with incomplete data sets. Said another way, UNICEF and its partners were willing to embrace a more commercial/classically entrepreneurial position of taking decisions, monitoring the results of those decisions and adjusting accordingly.

Conclusion 2: UNICEF’s competitive advantage lies in its strategic and long-term relationships with government partners and its ability to manage IT enabled programming (Based on findings 3, 5, and 19)

The competitive advantages identified in the findings above suggest that UNICEF has the potential to craft a unique position in the market for health systems strengthening. This advantage could also potentially be used in other sectors that exhibit similar characteristics and are data rich (e.g. education, environment). In particular, UNICEF’s reputation as a manager of programming that contains, or relies upon, enabling technology has been established and can be acted upon.

Conclusion 3: UNICEF comparative advantages, if any, related to implemented technology enabled programming remain unknown. (3, 5 and 19)

The findings from the evaluation indicate that any comparative advantage UNICEF enjoys in the health systems strengthening space remain unknown in terms of how $1 USD ultimately results in some result of better child health outcomes.

Conclusion 4: The PMR Initiative’s attempts to engage citizen feedback have produced positive results, but have not yet inspired a new norm for how citizen feedback is gathered, utilized and managed. (Based on Findings 4, 5, 7, 8 and 10)

The evaluation finds that citizens are interested in participating in health systems strengthening and that managers are interested in both collecting and using this feedback to their advantage. However, feedback is still received via mostly traditional channels and UNICEF’s attempts to introduce technology-enabled feedback patterns has not yet gained traction in a way that inspires managers or citizens to change.
Conclusion 5: The PMR Initiative has realized typical results in terms of knowledge exchange and contributed to the development of new tools and channels for the same. However, there is still some distance to go to achieve a true paradigm shift within UNICEF for Knowledge Exchange. (Based on Findings 9 and 10)

The PMR Initiative emphasized KE as one of its intermediate outcome pillars and the programme, in general, saw extensive sharing of information happen within countries and across the region. However, the methods and channels used for KE were traditional in nature: within countries, face to face communication was emphasized and long establish platforms, such as email or in-person workshops, were preferred in UNICEF. While the new KE platforms developed by UNICEF as a part of this initiative (i.e. on Yammer and Sharepoint) did not gain traction with country staff or government partners, other outlets, such as webinars and Skype meetings were seen favourably.

Conclusion 6: The scalability and sustainability of programming gains remains a high-quality goal. The PMR Initiative offers three unique paths that can be used as models for both large scale releases and continued refinement of this topic within UNICEF. (Based on Findings 11, 12, 13, and 14)

Except for Zimbabwe, the focus of the PMR Initiative was investing in existing, government owned, HMIS to create or enhance reporting and analysis. As such, the gains realized from the Initiative within these systems have the potential to be scaled or replicated in other, similar settings. In the case of Zimbabwe, because the NRTMS is web based and open source, it too can be scaled nationally, but replicating it in other markets or for other countries would require start-from-scratch types of customization.

Conclusion 7: The PMR Initiative has highlighted critical opportunities for innovation at the beginning and end of the feedback loop in health system strengthening. (Based on Findings 8 and 19)

UNICEF has shown that investing at the managerial level for health system strengthening has immediate and high value through results such as efficiency gains and access to analysis for non-technical staff. However, the evaluation has also highlighted a clear need at both the beginning of the data chain – where PMR programmes are reliant on volunteer or low paid staff for data collection – and at the end of the feedback loop – when poorly performing indicators are identified, by mobilizing necessary resources for a solution.
Recommendations
The recommendations below flow directly from the conclusions stated above. The evaluation team suggest prioritising recommendations along the ordinal structure below:

Recommendation 1: Continue to invest in the “Management Using Data” culture in ESAR by leveraging UNICEF’s unique relationship with government partners for long-term investment plans and replicating gains within healthcare and in other sectors. (Based on Conclusion 1 and 2)

Undoubtedly, the clearest gains in all four countries made by the PMR Initiative are found in managers using collected data to understand how they, and their facilities, are performing. UNICEF, and its partners, should continue to support the building of a robust management culture where individuals not only demand data for their management decisions, but also one where trust in data is the norm and understanding of data is expected at all levels.

Potential directions that could be taken in subsequent programming include:

- Build capacity around short, medium and long-term planning and strategy. For managers to continue to be excited about data, tangible results from using data will need to happen in the short term. To that end, UNICEF should seek to work with managers to develop short, medium and longer-term planning and strategies that allow managers to have quick wins that roll up into greater gains over the long term.
- Seek to incentivize individuals or teams around data use and analysis. Similar to the scorecard approach for RMNCAH, there may be other opportunities for a competitive system that compares facility or district performance to continue feed into emotional attachment to data.
- Provide simple and transparent means for managers to identify and report on data quality issues. Make sure this system also includes clear owners with authority to take action, accountability, and a feedback mechanism that makes it easy to see what actions have been taken to remedy issues.
- Establish a professional environment where failure is tolerated and expected, as long as learning and adaptation also happens – not every decision based on data will result in positive outcomes, or any tangible outcomes.
- Encourage customization and creative solutions from managers based on existing and future automated analytical tools. As these unique solutions begin to emerge, facilitate a platform or method for sharing in the country, regionally and globally.
- Seek ways to make digital analytical tools available to all levels of the health care system, especially non-technical managers.
- Provide opportunities for members of the health sector to demonstrate gains and outcomes to other sectors and to other areas of the health care system.

Recommendation 2: Bolster UNICEF’s competitive advantage as a manager of enabling ICT solutions by investing internally in skilled information managers. (Based on Conclusion 2)

UNICEF has established itself as a leader in managing programs that rely upon ICT functionality to enable the realization of expected outcomes for children. However, this is not a unique advantage and one that is coveted by many other organizations across the social sector. UNICEF should continue to differentiate itself by investing in individuals who are skilled information managers. These individuals should be tasked with answering the question, “How could [insert programme name] be enhanced, made more efficient, scale or be more sustainable through better data and subsequent analysis?”

