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MIDTERM EVALUATION OF MEASURE EVALUATION PHASE III

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ACRONYMS

AIME	AIDS Monitoring and Evaluation
BGH	Bureau for Global Health, USAID (also known as GHB)
CB	Capacity building
CBT	Capacity building and training
CDC	U.S. Centers for Disease Control and Prevention
CESAG	Centre Africain d'Etudes Superieures en Gestion (Senegal)
CLDS	District AIDS Control Council, Rwanda
CNCS	National AIDS Control Council, Mozambique
CNLS	National AIDS Control Commission, Rwanda
CoP	Community of Practice
CSI	Child Status Index
DDU	Data demand and use
DHS	Demographic and Health Survey
DOD	U.S. Department of Defense
DQA	Data Quality Assessment/Data Quality Assurance/Data Quality Audit tool
DSW	Department of Social Welfare, Tanzania
E2G	Excel to Google Earth thematic mapping tool
FMoH	Federal Ministry of Health, Nigeria
FOG	Fixed obligation grant
GAVI	Global Alliance for Vaccines and Immunizations
GBV	Gender-based violence
GFATM	Global Fund to Fight AIDS, TB and Malaria
GHB	Global Health Bureau (also known as BGH)
GHI	Global Health Initiative
GIS	Geographic information systems
HIDN	Office of Health, Infectious Diseases and Nutrition (of USAID's BGH)
HIS	Health information system
HMN	Health Metrics Network
HPN	Health, population, and nutrition
HQ	Headquarters
HSS	Health systems strengthening
IHFAN	International Health Facility Assessment Network
IMEA	Institute for Applied Medicine and Epidemiology, Senegal
INSP	Instituto Nacional de Salud Pública (Mexico)
IP	Implementing partner
JFA	Joint Financing Agreement
K4H	Knowledge for Health Project
KM	Knowledge management
LDP	Leadership development program

M&E	Monitoring and evaluation
MARP	Most-at-risk-population
MDG	Millennium Development Goal
MEASURE	Monitoring and Evaluation to Assess and Use Results Activity's Monitoring and Assessing for Results Program
MEMS	Monitoring and Evaluation Management Service
MERG	Monitoring and Evaluation Reference Group
MoH	Ministry of Health
MOHSW	Ministry of Health and Social Welfare, Tanzania
MPH	Masters of Public Health
NACA	National Agency for the Control of AIDS (Nigeria)
NASCP	National AIDS and STD Control Program (Nigeria)
NGO	Non-governmental organization
NIMR	National Institute for Medical Research
OD	Organizational development
OGAC	Office of the U.S. Global AIDS Coordinator
OHA	USAID's Global Health Bureau Office of HIV and AIDS
OVC	Orphans and vulnerable children
PAHO	Pan American Health Organization
PEPFAR	U.S. President's Emergency Plan for AIDS Relief
PHFI	Public Health Foundation of India
PHN	Population, health, and nutrition
PLWHA	People living with HIV/AIDS
PMI	President's Malaria Initiative
PMP	Performance management plan
PMTCT	Prevention of mother-to-child transmission of HIV
PLACE	Priorities for Local AIDS Control Efforts
PRH	Population and Reproductive Health (office in USAID/BHG)
PRISM	Performance of Routine Information System Management
RA	Resident Advisor (in-country MEASURE Evaluation project representative)
RBM	Roll Back Malaria Program
RDMA	USAID Regional Development Mission for Asia
RDQA	Routine Data Quality Assurance tool
RHINO	Routine Health Information Network
RHIS	Routine health information systems
SACA	States Agency for Control of AIDS (Nigeria)
SAVVY	Sample Vital Registration with Verbal Autopsy
SI	Strategic information
SPBO	Strategic Planning and Budget Office (USAID/BGH)
STD	Sexually transmitted disease
TA	Technical assistance
TAMS	Textual Analysis Mark-up System

ToT	Training of trainers
TWG	Technical working group
UEMOA	West African Economic and Monetary Union
UNAIDS	Joint United Nations Programme on HIV/AIDS
UNC	University of North Carolina
UNICEF	United Nations Children's Fund
USAID	U.S. Agency for International Development
UP-SHSPH	University of Pretoria School of Health Systems and Public Health
VLDP	Virtual Leadership Development Program
WAHO	West African Health Organization
WCA	West Central Africa
WG	Working group
WHO	World Health Organization

EXECUTIVE SUMMARY

The MEASURE Evaluation Project is a Leader with Associates Cooperative Agreement, implemented by the Carolina Population Center at the University of North Carolina, in partnership with Futures Group International, ICF Macro, John Snow Inc., Management Sciences for Health, and Tulane University. The project's current phase, Phase III (August 2008 to August 2013), has a ceiling of up to $181 million, of which about $87 million to date has been obligated. The two previous phases of the project ran from 1997 to 2008.

The project's development objective is "improved collection, analysis and presentation of data to promote better use in planning, policy-making, managing, monitoring and evaluating population, health and nutrition programs." MEASURE Evaluation Phase III is to accomplish this through achievement of the following six results related to monitoring and evaluation (M&E) data: increased user demand for data for decision-making; increased technical and managerial capacity; increased collaboration and coordination; improved design and implementation of the information-gathering process; increased availability of data, methods and tools; and increased facilitation of use. To achieve these results, MEASURE Evaluation develops methodologies, disseminates data, builds capacity, promotes best practices in M&E of health programs, and works to address country and global M&E needs.

EVALUATION SCOPE AND METHODOLOGY

This external technical evaluation is the second part of a two-part evaluative process, the first part of which was a facilitated management assessment completed in May 2011. The purpose of this technical evaluation is the following:

- To evaluate whether or not the project's activities are leading to the expected results
- To identify if there have been technical gaps that have prevented achieving results
- To identify potential technical future directions

The evaluation examines, in particular, USAID and recipient satisfaction with project activities and progress on the following three important project components: knowledge management (KM), data demand and use (DDU), and capacity building and training (CBT).

The evaluation team consisted of five individuals with expertise in M&E, KM/DDU, and CBT. It employed a variety of data collection methods to capture the wide range of project activities, including document review, in-depth key informant interviews in the U.S. and in USAID Missions, site visits to countries with substantial project activity, electronic surveys, and direct observation. Interviews with some 200 stakeholders were analyzed using a social science software program and combined with data from documents and direct observation to develop findings. Limitations included a sample size of only five site visits, all in Africa, time constraints to analyzing results, and an absence of good baseline data and outcome targets for individual activities and overall project performance.

OVERALL PROJECT PERFORMANCE

Though the project faithfully maintains performance information as agreed to in its performance management plan (PMP), this information is not very helpful for the evaluation because it contains no outcome-level performance targets by which to compare progress. Its outcome indicators relate to evidence of completed successful activity for each result. These results appear low, but for an institutional development project such as this one, where achievement of

results is a long-term process, completion of benchmarks on the road to successful activity may be more appropriate short-term indicators.

Based upon stakeholder feedback and review of documentation, the project has made good progress in its results areas. MEASURE Evaluation is widely known among USAID informants. The project is considered to have world-class expertise in M&E. Respondents who have used it are quite satisfied with its work and would use it again if need arose, with a few exceptions. Most important, informants agree that there has been a clear cultural shift toward acknowledging the importance of data—both the need for data quality and the potential uses of data. Though HIV/AIDS donor requirements promoted this, MEASURE Evaluation deserves credit for implementing activities in ways that fostered this major attitudinal change.

U.S.-based stakeholders familiar with project activities most frequently pointed to its work in development and strengthening of country health information systems, indicator development, and promotion and rolling out of useful tools. They also cited achievements in international collaboration, particularly the Roll Back Malaria (RBM) M&E Reference Group, where they said the project has added significant value in bringing donors together and developing global indicators. U.S. informants rarely noted the project's substantial work in CBT, though it is highly appreciated by country stakeholders. Many consider DDU as an area in need of more attention.

Informants identified the following areas for improvement, similar to those in the previous management assessment: slow turn-around time on some documentation requirements; insufficient qualified backup personnel to the principal researchers; uncertainty about the designation of responsibilities when there are issues; and concerns that the project's size and scope make it difficult to understand and explain, especially when there is a need to communicate its capabilities and achievements.

The project is well aligned with Global Health Bureau priorities, including the Global Health Initiative (GHI), the President's Malaria Initiative (PMI), and the U.S. President's Emergency Plan for AIDS Relief (PEPFAR). It could do more, however, to foster priorities such as health systems strengthening (HSS) through heightened attention to the organizational development (OD) factors affecting HSS and through development of indicators of progress in HSS. Though it has done substantial work on gender issues, more needs to be done in this area.

STRATEGIC PARTNERING

MEASURE Evaluation is a valued member of most international M&E working groups and is frequently called on to provide advice on groups in which it does not have formal membership. Its ability to participate in country-level, multi-agency bodies depends upon the breadth of its USAID-supported activities in-country and whether USAID has given it the mandate—and funding flexibility—to participate. Where USAID has done so, the project has an excellent track record. In those countries where the project's scope is to work with host country institutions, it makes a strong effort to ensure that the host country is "in the driver's seat," aligns its activities with national plans and strategies, uses collaborative approaches to transfer skills, and encourages use of local or regional experts to promote country ownership and South-South dialogue. MEASURE Evaluation is collaborating well, though it could reach out more systematically to other projects to share M&E experience.

KNOWLEDGE MANAGEMENT (KM)

The project's KM focus is primarily on dissemination. Project and USAID Mission staff both define KM as imparting of knowledge rather than learning from others or sharing knowledge. A focus on dissemination is too limited to effectively leverage the wealth of implementation

practices generated in the field. MEASURE Evaluation's Communities of Practice (CoPs) are underused and can promote minimal knowledge sharing, with the leader controlling a one-way flow of information. Publications are primarily reporting vehicles rather than offering critical "how-to" knowledge. The "how-to" knowledge resides in the field, but it is widely dispersed and is largely unavailable to a broad audience of M&E professionals. Needed now is the exploitation of that knowledge.

DATA DEMAND AND USE (DDU)

The evaluation team found widespread familiarity with and use of MEASURE Evaluation DDU tools among USAID staff in Washington and in the Missions, country counterparts, USAID implementing partners, and staff of international organizations. The project is attributed with achieving far-reaching success in building demand for data availability and quality, and there are some examples in the field of where these data have been used for decision-making. Tools are being used appropriately, and the project has built and reinforced cultures that demand data availability and quality. Informants uniformly view geographic information systems (GIS) work as high-quality technical input.

The DDU program as described by MEASURE Evaluation project headquarters differs from what was observed in the field and described in informant interviews. While headquarters describes a comprehensive, systematic approach to bring together data producers and users, USAID interview respondents viewed the focus to be primarily on data availability and data quality. USAID and country counterpart informants underscore a need for the project focus to go beyond raising awareness about the importance of high-quality data to more attention on data use.

CAPACITY BUILDING AND TRAINING (CBT)

MEASURE Evaluation views every request for assistance made by a Mission, a government, or an organization as an opportunity to build a level of capacity in M&E. While the project has a well-articulated capacity-building strategy for the overall project, capacity-building objectives and targets are not clearly stated at the country or activity level, except for the regional training centers. In general, the capacity that has been built is related to current needs and systems, but it is unclear to the evaluators whether the skills, knowledge, and abilities are transferable to other health elements or to future M&E needs.

MEASURE Evaluation has had an impact on building the capacity of individuals within many developing countries to independently collect, monitor, and report quality data. This success has contributed to a shift in how people view the value of health data, though many informants stated that the ability to use data has not yet improved.

MEASURE Evaluation has built M&E capacity at the organizational level. The project offers a number of developmental programs that help organizational teams build leadership and management skills and identify organizational barriers to improving M&E systems using management system assessment tools. The project's two leadership development training programs are highly regarded by participants and have costs comparable to similar programs in the U.S., but have not yet attracted much Mission financing. Beyond leadership and management training, however, the project has not yet fully incorporated organizational development into its CBT plans and activities.

In many countries, MEASURE Evaluation has had an impact on developing capacity at the national health system level. Most often, it has done so by working with governmental organizations or technical working groups (TWGs) that include multiple agencies. Mission staff

surveyed cited significant results within their countries from MEASURE Evaluation's assistance. Some work has been done at the district and community levels; however, these health system levels need more attention to become independent in their M&E capabilities. More attention is also needed on monitoring service delivery in the private sector.

There is a high demand for M&E training programs, and training participants report satisfaction with the format and content of the courses. Observation of training programs during the country site visits highlighted a number of excellent training practices, including targeting to specific audiences; use of interactive techniques; and selection of examples drawn from the region. Adding other good training practices could further improve their effectiveness.

After extensive support to regional training institutes, their faculty members are mostly capable of delivering courses independently, with their limited support MEASURE Evaluation. The M&E courses the centers provide are indeed improving the capacity of individuals trained. Demand is higher than they can accommodate. Even so, long-term financial sustainability is a major concern.

TECHNICAL NEEDS

Asked about priority M&E needs, most informants agreed on some common areas, including finding better ways to monitor and evaluate HSS and CBT progress, identifying gender-based factors limiting access to services, and evaluating the cost-effectiveness of alternative interventions. Other needs were for advocacy of data use and rapid assessments of health outcomes.

SUMMARY OF KEY RECOMMENDATIONS FOR REMAINDER OF PROJECT LIFE

- To better evaluate project achievements, establish end-of-project targets for all outcome indicators in the PMP, and for significant new activities, include baseline information and outcome targets in the design.
- For enhanced KM, promote a broader definition, one that encourages field staff to reach out to others working on similar issues and encourages others to share those lessons through inexpensive social media tools such as Skype conferences and webinars. Shift CoPs to a platform with greater capability and availability of a larger range of social media.
- Encourage greater data use by focusing on bringing together data collectors and data users, where possible, in organizational teams, and by building skills in advocacy and communications related to data use. Encourage DDU work at subnational levels.
- To better evaluate CBT progress, identify indicators and targets for progressive levels of capacity built at all levels of the health system. In countries with large programs, develop capacity-building plans at the national level that outline specific goals and planned activities but that also continue to allow for unplanned opportunities to add capacity-building activities.
- Put more emphasis on building strong organizations by setting specific targets for organizational development (OD) and including OD in other requested activities. This will require advocacy to convince Missions of the importance of OD in effective M&E systems and a strategic vision of how OD can improve sector-wide performance in M&E.
- Focus OD of the regional centers on developing short- and long-term strategies for technical and financial sustainability through strategic planning and developing an advocacy strategy.

- Build capacity of governments and individuals to systematically incorporate gender considerations into routine health information systems (RHIS). Measurements of social, legal, health, and other indicators affecting the health of women, girls, and at-risk populations can then be used to inform the design of projects and activities.

FUTURE PROJECT STRUCTURE

There is clear need for a follow-on M&E activity with the following characteristics: flexibility to respond to changing needs and priorities; ability to address crosscutting, global issues; built-in mechanisms to foster synergies among project components; mechanisms to promote sharing of regional expertise; a greatly enhanced KM function that focuses on the "how-to;" modeling of best practices in evaluation by including baseline and targets for each indicator in the project design, including benchmarks for progress on outcomes, and by building outcome-level evaluation data into CBT activities; and mainstreaming of OD concepts into all results areas. The follow-on activity should have a "Dare to Fail" fund that promotes experimentation and a grant mechanism to provide funds to in-country organizations to carry out M&E activities and foster country ownership.

I. INTRODUCTION

BACKGROUND

The Monitoring and Evaluation to Assess and Use Results Activity's Monitoring and Assessing For Results program, known as the MEASURE Evaluation Project, is a Leader with Associates Cooperative Agreement, implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill (UNC), with five implementing partners: Futures Group International, ICF Macro, John Snow, Inc., Management Sciences for Health, and Tulane University. The project's current phase (Phase III), which began in August 2008 and will end in August 2013, has a ceiling of up to $181 million, of which about $87 million to date has been obligated. The two earlier phases of the project ran from 1997 to 2003 and from 2003 to 2008.

The project's development objective is "improved collection, analysis and presentation of data to promote better use in planning, policy-making, managing, monitoring and evaluating population, health and nutrition programs." This will occur through achievement of the following six results:

1. Increased user demand for quality information, methods, and tools for decision-making
2. Increased in-country individual and institutional technical/managerial capacity and resources for the identification of data needs and the collection, analysis, and communication of appropriate information to meet those needs
3. Increased collaboration and coordination in efforts to obtain and communicate health, population, and nutrition data in areas of mutual interest
4. Improved design and implementation of the information-gathering process, including tools, methodologies, and technical guidance to meet users' needs
5. Increased availability of population, health, and nutrition data, analysis, methods, and tools
6. Increased facilitation of use of health, population, and nutrition data

To achieve these results, MEASURE Evaluation develops new methodologies, disseminates data, builds capacity, promotes implementation of best practices in monitoring and evaluation (M&E) of health programs, and works to address country and global M&E needs.

Project activities are organized into two categories: core-funded and field-funded activities. Core-funded activities comprise Global Health (GH) Bureau-wide activities and element-specific activities. The former features crosscutting activities that contribute to better monitoring and evaluation across health elements.[1]

PURPOSE

This external technical evaluation is the second part of a two-part evaluative process, the first part of which was a facilitated management assessment completed in May 2011. Together, the two-part process is intended:

- To assess project performance and compare results with objectives outlined in the agreement
- To gather information that will help to improve the management of the project

[1] The health elements are HIV/AIDS, tuberculosis, malaria, avian influenza, maternal and child health, family planning and reproductive health, other public health threats, and water supply and sanitation.

- To gather information that will result in recommendations for a potential future project

Specifically, the purpose of this external technical evaluation is three-fold:

- To evaluate whether or not the project's activities are leading to the expected results
- To identify if there have been any technical gaps that have prevented achieving intended results
- To identify potential technical future directions

KEY EVALUATION QUESTIONS

Following is a summary of the key evaluation questions found in Appendix A, the scope of work:

- How satisfied have stakeholders, including country-level stakeholders and the Global Health Bureau (GHB), been with the project's work in Phase III, particularly the project's work on the Bureau-wide agenda, and how strategically has the project partnered with others to achieve results?
- What are the gaps and technical needs that should be addressed, and what would be the best project structure for addressing those needs?
- How useful, appropriate, and timely have the project's DDU and KM products been?
- How well have its CBT activities met the needs of stakeholders and increased capacity at national, subnational, and organizational levels?

METHODOLOGY

The five-person evaluation team consisted of a team leader with M&E expertise, two KM specialists, and two OD specialists. The USAID project management team consulted with the team on development of the workplan and data collection methods.

The evaluation used five primary data collection methods: review of key documents; in-depth key informant interviews both in the U.S. and in countries visited by team members; focus group discussions; on-line surveys; and direct observation.

Documents included reports and publications of USAID and MEASURE Evaluation that describe expectations and progress (found in Appendix C). Team members reviewed the project website as well as CoP and online forum discussions.

Key informant interviews with stakeholders in the U.S. and country Missions were conducted in person, by telephone, or by e-mail. Interviews followed a semi-structured format, using an interview guide that allowed for relevant unplanned discussions. In all, 70 U.S.-based individuals were interviewed, representing USAID, the project, other U.S. Government agencies, international agencies, and NGOs. Members of 14 USAID Missions outside of countries visited were interviewed or responded to e-mail questions. (Appendix B lists individuals interviewed; Appendix D contains questionnaires and survey instruments.)

Team members visited four countries with substantial investments in MEASURE Evaluation—Mozambique, Nigeria, Rwanda, and Tanzania—as case studies of the technical areas of interests, capacity building, and KM/DDU. In addition, an OD team member visited the Centre Africain d'Etudes Superieures en Gestion (CESAG), a regional training center in Senegal that has benefited from successive project investments. (Summaries from country visits are in Appendix H.) Besides conducting key informant interviews, evaluation team members observed events such as training programs and held group discussions with former project trainees. In total, the

site visit teams received inputs from 128 country-based individuals representing government organizations, implementing partners (IPs), USAID, NGOs, other donors, and trainees.

The evaluation team issued brief surveys to the following four CoPs to obtain data on the use of CoPs as a KM tool: the Bureau of Global Health (BGH) M&E Working Group (WG) the Routine Health Information Network (RHINO), the Child Status Network, and the M&E of Malaria Network. The team also reviewed results of surveys carried out earlier by the project of the DataUse Net and the AIDS Monitoring and Evaluation (AIME) Net.

Finally, team members directly observed the project's annual all-staff meeting and the semiannual meeting of the BGH M&E WG, which the project chairs.

The team used a social science software program (Textual Analysis Mark-up System, or TAMS) to code into key categories, sort, and analyze notes from the large number of interviews conducted. These results were compared with findings from documentation and direct observation to produce the team's findings. (Coding categories are in Appendix E.)

LIMITATIONS TO METHODOLOGY

Lack of Baseline Data or Outcome Targets: A severe limitation was the lack of baseline data for individual activities and lack of outcome-level data for either individual activities or program-level indicators. The study questions necessitated that the evaluation team make a determination about levels of satisfaction, usability, appropriateness, and timeliness in relation to DDU, KM, and CBT. Each of these terms (satisfaction, usability, appropriateness, and timeliness) is comparative, rather than absolute, and necessarily raises questions of degree. The assessment of comparative terms is more appropriately made in terms of expectations, which were absent.

Sample Selection: The site visit data collection was limited to five countries in Africa, drawn as a purposive sample based on a relatively large dollar amount of field support, the presence of a Resident Advisor (RA) in country, and a portfolio of activities that were relevant to the evaluation questions. The use of a convenience sample rather than a randomly drawn sample limits the generalizability of the study findings; for example, the findings may not generalize to countries without an RA present, or to countries in other regions such as Latin America. The telephone interviews conducted with 14 field Missions served to mitigate some of this risk.

Selection of Informants: Although the interviewers had some input into which organizations were interviewed, the USAID management team selected U.S.-based informants, and project personnel selected interviewees for site visits with review by USAID Mission activity managers. The site visit interviewers primarily interviewed technical, M&E people. Interviews with senior managers might have offered a different or broader perspective.

Time Constraints: The time from initiation of the study to the completed report was about two months, limiting time for data collection, analysis, and writing. Interviewers spent only five days in each country and two days with CESAG, the regional training institute in Senegal. With one exception, time was inadequate for interviews at the province level or below.

II. PROJECT PERFORMANCE

FINDINGS

Performance Against Expected Results

USAID's primary means for monitoring project performance is by review of progress on the indicators found in the project's PMP. MEASURE Evaluation III has developed and refined a PMP that includes meaningful outcome indicators as well as output indicators for each result area. It is clear that project staff take seriously monitoring progress on these indicators. Instances of performance cannot be counted as results for a particular indicator unless they have been clearly justified and, for the most important indicators, approved by the project director. The project does not provide a full PMP assessment in its annual report to USAID, though it does include numbers and examples for some key indicators.

Table 1. Measure EVALUATION III Results and Illustrative Key Outcomes

Results (shortened) and Illustrative Key Outcomes[2]	Task Order	Year 2	Year 3
Result 1: Increased user demand 1.1: Instances where country organizations or programs request and/or secure non-USAID funding for M&E or health information system (HIS) staff and/or activities as a result of MEASURE Evaluation activities	1	2	5
Result 2: Increased individual and institutional technical/managerial capacity 2.1: Instances of regional, national, or subnational institutions assisted in M&E/HIS strengthening by MEASURE Evaluation that demonstrate increased capacity to independently carry out M&E/HIS activities	3	5	11
Result 3: Increased collaboration and coordination 3.1: Instances of outputs produced by international or national communities of practice or coordinating mechanisms in which MEASURE Evaluation had a leadership role	11	7	9
Result 4: Improved design and implementation of the information-gathering process 4.1: Instances of M&E or HIS systems with demonstrated improvement in system performance	6	5	5
Result 5: Increased availability of data, analyses, methods, and tools 5.1: Instances of key actionable research findings, experiences, and/or lessons learned from data analysis, methods, or tools developed by MEASURE Evaluation that are available to decision makers and/or stakeholders	12	16	28

[2] Though we have selected only one outcome indicator for each result in this table, there are others. Year 1 results are excluded because the project was in start-up mode and few results could be expected that year. The task order year was included for comparison purposes. All indicators are annual counts, with baseline at zero.

Table 1. Measure EVALUATION III Results and Illustrative Key Outcomes			
Results (shortened) and Illustrative Key Outcomes[2]	**Task Order**	**Year 2**	**Year 3**
Result 6: Increased facilitation of use 6.1: Documented/reported instances in which information is used as a result of MEASURE Evaluation activities in decision-making in programs, policy, or advocacy	3	3	7

Comparison of results under the key outcome indicators in each results area for the period of the task order (Years 2 and 3) lend the following conclusions:

- Results through Year 3 show steady achievements on key outcomes in all results areas.
- Relative to small budgets allocated to them, Results areas 1 and 6 are showing good achievement, particularly in comparison with other, better-funded results areas. This may be a result of the attention the project is rightly placing on DDU.[3]
- All results seem quite low for the amount of money going into the project and number of field Missions supported.

All of these conclusions are highly tentative, however, for the following reasons:

- It is not possible to know what the expected or hoped-for level of achievement was at the start of the project, given the absence of targets for any indicators that could provide a basis for comparison. USAID did not require the project to establish targets primarily because it is difficult to set global, life-of-project targets for field-based, demand-driven programs.
- One cannot compensate by looking at progress on individual activities, since neither baseline information nor outcome targets have been established for most of these.
- The approved indicators do not appear to capture the breadth and depth of project activity. They are "completion" indicators that cannot be "counted" until an outcome has been entirely achieved. In institutional development, which occurs over years, milestone indicators that demonstrate an organization's growing maturity offer a better assessment of progress than completion indicators.

For these reasons, the PMP and its related indicators are not useful management tools for assessing project progress or levels of achievement.

Stakeholder Satisfaction with Project Performance

MEASURE Evaluation is widely known among USAID informants, and nearly all, even those in USAID/Washington who are not very familiar with its activities, distinguish it from MEASURE DHS[4] and have some understanding of its purpose and reputation. The project is considered to have world-class expertise in M&E. Respondents who had used it were quite satisfied with its work—even effusive—and would use it again if the need arose, with a few exceptions. Field

[3] In years 1 through 3, result areas 1 and 3 have captured only 3% each of total obligations, compared with 31% for Result 2, 47 percent for Result 4, and 13% for Result 5. Result 2 also received 3% of obligations. Of course, though every activity is assigned a primary result area, many activities have components of several results areas, so these percentages have to be taken as rough estimates only.
[4] The Demographic and Health Survey (DHS) program under the MEASURE Activity is a separate procurement with separate implementing agencies, funding ceiling, and results, and is not part of this evaluation.

Missions that had not used the project had other resources they could tap for M&E services, but expressed no negative views on the project.

When asked about its achievements, U.S.-based stakeholders familiar with project activities most frequently pointed to its work on Result 4 (improvements in the information- gathering process), in particular development and strengthening of country RHIS and HIS, indicator development, and promoting and rolling out useful tools, including Performance of Routine Information System Management (PRISM), Child Status Index (CSI), and Data Quality Assessment (DQA) tools.[5] The next most frequent result area cited was Result 3 (collaboration and coordination), especially the project's contributions to the RBM Monitoring and Evaluation Reference Group (MERG), BGH M&E WG, and work with the World Health Organization (WHO), the United Nations Children's Fund (UNICEF), the Pan American Health Organization (PAHO) and others on specific activities. Respondents were able to point to contributions that they felt added value to the partnerships. Despite the emphasis the project places on capacity building, only two respondents outside of the USAID management team cited the project's work in this area. Only one respondent considered the project's work in DDU as one of its key achievements in Phase III, while another thought the project was unsuccessful in getting data tools used.

Field respondents had a different perspective. Result 2 (capacity-building) activities were cited nearly as frequently as activities under Result 4, responses were in all cases specific, and many respondents went beyond describing the capacity-building activity to describe the outcome: what host country individuals can now do on their own as a result of the activity. A few respondents gave examples of how the project's work led to increased demand for and use of data for decision-making. Field respondents recognized the project's work in collaborating on multidonor working groups, though in only a few cases did they call it a key achievement.

Following are some common themes among respondents both in Washington and in the field concerning improvements the project could make:

- Several respondents commented on the project's slow turn-around time. It generally had to do with preparation of documents, ranging from workplans to PMPs to reports.
- Some feel the project is stretched too thin, and as a result uses junior, less-qualified people on activities that it doesn't consider to be a high priority.
- Some respondents are confused about whom to go to, either within the project or in the USAID management team, when there are issues and the individual assigned to the activity is unavailable. This is attributed partly to the absence of qualified back-up personnel to the principal researchers.
- There are some U.S.-based stakeholders who consider the project to be too big and complicated for them to understand its activities and whether or not they are useful. Unaware of the project's emphasis on capacity-building, some respondents question whether the project is doing enough to foster country ownership of improvements in data collection and quality.
- Several respondents, both in USAID and in the project management team, feel that the project has been swamped by the requirements for HIV/AIDS, to the detriment of other health elements.

[5] Performance of Routine Information System Management (PRISM), Child Status Index (CSI), Data Quality Assessment/Assurance (DQA).

Other Findings on Project Performance

Review of the PMP and other documents, discussions with informants in the U.S. and in the field, and direct observation lead to some broader findings on the project's performance.

- Most important, there has been a clear cultural shift toward the importance of data, need for data quality, and potential uses of data. Though U.S. President's Emergency Plan for AIDS Relief (PEPFAR) and the Global Fund to Fight AIDS, TB, and Malaria (GFATM) monitoring requirements had much to do with this, MEASURE Evaluation deserves credit for implementing activities in ways that fostered this culture shift.
- The project has not incorporated ways of systematically evaluating its activities and progress. Each activity should have baseline and outcome targets. The project should model the M&E features it asks recipients to implement.
- Related to the above, there seems to be some inconsistency in work scopes and workplans at the country level. What is often lacking is a conceptual framework, indicators, and targets, with relevant benchmarks for graduation, and a section on how data will be more effectively utilized to improve programs at the national, subnational, and community levels. The team noted that USAID doesn't provide templates for this purpose. These would add cohesiveness to the project activities and provide for evaluation of activities, if used in countries with larger programs and RAs.
- The past focus has been on monitoring. With the Agency's new evaluation policy, there is a strong desire within USAID to see MEASURE Evaluation take leadership in evaluation guidance and methodology.
- Organizational development (OD) has not been fully integrated into project structure or activities. There is recognition, both within MEASURE Evaluation and among stakeholders, of the need to bring together data collectors with decision-makers if data are to be used, but the importance of OD to this process is not clearly stated or, we think, internalized. This cannot happen overnight, but can happen sooner with a stronger effort.
- There are increasing concerns about costing and cost-effectiveness of alternative activities and a desire for MEASURE Evaluation to provide support in this area.
- Informants do not see MEASURE Evaluation's activities in Phase III as particularly innovative, though a few important innovations were noted. This was attributed partly to the low priority USAID field Missions place on evaluation research, and the emphasis Phase III places on data use rather than on new tool development. However, there are plenty of areas where innovation is needed. For example, several USAID informants have expressed a need for developing ways of obtaining data on health outcomes through inexpensive, rapid assessment means between Demographic and Health Surveys (DHSs).[6] Areas of innovation that respondents were excited about include the project's geospatial work, the Excel-to-Google Earth thematic mapping tool (E2G) methodology, and the community trace and verify tool.

Project Adherence to Global Health Bureau Priorities, Including Presidential Initiatives

The project is considered well aligned with Global Health Initiative (GHI) priorities. In reports and CoPs, project staff make an effort to link activities and subject matter with GHI. They are leaders in M&E, with an understanding of the rigor USAID needs and the importance of basing decisions on evidence—important aspects of GHI and of the new USAID evaluation policy. They have been mindful of incorporating PEPFAR and PMI principles into their work in HIV/AIDS and

[6] Demographic and Health Surveys (DHSs) are generally carried out every five years.

malaria. There are a few concerns, however, especially related to gender and to health systems strengthening.

Table 2. GHI Principles and Informant Views on MEASURE Contributions

GHI's Seven Principles	Informant Views on MEASURE Evaluation's Contribution
Strengthen and leverage key multilateral organizations, global health partnerships, and private sector engagement	It has played an important role on international monitoring and evaluation bodies (e.g. MERGs, TWGs) and is generally appreciated and admired for its participation. Informants can cite specific examples of project contributions.
Increase impact through strategic coordination and integration	The project is a member of all key global and regional M&E working groups and is viewed as a strong contributor. Project staff often participate in country-level TWGs as well. Bureau-wide activities and work with RHISs strengthen integration.
Implement a woman- and girl-centered approach	It has done good work in gender, especially development of gender-based violence (GBV) indicators and collaboration with international partners on a compendium of gender indicators, but much more work is needed in this area. There is some concern that the project is not well enough staffed to take this on at the needed level.
Encourage country ownership and invest in country-led plans	The project's country-level work is widely considered to build on country systems and plans where possible.
Build sustainability through health systems strengthening	Project support for improvement and use of RHISs is viewed as an important element of HSS, but some point out that OD and leadership needs for strong health systems have not been adequately addressed.
Improve metrics, monitoring, and evaluation	The project's technical capacity in monitoring and evaluation for health is nearly universally considered outstanding.
Promote research and innovation	Informants feel that research has had a lower priority and less funding in Phase III.

Some Washington-based informants believe MEASURE Evaluation is well-placed to help in development of indicators to track performance on the seven GHI principles and to establish an evidence base for GHI principles (e.g., that integrated programs are more effective than vertical programs and that country ownership is critical for sustainability of systems). Evaluation experts in USAID and in the project point out, however, that these subject areas must be well-defined before research can be undertaken or indicators defined. Further, some principles lend themselves more to research or evaluation methods than to indicators that can be tracked regularly, and some may be too broadly defined for evaluative research to be effective at all.

Global Health Bureau-wide Agenda

USAID staff involved in the process agree that there is no Bureau-wide agenda. The contribution each office is expected to make for the Bureau-wide agenda is proportional to that office's portion of overall core funding. MEASURE Evaluation suggests the specific activities based on the projected budget, then GHB offices meet together to decide which activities they are willing to fund. What the three offices agree to is what gets funded, "which isn't necessarily the highest priority activities." There are two problems with this process: first, the Bureau is reacting to

proposals rather than determining its own priorities; second, the offices consider the budget process unfair. From a MEASURE Evaluation standpoint, leaving some flexibility in the Bureau-wide agenda is critical to "get new ideas out there regarding DDU and OD" and to "put the pieces together" by going beyond immediate needs in the field and fitting these activities into a more cohesive, strategic approach. For this reason, it is important to get MEASURE Evaluation's inputs on the Bureau-wide activities that should be funded. Nonetheless, GHB offices should be more proactive in ensuring that the issues of greatest interest to them are considered.

Discussed in Section VII of this report are some M&E needs about which respondents agree and on which a Bureau-wide M&E agenda could be based. GHB's Strategic Planning and Budget Office (SPBO) attempted this year to introduce a more rational process for determining the Bureau's M&E agenda, though it has not yet progressed and does not change the budgeting process. The funding provided by each office or program element for Bureau-wide activities has little relationship to the funding levels from field support or centrally funded health element-specific support. Yet if Bureau-wide activities are to provide the global leadership, capacity-building, and knowledge-sharing that will inform field activities, there is a case to be made that the core funding allocated to Bureau-wide activities should, to some extent, reflect the funding priorities of field support and overall element-specific support.[7]

Table 3. Comparison of Funding by Office and Program

Office/ Element	Bureau-wide Obligations	Field Obligations	Core Element-specific Obligations	Field Plus Core Element Specific	Percent of Bureau-wide	Percent of Field Support	Percent of Field Plus Core
FP/RH[8]	3,250,000	4,153,000	n.a.		35.0	7.5	5.6
HIV/AIDS	2,403,300	39,460,034	12,364,790	51,824,824	25.9	71.1	70.3
HIDN:	3,631,400				39.1	21.4	24.1
• MCH		6,140,000	902,000	7,042,000		11.1	9.6
• Malaria		4,335,800	3,825,600	8,161,400		7.8	11.1
• TB		567,000	450,000	1,017,000		1.1	1.4
• Avian Influenza			625,000	625,000			0.8
• Nutrition & Water Sanitation		800,000	50,000	850,000		1.4	1.2
					100%	100%	100%

USAID's Global Health Bureau Office of HIV and AIDS (OHA) contributes substantially less than USAID's BGH Population and Reproductive Health (PRH) or USAID's BGH Office of Health, Infectious Diseases and Nutrition (HIDN) to Bureau-wide funding, despite high levels of field support and HIV-specific core funds. This is in part because of restrictions on PEPFAR funding. While PRH has its own associate award and has very little field support, it provides

[7] See Appendix 6 for dollar amounts that back up this percentage breakdown.
[8] PRH has its own associate award, which accounts for the limited element-specific support for the leader award.

more than a third of Bureau-wide funding. HIDN's contribution is nearly 40%, though its element-specific core and field support contribute less than a quarter of the total. On the other hand, the large contributions of PRH and HIDN to Bureau-wide funding may provide something of a counterbalance to the heavy field support contributions in HIV/AIDS, as they help ensure that Bureau-wide activities are indeed of value to health as a whole rather than primarily to HIV/AIDS. Nonetheless, a larger share from OHA may be more equitable to the other offices.

RECOMMENDATIONS FOR THE REMAINDER OF THE PROJECT

1. The project needs to begin developing the data to enable more conclusive evaluation results. This includes setting life-of-project targets for each indicator. New activities—at least large activities in countries with significant investments—should begin with baselines and include targets not just for outputs but for outcomes. Cost-effectiveness or costing data should be included where relevant. The USAID management team should make this a requirement for approval of activities.
2. Assuming funds can be obtained, for example through Bureau-wide funding, the project should be given the mandate to develop guidelines and methodologies to implement the new Agency evaluation policy within the health area.
3. The USAID management team and MEASURE Evaluation should agree on how the project can engage more in work on gender, measurement of HSS progress, and cost-effectiveness.
4. If SPBO fails to do so, the USAID project management team should initiate a process of working with GH offices to determine priorities for the project's Bureau-wide funding component. The project's Stakeholder Engagement Tool, with an unbiased Bureau staff member facilitating, could be a valuable way of reaching agreement on overall priorities, leaving room for project inputs as well. As part of this, the team should consider requesting a change in office allocations to the Bureau-wide program.

III. STRATEGIC PARTNERING

FINDINGS

The evaluation scope of work asks "How strategic has MEASURE Evaluation been in partnering with other stakeholders and donors to achieve the greatest results?" There are several types of partnering: participation in global, regional, and country-level multi-agency fora or less formal partnering with an international organization or group of organizations to accomplish a specific task; participation in U.S. Government interagency WGs related to PEPFAR or PMI; partnering with host countries; and collaboration with other USAID IPs. In most of these, MEASURE Evaluation's role has been both strategic and highly valuable, according to key stakeholders.

Global, Regional, and Country-Level M-Agency Fora

MEASURE Evaluation is a valued member of most international M&E WGs and is frequently called on to provide advice on groups in which it does not have formal membership. The project's international collaboration includes, but is not limited to, the RBM MERG, the UNAIDS MERG, the International Task Team on prevention of mother-to-child transmission of HIV (PMTCT) MERG, the most-at-risk population (MARP) MERG, the GIS TWG, the UNAIDS West and Central Africa TWG, the Country Health Systems Surveillance group with WHO, the Global Alliance for Vaccines and Immunizations (GAVI) DQA WG, and the Health Metrics Network (HMN). As an international agency respondent put it, "They are technically very sound, so they bring their technical capacity and skills and share willingly."

USAID allocates funds to the project specifically to provide global leadership, and this enables project staff to contribute their expertise substantially to these fora. Through provision of sound technical contributions, the project has built a reputation that gives it influence in development of globally accepted tools, methods, and indicators. One of the project's current international efforts is participation in development of a Compendium of Gender Indicators. The process of obtaining international agreement on this is a time-consuming process that is causing frustration both among project staff and in USAID. Achieving agreement globally in such bodies is always difficult and often slow, but when the result is an internationally recognized procedure, tool, or policy that eliminates duplication and reduces the reporting burden on recipient governments, it is worth the effort.