While an understanding of technical areas (e.g. Education, Protection, Health, WASH) are important, the existing skill sets of these individuals should first emphasize:

- A passion about data, analytics and their ultimate usefulness in achieving better outcomes for children;
• An intrinsic understanding of ICTs and the willingness to play, bend, break and fix ICTs to understand their usefulness;
• A clear understanding of information management, including storage, accessibility, interoperability, systems integration and meta data;
• At least an appreciation for data science and how data can be pooled, dissected and used in unique ways;
• A proven ability to think across sectors and silos;
• A proven track record in charting long-term visions associated with clear, short term milestones that produce tangible benefit;
• A personality that is willing and able to connect and partner with the private sector;
• A personality who is able to forge new relationships, managing existing ones and build community around data sharing; and
• An individual that “gets” the open source movement.

Importantly, while ICTs are often a part of the data-enabling conversation, the real key here is information management and the use of information for management decision making. Creating or including an ICT component is not always necessary and should be approached with the same care as any other aspect during programme design.

Recommendation 3: Invest in establishing UNICEF’s comparative advantage to make the case that ICT investments are the best use of donor funds for achieving better health outcomes for children. (Based on Conclusion 3)

As noted in this report and the country reports, the evaluation team was unable to determine if UNICEF has a comparative advantage related to enabling ICT solutions, improving the incorporation of citizen feedback and scaling or replicating programming. While this is not an easy question to answer by any estimation, answering it is mostly a function of available time and data.

UNICEF should invest in answering the comparative advantage question for two important reasons: first, understanding the optimal way to spend donor funds to achieve better health outcomes for children directly supports UNICEF’s mandate. Second, if it is possible to establish that investing $1 USD in ICT enabled programming delivered by UNICEF results in better, more or broader health outcomes for children than other alternatives, knowing this would be a powerful competitive advantage for the organization.

Recommendation 4: Continue to invest in collecting and responding to citizen voice by iterating current solutions and seeking new solutions from a larger community of practice. (Based on Conclusion 4)

UNICEF has been a leading advocate and practitioner for including citizen voice in programme design and delivery for many years. However, the attempts to include citizen voice via ICT enabled solutions in the PMR initiative generally fell short of expectations, or in the case of Kenya, was not used.

Citizen feedback is essential for success in development programming. To that end, as noted above in Recommendation 1, results from the PMR Initiative should be seen as a moment of reflection for UNICEF in order to learn and iterate, so that the next programming cycle might attempt something new. In the spirit of working together to create greater efficiencies collecting and responding to citizen voice, UNICEF should shy away from going it alone. One immediate opportunity would be to engage FeedbackLabs, in

22 Citizen voices remain an underutilized engine for global change. Globally, there is a disconnect between citizens, service providers, and governments. As a result, opportunities to make adjustments, target services to needs on the ground, and adapt to changing conditions are unrealized. Feedback Labs aim to set the stage for a improved ecosystem that links citizen feedback with service providers and governments to create a force multiplier—rewarding what works, adapting and learning from what doesn’t, and ensuring the most targeted, creative, and
one of their LabStorms, and use this community of more than 300 organizations as a catalyst for cracking the code to gathering and engaging with feedback from rural communities.

As an aside, at the time of this evaluation, the citizen feedback component in Zimbabwe was only just beginning to gain traction. UNICEF should monitor this process (based on U Report) as it is different than those used in the other three countries. There may be additional successes and challenges that can be learned.

Recommendation 5: Continue to evolve knowledge exchange at UNICEF through changes in organizational structure, professional culture and leadership buy in. (Based on Conclusion 5)

The evaluation found that the PMR Initiative fell short in terms of finding new, unique or scalable means for sharing knowledge. However, gains were made and, similar to citizen voice above, this should be seen as an opportunity for reflection, iteration and new design. Three areas UNICEF can concentrate on in the near term to improve its Knowledge Exchange practice are:

**Organizational structure:** UNICEF’s decentralized organizational structure creates natural boundaries between COs, within regions and globally. These physical boundaries are further compounded through the division of UNICEF’s work into separate sectors. While it is beyond the scope of this evaluation, it is clear that this structure provides little to no incentive for UNICEF staff or teams to regularly and reliably share information. When funding streams are added to this equation, incentives are reduced further. UNICEF should seek to find incentive options to break these barriers.

**Professional culture:** UNICEF’s professional culture does not currently reliably reward risk taking. UNICEF should pursue messaging and a clear incentive structure that rewards risk taking with regard to information sharing in order to establish a new norm regarding expectations about what happens with the lessoned learned in each CO.

**Leadership:** Underlying both of the above is the need for clear, strong, consistent and sustained leadership on knowledge exchange. If the organization and its staff do not perceive that KE is a high priority, with incentives for good performance and limitations for poor performance, change will not happen. This leadership position should come from the highest level possible and be tied to one or two, simple, clear goals. Communication about leadership expectations should be communicated at every opportunity and over a sustained period (2-3 years) in order for the message to become a part of the UNICEF culture.

Recommendation 6: Seek to shift UNICEF staff and partner mindsets about transferability of ICT enabled programming, and knowledge exchange, from “plug and play” to “customization.” (Based on Conclusions 5 and 6)

There are clear opportunities for gains made in the PMR Initiative to be replicated in other context, in both the health sector and other sectors. UNICEF should ensure that the following two criteria are present in any new context for replication to be successful.

First, ensure any receiving context has a minimum enabling environment. This environment includes:

10. National ownership and leadership of the system(s) that will receive the intervention;
11. National systems that are owned and operated by the government that can be enhanced;
12. The ability to partner with government and civil society;
13. The ability to foster development and improvement of infrastructure and policy;
14. The ability to align programmatic goals with accountability frameworks, incentives and actions;

Feedback Labs aims to change the norms in development, aid, and philanthropic policy to be more responsive to the people that those policies aim to help; by catalysing the widespread adoption of closed feedback loops in philanthropy, international aid, and governance with respect to the voice of citizens. See http://www.feedbacklabs.org
15. Expertise that can be systematic about adopting and scaling innovations that are effective;
16. The ability to invest in adequate ICT capacity;
17. A long-term vision that allows sufficient time and investment for action and impact; and
18. The ability to focus on short term milestones along a longer-term road map.

Second, ensure that UNICEF staff and partners understand that replication of any ICT enabled process or system will, by its nature, require customization. As noted in the Uganda country report, there is a tendency for non-technical UNICEF staff and partners to desire systems and processes that are transferrable as “plug and play.” However, even systems that are built on a widely used, open source platform such as DHIS2 will require customization. As an example, consider the RMNCAH scorecard. While the underlying methodology for producing this scorecard remains the same across all context, at a minimum, the indicators chosen and their respective criteria (e.g. denominator) will need to be changed. And, therefore, the functionality of the ICT system will need adaptation.

Developing the capacity to establish an enabling environment and then offer the customized ICT enabled solution for that environment offer another opportunity for greater competitiveness at UNICEF.

Adopting a customization mind set also applies to the Knowledge Exchange approach at UNICEF. For example, while setting a single standard cap for the group sizes would be unrealistic, UNICEF should consider smaller group sizes in Yammer that target more specific populations.23 By so doing, UNICEF could create groups that are more manageable in terms of engagement by focus on a particular result area or competency. Slack is one example of a successful application of this paradigm where users have the ability to set up channels as necessary for almost any particular topic and invite users as necessary.

Further customization for KE could be employed with Sharepoint. This repository should have a requirement for all information to have associated meta data that enables faster and more accurate searching.

**Recommendation 7:** Use ICT enabled programming as a bridge for multisectoral programming and scaling vertically. (Based on Conclusion 6)

The implementation of the PMR Initiative in Zimbabwe was clearly unique, as compared to Kenya, Swaziland and Uganda, and this has led to its own set of outcomes. One clearly positive gain from the Zimbabwe experience is the multisectoral nature of the implementation, which is in contrast to the health sector only implementation of the other three countries. UNICEF should continue to pursue similar opportunities where ICT enabled programming can overcome barriers, break silos or bridge gaps between sectors for a more holistic and integrated approach to achieving better outcomes for children.

In a similar vein, UNICEF should seek to leverage its success in vertically scaling the programming of the PMR Initiative to achieve the same horizontally.

**Recommendation 8:** Capitalize on opportunities exposed by the success of the PMR Initiative in closing the feedback loop to address the “no available resource” challenge and ensuring data collection is sustainable. (Based on Conclusion 7)

UNICEF should immediately seek to capitalize on the two major challenges exposed by the success of the PMR Initiative: Closing the feedback loop to address the “no available resource” challenge and ensuring data collection is sustainable. As with other areas mentioned above, “solving” these problems could create significant competitive advantages for UNICEF.

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23 For example, as of 28/05/2017, the size of the RTM CoP was 144.
One option for closing the feedback loop could be the creation of a basket of funds that can be used to target identified problem areas in partnership with local governments. To ensure sustainability of data collection, UNICEF could work with partners to establish processes for data collection that offers a sustainable and worth-while system of incentives.
## Annexes

### List of people interviewed

#### Kenya

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<th>Given name</th>
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<tr>
<td>Victor</td>
<td>Achieng</td>
<td>M&amp;E Specialist,</td>
<td>UNICEF</td>
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<tr>
<td>Eunice</td>
<td>Ndungu</td>
<td>Maternal-Newborn Health Partnerships and M&amp;E Officer at UNICEF</td>
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<td>Elijah</td>
<td>Asadhi</td>
<td>Monitoring Officer</td>
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<td>Dr. David</td>
<td>Soti</td>
<td>Head. Dept. Preventive and Promotive Health Services</td>
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<tr>
<td>Dr. Hellen</td>
<td>Kiarie</td>
<td>Acting Head- M&amp;E Unit, Div. MEHRDHI</td>
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<tr>
<td>Dr. Peter</td>
<td>Cherutich</td>
<td>Head. Div.MEHRDHI</td>
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<tr>
<td>Nancy</td>
<td>Amayo</td>
<td>Technical Officer, Health Information Unit, Div.MEHRDHI (Driving RMNCAH Score-card Agenda for Health Sector)</td>
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<tr>
<td>Dr. Dan</td>
<td>Orwa</td>
<td>Team Lead</td>
<td>University of Nairobi - School of Computing and Informatics</td>
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<td>Raphael</td>
<td>Pundo</td>
<td>Program Director</td>
<td>Aura Safira Consulting</td>
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<td>Dr. Elijah</td>
<td>Abade</td>
<td>Systems Architect</td>
<td>University of Nairobi - School of Computing and Informatics</td>
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<td>Dr. Samuel</td>
<td>Omondi</td>
<td>County Director of Health</td>
<td>Siaya County Health Management team</td>
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<td>Dr. Gordon</td>
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#### Swaziland

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<td>Zanela</td>
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<td>Fortune</td>
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<td>HMIS Senior Statistician (Gates initiative project manager)</td>
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</tbody>
</table>
### Thabang Masangane
- **Quality Assurance Coordinator**
- **Ministry of Health**

### Sikhumbuzo Dlamini
- **Network Engineer**
- **Ministry of Health**

### Kevin Sikwebele
- **CEO**
- **IHM Africa**

### Bheki Mamba
- **Program Manager**
- **IHM Africa**

### Sicelo Kunene
- **Software Developer**
- **IHM Africa**

### Youth Groups
- **Boy Scouts Association of Swaziland**

### Site Visits
- **Piggs Peak Government Hospital (Hhohho Region)**
  - Regional Health Management Team
  - **Ministry of Health**

- **Cana Alliance Clinic (Manzini Region)**
  - Health Management Team Facility levels
  - **Ministry of Health**

### Uganda

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### Zimbabwe

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<td>Herbert Zvirenr</td>
<td>Analyst</td>
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Interview Guides

**Key Informant Interview Guide**

Key informant interviews are semi-structured. **The following is a guide, not a questionnaire.** It is expected to be more of a discussion than an ‘interview’. Some interviewees will know much more about the PMR programme than others. Some interviewees will have more useful insights than others. The interview will be led by an international ISG project team member. Each interview will last approximately one hour, though group interviews may require more time.