MEASURE's ability to participate in country-level multi-agency bodies depends upon the breadth of its USAID-supported activities in country and whether USAID has given it the mandate—and funding flexibility—to participate in these groups. Where USAID has done so, the project has an excellent track record. In only a couple of countries did respondents feel that the project had not made an important contribution to country-level and regional groups.

U.S. Government Interagency TWGs

MEASURE Evaluation contributes substantially to U.S. Interagency TWGs. One U.S. Government informant said, "One of the things MEASURE Evaluation has done is facilitated conversation across agencies and with multilaterals around standards for doing technical work. They have been extremely valuable from that point of view. The E2G course was developed by the project, but coordinated inputs from a variety of players. It was a good example of not being parochial, but looking at the big picture."

At the headquarters level, PEPFAR informants outside of USAID did not understand the full scope and purpose of the project. Some were not aware of its focus on capacity-building and for this reason were concerned about the project's "lack of transparency," but acknowledged that

the project has "left a big footprint" in terms of developing tools that all U.S. Government agencies can use. PEPFAR informants see a continuing role for the project in transferring skills to host countries to ensure country ownership and in finding ways to measure progress in capacity-building.

At the country level, the project's role in U.S. Government TWGs is dictated by the scope of USAID-funded activities and by the relationships among U.S. Government agencies in country. Where it is included on the PEPFAR Strategic Information (SI) TWG, MEASURE Evaluation is considered a valuable partner.

Partnering with Governments and Host Country Institutions

Since this topic is discussed in Section VI on capacity-building, suffice it to say here that in those countries where the project's scope is to work with government and host country institutions, it makes a very strong effort to ensure that the host country is "in the driver's seat," aligns its activities with national plans and strategies, uses collaborative approaches to transfer skills, and encourages use of local experts—or experts from the region—to promote country ownership and South-South dialogue. As one USAID informant said, "They naturally choose local individuals who can do the work, rather than calling on their own staff."

Collaboration with Other IPs

In the U.S., MEASURE Evaluation serves as secretariat for the Global Health Bureau (GHB) M&E WG, consisting of all GHB-funded project partners. This is the primary vehicle for central-level cooperation on M&E. At the field level, in those countries where the project scope calls for working with in-country IPs (for example on indicator development and DQA), the project has a good reputation for working collaboratively with other IPs. Talking of one DQA exercise, the USAID informant said of the project, "They did extraordinarily well in coordinating with other implementing partners—who were the object of the assessment—to get their buy-in and cooperation." Another informant added a caveat and advice: "While the organization has always shown a willingness to collaborate with all in-country partners, this has been at times challenging, . . . underlying issues being the absence of mutual agreement on priorities among partners and limited interaction among stakeholders. The SOW needs to be clear on outlining the key collaborating partners and MOUs[9] developed to ensure agreement on priority activities and approaches."

The team found few examples of MEASURE Evaluation reaching out to other projects to share issue-specific methods or advice, even when a project subpartner is working in the country as an IP on another project, although project staff advise that this happens informally and therefore may not be apparent in documentation. There are exceptions. In Rwanda, project staff collaborate with Monitoring and Evaluation Management Service (MEMS) and the Integrated Health Systems Strengthening Project. In general, there may be reluctance to reach out because of funding issues, or simply because of competition among different IPs.

Collaboration with the Private Sector

The team found no examples of project collaboration with the private sector other than NGOs and, in the case of Tanzania, capacity-building work with a local consulting firm. This absence is likely because USAID Missions have not included private-sector organizations in their agreements with the project; however, given the importance of the private sector in health care provision in the developing world, this is an area that should get more attention in the future.

[9] Memoranda of understanding.

RECOMMENDATIONS FOR THE REMAINDER OF THE PROJECT

MEASURE Evaluation is doing a good a job as possible on collaboration, when USAID allows it. The project should be commended on its outstanding work in furthering collaboration in the international community and within countries. Following is the one recommendation made concerning strategic partnering:

1. Project staff in the U.S. and in the field should be encouraged to look for opportunities to share knowledge and techniques, and, where possible, collaborate on activities with IPs working in the same or similar areas, when both partners could benefit from doing so.
2. MEASURE Evaluation should use what is known from the field of social networking, including social network analysis, to teach field staff how to be strategic in their partnerships.

IV. KNOWLEDGE MANAGEMENT

FINDINGS

Project KM Strategy

The project's KM strategy, as it is operationalized through the lines of action listed in the MEASURE Evaluation KM Strategy,[10] is

- To expand effective processes for publications and communication, e.g. online, CDs, paper, website, newsletter, and conferences
- To promote communities of practice in M&E
- To make data available and facilitate access to them
- To foster an organizational culture of knowledge-sharing
- To collaborate with the broader MEASURE family such as USAID's Knowledge for Health Project (K4H) to better access relevant data and to integrate KM into their M&E work
- To facilitate knowledge sharing, use, and management with the USAID community
- To take advantage of new technology

Funding for KM supports five personnel. The project strategy has been to avoid making KM a separate siloed function. Hugh Rigby, who leads KM efforts, said: "Before Phase III started, I identified the communication activities currently in the project and re-labeled them 'KM' and expanded them. I didn't want others to feel that we were setting up another area of activity that would have to be funded, so I presented it as something that everyone was doing already and that we needed to put more emphasis on it and rethink it as necessary."

Progress on PMP Indicators Related to KM

Result 1 (increased collaboration and coordination in efforts to obtain data) and Result 5 (increased availability of data, analyses, and tools) both relate to KM. The PMP Year-3 achievements for Results 3 and 5 are in Appendix F, labeled as Tables 1 and 2 respectively. These results indicate, in summary, that membership in the M&E CoPs, as well as the number of M&E CoPs, continue to increase. However, the number of discussion threads and the number of members who post to the CoPs is low, e.g., 29 new threads posted and 63 members who posted in Year 3. KM has been successful in producing and making available publications through the website. In particular, the number of publications downloaded by non-MEASURE Evaluation users in Year 3 is impressive: 295,361.

Results of Surveys of CoPs

The evaluation team conducted an online survey (using Survey Monkey) of three online CoPs—the Routine Health Information Network (RHINO), the Child Status Network, and the M&E of Malaria Network—and one network that so far functions as a face-to-face CoP—The BGH's M&E WG. Appendix F displays the response rate in Table 3 and the responses in Table 4.

The surveys indicate that respondents in the online communities primarily read (79%) rather than actively participated in discussions. Most (88%) would like to move from a listserv to a collaborative platform. Respondents also want more active features, for example, yellow pages (57%) to facilitate contacting other members, webinars (49%), and teleconferences (47%).

[10] October 29, 2009.

Responses from the Global Health M&E Network were similar in regard to webinars (50%) and yellow pages (63%). In the Global Health M&E Network, a larger percentage of people emailed each other and benefited by learning about what others are doing (80%).

The team joined and then followed two communities (electronic mailing lists) over a period of two months. Most content related to announcements, job postings, links to studies, and newsletters from other organizations, though one week-long discussion forum occurred.

The team also reviewed results of two surveys carried out previously by the project—one on DataUse Net and one on AIDS monitoring and evaluation (AIMENet.) The AIMENet study reported that participants wanted a more active format, while the DataUseNet study conducted in 2010 found participants satisfied with the current electronic mailing list format.

Interview Results on Knowledge Management

Interviewees were asked if they used the MEASURE Evaluation website, if they subscribed to *Monitor*, and if they belonged to a MEASURE Evaluation-sponsored CoP.[11] Interviews conducted from Washington show a considerably less positive picture than do the numbers from the PMP third-year results. Of the Washington interviewees, 19% reported using the website; 13% read *Monitor*; and 20% belonged to a MEASURE Evaluation CoP. The site-visit interviews provided even lower percentages of activity. Only 12% used the website, less than 1% read *Monitor;* and 11% were members of a MEASURE Evaluation CoP. Some respondents had heard about one or more of the initiatives, but did not engage in them. Others visited websites other than MEASURE Evaluation's site. Several people cited a language barrier as a reason for non-use, while others simply said they were too busy. Some mentioned that the website was too hard to navigate, while others noted it was now much improved. The most common response was "I haven't heard of it," whether it was the website, *Monitor,* or the CoPs.

Findings on Project Performance in Knowledge Management

Based upon the data and results described above, the following broad findings emerge:

- The project's KM focus is primarily on the dissemination of publications. Project and USAID Mission staff similarly defined KM as the number of publications produced rather than the broader idea of learning from others or sharing knowledge with others. A focus on dissemination is too limited to effectively leverage the wealth of implementation tactics and practices that are being generated in field offices.
- There is room for the KM team to take a more proactive approach to building communities. However, current staffing levels for KM may prevent staff from providing greater levels of community support. Help is offered when requested and CoP moderators have met at all staff meetings to share experience. Checklists for how to start and manage a community have been prepared and shared, but there was little evidence of more comprehensive or systematic training. There has been a two-day training of moderators, and a new community for CoP moderators has formed. Beyond that, each CoP leader (moderator) is free to manage the community based on his/her time, availability, and interest.
- MEASURE Evaluation's CoPs are underutilized and able to promote only minimal knowledge- sharing among members. The format of most CoPs mirrors the headquarter's definition of KM as the dissemination of knowledge, with the leader controlling a one-way flow of knowledge. Even periodic fora require members to send responses to the leader who then posts them. While the hosted discussions have generated interest and

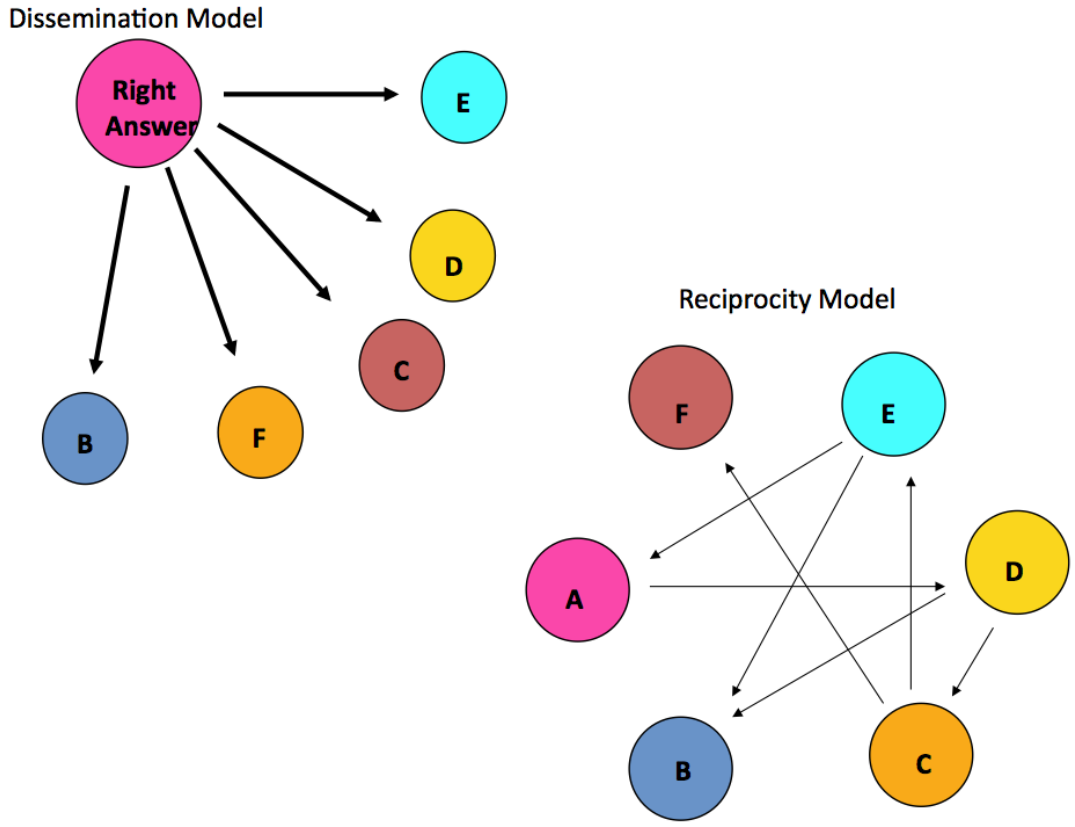
[11] Results of interviews conducted from Washington are displayed in Table 5 of Appendix F. Results from interviews conducted during site visits are displayed in Tables 6 and 7.

participation, there is untapped potential for knowledge exchange between and among community members.

- Publications reviewed by the team are primarily reporting vehicles rather than offering critical "how-to" knowledge about implementation. Even case studies provide little of the kind of detail that would allow others to effectively implement a strategy that has been developed in another project or country.

There are two categories of knowledge that organizations need to share—expert knowledge and "how-to" knowledge, as shown in the figure below. Expert knowledge is shared through the Dissemination Model, which is based on the assumption that there is a legitimized source of knowledge, i.e., experts, who are responsible for providing their knowledge to those who have less expertise. By contrast, "how-to" knowledge is best shared through the Reciprocity Model. The assumption behind this model is that all projects are learning from their experience and have something both to share with others and to learn from others. The Reciprocity Model does not share evidenced-based truth, rather what is shared are lessons derived from experience. Both types of knowledge are valid and necessary.

Figure 1: Dissemination and Reciprocity Models



Organizations that have implemented KM have discovered that they need processes and personnel in place to share both types of knowledge. Currently, within MEASURE Evaluation, only the Dissemination Model has established practices. Since 1997, MEASURE Evaluation has funded the development of tools, new training modules, and technical assistance. After this length of time, much of the "what-to-do" has been fully developed. The knowledge of "how-to-do" implementation resides in the field, but that knowledge is widely dispersed and is largely unavailable to a broad audience of M&E professionals worldwide. What is needed now is the exploitation of that knowledge.

RECOMMENDATIONS FOR THE REMAINDER OF THE PROJECT

Even without an increase in staff or budget, the following are changes that KM could make to better leverage knowledge in the second half of MEASURE Evaluation III.

1. Promote a broader definition of KM, one that encourages field staff to reach out to others working on issues similar to their own, and encourages others to share those lessons through inexpensive social media tools such as Skype conferences and Adobe Connect or webinars. The broader definition of KM would begin to build a culture of knowledge-sharing.
2. Move CoPs that now function as electronic mailing lists to a platform with greater capability for interaction and use of social media and provide comprehensive and systematic training for facilitators of communities that offer research and best practices for community facilitation. If personnel are not available, there are numerous consulting firms that offer this service.
3. Encourage field staff and U.S.-based staff providing technical assistance in-country to promote the use of the website, *Monitor,* and the CoPs during training and during technical assistance conducted with implementing partners and cooperating agencies. To accomplish this recommendation, field staff themselves would need to become more consistent users of these resources.
4. Broaden the type of publications requested and rewarded by headquarters. Publications from the field are needed to report on the tactics and practices of implementing the tools. Publications should not be limited to those of an academic or technical nature. Project staff, USAID staff, country counterparts, and M&E professionals worldwide would benefit from more accessible materials that have a story format with a journalistic tone. Only those who have struggled with implementation in the field can produce these lessons learned and best practices. MEASURE Evaluation should track any project outcomes that occur based on the exposure to and use of lessons learned from project implementation.
5. Continue the work of editing and disseminating publications. Where possible, the KM team should be involved in activities from the start so that they can influence decisions on formats. Working with authors early in the development of publications would allow them to identify a broader range of formats for knowledge, e.g. videos, podcasts, webinar discussions, blogs, wikis.
6. Foster greater knowledge transfer at All-Staff Meetings through fewer presentations and more exchanges of knowledge, such as knowledge cafes, reciprocity circles, storytelling events, etc; use informal seating arrangements that engender a feeling of community, such as circles of chairs rather than tables; use hand-held microphones that can be passed around to participants rather than stationary microphones.

V. DATA DEMAND AND USE

FINDINGS

Data Demand and Use (DDU) Strategy

The DDU crosscutting component has as its vision to fully integrate data use into the regular M&E process and to institutionalize data use approaches and tools in select countries in all M&E activities. MEASURE Evaluation sets out to achieve this vision by

- Generating demand for information
- Improving data collection
- Making data more available
- Facilitating the use of information to inform decisions

The project also endeavors to apply lessons learned from MEASURE Evaluation II in facilitative data use while expanding the technical strategy in new directions.

The DDU lines of action are to build data-use capacity through technical assistance (TA) and training; to develop, apply, and evaluate tools and approaches; and to demonstrate global leadership by raising awareness.

According to Tara Nutley, who leads the program from headquarters (HQ), HQ provides guidance to field staff on taking a comprehensive, health-systems approach to planning and implementing DDU activities.

Table 4. DDU Product Composition

Tools	• Assessment of Data-Use Constraints • Framework for Linking Data with Action • Information-Use Mapping • Stakeholder Analysis • PRISM Tools
Capacity-Building Curricula	• Data Demand and Use Concepts and Tools: A Training Tool Kit • Introduction to Basic Data Analysis and Interpretation: A Training Tool Kit • Integrating Data Demand and Use into a Monitoring and Evaluation Training Course: A Training Tool Kit • Data Demand and Use: Using Data to Improve Service Delivery. A Training Tool Kit for Preservice Nursing Education • Designing High-Impact Research: A Training Tool Kit for Researchers • Data Use for Program Managers. An eLearning Course
Guidance Documents	• Seven Steps to Use Routine Information to Improve HIV/AIDS Programs: A Guide for HIV/AIDS Program Managers and Providers • Making Research Findings Actionable: A Quick Reference to Communicating Health Information for Decision-Makers
Data Use Approaches	• Strengthening an Organization's Capacity and Systems to Use Data • Designing Program- and Policy-Relevant Research

MEASURE Evaluation's implementation of DQAs of USAID missions' IPs and promotion of spatial tools and data to help with M&E are reviewed in this section.

MEASURE Evaluation is called upon by several USAID missions to conduct DQAs of USAID IPs. MEASURE Evaluation's approach to DQAs is 1) to introduce the DQA process and principles to IPs in a pre-DQA workshop, 2) to conduct the field work, in some cases, alongside a local partner with whom they work to build capacity to conduct DQAs, 3) to deliver preliminary results to IPs, 4) to deliver a final report, along with long-term recommendation to the IPs, and 5) to use the results of the full report as an entree for deeper capacity-building efforts to build in-country ownership of DQA methods and approaches.

The main ways the project applies spatial tools are through

- E2G thematic mapping tool
- PEPFAR eLearning course
- Workshops on GIS
- Global leadership (development of global standards)
- Bringing together the health sector and mapping professionals in countries
- Orphans and vulnerable children (OVC) mapping

The PMP tracks DDU in Result 1—Increased user demand for quality information methods and tools for decision-making—and Result 6—Increased facilitation of use of HPN data. In addition to supporting project Results 1 and 6, the data-use technical strategy also supports Result 2 by providing capacity-building through data-use training workshops, direct TA with in-country colleagues, webinars, and e-Learning courses; Result 3 by reaching out to projects and donors that highlight data use in their project objectives and by expanding partnerships within and beyond the usual partners in strategic information (SI) and M&E; Result 4 by addressing data use during the design and implementation of M&E and RHISs, by strengthening data use tools, by developing "how-to" technical guidance for broader data use approaches, and by highlighting the link between data use and improved data quality; and Result 5 by focusing on data analysis, interpretation, presentation, communication, and data-use workshops to strengthen the availability of health, population, and nutrition (HPN) data.

Findings on Performance of DDU

The evaluation team found widespread familiarity with and use of MEASURE Evaluation DDU tools among USAID staff in Washington and in the missions, country counterparts, USAID IPs, and staff of international organizations. The MEASURE Evaluation project is attributed with achieving far-reaching success in building demand for data availability and quality, and following are some examples of where these data have been used for decision-making in the field:

- Many tools are being used appropriately in their contexts (e.g., PRISM and other DDU tools at the Regional Training Centers; DDU training at individual and organizational level; data mapping; Child Status Index; and 12 component framework).
- The project has built and reinforced cultures that demand data availability and quality (e.g., DQAs of IPs in Tanzania and Mozambique; Ministry of Women's Affairs and National AIDS Control Agency in Nigeria; and in CESAG courses, Child Status Index, and GIS activities). This comment from a DQA training participant in Nigeria sums up the change he experienced, "The DQA opened my eyes to see that it is one thing to have data and another thing to have quality data that can be translated to decisions." This success, though widespread, has occurred at some but not all levels, e.g., there has been no real work at the community level in Rwanda; limited work at the national level in Tanzania; need to focus on NGOs in Nigeria.

- There are some examples of data being used for decision-making—e.g., in Rwanda allocation of additional beds in a district hospital following a DDU training program of district-level staff and a trainee's subsequent advocacy for the additional beds based on data that demonstrated the need—but there is a great demand for assistance for data use.

Project documents state that in MEASURE Evaluation II, measuring data use proved challenging. In MEASURE Evaluation III, the project set out to address this issue by implementing a data-use results tracking system that reviewed workplans and quarterly reports to identify data-use results. Core resources of one half-time person are dedicated to implementing and maintaining the tracking system. Despite this effort, challenges persist. Results from DDU follow-up through June 17, 2011, are included in the table below.

Table 5. Data Demand and Use Training Follow-up, June 17, 2011

Training Event	Date	6 Month Follow-up Available?	12 Month Follow-up Available?	Report
AIDSRelief Nigeria Program Managers	June 2009	No, response rate too low	Yes	12 month–Strengthening an Organization's Capacity to Demand & Use Data DDU
AIDSRelief Nigeria M&E Officers	June 2009	Yes	Yes	6 & 12 month–Y2 Annual Report (AR)
High Impact Research at IUSSP	Sept 2009	Yes	Yes	6 month–Y2 AR 12 month–Y3 AR
High Impact Research at Kampala Family Planning conference	Nov 2009	No, response rate too low	No, response rate too low	None
Kaduna, Nigeria DDU Implementing Partners workshop	Feb 2010	Yes	Yes	6 month–Strengthening an Organization's Capacity to Demand & Use Data DDU 12 month–Y3 AR
Lagos, Nigeria DDU Monitoring and Evaluation Officer workshop	Feb 2010	Yes	No, response rate too low	6 month–Strengthening an Organization's Capacity to Demand & Use Data DDU
High Impact Research at Global Health Council	June 2010	No, response rate too low	Scheduled for July	Forthcoming
AIDSRelief Nigeria Program Coordinators	July 2010	Yes	Scheduled for August	6 month–Y3 AR
Building Leadership Capacity for Health Management Information Systems Information Use in Ethiopia	Feb 2011	PRISM assessment planned		Forthcoming

Of the nine DDU trainings captured, eight were eligible for follow-up. But over a third of these had inadequate data for the six-month follow-up. Twelve-month follow-up figures were similarly incomplete, with a third of activities eligible for follow-up recording too low a response rate. Where data were gathered, indicators tracked appear to be limited to quantitative data: percent who had presented data graphically, percent who had assisted decision-makers, percent who had implemented solutions to barriers, and percent who felt they could explain data to clinicians. For DDU components delivered through longer M&E training courses, project staff report that MEASURE Evaluation CBT staff gather participant feedback, but to keep evaluation forms short, no DDU questions are included.

The DDU activities are making good use of available CoP mechanisms and other online venues for collaboration. Membership in DataUseNet has risen from 424 in September 2009 to 735 in February 2011 and 856 as of July 12, 2011. This is impressive considering the limited functionality of the CoP as described in the previous section. The network has primarily grown organically following the "From Data to Impact: Using Health Data for Results" symposium in Arusha, Tanzania, January 28-29, 2009. On GIS, the project shares files within the project via Dropbox and is working with the WHO to manage a Public Health GHI Group Googlesite (https://sites.google.com/site/publichealthgisgroup/).

DQAs are used as an entry point into capacity-building. As it was described to team members, MEASURE Evaluation carries out an assessment of organizational factors that may affect its ability to ensure good quality data and then arranges appropriate training and mentoring to support needed improvements.

The evaluation team noted that the DDU program, as described by MEASURE Evaluation project HQ, differs slightly from what was observed in the field and described in informant interviews. While HQ described a comprehensive, systematic approach to bring together data producers and users and sent examples of the guidance it shares with project field staff and USAID Missions on ways to incorporate DDU interventions into field programs, USAID interview respondents viewed the focus to be primarily on data availability and data quality. Both USAID and country counterpart informants underscore a need for project activities to go beyond raising awareness about the importance and availability of high-quality data and focus more on data use.

Informants uniformly view GIS work as high-quality technical input. The evaluation team observed a GIS training in Rwanda and generally agrees with this conclusion. The training brought together one or two people from a number of organizations, most often M&E and IT staff, and contained relevant data on HIV/AIDS in sub-Saharan Africa, but not from participant organizations. Materials were shared online with participants several weeks prior to the training. Participants took pretests on the first day of the training, but that left little time for course customization based on participant knowledge. On the last day of the training, however, participants mapped data and used data from their organizations, which trainers had collected prior to the training.

The primary sources of knowledge about tools among country counterparts and IPs are training courses or one-to-one contact with MEASURE Evaluation staff. At the district and community levels, there is sometimes an unmet need to better understand how data are used.

RECOMMENDATIONS FOR THE REMAINDER OF THE PROJECT

1. There should be a continued strong focus on making sure that data are demanded and used at all levels of the health sector and across all health elements. More work is needed on DDU at district and subnational levels in most countries.

2. Data use can be encouraged by moving beyond indicators to bring together data collectors and data users and by building skills in advocacy and communications related to data use.
3. MEASURE Evaluation should diligently follow up with participants to measure outcomes of DDU activities and capture information on post-training data use. There should be a renewed effort to think through better ways to capture DDU training outcomes—both quantitative and qualitative—from country counterparts. Possible ways to accomplish that are to better utilize DataUseNet to gather information or to run a contest with a symbolic monetary award for the best stories of linking data with action among training course participants. Field staff should facilitate such efforts.
4. DDU training should use a team-based approach to help achieve increased impact. This recommendation is discussed further in Section VI below.
5. While awareness of DDU tools, trainings, and approaches was high, most informants heard about these through person-to-person contact. MEASURE Evaluation should promote awareness of DDU activities beyond the immediate audience served by the project via the website and online training materials.
6. The evaluation team heard about a plan to develop an online course on the Framework for Linking Data With Action and distribute it via webinars. Based on CoP survey feedback gathered in this evaluation, this type of interactive approach would be welcomed.

With additional resources, the following other recommendations could be implemented:

1. There should be an effort to increase country ownership and sustainability of DDU tools by transferring skills to local M&E organizations. Efforts in Tanzania to develop a local firm to take over the DQA work, which is gaining some traction, should not only be expanded to include additional firms in Tanzania but also extended to other countries where MEASURE Evaluation is active. This will require advocating to missions by the USAID management team, as it involves additional costs.
2. There is strong country demand for expanding the focus of DDU tools to more than one health element. MEASURE Evaluation should help USAID find ways to apply its work across the health sector into other health elements (e.g., as is demanded in Rwanda) and across health-related non-health ministries (e.g., as is demanded in Nigeria). This, of course, is contingent upon receipt of funding from different health element accounts.
3. GIS work should be rolled out more widely. Again, this requires resources. In the roll-out, MEASURE Evaluation should ensure that the GIS training is 1) closely coordinated with national bodies that are responsible for GIS work in country health sectors and with other partners, e.g., NIMRI and CDC in Tanzania; 2) expanded in scope in the regional training centers; and 3) made more efficient and cost-effective by training a few local/regional organizations that would then be able to train others.

VI. CAPACITY BUILDING AND TRAINING (CBT)

MEASURE Evaluation III's capacity-building (CB) strategy is to improve sustainable M&E performance in the health sector in developing countries by strengthening technical, managerial, and leadership capacity of individuals and institutions for the identification of data needs as well as the collection, analysis, and use of appropriate information to meet those needs. The project works at three levels—individual, organizational, and health system—and provides customized technical assistance to assess and address specific capacity gaps and needs. Support is also provided to regional training partners and through participation in global and regional CB working groups, e.g., UNAIDS M&E Training Curricula Harmonization and West Central Africa (WCA) TWG for preparation of the Senegal National Institute for Applied Medicine and Epidemiology (IMEA) course.

This section lists overarching findings and themes from the five country programs visited by the evaluation team, describes major findings at each system level in which MEASURE Evaluation works, and highlights findings in a few specific areas of interest—general training, the regional training centers, and the VLDP and LDP programs.

FINDINGS

Overall Findings

MEASURE Evaluation has helped to build M&E capacity in many countries. The project views every request for assistance made by a Mission, a government, or an organization as an opportunity to build capacity in M&E. The project builds CB efforts into scopes of work and workplans, but the evaluation team found little evidence of country-specific CB plans, except for the regional training centers.

In places where MEASURE Evaluation is highly regarded and has had an impact on national-level capacity, such as in Nigeria and Rwanda, the staff members appear to have a well-rounded set of technical, managerial, and relational abilities. They also appear to be highly effective at understanding the context and how to work in rapidly changing environments.

One notable gap in MEASURE Evaluation's capacity-building efforts is that it has not set targets for capacity-building. Without targets, it is difficult to monitor progress and determine if the project is on track to meet its goals. Other than training databases and progress reports, the evaluation team was unable to find measurements of change in capacity at the various system levels. Contextual factors (or factors outside the control of most health-sector actors) can have a strong influence on capacity or the desired outcome of capacity-building interventions. This makes it more difficult to effectively gauge MEASURE Evaluation's contributions toward building capacity. However, several stakeholders believe that as the premier project for M&E, MEASURE Evaluation should lead the way in setting targets and monitoring CB progress.

The evaluation team did not find much evidence that MEASURE Evaluation has evaluated the impact of specific capacity-building interventions on capacity outcomes or the links between capacity and performance variables. The indicators in the PMP under Result 2 don't lend themselves to more in-depth evaluation research, nor does the PMP provide options for researching how the outputs for Result 2 contribute to achieving the other results and the purposes of the project.

Findings from Country Visits

MEASURE Evaluation activities are targeted at various levels of the health system. In some cases, activities are primarily targeted at a single level, e.g. Tanzania's work with U.S. Government IPs. In other countries, e.g. Nigeria, MEASURE Evaluation works to build capacity at multiple levels.

The country visits to Mozambique, Nigeria, Rwanda, Senegal, and Tanzania provided one data set for examining the extent to which MEASURE Evaluation has built capacity in M&E within countries. While there are limits to using these data for identifying general themes, the visits provided some rich insights into the level and types of capacity built within countries with heavy MEASURE Evaluation investments and large activity portfolios. The table below lists the overall capacity-building themes that emerged from the country site visits, as determined by the frequency of responses from the country key-informant interviews.

Table 6. Capacity-Building Themes from Country Visits

Theme	Finding
System level with the greatest advancements in capacity built	Individual
Skills and/or abilities developed	Collecting, monitoring, and reporting data
Attitudinal or paradigm shift	Appreciation for collecting quality health data
Health element receiving the most focus	HIV/AIDS
Needs for the future	Focus on evaluation and data use Create CB plans that include a system-wide approach to OD and ownership

These themes reflect the current state of the capacity built in the countries visited, not in any single country or organization. However, the following two conclusions are worth noting:

- It is difficult to attribute capacity-building success to MEASURE Evaluation Phase III activities alone. Since MEASURE Evaluation has worked in these countries for several years, it is likely that progress is a result of many years of work and is also related to other external forces. However, this challenge should not be used as a reason not to measure advances made.
- In general, the capacity that has been built relates to current needs and systems, but it is unclear to the evaluators whether the skills, knowledge, and abilities are transferable to other health elements or to future M&E needs. One might be independently able to collect, analyze, and report on specific indicators such as numbers of people tested each month for HIV infection. However, the ability to collect and report good quality data on this indicator is no indication of an individual's ability to recognize the need to collect data on other health issues, nor does it indicate his/her ability to develop good indicators for other health issues or to build the systems needed to collect new data.

Findings on Capacity Development at the Individual Level

Capacity at the individual level is fundamental if a country is to achieve independence in its ability to plan, implement, and evaluate its M&E activities. Individual-level capacity typically refers to the desire and ability of human resources within a country to plan and execute particular goals independently using one's own set of knowledge and skills.

MEASURE Evaluation most often uses training and technical assistance strategies to develop the capacities of individuals to perform M&E functions within a country. Formal training programs include face-to-face training programs and distance-based, self-directed courses. Technical

assistance includes one-on-one mentoring or coaching, feedback on proposals, papers, or M&E plans, and guided application of skills while working on a task such as joint problem-solving or planning with people being mentored.

MEASURE Evaluation has had an impact on building the capacity of individuals in many developing countries to independently collect, monitor, and report quality data. This success has contributed to a shift in how people view the value of health data. "I was so scared about M&E before MEASURE came to help us. So now when someone says 'M&E,' they pique my interest." There is a continuing need to reinforce these skills. Some respondents feel that frequent staff changes necessitate "continuous training and refresher courses." There is little evidence that MEASURE Evaluation creates in-country training plans that support ongoing learning.

While data collection skills have improved, many key informants stated that the ability to use data has not. Data use is important on all levels of the systems, including at the local level where much data are collected, but the importance is not understood. Skill sets for data use include analysis as well as negotiation, influence, and leadership. Informants expressed need for skills in the "E" of M&E – that is, the capacity to plan and conduct evaluations.

The project has contributed to the capacity of some individuals to become trainers of M&E and of others to create plans or M&E strategies for their organizations. One example is the training of staff at the National Agency for the Control of HIV/AIDS (NACA), staff in the National HIV/AIDS Division and the Department of Health Planning in the Federal Ministry of Health (FMoH), and the Federal Ministry of Women Affairs in Nigeria. These individuals are now able to train others and lead the planning of other M&E activities. Mentoring and coaching is also a strategy for building individual competence. While seen as a successful approach, this methodology is often implemented informally.

Findings on Capacity Development at the Organizational Level

Building organizational capacity to perform M&E functions is dependent on the skills and abilities of the individuals working within the organization, on the resources available (physical and capital), as well as on the values, culture, policies, and structures of the organization. An individual's abilities in collecting, analyzing, and utilizing health data will have no impact at the organizational level if the individual doesn't have the resources or support to use his/her M&E skills. The organization will also not maximize the benefits of having competent staff if it is struggling with ineffective management systems. Therefore, M&E capacity at the organizational level is dependent not only on trained staff but also on effective leadership and management.

MEASURE Evaluation uses TA as a strategy to build organizational capacity. TA takes many forms such as assistance in developing M&E plans, assistance in conducting internal organizational assessments, and support to follow through on recommendations. In some countries, MEASURE Evaluation has successfully embedded staff within key organizations, such as Rwanda, though this strategy doesn't work in every country, as embedded staff can end up taking on work for the agency instead of building the capacity of others. To prevent this, MEASURE Evaluation-Nigeria has decided to embed staff within agencies for no more than three days a week and assure that they have clear scopes of work.

MEASURE Evaluation has built M&E capacity at the organizational level. The PMP, Indicator 2.1, shows an increase in the number of organizations conducting M&E activities independently. Organizations have hired M&E officers, created M&E plans, and strengthened their ability to report on indicators and use M&E tools.

Organizations at all levels still struggle with leadership and management issues. One of the most commonly mentioned challenges to building organizational capacity is staff turnover. This and other management issues impact organizations' ability to effectively conduct M&E. As one

stakeholder said, "you can get people to see how information should be used for decision-making, but unless you can get them to change the way they do business it isn't going to change—at this point, it is no longer an M&E issue but requires a higher level of interaction."

MEASURE Evaluation now offers a number of developmental programs that help organizational teams build leadership and management skills and identify organizational barriers to improve M&E systems using management system assessment tools. One organization benefiting from organizational development services offered by MEASURE Evaluation is CESAG. CESAG is attempting to strengthen its ability to be a high-functioning and financially stable regional training center. While the number of requests for organizational development services has increased, this set of services appears undervalued by some stakeholders in Washington and in the missions. For example, one person said the project "has tried to insert OD activities and we're not sure what the value added is in that."

Findings on Capacity Development at the National Health System Level

A health system is a collection of institutions or organizations and the health personnel in those organizations, working together to deliver health care and/or promote better health. The type of health system (centralized, decentralized, or mixed) in place in each country has an impact on the manner in which the health information system (HIS) and broader M&E systems operate.

In most cases, MEASURE Evaluation works with country counterparts to develop systems and skills so organizations can work independently. One example is in Tanzania, where MEASURE Evaluation is developing the skills of an in-country consultancy group to take over the DQA process that MEASURE conducts for IPs. While more than one competent consultancy group would be preferable, this is a good model.

Technical assistance is one method that MEASURE Evaluation has used to assist countries in building their HISs. The type of assistance provided depends upon the needs of host countries. Yet, to date, most capacity-building experiences and measurement have focused on organizational and health personnel (individual) capacity through training (on-the-job and formal), mentoring and coaching, and distance learning.

Much of the national-level CB effort has been in strengthening the RHIS. In addition to the PRISM) framework and a set of tools to measure RHIS performance, the project has employed a wide range of activities under the HIS component, such as developing community-level, information-reporting tools and DQA tools (used for example for OVC data collection and reporting system at village, commune, district, province, and NGO levels); advancing the state of the art in routine vital events registration through the development of the Sample Vital Registration with Verbal Autopsy (SAVYY) tools; TA for RHIS strengthening such as developing HIV/AIDS reporting systems in PEPFAR countries and creating databases such as PEPFAR Monitoring Systems (PMS); and creating two global networks for sharing experiences, tools, and lessons learned RHINO and International Health Facility Assessment Network (IHFAN).[12] As of 2010, around 18 countries in Africa, Asia, and Latin America have applied the principles and approaches of the PRISM framework as well as the tools to assess performance of their RHIS and to guide the RHIS strengthening process. Twelve countries have adopted PRISM tools fully (four in Latin America), while some modified and implemented tools selectively (three in Latin America).[13]

[12] RHIS Working Group, Routine Health Information (RHIS) Strategy, March 2010.
[13] Belay, Hiwot and Theo Lippeveld. "Inventory of PRISM Tools Application." Draft study report, May 2010.

In many countries MEASURE Evaluation has had an impact on developing capacity at the national health system level. Most often, it has done so by working with governmental organizations, such as the Ministry of Health (MoH) (Côte d'Ivoire, Liberia), the Ministry of Health and Social Welfare (MOHSW) (Tanzania), the Central Statistical Office (Zambia), or technical working groups (TWGs) that include multiple agencies. Mission staff surveyed for this evaluation shared significant results within their countries due to MEASURE Evaluation's assistance. The Regional Development Mission for Asia (RDMA) benefited from M&E TA for the development of national PMPs for HIV/AIDS, avian influenza, malaria, and tuberculosis. In the Dominican Republic, MEASURE Evaluation contributed to the re-launching of the Consejo Presidencial del SIDA HIV/AIDS M&E TWG. This has led to improved coordination of HIV/AIDS M&E efforts. In Rwanda, MEASURE Evaluation supported the harmonization of indicators, facilitated the development of standards of practice, and helped support the writing of a grant to the Global Fund, which brought $400 million dollars into the country. MEASURE Evaluation has been most successful in HIS strengthening in Latin America and the Caribbean (2005-2010), where it has been working toward increasing the capacity of the participating countries to take action on their own to improve their respective HISs and available data, in close collaboration with PAHO.

Key informants noted that despite success at the national level, "there is still a lot of work do in terms of strengthening the districts, particularly with civil society." Some work has been done at the district level, such as Rwanda's training of the district level M&E officers, and at the community level, such as the OVC work in Nigeria and Tanzania. However, these levels need more attention to become independent in their M&E capabilities.

Similarly, some informants noted that "while government capacity has improved, the private sector and NGOs have been neglected." In many developing countries, most health expenditure is out-of-pocket and spent in the private sector. Yet although almost every national health strategy has a component to improve public-private partnerships, in reality the monitoring of private sector service delivery is ineffective.

Most project health system strengthening efforts have been for national M&E systems for HIV/AIDS and national AIDS coordinating bodies. In this context, data- and information-gathering are multisectoral, with only a few indicators that are directly health-related, which most often poses a problem when marrying HIV/AIDS M&E with the health sector information systems.