**NOTE: The interview/discussion questions will be prioritized or adjusted to the specific respondents to be interviewed and will be localized to the country context.**

For each KII the project team member will begin with introductions and provide a brief explanation of the purpose of the meeting/discussion, its emphasis on a participatory and learning oriented approach, and express appreciation for the respondent’s participation in the interview/discussion.

**Relevance:**

1) Is the PMR initiative an appropriate response to this country’s needs?
2) Is UNICEF the right organization to implement this type of work? Why or why not?
3) Does UNICEF have the capacity (staff, know how, funding, etc.) to do this work?

**Effectiveness:**

1) What has truly changed in terms of being able to effect health outcomes in this country because of the PMR initiative?
   a. Ask for specific examples

**Sustainability and Scalability:**

1) What happens now that the UNICEF PMR initiative has ended in this country?
2) Have budgets been allocated for the initiative(s) in this country to carry it forward?
3) Does a workplan exist for the initiatives in this country to carry it forward?
4) Are staff and other necessary resources available in this country to carry it forward?

**Replicability:**

1) What is UNICEF’s “core” business?
2) Was there a better way to allocate the PMR initiative funding to effect health outcomes for women and children? How?
3) Does UNICEF have one or more particular advantages over similar organizations (IOs, iNGOs, Private companies) in terms of being able to deliver services like the PMR initiative?
   a. Monitoring platforms for real time data?
   b. Citizen / community feedback platforms?
   c. Knowledge sharing platforms?
Outcome 1.1 – More Real Time Data Available

1) What monitoring platform(s) were established or enhanced for the PMR initiative?
2) Do these (this) platform provide reliable, relevant and more real time data?
3) What specific types of data have now been made available which weren’t reliably and routinely available prior to the initiative?
4) Are decisions being regularly made using the data? (Get specific examples)
   a. What is the process that leads to decision making?

Outcome 1.2 – Citizen / Youth / Community feedback

1) Does a citizen/community feedback platform exist or was enhanced? Which one?
2) Does this platform provide reliable, relevant and more real time information?
3) What specific types of data have now been made available which weren’t reliably and routinely available prior to the initiative? (where possible, provide supporting documentation, press releases/interviews, etc.)
4) Who uses the platform and with what frequency? (where possible, provide supporting documentation, press releases/interviews, etc.)
5) Are decisions being regularly made using the data? (Get specific examples)
   a. What is the process that leads to decision making?

Outcome 1.3 – Quarterly performance reviews

1) In which districts/sub-counties were activities ongoing? (where possible, provide supporting documentation, press releases/interviews, minutes of meetings etc.)
2) Which decentralized bodies were targeted by the PMR initiative in this country?
3) Who were the targeted decision makers / bodies?
4) How, specifically, do the new or enhanced platforms (and their resulting reports) add value to their respective systems, processes and decision makers? (do
5) Does their existence result in better care/protection/health of women and children? (where possible, provide supporting documentation, press releases/interviews, etc.)
6) What data was available prior to the initiative?
7) What new data is now available? (where possible, provide supporting documentation, press releases/interviews, etc.)
8) What new data demands are pending right now?
9) Can you provide examples of recent and future decisions that will be influenced by the newly available data?

Outcome 2.1 – Knowledge exchange

1) Do you have access to knowledge platforms for exchanging learning about the PMR initiative?
2) Which KE platforms exist, or how was an existing one enhanced?
3) How have you used the KE platform during the PMR initiative?
4) What is the plan for the KE platform now that the PMR initiative has concluded?

5) What could be done in the future by UNICEF to strengthen knowledge capture and sharing within a similar programme, within the region and more broadly?

**Outcome 2.2 – National Plans for decentralized monitoring**

1) What is the current plan to sustain and ultimately scale the PMR initiative in this country?

2) Do national scale up plans exist for tested PMR models?
   a. If yes, what is the budget allocation?
   b. What other resources have been allocated?

**Most Significant Change Guide**

Evaluators will explain to participants:

The Most Significant Change technique is an alternative evaluation methodology, specifically suited for complex programming, that seeks to uncover results and impact that would otherwise not be revealed through other methods.

I would like for you to consider the following question as it relates to your experience with the PMR initiative and how it has created change in this country. We will record your stories and they will be shared with others in a two-step process to determine how value has been created via the PMR initiative.

**Question:**

Looking back over the entire PMR initiative, if you had to summarize what you think was the most significant change in this country because of the program in a single story... what would that story be?
TOR for assignment

Title: End-of-programme evaluation of UNICEF’s regional Institutional Strengthening Support Initiative on decentralized Programme Monitoring and Response (PMR)

Location: Desk review with pre-field interviews in Nairobi and field visits to Kenya, Swaziland, Uganda and Zimbabwe

Duration: 3 months

Background and Justification

The twenty-one countries of UNICEF’s Eastern and Southern Africa region (ESAR) collectively bear a significant proportion of global under-five mortality, malnutrition and HIV despite notable improvements made in recent years. To further accelerate improvements in child health and nutrition outcomes, there is an increasing trend within ESAR countries to decentralize responsibility for planning and delivery of essential child survival and development services as a means to bring public decision-makers closer to local communities and needs, build local capacity, and improve accountability.

Concurrently there has been an observation from past UNICEF and other UN agencies' work that, for most service delivery systems at decentralised levels, the traditional model of input-output monitoring and occasional impact monitoring (at the end of a multi-year period) is not addressing data gaps related to the achievement of intermediate results. This means there is a lack of "early warning data, as well as feedback loops, to signal whether services are likely to be effective or not; implementation bottlenecks and barriers need to be removed; and mid-course programme adjustments need to be made. The detrimental effects of an absence of intermediate results monitoring and more real-time response are many. These include ineffective planning and budgeting, inefficient use of material and human resources, and continued existence of large underserved populations of children.