Building the capacity of countries to use health data for decision-making remains an important need. In Nigeria, MEASURE Evaluation assisted in increasing the capacity for e-health data storage in the M&E unit in the Department of Planning, Research, and Statistics in the FMoH. Key informants stated that this should make it easier to use health data. It remains to be seen whether this indeed will improve data use.

Findings on Training in General

MEASURE Evaluation uses training to build capacity at the individual and organizational levels. Individual-level training courses range from two-day, face-to-face events that focus on the basics of M&E to two- to three-week expanded M&E courses at regional training centers such as CESAG in Senegal and the Instituto Nacional de Salud Pública (INSP) in Mexico. Other topics include the use of GIS data, impact evaluation, and data analysis and data use, to name a few.

MEASURE Evaluation's progress at training others to become M&E trainers is worthy of praise. For example, Public Health Foundation of India (PHFI) held a three-day training of trainers (ToT) workshop for PHFI faculty members who will teach M&E workshops and M&E courses in the future Masters of Public Health (MPH) program. Keeping high-quality training standards and

translating courses from one context to another without losing the integrity of the core content is of concern to a few who were interviewed for this evaluation.

MEASURE Evaluation provides a range of options for continuous learning via the Internet. Courses such as M&E Fundamentals have been translated into several languages, and a new DDU course will be piloted in Nigeria. While the numbers of distinct users of online courses through MENTOR is impressive, almost 15,000 visitors from October-December 2010,[14] very few people interviewed during the site visits were aware of the courses that were available online either through MEASURE Evaluation or other more sustainable websites such as the Global Health Bureau's training website (www.globalhealthlearning.org) and the UNAIDS M&E website (www.globalhivmeinfo.org).

MEASURE Evaluation supports graduate level M&E education for a limited number of people who work in the field of M&E. While this support benefits both the individuals and the academic organizations, it is not clear if this intervention is linked to larger capacity-building strategies.

There is a high demand for M&E training programs, and training participants report satisfaction with the format and content of the courses. Six- and twelve-month post-program follow-ups of core-funded M&E courses show that at least 95% of participants report that they are using knowledge and skills gained in the courses in their current work.

Observation of training programs during the country site visits highlighted a number of excellent training practices. First, the trainings are provided to a specific audience—people who are open to learning because the knowledge is needed immediately in their work. Second, they are interactive. Specifically, they include activities that help individuals build the needed skills with guided support. Finally, the training programs use examples that are relevant to the audience. The team observed this at a GIS training hosted in Rwanda. The MEASURE Evaluation facilitators gathered data from Africa to illustrate specific points in their presentation of how mapping can help in understanding a community health problem. They also sought specific organizational data from the organizations that had sent individuals to the training. The relevance of the material used in a training program is known to increase the impact of the program on individuals.

While some informants consider MEASURE Evaluation's training programs to be "one of their best achievements," others would like to see more training programs customized to specific health interests, such as malaria and gender. While MEASURE Evaluation has been successful in designing and delivering training programs, there are a number of things they could do to even further maximize the transfer of learning to real-world settings. These are addressed in the recommendations section of this report.

A gap identified by key informants during the country visits was the lack of in-country M&E academic programs. Nigeria has had success in establishing short-term and long-term training in M&E in two schools of public health. This institutionalization of training will contribute to creating sustainable capacity for M&E in the country. Other countries such as Rwanda have also started to work with universities; however, for most individuals, to seek a degree in M&E, they must travel outside of their home country.

Findings on Capacity Development at Regional Training Centers

Since Phase I, MEASURE Evaluation has worked with five regional universities and training centers to build capacity to conduct short- and long-term M&E training programs, to provide TA in M&E, and to conduct evaluation studies. The goal is that these training partners will

[14] From page 6, Capacity Building Lines of Action.

become centers of excellence for M&E in their regions. The centers focus on country, regional, and global public health and health system priorities.

MEASURE Evaluation has assisted these centers in designing and implementing different regional short-courses for M&E and supported them in the development of M&E tracks as part of MPH degree programs. The project also seeks opportunities for conducting collaborative evaluation research with the regional centers, and provides technical assistance, either in-country or through mentoring and coaching, and distance learning.

The support has evolved over the years, and all faculty and local facilitators have matured to the extent that they are mostly capable of delivering the courses independently, with MEASURE Evaluation's support being limited to TA of ToT workshops and in some cases facilitation of "new" modules in the training courses.

Demand is much higher than what these centers can accommodate, and the majority of participants are funded by sources other than MEASURE Evaluation. Despite this success, the long-term financial sustainability of these centers is a major concern. Given this, more effort should be undertaken to encourage countries in the region to fund their M&E experts to participate in the courses offered at these academic centers, though fees alone may be insufficient to meet all costs.

The M&E courses currently provided by the regional centers are indeed improving the capacity of the individuals attending the workshops. Participants report that they can use what they learned in their own practice on post-program evaluations. However, it remains unclear if their participation in courses has improved the performance of the M&E systems in their own organizations and/or own countries.

Several of these regional institutions are also providing South-to-South TA and training for partners in the countries of their regions. Examples are CESAG (Senegal), providing assistance to francophone countries in Africa and even Haiti, and the University of Pretoria School of Health Systems and Public Health (UP-SHSPH)[15] in Pretoria, assisting training partners in Ghana, Nigeria, Sudan, and Southern Sudan. This can clearly be called a success for MEASURE Evaluation and should be encouraged and supported.

MEASURE Evaluation's work on strengthening the organizational capacities of the regional training centers will be instrumental in stimulating strategic thinking and planning, especially where it concerns financial sustainability. CESAG, for example, very much welcomes the support from MEASURE Evaluation in this respect.

MEASURE Evaluation has drawn on useful lessons from the experience in Latin America, where solutions and best practices that were designed at the country level or in a subregional context were shared with the region as a whole, which in turn strengthened training capacity in the region. This example is being followed in other regions, and the dialogue on how to address common issues and how to incorporate lessons learned in the training programs has started. An example is the participation of MEASURE Evaluation in the regional collaboration initiated by the West Africa Health Organization (WAHO). CESAG participates in the discussions, which are currently led by Rwanda. Common issues are being mapped with an intention to streamline health information systems and harmonize donor requirements and national information systems.

A gender module is not systematically included in training curricula, except in Asia.

[15] University of Pretoria School of Health Systems and Public Health.

Findings on the Virtual Leadership Development Program (VLDP) and Leadership Development Program (LDP)

In Phase II, MEASURE Evaluation recognized a need for additional attention on developing the effectiveness of organizations as a strategy for enhanced M&E capacity. Those interviewed during the country visits supported the need for leadership and management training for organizations. In MEASURE Evaluation Phase III, leadership and management training programs were added to the portfolio of services, including the VLDP and the LDP.

Both the VLDP and LDP have been designed to include best practices for formal leadership development programs. They use teams as the focal point for learning. They have those teams apply new knowledge or tools to a relevant, real-world challenge. They extend for several months and provide just-in-time feedback or coaching from faculty or team coaches. The VLDP has been able to reach people who have very little ability to obtain high-quality training and connect them to others around the world who face similar challenges. The LDP connects people who may live geographically close but in work have been miles apart.

The VLDP is in high demand by people around the world. Since it is core-funded, it is free to participants. Each program typically turns away a large number of applicants. For example, the second VLDP accepted 10 teams from a pool of 99 applications.[16] Many applicants not accepted into the program are turned away because their team is not intact or they have not identified a project that will allow them to build leadership and M&E skills.

The LDP program, which has a face-to-face component, is usually conducted in one country and therefore should be funded by field support. There has been little Mission demand for this training program.

Participants see VLDP as very valuable. VLDP teams from Rwanda, Nigeria, and Tanzania stated that their participation in this program increased their skills in both leadership and M&E. With regard to impact on their leadership, working together as a team and improving their communication skills were the most frequently mentioned benefits. In some cases, participants went to great lengths to participate in the program, such as driving to Internet cafes to participate in the online portions of the program. Internet connectivity continues to be a challenge for some VLDP teams living in remote areas.

The project evaluates VLDP at 6 and 12 months post-program. Pre- and post-Climate Surveys are done, and the outcome of the team project is followed. This approach is very limited in what it provides to those who might invest in this activity as a strategy for leadership development. The outcome of a single team project is not an indicator of a team's ability to demonstrate leadership while facing other work challenges.

The cost of one VLDP program is between $70,000 and $120,000 and the cost of an LDP program is in the range of $120,000 to $180,000. Actual costs are determined using a costing model that includes a number of factors such as consulting daily rates and travel costs.[17] The cost of the VLDP and the LDP are comparable to the costs of many leadership development programs within the United States that are available to public health practitioners. They are cheaper than other initiatives, such as the National Public Health Leadership Institute, which has a budget of $500,000 per year for 50 participants. An issue in determining cost effectiveness of these programs is the lack of good indicators of success.

[16] MSH Mid-project Report.
[17] MSH LDP Costing Model.

As good as it seems to participants, VLDP may not be living up to its potential as a country strategy for building organizational capacity. Since VLDP is a virtual program offered to many teams around the world simultaneously, the impact of the program on any one country is negligible. In some cases, as in both Rwanda and Tanzania, the VLDP teams have not connected in any way to any other MEASURE Evaluation activities and in the case of Tanzania, the project's country team was not even aware of the most recent VLDP training.

LDP is a much better option for building both organizational and country-level capacity for leadership. It has several benefits. First, teams are supported by an in-person coach (versus a virtual coach who provides help to all teams in the VLDP) as they move through the program. Second, the program is longer by at least three months. Leadership is not built overnight and needs long-term nurturing. The LDP also is more likely to hit a critical mass of organizations within a country for development. Rather than one organization as in a VLDP, an LDP can support several teams in a single country or city. The LDP model is much more likely to result in a significant expansion of social networks than the VLDP. The LDP, like any in-person cohort program that is offered over time, provides connections between people that might not normally occur. This can be used as a strategy to bring people from multiple disciplines or from multiple agencies together in a way that supports a strategic level of networking. Finally, the LDP also can be used as a strategy for expanding the in-country pool of trainers, which increases sustainability chances.

Given the potential of the LDP model to build organizational leadership and to enhance in-country collaboration at a slightly higher cost than the VLDP, the project should promote the use of this strategy moving forward. The VLDP should continue to be offered as it provides value to specific organizations. It may also provide an entry point for leadership development in countries not yet interested in supporting an LDP program. To gain a greater return on the investment in VLDP, however, teams should be strategically linked to other MEASURE Evaluation activities within their countries, if possible, to maximize the transfer of learning.

The VLDP and LDP are designed using best practices from the field of leadership development. Because they are used in resource-challenged settings, they are unable to maximize the use of technology for instruction and interaction. However, as bandwidth improves, these programs should include more methodologies that appeal to visual learners. For now, the use of VLDP and LDP could be enhanced with the specific recommendations listed below.

RECOMMENDATIONS FOR THE REMAINDER OF THE PROJECT

Strengthen Measurement of Capacity Building

- Identify indicators and targets for progressive levels of capacity built at all levels of the health system and monitor progress.
- In countries with large programs, develop national-level capacity-building plans that outline specific goals and planned activities but also continue to allow for unplanned opportunities to offer capacity-building activities.
- Evaluate the strengths of various capacity-building interventions on capacity outcomes. This may be an appropriate investment for the Bureau-wide agenda.

Improve CB Results at the Individual Level

- Formalize mentoring and coaching as a deliberate process that has clear objectives and is monitored and evaluated.
- Build on the gains made in monitoring to date, focus on helping people learn how to conduct evaluations.

- Create country-specific training plans in countries where there are large investments in training.
- Link the support of individuals pursuing master's degrees to a larger capacity-building strategy for their home country.

Improve CB Results at the Organizational Level

- Put more emphasis on building strong organizations by setting specific targets for OD and by including OD activities in other requested activities. This will require advocacy from USAID/Washington and the project to convince Missions of the critical importance of organizational issues on developing effective M&E systems.
- Identify ways to better show the connection between strong organizations and effective M&E systems, starting by identifying clear indicators of OD and monitoring progress over time.

Improve CB Results at the National Level

- Continue to respond to demand for specific CB activities, but also develop strategic CB plans in countries with large investments.

Improve Training in General

- Put more focus on the "pre" and "post" phases of training programs. Involving participants prior to their training experience better prepares them for their learning. Individual assessments and case-study preparation are two things individuals can do, in addition to pre course reading, to be better prepared for the sessions. Some of these activities can also help the trainers better prepare for the session as well by better understanding the needs of their audience. Phase III of training or post-training time is also valuable because it is the time that individuals are attempting to try what they have learned. Individual coaching either on the phone or online can help an individual further internalize the skills and knowledge gained at the training program.
- Require participants to attend sessions in organizational teams. To maximize training as an organizational CB strategy, more of MEASURE Evaluation's training programs, including DDU training, need to use a team approach. Organizational teams (of three or more individuals) can learn together and support each other after the training in their home agency. A team approach can also reduce the impact of the high levels of employee turnover that many organizations experience.
- Seek to understand the extent to which organizations are capable of transferring skills learned from HIV/AIDS M&E to other health elements and identify a strategy for ensuring that this level of mastery is obtained.
- Expand the strategy of guided application of skills from the training program setting to the real world. To maximize the transfer of knowledge and skills from a classroom style program to a real-work environment, individuals or teams must work on real problems with a guide. Using an action-learning approach, which offers organizational teams a supportive learning guide while they apply their new knowledge back home, is one way to help support transfer of learning. The LDP program that provides teams with a coach is a good example.
- Begin transferring the delivery of standardized M&E courses to in-country partners. The project should focus facilitated training programs on skills that require a higher level of training expertise, such as data use, negotiation, and organizational development.
- To ensure quality of standardized M&E courses to in-country partners, develop a CB plan that identifies stages for vetting trainers. MEASURE Evaluation in Rwanda uses a CoP

approach to building the skills of new trainers. They meet with their master M&E trainers every Friday to discuss training challenges and techniques.

Support CB Work at the Regional Centers

- Focus OD of the Regional Centers on developing short- and long-term strategies for sustainability, in both technical and financial terms. This could be done through strategic planning, documenting best practices, and developing an advocacy strategy. Advocacy should be done with a view to create critical mass for M&E training from a given country, perhaps through requirements that several people from a particular organization attend, which could influence decision-making.
- Improve the follow-up mechanisms for trainees to continue supporting them in their own settings.
- Ensure that gender concerns are well integrated in each training course.

Recommendations Specific to the VLDP and LDP

- Promote wider use of LDP as a tool for building both organizational and health system management.
- Establish indicators of success for these programs for leadership.
- Study the effectiveness of VLDP/LDP on leadership and management.
- Find ways to better demonstrate the value added by these programs to organizations and specifically to their capacity to carry out M&E.
- Link VLDP and LDP to other MEASURE Evaluation CB activities occurring in the participants' organization or country.

VII. TECHNICAL NEEDS AND FUTURE DIRECTIONS

NEAR-TERM (THE NEXT TWO YEARS)

Findings

The team's interviews with stakeholders resulted in a wide variety of opinions concerning the most important technical needs in monitoring and evaluation of health, but there were important common themes that point to priority areas that the project could address. Some of the former areas could become the basis for a discussion of a GH Bureau-wide M&E agenda, as respondents throughout the Bureau made many of the same points. Meeting other near-term needs would require field contributions.

Supporting Key GHI Principles

Washington respondents see a need for development of indicators to measure progress against each of the seven principles. Indicators are apparently being developed by the GHI launch team, but there remain some key health initiatives related to these principles in which it is appropriate for the project to work in light of GHI priorities.

- Health system strengthening: There needs to be a way of determining how much progress is being made through USAID and other donor interventions, and where future interventions should be directed. (See also the separate point on harmonization of RHIS and M&E systems below.)
- Capacity building: There needs to be a way of measuring progress on CB activities.
- Gender: MEASURE Evaluation has developed an internal gender strategy aimed at raising awareness, integrating gender considerations into all project activities, and improving the M&E of gender-related issues in health. The project has done excellent work in developing indicators for GBV and supporting a globally-recognized compendium of gender indicators, but informants believe much more can and should be done. The team did not find much evidence of a systematic approach to integrating gender in M&E conceptual frameworks and logic models or to determining how gender-specific data influenced demand for richer data. There is a need to build capacity of government and individuals to systematically include gender considerations into district health information systems that allows for measuring social, legal, health, and other indicators affecting the health of women, girls, and other at-risk populations and assessing their priority needs to inform design of projects and activities. Existing gender training modules need to be adapted to training programs to take into account region-specific features and for use in CB at the country level.

Costing and Cost-effectiveness

U.S.-based respondents are increasingly concerned about the need to introduce costing of interventions into M&E decisions, so that the value for money of alternative ways of addressing issues identified through data analysis can be assessed.

Measuring Health Outcomes

The need for finding rapid, low-cost ways of estimating health outcome information between DHS and other large-scale surveys was frequently cited. More frequent outcome data can help decision-makers determine whether health interventions are having the desired effect. For U.S.-based stakeholders, this can be important information in advocacy for protecting funding levels.

Implementation of USAID Evaluation Guidelines

Respondents consider that MEASURE Evaluation could play an important role in developing implementation procedures to operationalize the Agency's new, more rigorous evaluation

guidelines, including both impact and performance evaluations, with attention to qualitative evaluations. The project could also strengthen capacity at the country and regional levels to carry out evaluations.

Advocacy for Data Use

Respondents in the U.S. and the field see the need to place greater effort on facilitating data use by finding ways of linking data collectors with data users and improving the skills of the former to advocate for better use of high quality data.

Harmonizing RHIS and M&E Systems

Despite the significant investment in building robust information systems that meet the needs of stakeholders, in many countries the proliferation of M&E subsystems (HIV, OVC, PMTCT) that have their own information systems remains a concern. Especially at the health facility level, staff is often overburdened with the reporting requirements. The project should continue to work in this area.

Including Private Sector Providers in Country Health Information

The low participation of the private sector, especially private for-profit players, in submission of routine service delivery data to the RHIS is another critical issue, since in most developing countries the private sector is a more important service provider than the government. Finding innovative ways to include these players in RHIS would fill an important need.

Fostering Regional and In-Country Talent and South-South Technical Assistance

In keeping with themes of country ownership and sustainability, informants see a need to ramp up efforts to involve and strengthen in-country institutions' ability to provide technical support for M&E, and to support South-South exchanges of M&E expertise. There are good examples of how the project is already doing this, and there is a strong desire to see this work expanded.

Recommendations for the Remainder of the Project

The USAID management team should consider which of the above areas of need, particularly those appropriate for Bureau-wide funding, should be recommended as project activities in Measure Evaluation's final years and work with the project to develop appropriate activities that can be completed in the time remaining.

Build capacity of governments and individuals to systematically include gender considerations in RHIS that allow for measuring social, legal, health, and other indicators affecting the health of women, girls, and other at-risk populations and assessing their priority needs to inform the design of projects and activities.

In its work improving M&E systems and RHIS, MEASURE Evaluation should develop a strategy to advocate harmonizing M&E systems at the global, country, and subnational levels and to stimulate regional dialogue.

LONGER TERM (FOLLOW-ON)

Findings on Technical Needs

The commonly cited long-term needs to address important technical gaps and emerging issues mirror those identified for short-term work, with the focus on longer-term solutions that require more than a two-year period to make progress. The central themes are the need for clear CB objectives, indicators, and timetables that provide clarity to USAID on how long assistance is expected to be needed before these objectives are met and the need for far greater engagement of local or regional institutions in the full range of M&E activities to foster country-

ownership and sustainability, heightened focus on DDU and knowledge sharing, and increased CB for both USAID and host-country staff on rigorous evaluation techniques, particularly qualitative evaluation. Continued global leadership and international collaboration on M&E is needed and desired.

Findings on Project Structure

The team was asked to consider what would be the optimal structure (i.e., type/number/size of mechanisms and organization/division if broken up) for the follow-on and why.

While the team does not purport to be expert at USAID project structuring or USAID procurement, the earlier management review and informant interviews point to the following consistent findings related to project structure:

- USAID/Washington, USAID Missions, and MEASURE Evaluation project staff consider it very important that the project be structured with considerable flexibility to respond to changes in USAID policies and initiatives and to emerging technical needs.
- Although some respondents thought that the project should be broken up—by creating regional projects, separating monitoring from evaluation, and creating additional country-based Associate Awards, none provided evidence or compelling arguments for why these approaches would work better than the current global approach. There is a push, however, for smaller procurements under USAID Forward to fund more and varied partners.
- The evaluation team found that MEASURE Evaluation is not achieving maximum synergies possible from its global structure for the following reasons:
  - Internal management structure of MEASURE Evaluation III does not facilitate integration of some parts of the project into the whole.
  - Current management approach does not maximize innovation. While the evaluation team found some examples among respondents of unsuccessful activities (e.g., the database project in Mozambique and failure to build organizational capacity in some cases), there was an apparent absence of project-led identification, analysis, and learning from failure.
  - The project's current KM model does not maximize the possible value that could be achieved from effectively transferring knowledge geographically between countries or across health elements.

In light of these findings, the team considered the pros and cons of breaking up the project into smaller, more cohesive pieces versus another broad project that tackles all aspects of M&E globally.

Table 7. Pros and Cons of Large vs. Small Projects

Project Size	Pros	Cons
Large Project	Greater possibilities for synergies and system-wide approaches and alignment with country priorities, if properly designed. Consistent with GHI and many countries' priority of an integrated approach across health elements. Missions have a one-stop shop for M&E services.	May be unwieldy to manage. Not in keeping with USAID Forward goals of more, smaller procurements that allow for more development partners including small businesses. Difficult to communicate the purpose, scope, and achievements when project is large and complex.
Small Project	Better alignment with USAID	Most regional bureaus (except Africa)

Table 7. Pros and Cons of Large vs. Small Projects		
Project Size	**Pros**	**Cons**
	Forward procurement goals. Regional approach could lead to more effective and efficient knowledge sharing within regions through more frequent, less expensive face-to-face meetings and South-South engagement. Ability to better focus on diverse regional priorities. Possibility of separating highly rated data availability and quality monitoring work from less mature evaluation activities.	lack funds for regional projects. More difficult to exploit synergies and communicate effectively across several projects than within a single project. Could make KM across regions more difficult. Increases management burden for USAID and may not reduce complexity. No mechanism for global leadership activities (i.e., Bureau-wide activities or involvement in global M&E groups) if a regional approach is taken. If project is broken up technically (e.g., M vs. E), global leadership is more complicated.

Recommendations for Elements of a Future Project

It may be premature to conclude that a change in project size will lead to improved project outcomes and impacts. Instead, the team recommends that USAID take a collaborative approach to structuring the follow-on project by soliciting USAID Mission input on this issue.

Though the evaluation team does not make a recommendation regarding project size and scope, the team has the following recommendations regarding other aspects of future program structure, including technical components that should be included in an request for application or request for proposal.

- Flexibility to respond to emerging needs. The follow-on project should be structured in a way that provides flexibility to respond to emerging issues and initiatives. Respondents considered flexibility to be a major advantage of the current project.
- Ability to address crosscutting, global issues. While the current management of MEASURE Evaluation by BGH, in collaboration with three technical offices, is challenging in terms of balancing priorities, it provides an opportunity for cooperation across the USAID project portfolio. Embracing this opportunity makes sense in light of the facts that M&E is a crosscutting issue and that USAID and countries are calling for more integrated approaches across health elements. Many informants echoed this thought.
- Built-in mechanisms to foster synergies among project components. If a global project is maintained, the team recommends the following ways to enhance synergies:
  - The lead implementing organization should have the capability to have a staff presence in field offices. This may lead to better integration between field and headquarters programs resulting from reinforcement of the priority on communication between field and headquarters offices by the staff person from the lead organization.
  - The approach to KM should be broadened, as described in the KM recommendations below.
- "Dare-to-Fail" fund. Incorporate a "dare-to-fail" fund to encourage increased experimentation with innovative activities. Such a fund is consistent with recent USAID

discussions encouraging identification, testing, and scaling creative solutions to development challenges. Cannon and Edmondson conclude that deliberate experimentation and the related willingness to fail can be seen as a means of accelerating an organization's learning.[18]

- Grants to country organizations. To solidify gains in country ownership, include an annual competition for fixed obligation grants (FOGs) among qualified country counterpart and/or local organizations that demonstrate high potential to manage activities. The evaluation team observed examples of such organizations in Rwanda, where host country counterpart institutions demonstrated strong country ownership and where countrywide capacity has been developed through a master trainer corps, and in Tanzania where a local firm is poised to carry out such activities as DQAs and GIS mapping with limited quality assurance by MEASURE Evaluation. The FOG is a simplified grant mechanism that provides payments based on outputs, such as milestones achieved rather than on inputs to in-country NGOs, firms, and country counterpart organizations. Up to $500,000 per year for up to three years may be transferred via this mechanism.
- Sharing of regional expertise. To build on regional ownership gains, support regional institutions providing technical assistance in M&E CB in the countries of their region and ensure their eligibility in competing for grants that will contribute to improved management for M&E at the country levels.
- Strong focus on identification and spread of best practices—the "how-to" exchange.

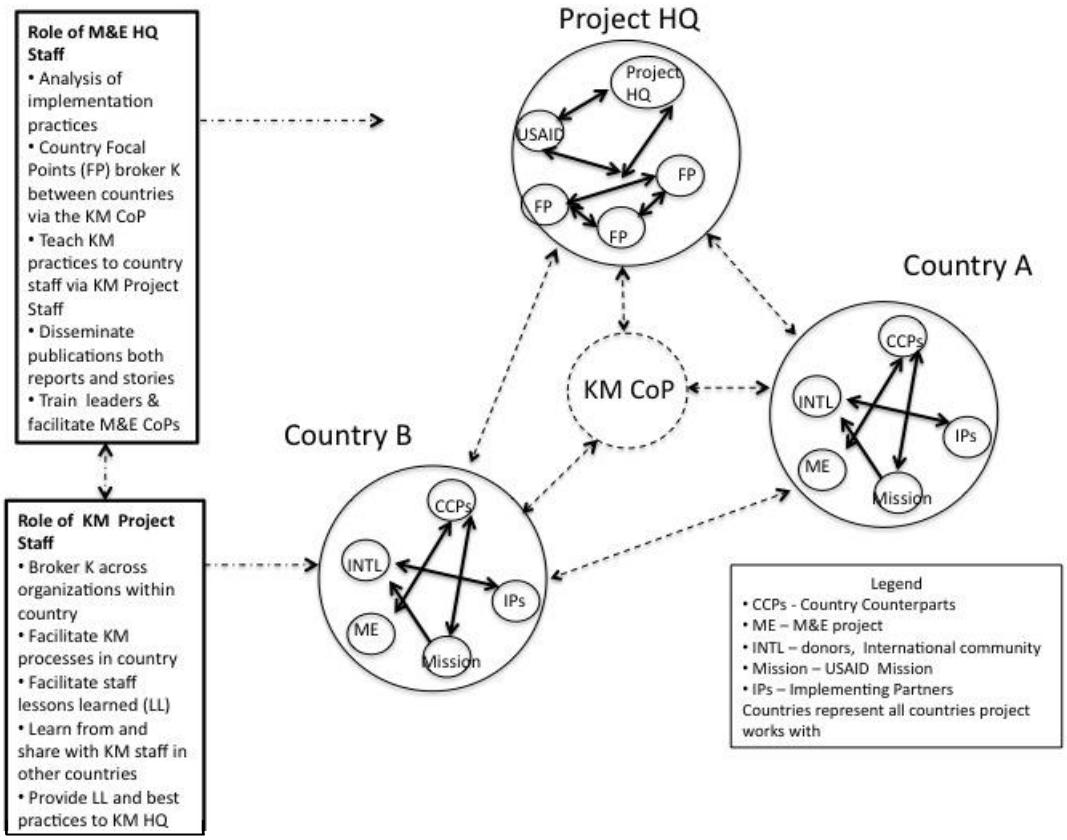
Few MEASURE Evaluation materials address field-based lessons in how tools were applied, what the outcomes of the applications were, and why.[19] A new project should play a stronger role in influencing data use by identifying best practices in data use and using KM practices to spread those approaches, e.g., through brokering of knowledge, peer assists, and other KM techniques.

- A greatly enhanced KM component that focuses on "how-to" information. To ensure that KM fosters the exchange of "how-to" information among practitioners in the field, as well as dissemination of global expertise, the following two complementary KM efforts are needed: 1) a rigorous analysis of which implementation processes are effective conducted by those who have been engaged in the implementation; and 2) processes and people to create the flow of knowledge from one project to another and from one country to another. The flow of knowledge requires continuous exchange among implementers, involving KM positions in country offices and an enlarged KM staff at headquarters.

[18] Cannon, Mark D., and Amy C Edmonson. "Failing to Learn and Learning to Fail (Intelligently): How Great Organizations Put Failure to Work to Improve and Innovate." Working paper, Cambridge: Harvard Business School, February 2004.

[19] One concrete example is the recently published *A Review of Constraints to Using Data for Decision Making: Recommendations to Inform the Design of Interventions.* While the findings in this document from country assessments were interesting, the recommendations were generic. It would be more helpful for policymakers to read detailed narrative examples of cases in which recommendations were applied and how application of the recommendations did or did not prove effective.

Figure 2. Project-wide Knowledge Management



Ways of ensuring a project-wide KM approach that facilitates knowledge sharing include the following:

- Teach KM practices to country staff.
- Appoint a KM coordinator for each country. Countries with relatively smaller budgets should dedicate a percentage of a staff person's time to KM. Establish a CoP of KM coordinators to facilitate knowledge flowing between countries
- Provide resources to hire CoP facilitators with KM expertise and technical topic familiarity to manage the communities, rather than the leader role being an "added responsibility" to current positions. If resources are too constrained for full-time facilitators, the project could consolidate several CoPs onto one platform with subcommunities managed by one expert community manager. Provide training for CoP leaders to actively facilitate CoPs.
- Modeling of best evaluation practices by incorporating methods of capturing performance for each result area into project designs. This includes development of baseline data and targets for overall project performance; use of "benchmark" or "milestone" indicators such as a "capability maturity model" appropriate for institutional development projects, as well as "completion" indicators, and specific ways of measuring progress on "soft" components such as capacity development and health system strengthening that do not lend themselves easily to quantitative indicators; activity and country workplans based on a standard template that include a provision for a conceptual framework, output and outcome indicators, and targets in countries with large USAID investments; and a strong focus on M&E of gender issues that goes beyond performance indicators.

- Incorporation of "graduation" or "phase-over" objectives and conditions for each activity. The specific conditions for successful completion of an activity, including the project's proposed interventions, the expected costs, and time required, should be estimated at the beginning of each activity, so that project implementers have a firm understanding of what it will take to achieve country ownership.
- Mainstreaming of OD concepts into all project results areas. A new project should fully integrate OD concepts and needs into its programming, particularly into its CB efforts, so that it is not viewed as an "add-on" by either the project or potential users of project services, and to ensure that important organizational issues are considered, particularly in the area of health systems strengthening.

VIII. SUMMARY OF KEY FINDINGS AND RECOMMENDATIONS

The evaluation has identified many findings and suggested many recommendations. This section summarizes the most important findings that suggest areas for improvement and the recommendations that follow from them for the remaining two years of the project. For the positive findings throughout the report, where no recommendations have been stated, the message is clear: keep doing what works well. The team also suggests that in determining how findings and recommendations should best be addressed, the USAID and project management teams should sit down together using the Framework for Linking Data to Action as a tool for defining specific recommendations, decision-makers, and key stakeholders who should be involved.

Table 8. Summary Findings and Recommendations for Remainder of the Project

Key findings	Resulting recommendations
Overall Project Performance	
Absence of targets for PMP indicators makes it difficult to judge progress against expectations.	Establish end-of-project targets for all outcome indicators in the PMP.
Absence of baseline and outcome-level targets for individual activities makes it difficult to judge progress on objective achievement accurately.	For all significant future activities, include baseline information and outcome targets in the initial design
The project is well aligned with GHI principles and PEPFAR and PMI priorities, but more M&E work is needed in gender, HSS, and innovation. There is no rational process for determining Bureau-wide priorities, though certain needs are clearly recognized throughout GH. The budgetary process is inequitable to PRH and HIDN.	Design process to canvass GH offices to determine highest priority needs to include in project Bureau-wide activity and consider whether a different basis for developing Bureau-wide budget would be more equitable to the GH offices.
Strategic Partnering	
The project has done an excellent job in partnering with international, host country, and IP organizations when mandated to do so. It has not reached out much to other IPs for issue-specific information-sharing.	Encourage project staff to seek opportunities to share knowledge and techniques and where possible collaborate on activities with IPs working in the same or similar areas, when both partners could benefit from doing so.
Knowledge Management	
The current focus on KM both at headquarters and in the field is primarily on dissemination.	Promote a broader definition of KM, one that encourages field staff to reach out to others who are working on issues similar to their own and encourages others to share those lessons through inexpensive social media tools such as Skype conferences and webinars.

Table 8. Summary Findings and Recommendations for Remainder of the Project	
Key findings	**Resulting recommendations**
MEASURE Evaluation CoPs are underutilized and able to promote only minimal knowledge-sharing among members. There is room for the KM team to take a more proactive approach to building communities; however, current staffing levels for KM may prevent staff from providing greater levels of community support.	CoPs that now function as listservs should move to a platform with greater capability for interaction and one that makes a larger range of social media available. Provide training for facilitators of communities that offer the research and best practice for community facilitation.
Publications are primarily reporting vehicles rather than also offering critical "how-to" knowledge about implementation. There are not enough case studies that provide the kind of detail that would allow others to effectively implement a strategy that has been developed in another project or country.	The type of publications requested and rewarded by headquarters should to be broadened to include tactics and practices of implementing the tools through a story/journalistic/multimedia format. Work with authors early in development of publications to identify a broader range of formats for knowledge, e.g. video, podcasts, webinars, discussions, blogs, wikis, etc.
Data Demand and Use	
Both USAID and country counterpart informants underscore a need for project activities to go beyond raising awareness about the importance and availability of high-quality data and focus more on data use.	Data use can be encouraged by moving beyond indicators to bring together data collectors and data users and by building skills in advocacy and communications related to data use. There should be an effort to increase country ownership and sustainability of DDU tools. Efforts in Tanzania to develop a local firm to take over the data quality assessment work, which are gaining some traction, should not only be expanded to include additional firms in Tanzania but also be extended to other countries where MEASURE Evaluation is active.
At the district and community levels, in some cases there is an unmet need to better understand how data are used.	There should be a continued strong focus on making sure that data are demanded and used at all levels of the health sector and across all health elements. More work is needed on DDU at district and subnational levels in most countries.
Informants uniformly view GIS work as high-quality technical input.	GIS work should be rolled out more widely. Again, this requires resources. In the roll-out, MEASURE Evaluation should ensure that the GIS training is 1) closely coordinated with national bodies that are responsible for GIS work in country health sectors and with other partners, e.g., NIMR and CDC in Tanzania; 2) expanded in scope in the regional training

Table 8. Summary Findings and Recommendations for Remainder of the Project	
Key findings	**Resulting recommendations**
	centers; and 3) made more efficient and cost-effective by training a few local/regional organizations that would then be able to train others.
Capacity Building and Training	
MEASURE Evaluation has not set targets for CB and therefore does not adequately monitor progress. Other than training databases and progress reports, the evaluation team was unable to find any attempts to set goals and to measure change in capacity at the various system levels. As the premier project for monitoring and evaluation, MEASURE Evaluation should lead the way in setting targets and monitoring CB progress.	Identify indicators and targets for progressive levels of capacity built at all levels of the health system and monitor progress. In countries with large programs, develop national-level CB plans that outline specific goals and planned activities but also continue to allow for unplanned opportunities to build in CB activities.
The capacity that has been built is related to current needs and systems, but it is unclear to the evaluators whether the skills, knowledge, and abilities that have been built are transferable to other health elements or to future M&E needs.	Seek to understand the extent to which organizations are capable of transferring skills learned from HIV/AIDS M&E to other health elements and identify a strategy for ensuring that this level of mastery is obtained.
Mentoring and coaching of key individuals is a strategy for building individual competence. While seen as a successful approach, often implementation of this methodology is informal.	To improve CB results at the individual level, formalize mentoring and coaching as a deliberate process that has clear objectives and is monitored and evaluated.
Informants expressed need for skills in the 'E' of M&E, that is, the capacity to plan and conduct evaluations.	Build on the gains made in monitoring to focus on helping people learn how to conduct evaluations.
Organizations at all levels still struggle with leadership and management issues. One of the most commonly mentioned challenges to building organizational capacity was the issue of staff turnover. This and other management issues impact organizations' ability to effectively conduct M&E activities. While the number of requests for organizational development services has increased, this set of services appears undervalued by some stakeholders in Washington and in the Missions.	To further build capacity at the organizational level, put more emphasis on building strong organizations by setting specific targets for OD and by including OD activities into other requested activities. This will require advocacy from USAID/Washington and the project to convince Missions of the critical importance of organizational issues on developing effective M&E systems. Identify ways to better show the connection between strong organizations and effective M&E systems, starting by identifying clear indicators of OD and monitoring progress over time.
While MEASURE Evaluation has been successful in designing and delivering training programs, there are a number of things they	Require participants to attend sessions in organizational teams. To maximize training as an organizational CB strategy, more of

Table 8. Summary Findings and Recommendations for Remainder of the Project	
Key findings	**Resulting recommendations**
could do to even further maximize the transfer of learning to real world settings.	MEASURE Evaluation's training programs need to utilize a team approach, including DDU. Put more focus on the "pre" and "post" phases of training programs. Begin transferring the delivery of standardized M&E courses to in-country partners.
Demand is much higher than the regional centers can accommodate, and in the long run financial sustainability of the centers is a major concern.	Focus OD of the regional training centers on developing short- and long-term strategies for sustainability, in both technical and financial terms. This could be done through strategic planning, documenting best practices, and developing an advocacy strategy. Advocacy should be done with a view to create critical mass for M&E training from a given country, perhaps through requirements that several persons from a particular organization attend, which could enhance decision-making.
The project evaluates VLDP at 6 and 12 months post-program. A pre- and post-Climate Survey is done, and the outcome of the team project is followed. This approach is very limited in what it provides to those who might invest in this activity as a strategy for leadership development. The outcome of a single team project is not an indicator of a team's ability to demonstrate leadership while facing other work challenges.	Establish indicators of success for these programs for leadership. Study the effectiveness of VLDP/LDP on leadership and management. Find ways to better demonstrate the value added by these programs to organizations and to their capacity to do M&E. Link VLDP and LDP to other MEASURE Evaluation CB activities occurring in the participants' organization or country.
Gaps and Technical Needs	
Key informants identified needs in the areas of measuring HSS and CB, deeper involvement in gender issues related to M&E, costing and cost-effectiveness, rapid techniques for measuring health outcomes, guidelines for implementing USAID's evaluation policies, and increased advocacy for data use.	The USAID management team should consider which of the identified areas of need, particularly those appropriate for Bureau-wide funding, should be recommended as project activities in its final years, and work with MEASURE Evaluation in developing appropriate activities that can be completed in the time remaining. Build capacity of governments and individuals to systematically include gender considerations into RHIS that allow for measuring social, legal, health, and other indicators affecting the health of women, girls, and other at-risk populations and assessing their priority needs to inform the design of projects and activities.