Further, although high-impact, evidence-based and affordable child survival interventions are known, a number of global studies have highlighted the poor institutional capacity within decentralized health and health-related systems in developing countries and the constraints faced by district management teams in the implementation of health and health-related services. These include a lack of reliable, timely, and strategically-selected and presented local data; insufficient emphasis on results; lack of identification of bottlenecks impeding effective coverage; failure to involve communities as active proponents in helping overcome obstacles to high Coverage; and a lack of analytic and prioritization capacity which is particularly needed within the context of chronic resource constraints faced by sub-national management teams. As a result, innovative and sustainable strategies are needed to strengthen district and other sub-national monitoring systems, including citizens community monitoring and social accountability feedback mechanisms, and data use practices in the health and/or health-related sectors as a means to achieve improved and more equitable delivery of quality services and outcomes for children and women.

To address the above, UNICEF Headquarters, in collaboration with its East and Southern Africa Regional Office (ESARO), decided to address the above highlighted issues by implementing a regional Institutional Strengthening Support initiative to improve the Programme Monitoring and Response (PMR) capacity of decentralized government decision-making bodies and communities in four countries (Kenya, Swaziland, Uganda & Zimbabwe).

At this time, UNICEF ESARO is seeking the services of a well-established and experienced consulting firm to Conduct an end-of-program evaluation which will systematically and objectively assess this regional initiative in relation to its design, implementation and results taking into account agreed evaluation criteria. The evaluation will assess both quantitative and qualitative results achieved in relation to the Initiative's Results Framework (see Annex A- Results Framework).
At this time, UNICEF ESARO is seeking the services of a well-established and experienced consulting firm to conduct an end-of-program evaluation which will systematically and objectively assess this regional initiative in relation to its design, implementation and results taking into account agreed evaluation criteria. The evaluation will be comprised of an end-line assessment of quantitative results achieved in relation to the initiative's Results Framework and a sequenced, field-based process and outcome evaluation.

Programme Description
In 2014, UNICEF Headquarters, in collaboration with its East and Southern Africa Regional Office (ESARO), decided to address the above highlighted issues by implementing a regional Institutional Strengthening Support initiative to improve the Programme Monitoring and Response (PMR) capacity of decentralized government decision-making bodies and communities in four countries (Kenya, Swaziland, Uganda & Zimbabwe).

The ESAR Institutional Strengthening Support in Program Monitoring and Response initiative was designed as a learning initiative with the following goals:

- improve service provision/programme performance during the course of implementation through improved monitoring of intermediate results, establishment of citizen feedback loops, and the use of monitoring and feedback data to adjust strategies as needed in a timely manner; and
- identify and promote those promising practices of programme monitoring and response, tested and proven by early adopter districts, through the development of national scale-up plans within participating countries and the establishment of knowledge exchange platforms.

The initiative is taking place in select districts in the four countries of Kenya, Swaziland, Uganda and Zimbabwe and within the context of existing national and sub-national government monitoring and management information systems. UNICEF’s design for this institutional support initiative is based on five programmatic pillars:

1. A reliable & quality (more) real-time data is available at the sub-national level for identifying and addressing barriers and bottlenecks to the delivery of health and/or health-related services (Nutrition, HIV, WASH)
2. Citizens/youth groups provide feedback on the delivery of health and/or health-related services
3. Quarterly performance reviews are conducted and acted upon by decentralized decision-making bodies using data from real time monitoring and citizen feedback
4. Knowledge is increased among UNICEF and relevant government staff in ESAR countries on the use of real time monitoring data for decision-making in the delivery of health and/or health-related Services; and
5. Evidence-informed National Plans of Action are developed within the four countries for scaling-up models for decentralized PMR.

These pillars also comprise the expected intermediate outcomes of the initiative as per the approved Results Framework.

UNICEF’s regional learning initiative endeavors to test whether sub-national, decision-making bodies in the health and/or health-related sectors (Nutrition, HIV, WASH) could improve the timeliness and effectiveness of their decisions and consequent actions if monitoring data were provided and used on a more timely, reliable and higher quality basis; and if associated citizen engagement and social accountability mechanisms were established or strengthened so that feedback from citizens and communities was also routinely used to inform priorities, decisions and actions by both institutional decision makers and citizens or communities themselves.

In other words, UNICEF’s hypothesis is that if decentralized management and/or front-line health worker decisions and responses are more timely and evidence-based, and if citizen feedback loops and social accountability structures are established, then over time improvements will be seen in:
a sector service provision/programme performance (i.e. coverage and quality of services); o communities’ commitment to invest in their own health and well-being; and o the health and well-being of vulnerable and previously under-served children and women, thereby improving equity of health outcomes.

Scope of Work

Purpose of the Evaluation This evaluation is being done to support the further national scale-up of documented effective PMR institutional strengthening interventions in the four initial participating countries; guide anticipated replication in other countries in which UNICEF operates; and add to the regional and global knowledge base by generating evidence on processes and outcomes related to strengthening decentralized PMR systems in the health and nutrition sectors. In addition, the evaluation's findings and recommendations will provide valuable information on the extent to which the work undertaken within these four countries is applicable to other sectors beyond health and nutrition.

The primary audiences for the evaluation will be UNICEF, UNICEF’s partners directly involved in implementation of the initiative (e.g. government bodies, other implementing partners and community organizations), and the current donors of the programme (the Bill and Melinda Gates Foundation and the US Fund for UNICEF). Secondary audiences will be other donors, development stakeholders, and professionals interested in improved programme monitoring and response, citizen engagement/social accountability, and data demand & use.