APPENDIX A. SCOPE OF WORK

Scope of Work
MEASURE Evaluation Phase III
Midterm Project Evaluation

I. TITLE

Activity: GH: MEASURE Evaluation Phase III Midterm Project Evaluation

Contract: Global Health Technical Assistance Project (GH Tech), Task Order No. 01

II. PERFORMANCE PERIOD

- Start date: o/a early May 2011
- Completion date: o/a end August 2011

III. FUNDING SOURCE

IV. OBJECTIVES AND PURPOSE OF THE ASSIGNMENT

Overall Purpose:

- To assess the project's performance to date and to assess whether or not the project's activities are achieving the intended results as outlined in the agreement
- To gather information that will help to improve the management of the project for the remainder of its implementation
- To gather information that will result in useful recommendations for a potential future project

External Technical Evaluation

- To evaluate whether or not the project's activities are leading to the results and outcomes outlined in the agreement
- To identify if there have been any technical gaps that have prevented achieving intended results
- Based on accomplishments toward results as well as the current/anticipated environment, identify potential technical future directions

V. BACKGROUND

MEASURE Evaluation Project is a Leader with Associates Cooperative Agreement. The project is implemented by the Carolina Population Center at the University of North Carolina at Chapel Hill (UNC), in partnership with five implementing partners including Futures Group International, ICF Macro, John Snow, Inc., Management Sciences for Health, and Tulane University. The project has a ceiling of up to $181 million. To date, $86,777,091 has been obligated to the project, 67% of which is field funding and 33% is core funding.

The MEASURE Evaluation Project's mission is to provide technical leadership through collaboration at local, national, and global levels to advance the field of global health monitoring and evaluation (M&E) across the spectrum of country health information system components and processes. The project began in 1997 and has gone through two phases: Phase I (1997-2003) and Phase II (2003-2008). Currently, the project is going through Phase III that will end in

2013. The project has been based on the premise that generating demand for data, improving data quality, and enhancing the use of data in policy formulation, program planning, and monitoring and evaluation, will improve health systems, and these improved health systems would, in return, positively impact health outcomes.

A special focus of the MEASURE Evaluation Phase III is on capacity-building and helping host countries move toward sustainability in all aspects of data collection, monitoring and evaluation, and further analysis of data for optimal use in program planning and policy development. The Activity Objective of MEASURE Evaluation Phase III is to be accomplished through achievement of the six results listed below:

Result 1: Increased user demand for quality information, methods, and tools for decision-making

Result 2: Increased in-country individual and institutional technical/managerial capacity and resources for the identification of data needs and the collection, analysis, and communication of appropriate information to meet those needs.

Result 3: Increased collaboration and coordination in efforts to obtain and communicate health, population, and nutrition data in areas of mutual interest.

Result 4: Improved design and implementation of the information-gathering process, including tools, methodologies, and technical guidance to meet users' needs.

Result 5: Increased availability of population, health, and nutrition data, analysis methods, and tools.

Result 6: Increased facilitation of use of health, population, and nutrition data.

In order to achieve these results, MEASURE Evaluation develops new methodologies, disseminates data, builds capacity, promotes the implementation of best practices in monitoring and evaluating health programs, and works to address country-level and global monitoring and evaluation needs.

All project activities are organized into two categories: core-funded and field-funded activities. Core-funded activities include two large segments: Global Health (GH) Bureau-wide Activities and Element-Specific Activities. The GH Bureau-wide agenda features activities that correspond to the following seven technical components: (1) methods and tools; (2) capacity- building; (3) data availability, demand, and use; (4) country ownership; (5) gender; (6) GIS; and (7) knowledge management. The element-specific activities include HIV/AIDS, Tuberculosis (TB), Malaria, Avian Influenza (AI), Maternal and Child Health (MCH), Family Planning and Reproductive Health (FP/RH), Other Public Health Threats (OPHT), and Water Supply and Sanitation (WSS).

Following is an illustrative list of information sources that the evaluators should consult prior to conducting the evaluation: the RFA, the proposal, the agreement, annual work plans, annual reports, performance monitoring plans, financial reports, and other referential or historic documents. The management team will provide a more comprehensive list of reference documents.

This midterm project evaluation should follow the Bureau of Global Health Guidelines for Management Reviews and Project Evaluations (2007), as well as the Agency's new Evaluation guidelines (2011). In addition, the evaluation should take into account relevant U.S. Government/USAID initiatives, policy developments, and reform efforts, such as the U.S. Government GHI and USAID FORWARD, that are linked to the Agency's commitment to Paris Declaration aid effectiveness principles such as alignment with country strategies and priorities,

strengthening and use of country systems, new partnerships and innovations, and strengthened monitoring and evaluation for accountability and results.

VI. SCOPE OF WORK (TASKS TO BE PERFORMED BY THE CONSULTANT TEAM)

The technical evaluation will focus strategically on big picture and overarching questions as well as two of the project's technical areas. Big picture and overarching questions can be divided into the following two categories: (1) questions about the existing project, and (2) questions relevant to the design of potential future project(s). The two technical areas that will be evaluated are (1) Data demand and use (DDU) including knowledge management (KM), and (2) capacity building and training (CBT). The specific questions for this phase of the evaluation are outlined below.

Big Picture and Overarching Questions

1. Questions for Evaluation of MEASURE Evaluation Phase III[20]
   - How satisfied have various stakeholders been with the work done by and assistance from MEASURE Evaluation Phase III, including the following?
     - Missions
     - GH
     - Other stakeholders, including private sector NGOs
   - What is the correspondence between the work MEASURE Evaluation has done under the bureau-wide agenda and what GH has wanted to accomplish under the bureau-wide agenda?
   - How strategic has MEASURE Evaluation been in partnering with other stakeholders and donors to achieve the greatest results?
2. Issues for the Follow-On Project(s)
   - Based on what has been learned from previous phases of MEASURE Evaluation, what would be the optimal structure (i.e. type/number/size of mechanisms and organization/division if broken up) for the follow-on and why?
   - What existing gaps and future technical directions/issues need to be addressed in the follow-on that are not currently being addressed in MEASURE Evaluation Phase III?

Technical Evaluation Questions

1. Data Demand and Use, Knowledge Management
   - Based on available evidence, are the project's DDU and KM products/methods/tools available, useful, and appropriate to key stakeholders?
   - What evidence exists that stakeholders have found the project's TA related to DDU and KM to be useful, appropriate, and timely?
   - What is the effectiveness of the project's approaches to receive feedback from DDU and KM users/stakeholders?
   - How effectively is the project partnering and collaborating with other CAs and global partners involved with DDU and KM activities?

[20] The big picture and overarching questions for MEASURE Phase III will be addressed in part via the management review, which will occur prior to the evaluation.

2. Capacity Building and Training
   - To what extent has the project's CBT efforts contributed to improved capacity at the country level (including at NGOs, government organizations at national and subnational levels, universities etc.)? What are the facilitators and barriers to achieving the intended results?
   - What is the quality of the curricula and trainings (master's degree programs, workshops, and distance learning) based on the available evidence (for example, evaluations by the participants including trainers, students, and others)?
   - To what extent is the project's portfolio of CBT activities meeting the needs of stakeholders?

VII. METHODOLOGY

Data Collection

The evaluation team will work collaboratively with the USAID management team to develop a detailed workplan as well as a data collection strategy including data collection instruments.

For the technical evaluation, it is envisioned that a select number of countries (approximately four with moderate to high M&E investments/money and time (for example, Zambia, Rwanda, Bangladesh, and Ethiopia) would be selected as case studies for the two technical areas of focus (DDU/KM and CBT). The evaluation team will consult with and receive approval from the USAID management team as to the selection of countries for case studies.

The primary methodologies for this evaluation will include (1) document review, (2) in-depth key informant interviews, (3) focus group discussions, (4) surveys, and (5) direct observation. The specific methodologies for each of the evaluation areas are identified and described below; however, where feasible, methods should be combined to address multiple questions at once.

1. Document Review
   - Big picture and overarching questions
     - RFA
     - Project agreement
     - Annual reports
     - Strategies (including KM, CBT, and DDU)
     - Workplans
     - PMP
     - SOWs for field-funded activities
     - Trip reports (review number and nature of TA requests and examples of country use, buy-in, and adaptation)
     - Results reporting (Mission & HQ)
     - Management review report
     - U.S. Government Global Health Initiative (GHI) Strategy
     - USAID FORWARD reform agenda
     - USAID Health Systems Report to Congress
   - Data Demand and Use and KM
     - CoP meeting notes

- Review "use" of products/methods/tools, including website downloads and dissemination of products via CD, print copy, etc.

– CBT
  - Participant evaluations of trainings, workshops, other country-level activities
  - Examination of the curricula and training objectives
  - Tracking retention of trainees within the country organizations using trainee database

2. Key Informant Interviews – in-depth semistructured interviews, in person when possible (for example during country visits), alternatively via phone or video conference
   – Big Picture and Overarching Questions
     - Project staff, including those from the field (potentially at the all-staff meeting in May) and building on what was already done for the management review)
     - BGH stakeholders
     - USAID Missions
   – DDU and KM
     - USAID Missions
     - Other users of the project's DDU and KM products/tools
   – Capacity-Building and Training
     - When then there is a lack of baseline data, include some retrospective questions within interviews to assess the change in time
     - Stakeholders to interview for capacity building activities include
       – USAID Mission staff
       – Key staff at HQ in the Bureau of Global Health
       – Trainers
       – Training participants
       – CDC country-level representatives
3. Focus group discussions
   – CBT
     - Representatives of local ministries
     - Training participants
     - Regional representatives
4. Surveys
   – DDU and KM
     - Survey (email/web-based/phone) with USAID Missions that have used, and those that have not used, the project's DDU/KM services
     - Survey MEASURE Evaluation staff, request documentation of feedback process
     - Survey both CAs and project staff on collaboration and communication
     - Survey key stakeholders—ask if their feedback was requested, if future interactions reflected any of the changes suggested
     - Email/web-based survey to community of practice participants, including the BGH M&E Work Group
   – CBT
     - Follow-up and survey of participants

- Initial survey with USAID Missions and BGH to inform subsequent in-depth interviews
- Survey of country-level CDC representatives

5. Direct observation
   - Big Picture and Overarching Questions
     - Attend the Management Review Debrief
     - Attend and observe the all-staff project meeting in May
   - DDU and KM
     - Observe DDU and KM activities in countries selected for case studies
   - CBT
     - Observe CBT activities in countries selected for case studies

VIII. TEAM COMPOSITION, SKILLS AND LEVEL OF EFFORT

Team Composition

The evaluation team will consist of five professionals that have demonstrated knowledge and experience in the areas described below. Depending on consultants identified, it is tentatively suggested that the team consist of the following professionals: team leader and two CBT specialists plus two data use and KM specialists. It is expected that each of the skills and qualifications described below are covered in their entirety by the Evaluation Team; however, it is understood that specific skills may fall differently across each of the three job descriptions than what is listed below. In addition to the team, GH-Tech may subcontract for specific expertise.

Team Leader/Monitoring and Evaluation Specialist will oversee all aspects of the evaluation. The team leader will liaise with the other consultants and with USAID/GH, oversee data collection and analysis, write sections of the report, and meld contributions of the technical consultants into a coherent set of responses and present conclusions and recommendations to USAID. The team leader should have prior experience and expertise in program evaluation and assessment, understanding of USAID program processes, and experience in monitoring and evaluation of global health programs. Qualifications include

- Track record of successful oversight of the evaluation of complex international technical assistance projects, preferably in health
- Excellent oral and written communication skills in English, including the ability to facilitate groups and present complex material
- Demonstrated knowledge of USAID's policies and priorities in HIV/HIDN/PRH and experience working in developing countries
- Skills in designing qualitative and survey research instruments and methodologies
- Knowledge of monitoring and evaluation in the area of international health (HIV/FP/RH)
- Must be available for travel

Capacity-Building/Organizational Development Specialist(s) (2 positions) will have specialized evaluation experience and expertise in CBT and OD programs in the international health and/or development sector. These individuals will bring the lens of his/her subject matter expertise and experience to bear on all aspects of the Scope of Work. S/he will work closely with the team leader to assess the progress, quality, and relevance of the CBT/OD activities of the project. S/he will work seamlessly with the team leader to interview key informants, conduct data collection and analysis, and write sections of the final report. Qualifications include

- Demonstrated ability to implement and evaluate training programs, including virtual training, with an understanding of CBT/OD programs for building health information systems in developing countries
- Experience in developing and/or evaluating training curricula
- Experience in adult learning and distance learning
- Demonstrated ability to undertake content analysis and write a report
- Must be available for travel

Data Demand and Use/Knowledge Management Specialist(s) (2 positions) will have specialized evaluation experience and expertise in KM and M&E in the international health and/or development sector. These individuals will bring the lens of subject matter expertise and experience to bear on all aspects of the Scope of Work. S/he will work closely with the team leader to assess the progress, quality, and relevance of the DDU and KM activities of the project. S/he will work seamlessly with the team leader to interview key informants, conduct data collection and analysis, and write sections of the final report. Qualifications include

- Experience in M&E of international public health programs and approaches to using data for program improvement
- Experience in the area of Health Systems Strengthening and/or Health Management Information Systems
- Strong background in KM concepts, principles, and practices
- Educational background in a field relevant to data use and knowledge management, such as public health, library science, database administration, information technology, research, or business administration
- Knowledge and experience in website development
- Must be available for travel

Illustrative Level of Effort Table	
Task	**LOE**
Document Review	5 days
Team Planning Meeting	2 days
All Staff Meeting	2 days
Creation of Data Collection Instruments	3 days
Revision of Data Collection Instruments	2 days
Data Collection	21 days
Data Analysis	4 days
Report Writing	5 days
Debrief	1 day
Report Finalization	5 days (TL) 3 days (Team)
Final presentation at USAID	1 day
Total	TL: 51 days; Team Members: 48

A six-day work week is approved for in-country work.

IX. LOGISTICS

MEASURE Evaluation Management Team will provide overall direction to the evaluation team, identify key documents and key informants, and liaise with USAID Missions to ensure logistical support for field visits prior to the initiation of field work. MEASURE Evaluation Management Team shall be available to the team for consultations regarding sources and technical issues, before and during the evaluation process.

Client Roles and Responsibilities:

Before Work

1. Consultant Conflict of Interest. To avoid conflicts of interest or the appearance of a COI, review previous employers listed on the CVs for proposed consultants, and provide additional information regarding potential COI with the project contractors or NGOs evaluated/assessed and information regarding their affiliates.
2. Documents. Identify and prioritize background materials for the consultants and provide them, preferably, in electronic form.
3. Site Visit Preparations. Provide a list of site-visit locations, key contacts, and suggested length of visit for use in planning in-country travel and accurate estimation of country travel line items costs. Missions can protect scarce budgets by using their in-country knowledge to suggest the travel calendar (i.e., number of in-country travel days required to reach each destination and number of days allocated to interviews at each site).
4. Lodgings and Travel. Provide guidance on recommended secure hotels and methods of in-country travel (i.e., car rental companies and other means of transportation) and identify a person to assist with logistics (i.e., visa letters of invitation etc.)
5. USAID-Supplied Participants. Provide guidance regarding participation in the assignment by mission and USAID/W staff (i.e., who will participate, how long, source of funding for their participation).
6. Locally-Established Ceilings and Rates. Provide information as early as possible on ceilings for pay to in-country hires and allowable lodging and per diem rates for government officials, stakeholders, and MOH staff that will travel/participate in activities with the team (i.e., what is per diem amount? is TL responsible to pay this? length of time? etc.).

During Work

1. Formal and Official Meetings. Arrange key appointments with national and local government officials and accompany the team on these introductory interviews (especially important in high-level meetings).
2. Other Meetings. If appropriate, assist in identifying and helping to set up meetings with local professionals relevant to the assignment.
3. Facilitate Contacts with Partners. Introduce the team to project partners, local government officials and other stakeholders, and where applicable and appropriate, prepare and send out an introduction letter for team's arrival and/or anticipated meetings.

After Work:

1. Timely Reviews. Provide timely review of draft/final reports and approval of the deliverables.

X. DELIVERABLES AND PRODUCTS

USAID Criteria to Ensure the Quality of the Evaluation Report

- The evaluation report should represent a thoughtful, well-researched, and well organized effort to objectively evaluate what worked in the project, what did not, and why.
- The evaluation report shall address all evaluation questions included in the Statement of Work (SOW).
- All modifications to the SOW, whether in technical requirements, evaluation questions, evaluation team composition, methodology, or timeline need to be agreed upon in writing by the AOTR.
- The evaluation methodology shall be explained in detail and all tools used in conducting evaluation such as questionnaires, checklists, and discussion guides will be included in an Annex in the final report.
- Limitations to the evaluation shall be disclosed in the report, with particular attention to the limitations associated with the valuation methodology (selection bias, recall bias, unobservable differences between comparator groups, etc.).
- Evaluation findings should be presented as analyzed facts, evidence, and data and not based on anecdotes, hearsay, or the compilation of people's opinions. Findings should be specific, concise, and supported by strong quantitative or qualitative evidence.
- Sources of information need to be properly identified and listed in an annex.
- Recommendations need to be supported by a specific set of findings.
- Recommendations should be action-oriented, practical and specific, with defined responsibility for the action.

- Final workplan and data collection instruments: The evaluation team will prepare a detailed workplan in response to SOW requirements and evaluation questions. The detailed workplan should identify the countries for site visits, the individuals and stakeholders for surveys and in-depth interviews and should include each of the proposed data collection instruments (i.e. structured interview guides, surveys, observation forms, etc.). A draft of the detailed workplan and data collection instruments should be submitted to the MEASURE Evaluation Management Team for input prior to finalization.
- Draft Report: This report should describe the findings from the technical evaluation as well as findings related to the big picture and overarching issues spanning both the Management Review and the evaluation. The report should separately and comprehensively address each of the objectives and questions listed in the Statement of Work as well as the findings, interpretations, conclusions, and recommendations which should be clearly supported by the collected and analyzed data. Findings should be presented graphically where feasible and appropriate using graphs, tables and charts. The final report should make recommendations for future action, including recommendations that may be relevant to the implementation of the second half of the existing project as well as for the redesign of the future project(s) in either technical and/or managerial aspects. The report should not exceed 40 pages in length (not including appendices, list of contacts, etc.). The final report should contain an executive summary, table of contents, main text including findings, conclusions, and recommendations. Annexes should include the Scope of Work, description of the methodology used, lists of individuals and organizations consulted, data collection instruments (i.e. questionnaires and discussion guides etc.), and bibliography of documents reviewed. The executive summary

should accurately represent the report as a whole and should not exceed two pages in length.

- Final Report: After receiving the draft version of the report, USAID will have 10 days to respond with one set of comments. The Team will then have one week to revise the report and submit it to USAID. An electronic version of the Final Report should be submitted to the MEASURE Evaluation Management Team along with 15 hard copies. GH Tech will provide the edited and formatted final document approximately 30 days after USAID provides final approval of the content. The report will be released as a public document on the USAID Development Experience Clearinghouse (DEC) (http://dec.usaid.gov) and the GH Tech project website www.ghtechproject.com).
- Final Presentation: The final report is to be accompanied by a PowerPoint presentation that aims to debrief selected stakeholders of the results and recommendations stemming from the midterm evaluation. A draft of the Final Presentation should be submitted to the MEASURE Evaluation management team prior to finalization.

XI. RELATIONSHIPS AND RESPONSIBILITIES

This evaluation will be a participatory external review, in the sense that the GH Tech evaluation team will work collaboratively with the USAID management team throughout the duration of evaluation.

The evaluation team will consult with the USAID management team regarding the methodology, approach, and data collection instruments, but will be primarily responsible for data collection, analysis, and report writing.