Evaluation Objectives

The objectives of the evaluation are to:

• Assess achievement towards the programme’s expected results (milestones, outputs, intermediate outcomes, and primary outcomes) as per the initiative’s Results Framework;
• Assess the extent to which the programme activities have changed how (more) real time data is collected, analysed, packaged, disseminated, and used (i.e. the extent of uptake by targeted decentralized decision making bodies);
• Assess whether, and how, mutual and ongoing learning on PMR is taking place across target decentralized government units and countries, as well as within target UNICEF offices;
• Understand and document the range of contextual/environmental factors that served as enablers/disablers to the results achieved, including programme design, implementation, management and coordination processes;
• Assess the programme’s relevance, effectiveness, sustainability, scalability, and replicability to determine if the package of support interventions and tools employed by UNICEF’s four participating COs can serve as applicable models for other UNICEF countries and stakeholders in similar context and sectors, and other social sectors;
• Determine if the four UNICEF COs can serve as ‘centres of excellence’ within UNICEF globally on decentralized PMR or specific aspects of decentralized PMR;
• Document best practices and lessons learned related to:
  o Effective PMR among decentralized public decision-making teams
  o Institutional support aimed at strengthening decentralized PMR mechanisms, processes and practices, and
  o Adaptive programming during implementation through the availability and use of real-time monitoring and citizen-feedback; and
• Recommend whether this type of institutional strengthening initiative focused on PMR should be continued within ESAR and/or other UNICEF regions as a programming strategy regardless of sector, and if yes, how it would best be placed within UNICEF’s organisational structure.

Evaluation Scope
The evaluation will cover the entire programme period of the ESAR PMR initiative from November 2014 until present (with the official ending date of the programme 30 June 2016). There are no comparators for assessment. UNICEF offices to be included in the evaluation process will be the four participating COs (Kenya, Swaziland, Uganda, Zimbabwe), ESARO and NYHCR.

It is likely the consulting firm will carry out the work in five phases:

Phase 1 - Desk Review and Inception Planning (approximately 2.5 weeks): Thoroughly review key reference documents related to the overall initiative, as well as reports and other documentation submitted by the countries over the course of implementation. Prepare a full design for the endline assessment and end-of-programme evaluation, as a separate annexed document to the Inception Report and proposed Work Plans Timeline. The evaluation design is to include an analytical framework and data collection tools.

Phase 2 - Preliminary Review: Undertake a preliminary review of the participating countries to verify existing end-line assessment and evaluation data (quantitative and qualitative).

Phase 3 - Verification Field Visits (to 4 countries over approx 4 weeks): Undertake field visits to the participating countries to verify existing end-line assessment and evaluation data (quantitative and qualitative).

Phase 4 - Analysis, Reporting and Validation (approx 4 weeks): Submit Well-supported preliminary findings, conclusions and recommendations for discussion and comment at a remote Validation Meeting with key internal UNICEF stakeholders. Prepare full versions of draft evaluation reports following Validation Meeting.

Phase 5 - Dissemination (approx 2 weeks): Following Validation Meeting, present Conclusions and recommendations at high-level review and forward-planning Partners Forum to be held in Uganda in mid-May 2017. Incorporate feedback from final review forum and submit final evaluation reports.

Additionally, the consulting firm will take into account the below outline of processes when developing its proposed workplan (subject thereafter to agreements made during the Inception Phase of the contract):

1. In consultation with the 4 COs and ESARO, decide on the final set of data sources and specific attributes of the data systems that will be assessed in the Countries at the various decentralized administrative levels targeted by the Initiative, as well as within UNICEF. The Evaluation Team may also be asked to analyze existing data to produce a baseline for some of the evaluation questions where possible and as needed.

2. Develop in a collaborative manner with UNICEF (ESAR PMR initiative Steering Committee and the 4 COs) and obtain written email approval for the key evaluation questions and analytical framework to drive the evaluation (see Annex B: List of indicative Evaluation Questions). In addition to questions focused on the evaluation of outputs and outcomes, there is also need to understand the range of contextual/environmental factors that served as enablers 1 disablers to the outputs and outcomes achieved, including programme management and implementation processes.

3. Develop an analysis plan. Mixed forms of analysis are encouraged to facilitate triangulation of data and strengthen the basis for evaluation findings, conclusions and recommendations.

4. Develop, share and obtain Written email approval for the data collection and assessment tools to be used for (i) data systems/monitoring systems; (ii) citizen engagement mechanisms/ processes; (iii) data use processes/practices; (iv) knowledge exchange platforms/processes, and (v) sustainability and scale-up planning processes. The tools will need to be contextualized by type of data source.
5. Develop a Sampling Plan for those aspects of the evaluation requiring it (e.g. in relation to the large number of facilities and communities that could potentially be involved in the evaluation).

The bidder will build upon the baseline and evaluability assessment work done at the beginning of programme implementation by an external consulting firm, and take into account secondary data gathered over the course of programme implementation in accordance with the initiative’s Results Framework and associated M&E Plan, to propose output and outcome measures that may go beyond those for which data is currently being gathered. These will be developed in relation to the core research questions agreed with the contractor during the Inception Phase. Please refer to Annex B for a nascent, though indicative, list of potential evaluation questions to be considered and further developed by the consulting team.

Methodology

The overall methodological approach and design of this evaluation will be participatory, involving an appropriate range of individuals directly involved in implementation and oversight of the initiative as well as other relevant stakeholders. The approach will be both theory- and case-based and will employ mixed methods, both quantitative and qualitative, to support triangulation of data gathered. Emphasis will be placed on gathering disaggregated data by geographic area, programmatic pillar, implementing partner, and perhaps on additional variables yet to be decided.

While it is clear from the objectives that the evaluation will have a focus on outputs and outcomes (not impact), there are also a number of process issues of relevance. Bidders will include in their proposals a full evaluation design, including the approach to be taken to complete the endline assessment of quantitative results as compared to the baseline. The design will include evaluation criteria, key research questions, sampling plan, and data collection and analysis methods.

The data collection and analysis methods proposed by the bidder will be sufficiently rigorous to ensure an unbiased assessment of both the processes (how the initiative was implemented) and the outputs and outcomes (what results were achieved through the initiative - either through direct contribution or through leveraging of other relevant actors and resources). The consulting team is further encouraged to utilise a range of data collection methods including desk reviews, key informant interviews, questionnaires, focus group discussions, technical reviews of data monitoring and management information systems and protocols, direct observation (particularly of performance 1 data review meetings and community engagement processes), etc.

The consulting team, with support from each county (UNICEF staff and relevant national and local government staff), will identify the specific systems in each district to be assessed. The systems to be assessed need to be agreed with each country. Key informants for each system could include developers, managers, users and oversight bodies. He/she will also have consultations with partners that fund such systems. 9 UNICEFESARO in coordination with the 4 participating COS will strive to assess the reliability of the disaggregated data prior to the start of the evaluation. Verification of UNICEF’s assessment will be required of the consulting firm.

The methodology proposed by the bidder will be evaluated for its logical and explicit links between the evaluation questions/criteria, data sources, data collection methods and analysis methods. Primary data sources will include, though not limited to:

- Health/Nutrition Management information System data reports;
- citizen engagement mechanism data reports; and
- meeting minutes and action plans from targeted decentralized government decision-making bodies and community groups;
- Individuals, Committees/teams and implementing partners involved in the direct implementation, technical support, oversight and funding of the programme at the country, regional and global level;
• Target decision-making bodies intended to benefit from the country-specific institutional support interventions implemented within each of the countries (health/nutrition management teams; facility management teams; ward and village leadership committees; citizen groups)

Secondary data sources will include, though not be limited to:
• Baseline & evaluability assessment reports prepared by an external consulting firm (see Annex C for a summary of these assessment findings).
• UNICEF programme documentation as available in the RTM Community of Practice document and video libraries (e.g. data submitted by the COs in monthly monitoring reports including that gathered through periodic country-level spot checks, monthly coordination/management meeting minutes, ESARO TAQA trip reports, annual programme review reports, stakeholder mapping)
• Knowledge products produced as outputs of the initiative

The proposed methodological approach should be clear on how the evaluation will be sequenced over the three-month period from March - May 2017, including which questions will be addressed at which time points. It is envisaged that for some questions trend data will need to be gathered and analyzed while for others an end-line position may be sufficient. Information should also be provided on where data to address each question are expected to come from, how any sampling needed will be undertaken, and where data will be quantitative or qualitative in nature.

The evaluation is to be conducted in accordance with UNICEF’s evaluation guidelines and UNEG quality guidelines and ethics principles for evaluation and research. Assumptions and limitations of the chosen evaluation methods will also be included in the bidder’s proposal and later in the more refined Inception Report. Quality assurance to ensure a high standard of design and reporting is expected within the Evaluation Team, but will also be supported at certain agreed stages through ESARO’s PPME Office and the ESAR PMR initiative’s Steering Committee. In addition, UNICEF’s ESARO’s external quality assurance service (provided through an organization known as Universalia) will provide inputs and recommendations on the evaluation TOR, design documents and reports.

Ultimately the methodology will be mutually agreed between UNICEF ESARO and the external Evaluation Team. The Evaluation Team will be responsible for putting forward their approach to answering the key questions and presenting this in their proposal document and later again in the Inception Report. UNICEF does not wish to prescribe any particular methodology but expects that Evaluation Teams’ previous experience and expertise will be utilized to develop the most efficient and effective evaluation approach. Limitations to the Evaluation

The four countries participating in the learning initiative began at considerably different developmental levels in relation to the existence and/or functionality of decentralized programme monitoring and response institutionalized systems and practices. Therefore, their beginning and ending points in relation to any of the integrated programmatic pillars is expected to vary from country-to-country. Other significant limitations to the evaluation are not expected though the quality of information provided by some sources is anticipated to be an issue.

Within the evaluation timeframe and budget, it will also not be possible to gather primary information from all related sources and therefore the evaluator will be encouraged to utilize both primary and secondary data sources-particularly data gathered by the UNICEF programme managers and implementation teams as part of the programme’s monitoring plan. Citizen and community groups, representing vulnerable populations, will be available and included in the evaluation as focus group discussants, interviewees or participants in other forms of evaluation data collection.
### PMR INITIATIVE LOGFRAME

#### Intermediate Outcomes, Outputs, Milestones & Activities for 4 Country Offices

<table>
<thead>
<tr>
<th>Intermediate Outcome</th>
<th>Output</th>
<th>Output</th>
<th>Kenya</th>
<th>Activities</th>
<th>Swaziland</th>
<th>Activities</th>
<th>Uganda</th>
<th>Activities</th>
<th>Zimbabwe</th>
<th>Activities</th>
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<tr>
<td>1.1 Reliable &amp; quality real-time data is used by districts for identifying and addressing barriers and bottlenecks to the delivery of health, nutrition, HIV and/or WASH services</td>
<td>1.1.1 Platform for collection of real time monitoring data established or updated</td>
<td>1.1.1 Platform for collection of real time monitoring data established or updated</td>
<td>1. Facilities' readiness assessed</td>
<td>1. Facilities' readiness assessed</td>
<td>1. Vehicle procured for transferring data from health facilities to regions</td>
<td>1. HMIS platform strengthened in all facilities</td>
<td>1. Vehicle procured for transferring data from health facilities to regions</td>
<td>1. HMIS platform strengthened in all facilities</td>
<td>1. ODK platform established for NRTM Data System</td>
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<td>1. DHIS2 platform at facility-level in 4 sub-counties (districts)</td>
<td>1. DHIS2 platform at facility-level in 4 sub-counties (districts)</td>
<td>2. Facilities' infrastructure upgraded</td>
<td>2. Facilities' infrastructure upgraded</td>
<td>2. HMIS officers trained on data management and quality assurance</td>
<td>1. DHIS2 platform at facility-level in 4 sub-counties (districts)</td>
<td>2. Facilities' infrastructure upgraded</td>
<td>2. HMIS officers trained on data management and quality assurance</td>
<td>1. ODK platform established for NRTM Data System</td>
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<td></td>
<td>2. Digital DHIS2 reporting operational at facility &amp; community levels (moved from paper-based system)</td>
<td>2. Digital DHIS2 reporting operational at facility &amp; community levels (moved from paper-based system)</td>
<td>3. Uploading rights for facility HWs obtained</td>
<td>3. Uploading rights for facility HWs obtained</td>
<td>3. Uploading rights for facility HWs obtained</td>
<td>2. Digital DHIS2 reporting operational at facility &amp; community levels (moved from paper-based system)</td>
<td>3. Uploading rights for facility HWs obtained</td>
<td>3. Uploading rights for facility HWs obtained</td>
<td>1. Data system requirements determined</td>
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<td>1.1.2 Data use reports developed monthly</td>
<td>1. DHIS2 Routine System Reports</td>
<td>1. DHIS2 Routine System Reports</td>
<td>1. TOT training on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>1. TOT training on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>1. DHIS2 platform strengthened in all facilities</td>
<td>1. TOT training on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>1. TOT training on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>1. TOT training on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>2. FNC server &amp; connectivity assessed</td>
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<td>1. All levels of trainings complete on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>1. All levels of trainings complete on DHIS2 &amp; Quality Data Audits (TOTS, facilities, CHWs, CHEWs)</td>
<td>2. Facility HWs trained on DHIS2</td>
<td>2. Facility HWs trained on DHIS2</td>
<td>2. TOT trained on revised HMIS tools</td>
<td>2. Facility HWs trained on DHIS2</td>
<td>2. Facility HWs trained on DHIS2</td>
<td>2. TOT trained on revised HMIS tools</td>
<td>3. TOR for Data Systems/Consultant developed</td>
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**International Solutions Group**

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<table>
<thead>
<tr>
<th>Intermediate Outcome</th>
<th>Kenya</th>
<th>Swaziland</th>
<th>Uganda</th>
<th>Zimbabwe</th>
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<tbody>
<tr>
<td></td>
<td>Output</td>
<td>Milestones</td>
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<tr>
<td></td>
<td>2. Citizen/ youth groups provide feedback on the delivery of health, nutrition, HIV and/or WASH services</td>
<td>7. CHWs report to MOVE-IT using mobiles</td>
<td>4. RMNCH Scorecards developed</td>
<td>3. Data Quality Assessment Reports</td>
</tr>
<tr>
<td>1.2 Citizen/ youth groups provide feedback on the delivery of health, nutrition, HIV and/or WASH services</td>
<td>1.2.1 Platform for collection of citizen feedback information established (may be Rapid-Pro SMS Platform)</td>
<td>1. Determine which type of SMS-based system to establish and then develop additional activities</td>
<td>1. Report Platform operational</td>
<td>TBD</td>
</tr>
<tr>
<td>3. Household Registration Dashboards developed</td>
<td>3. Updated HMIS tools/report s operational at community level within 3 districts</td>
<td>System Reports operational in 60 villages</td>
<td>3. Updated HMIS tools/report s operational at community level within 3 districts</td>
<td>TBD</td>
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<td>2. Citizen/ youth groups provide feedback on the delivery of health, nutrition, HIV and/or WASH services</td>
<td>1.2.1 Platform for collection of citizen feedback information established (may be Rapid-Pro SMS Platform)</td>
<td>1. Determine which type of SMS-based system to establish and then develop additional activities</td>
<td>1. U-Report Rapid-Pro SMS Platform</td>
<td>TBD</td>
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<tr>
<td>1.2.2 Citizen feedback reports developed each month</td>
<td>1. Community operational in all 241 CLUs in Homa Bay County 2. (later CLUs in Siaya County to be added) 3. SMS-based citizen feedback system operational 4. SMS system integrated with CSCs operational</td>
<td>1. U-Reports U-Reports operational 2. U-Report developed 3. Opinion polling surveys conducted 4. Opinion polling surveys conducted</td>
<td>1. U-Reports U-Reports available with expanded citizen feedback 2. Commtty Scorecards 3. Community Scorecards operational</td>
<td>1. Observation workshop for citizen groups on citizen engagement 2. Tool for village-level review of citizen feedback information developed 3. Tool for ward-level review of citizen feedback information developed</td>
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<td>1. Recruit additional U-Reporters sent 2. Feedback Strategy Developed</td>
<td>3. Review Strategic Plan for FY 2011-2012...</td>
<td>4. Reports developed on feedback expanded on feedback</td>
<td>5. Reports available with expanded citizen feedback</td>
<td>6. Reports developed on feedback expanded on feedback</td>
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<tr>
<td>1.3.2 Quarterly performance reviews result in updated Action Plans using information from real-time data use reports (including citizen feedback reports)</td>
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<td>1. Sub-County (District) Action Plans updated (using data use reports)</td>
<td>1. Information from real-time data use reports used:</td>
<td>1. Information from real-time data use reports verified</td>
<td>1. Information from real-time data use reports (using data use reports)</td>
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<td>2. County Action Plans updated (using data use reports)</td>
<td>i. DHIS2 routine system reports (with CHWs routine mobile data included)</td>
<td>2. Facility quality data audits conducted quarterly</td>
<td>2. Facilities’ Action Plans updated (using data use reports)</td>
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<td>iv. Quarterly Facility Quality Audit Reports</td>
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<td>iv. HMIS Routine System Reports</td>
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<tr>
<td>1.3.3 Actions taken based on quarterly performance reviews within timeframe specified in District Action Plans</td>
<td>1. Actions taken by CHMTs/Sub-Counties within timeframe specified in respective Action Plans</td>
<td>1. Actions taken by RHMTs, Facility Managers, &amp; QA Program within timeframe specified in respective Action Plans</td>
<td>1. Actions taken by DHMTs, Facilities &amp; Communities timeframe specified in respective Action Plans</td>
<td>1. Actions taken by Districts, Wards, &amp; Villages within timeframe specified in respective Action Plans</td>
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<td>2.1.3 Toolbox for cross-country knowledge exchange &amp; learning developed</td>
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<td>2.1.4 Case Studies documenting lessons learned</td>
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<td>2.1.5 Recommendations Paper on scaling use of innovative technologies for real-time monitoring</td>
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<td>2.2 Evidence-informed National Plans of Action for scaling-up models for decentralize d programme monitoring</td>
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Tools Developed including:
1. Data Collection Training Materials
2. Indicators Manual
4. Guidelines at all levels= 3.

N/A
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<td>2.2.2 End-of-Project Evaluation Report Prepared</td>
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