XII. MISSION AND/OR WASHINGTON CONTACT PEOPLE/PERSON

USAID Management team points of contact: Erin Balch, Ana Djapovic Scholl
MEASURE Project point of contact: Sian Curtis
Mission points of contact: TBD

XIII. COST ESTIMATE (EXCLUDED)

XIV. REFERENCES (PROJECT AND RELEVANT COUNTRY DOCUMENTS)

- Guidelines for Management Reviews and Project Evaluations, Bureau of Global Health, 2007
- USAID Evaluation Policy, 2011
- RFA
- Project Proposal
- Cooperative Agreement
- Project Strategies (KM, DDU and Capacity Building)
- Project Workplans (years 1-4)
- Project Annual Reports
- PMP
- SOWs for field-funded activities
- Trip Reports
- Financial Reports
- Participant evaluations of trainings
- Community of practice meeting notes/records

- Capacity building and training curricula
- Previous LMS evaluations of VLDP and LDP
- Previous evaluation of capacity building under MEASURE Evaluation Phase II, 2005
- Management review data (interview transcripts) and final report
- SOW for Phase I Expanded Management review
- Checklist for Evaluation Reports
- U.S. Government Global Health Initiative (GHI) Strategy
- USAID FORWARD reform agenda
- USAID Health Systems Report to Congress

APPENDIX B. KEY INFORMANTS

USAID/WASHINGTON

USAID MEASURE Evaluation III Management Team

Krista Stewart, GH/OHA/SPER
Erin Balch, GH/OHA/SPER
Rachel Lucas, GH/PRH
Lisa Maniscalco, GH/HIDN
Kathleen Handley, GH/OHA
Ana Djapovic Scholl, GH/OHA
Kristen Wares, GH/OHA
Janet Shriberg, GH/OHA/OVC

GH/OHA Leadership

Paul Mahanna
Ben Gustafson

GH/OHA ISPE Team

John Novak
Elisa Ballard
Maria Au

GH/PRH Leadership

Scott Radloff
Ellen Starbird
Sarah Harbison

GH/PRH Division Chiefs

Mihira Karra
Liz Schoenecker
Mark Rilling
Kathryn Panther

GH/Gender Working Group

Diana Prieto (OHA)
Michal Avni (PRH)
Elizabeth Bowen (HIDN)

GH/HIDN Leadership

Richard Greene
Elizabeth Fox

GH/HIDN/Health Systems Division

Bob Emrey

GH/HIDN/Malaria

Bernard Nahlen (PMI Deputy Coordinator; RBM MERG)
Misun Choi (PMI M&E)

GH/HIDN/MCH/Water

Al Bartlett (Child Health)
Mary Ellen Stanton (Maternal Health)

GH/HIDN/Nutrition

Eunyong Chung

GH/HIDN/TB

Amy Piatek

GH/HIDN/Research

Neal Brandes

GH/KM and eHealth Teams

Madeleine Short Fabic, PRH (KM)

GH/HSS Team

Kelly Saldana
Estelle Quain

GH/SPBO

Carl Mabbs-Zeno, Sr. Economic Advisor
Madeleine Short Fabic, M&E Officer

GH/GHI Launch Team

Erin Eckert

AFR

Karen Fogg
Roy Miller
Stella Goings (retired)

LAC

Susan Thollaugh
Veronica Valdivieso

AME

Gary Cook
Kristina Yarrow

E&E

Susanna Baker
Paul Holmes

PPL/LER Office

Gerry Britan
Winston Allen

PEPFAR

OVC TWG

Bev Nyberg (OGAC)
Gretchen Bachman (OHA)

OGAC Strategic Information Group (SI)

Paul Bouey
Rob Lyerla
Vanessa Brown
Nate Heard

CDC SI

Abu Abdul-Quader

PRESIDENTIAL MALARIA INITIATIVE

CDC PMI

Steve Yoon

Roll Back Malaria (RBM) Monitoring & Evaluation Reference Group (MERG)

Tessa Wardlaw (recent past MERG co-chair), UNICEF
Holly Newby (current MERG co-chair), Statistics and Monitoring Section, Division of Policy and Practice, UNICEF
Rick Steketee, MASEPA-PATH

MEASURE EVALUATION MANAGEMENT TEAM

Sian Curtis, UNC, Project Director
Jim Thomas, UNC, HIV and other infectious diseases
Bates Buckner, UNC, Field operations
Phil Lyons, UNC, Finance
Jason Smith, UNC, Capacity Building and Knowledge Management
Stephanie Mullen, Principal Investigator, John Snow Inc.
Scott Moreland, Principal Investigator, Constella Futures
Ani Hyslop, Principal Investigator, Macro International

Xavier Alterescu, Principal Investigator, Management Sciences for Health
Anastasia Gage, Principal Investigator, Tulane University

OTHER MEASURE EVALUATION STAFF (AT ALL-STAFF MEETING)

Leah Gordon, UNC, Knowledge Management Specialist
Hugh Rigby, UNC, Communications Director
Alimou Barry, RHIS Senior Technical Advisor, John Snow Inc.
Tara Nutley, Senior Technical Specialist (DDU), Futures
Lee Sutton, UNC, M&E Team Leader
Beatriz Plaza, UNC, Research Associate
Scott McKeown, MSH, Organizational Development Advisor
Anupa Deshpande, Futures
Leontine Glassou, Resident Advisor to Cote d'Ivoire
Dra. Maria del Carmen Miranda, Resident Advisor to Honduras
Christine De La Tour, M&E Specialist (Macro)
Denise Johnson, M&E Specialist (Macro)
Dr. Ravi Goud, M&E Specialist (Macro)
Sujata Ram, Malaria Infectious Disease Resident Advisor, RDMA

MEASURE EVALUATION-SPONSORED COMMUNITIES OF PRACTICE (E-MAIL/INTERNET SURVEY)

BGH M&E Working Group
RHINO
Child Status Network
M&E of Malaria
(Note: team also reviewed results of MEASURE Evaluation's survey of Datause Net and AIMENet)

USAID COUNTRY MISSIONS (TELEPHONE/EMAIL INTERVIEWS FOR COUNTRIES NOT VISITED BY THE EVALUATION TEAM)

USAID/Zambia
Regional Development Mission for Asia
USAID/Honduras
USAID/Barbados
USAID/Angola
USAID/Bangladesh
USAID/Dominican Republic
USAID/Guyana
USAID/Liberia
USAID/Mali
USAID/Ethiopia
USAID/Peru

USAID/Uganda
USAID/South Africa

TANZANIA SITE VISIT INTERVIEWEES:

USAID/Tanzania

Erasmo A. Malekela, Project Management Specialist, M&E
Elizabeth N.E. Lema, OVC Project Management Specialist

MEASURE Evaluation Resident Staff

Dawne Walker, Resident Advisor, Activity Lead (Futures)
Zaddy Kibau, Senior M&E Specialist (Futures)
Prudence Masako, M&E Specialist (Futures)
Yohana Wilfred Mapala, M&E Specialist (Futures)
Camilius Kapela, M&E Specialist (Futures)
Agnes Nkye, Project Administrator (Futures)
Halima Mohamed, Office Assistant (Futures)

Implementing Partners

Herbert Mugumya, Chief of Party, Pamoja Tuwallee Children Program, Africare
Sesil C. Latemba, FHI, ICT and MVC Data Specialist
John Charles, FHI, Technical Officer, M&E
Garrett Hubbard, FHI, Program Manager
Dr. Godwin Munuo, PATH
Kandira Chuki, PharmAccess, M&E Manager
Salome Kisenge, Salvation Army (SAWSO)
Michael Machaku, M&E Officer, JHPIEGO
Herbert Nsauye, M&E Program Manager, World Education, Inc.
Eng. Koronel Kema, Paul Harris Fellow of the International Rotary, Program Manager AMREF in Tanzania

Host Country

Jeane Ndyetabura, Assistant Commissioner, Ministry of Health and Social Welfare, Department of Social Welfare
Commissioner, Ministry of Health and Social Welfare, Department of Social Welfare

Other U.S. Government Representatives

Zaharani Kalungwa, Database Administrator, CDC, National Medical Research Institute

RWANDA SITE VISIT INTERVIEWEES

USAID/Rwanda

Justice Kamwesigye, MEASURE Evaluation Activity Manager

MEASURE Evaluation Resident Staff

Andrew Koleros, Program Advisor/ Country Focal Person (Futures)

Joseph Mabirizi, Country Representative and Resident Advisor (Futures)

Candy Basomingera, Resident Advisor (Futures)

Kyampof Kirota, Resident Advisor (Futures)

Host Country Government

Gakunzi Sebaziga, Director of Planning, Coordination, Monitoring and Evaluation, National AIDS Control Commission (CNLS,) Ministry of Health

Anita Asiimwe, Executive Secretary, CNLS, Ministry of Health

Pierre Dongier, Technical Advisor, CNLS, Ministry of Health

Charles Ntare, Head of Health Management Information System, Ministry of Health

Jean Paul Mfizi, Decentralization Unit, Ministry of Health

Esperance Ndenga, Head of M&E Unit and Master Trainer, Ministry of Health

Joesph Ndengeye, Data Analyst, CNLS, Ministry of Health

Etienne Rugigana, Professor and Master Trainer, National University of Rwanda School of Public Health

Clorilole Mukarianzi, CDLS Coordinator, Kieukiro District

Alphonse Ndagijimana, CDLS Coordinator, Nyamasheke District

Edouard Muhima Lukayisha, CDLS Coordinator, Kayonza District

Joseph Tuyizre, CDLS Coordinator, Rubairi District

Tannier Sezobungo, CDLS Coordinator, Lusizi District

Onesire Nshimyumukish, CDLS Coordinator

Placidie Mugwaneza, Head of Clinical Prevention, Center for Treatment on AIDS, Malaria, Tuberculosis and Other Epidemics (TRAC Plus), Ministry of Health

Jean Pierre Nyemazi, Head of M&E, TRAC Plus

Mutagoma Mwumvaneza, Head of Epidemiology, TRAC Plus

Jean Claude Nduwamung, Superviseru, Hopital Kabaya/District Ngororero (VLDP trainee)

Jean Bizimana, M&E Officer, Hopital Kabaya/District Ngororero (VLDP trainee)

Elias Bizimana, Superviseur, Hopital Kabaya/District Ngororero (VLDP trainee)

Jean Paul Ntakinanirimana, Administrateur, Hopital Kabaya/Distraict Ngororero (VLDP trainee)

Tharcisse Ndagijimana, Chief of Nursing, Hopital Kabaya/District Ngororero (VLDP trainee)

Clemence Mukantwali, Data Manager, Hopital Kabaya/District Ngororero (VLDP trainee)

Joseph Ngomijana, Comptable, Hopital Kabaya/District Ngororero (VLDP trainee)

Christia Renzaho, Medecin, Hopital Kabaya/District Ngororero (VLDP trainee)

Michel Mbaraga, Laborantin, Hopital Kabaya/District Ngororero (VLDP trainee)

Delphine Irakarama, Phisiotherapeute, Hopital Kabaya/District Ngororero (VLDP trainee)

Eric Rubyutsa, Trainer in Health Information Systems, Health Management Information Systems Section, Ministry of Health (GIS training)

Michel Kaabera, Data Analyst, HMIS, Ministry of Health (GIS Training)

Joseph Ndengeye, Data Analyst, CNLS, Ministry of Health (GIS Training)

Eric Remera, Statistician, TRAC Plus (GIS Training)

Implementing Organizations

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Madina Mutagoma, M&E Officer, RRP+ (Rwanda Network of People Living with HIV/AIDS)

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Other U.S. Government and International Organizations

Jean Baptiste Koama, HMIS Specialist, CDC

Francois Sobela, HIV Advisor, WHO

Susan Kiragu, M&E Advisor, UNAIDS

Itete Karagire, M&E Officer, Global Fund Country Coordinating Mechanism (CCM)

Tedla Mezemir Damte, Clinical Director, International Center for AIDS Care and Treatment Programs (ICAP) of the Mailman School of Public Health, Columbia University

MOZAMBIQUE SITE VISIT INTERVIEWS:

USAID/Mozambique

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Host Country Government

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Cecilia Uamusse, M&E Officer, National AIDS Council (CNCS)

Dr. Manuel Dinis, Director of Health Department, Ministry of Defense

Engehheiro Escova, IT Advisor, Ministry of Defense

Dr. Antonio Pagule, Director of Planning and Cooperation, Ministry of Women and Social Affairs

Dr. Graciano Langa, Deputy Director, Ministry of Women and Social Affairs

Dra. Agatha, Head of Planning and Cooperation Department, Ministry of Women and Social Affairs

Dr. Benedito Manjate, National AIDS Council Program Manager for Gaza Province

Other Agencies

Jason Kneuppel, Informatics Advisor, CDC

Thandi Harris, PEPFAR Reporting and Planning Specialist, US Embassy

Antonio Langa, PEPFAR Coordinator, DOD

Implementing Partners

Rita Badiane, Representative, Pathfinder

Individuals ("Godmothers") recruited by NGOs located in Gaza district who were asked to assist in data collection (World Vision, PSI, Elizabeth Glazer Foundation)

NIGERIA SITE VISIT INTERVIEWS:

USAID/Nigeria

Akinyemi O. Atobatele, M&E Manager

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MEASURE Evaluation Resident Staff

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Samson Bamidele, M&E Advisor

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Bolaji Fapohunda, M&E Advisor

Nafysah Koguna, Adminstrative Officer

Host Country Government

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Shafie Ali, M&E Officer, Federal Ministry of Women Affairs and Social Development

Dr. Kayode Ogungbemi, Director of Knowledge Management, National Action Committee on AIDS (NACA)

Dr. Greg Ashefor, Deputy Director, National Action Committee on AIDS

Francis Agbo, Principal Program Officer, National Action Committee on AIDS

Allen Kenneth, M&E Officer, National Action Committee on AIDS

Perpetua Amodu-Agbi, M&E Officer, National AIDS and STD Control Program (NASCP)

Mercy Morka, M&E Officer, NASCP

Dr. Gbenga Ijaodola, Medical Officer, NASCP

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Bolaji Oladejo, Coordinator e-Health Data, Federal Ministry of Health, Department of Planning Research and Statistics, Data Documentation Center

Dr. Okoye, Director, Anambra States Agency for Control of AIDS (SACA)

Dr. Segun Ogboye, Director, Lagos SACA

Dr. Ashiru Rajab, Director, Kano SACA

Dr. Tunde Kutey, Coordinator of M&E Program, Obafemi Awolo University

Dr. Clara Ejembi, Public health physician and lecturer in Community Health, Ahmadu Bello University

Other Implementing Agencies

Bukola, M&E Manager, CiSHAN (HIV/AIDS NGO Network)

Banji Oladipupo, Data Manager, CiSHAN

Carlos Torres, Chief of Party, Nigeria M&E Management Services Project (MEMS)

Alhaji Zakariya Zakari, Deputy Chief of Party, Nigeria MEMS

Deanne Evans, Project Manager, Save the Children

Other International Organizations

Maryam Enyiazu, Child Protection Specialist, UNICEF

Dr. Jog Sagbohan, Senior M&E Officer, UNAIDS

SENEGAL SITE VISIT INTERVIEWS

USAID/Senegal

Izetta Simons, Health Nutrition and Population Officer

Amadou Mbow-Baye, Maternal and Child Health/family planning

Sounka Ndiaye, M&E specialist

CESAG

Prof. Alfred Gbaka, General Director

Jerome Bassene, General Secretary

Dr. Amani Koffi, Director, Health Management Institute

Dr. Denise Apologan, Health Economist and Facilitator

Host Country Government

Ibrahima Khaliloulah, Geographer, Health Information System Department, Ministry of Public Health

Oumou Kalsom Diallo Gueve, Head of IT, Health Information System Department, Ministry of Public Health

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Seynabou Ndour, M&E Manager, HIV/AIDS and focal point for PMTCT, Centre PMI de la Medina

Dr. Moussa Diakhate, Head of Health Management Information System, Health Information System Department, Ministry of Public Health

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"RAPPORT FINAL DU SEMINAIRE: Amélioration de la Performance des Systèmes d'Information de Routine (SISR) et de l'Utilisation de l'Information pour la Gestion des Systèmes de Santé." Report prepared from CESAG RHIS Workshop, 2010. Bassene, Jerome.

"CESAG Capacity Building Plan," MEASURE Evaluation.

APPENDIX D. QUESTIONNAIRES AND SURVEYS

USAID/W PERSONNEL WHO HAVE STRONG FAMILIARITY/EXPERIENCE WITH MEASURE EVALUATION

1. Satisfaction:
   - What in your view have been the key achievements of MEASURE Evaluation III thus far; i.e., what would not have happened, or have happened as quickly, without MEASURE Evaluation III?
   - To what extent is MEASURE Evaluation III's work aligned with the key priorities of GHB, GHI, and the international health community? Please give examples.
   - What are areas where MEASURE Evaluation III could do better, in terms of quality of interactions, processes that the project uses, technical work, or knowledge sharing? Please give examples.
   - Please comment on how well MEASURE Evaluation III is addressing or incorporating into its work emerging priorities, such as renewed emphasis on gender, sustainability, and country ownership?
2. Collaboration and partnering:
   - Is MEASURE Evaluation III doing enough to work collaboratively with other USAID central projects and CAs? In what ways are they working really well? Are important connections not being made, why not, and how can this be improved?
   - In what ways is MEASURE Evaluation III contributing to international and multi-donor/partner fora? (Please be specific.) To what extent is MEASURE Evaluation III collaborating with the organizations, and on the issues, that are of highest priority to USAID?
3. DDU, knowledge management and capacity building: (Depending on time, the last three bullets may be skipped.)
   - Which of MEASURE Evaluation III's KM products—such as its tools and methodologies, publications, website—do you use in your work? Please comment about the extent to which you find these products timely and useful. How could they be improved?
   - How do you find out about MEASURE Evaluation III innovations and activities that occur across elements? From your understanding, how well are products developed for one element getting transferred to others? Could this be improved?
   - In your view, is MEASURE Evaluation III adequately addressing capacity building needs? Please elaborate.
   - Are you a member of a Community of Practice? If so, please comment on its benefits.
   - How does siloing of KM and CBT within MEASURE Evaluation III structure affect the project's ability to provide KM and CBT support to its other activities?
4. Future directions:
   - Given your experience with MEASURE Evaluation III and other centrally-funded projects, what are the strengths and weaknesses of the mechanism and what would you like to see changed in a future project?
   - What are the technical gaps or emerging priorities that need to be addressed, either in the remainder of MEASURE Evaluation III or in a follow-on?
   -

OTHER USAID AND U.S.-BASED STAKEHOLDERS WHO ARE LESS FAMILIAR WITH MEASURE EVALUATION

1. Knowledge about MEASURE EVALUATION III
   - How familiar are you with MEASURE EVALUATION III and its activities?
     - Bureau-wide
     - In the areas of KM, DDU and CBT
     - In the field
   - Are you familiar with the project's M&E tools and resources? (E.g., Performance of Routine Health Information System (PRISM), Priorities for Local AIDS Control Efforts (PLACE), Monitoring and Evaluation System Strengthening Tool, Data Quality Assurance Tools, M&E Fundamentals, a self-guided course, and others) If yes, have you used them? How have you used them?

Note: Questions below will be used selectively, depending on the level of familiarity of the individual with the project.

2. Project responsiveness to priority needs:
   - What do you consider to be the most important needs for monitoring and evaluation in health (especially in the area of health that you work in), considering the priorities of the Global Health Bureau and your office?
     - Over the next two years
     - Over the longer term
   - From what you know about the MEASURE Evaluation III project, how well is it meeting Missions' or Headquarter's need? To what extent have its tools and research informed programming?
   - What are the M&E needs in the emerging priority areas of gender, sustainability, country ownership, and collaboration with the international community? Can you comment on how well MEASURE Evaluation III is addressing these needs?
   - From what you know about the project, what have been the key achievements of MEASURE Evaluation III thus far; i.e. what would not have happened, or have happened as quickly, without MEASURE Evaluation III?
3. DDU, knowledge management, and capacity building:
   - What do you view as the most important needs for M&E in health in these areas:
     - Capacity building,
     - Sharing of tools, methodologies and best practices,
     - Use of data for evidence-driven decision-making.
   - To what extent is MEASURE Evaluation III addressing these areas, and where should the focus of efforts be in the future?
   - Do you subscribe to any of MEASURE Evaluation III's online newsletters (MONITOR, AIMENet, etc). Why/why not?
   - Are you a member of any of the Working Groups or CoPs that MEASURE Evaluation sponsors (BGH cooperative agreement, M&E working Group, Datause Net, etc)? Why/why not?
   - Are you aware of the project's recent publications? Do you refer to or use any of the project's publications? If so, which ones? (Recent publications include "Quick Guide: Tools for Data Demand and Use in the Health Sector," "Stakeholder Engagement Tool,"

"Framework for Linking Data with Action," and "Fact Sheet: Strengthening Health Service Delivery by Community-Based Organizations—The Role of Data.")

- Have you seen any of the recent presentations done by the project, especially as part of the Global Health Initiative series? If so, which ones? If not, why?

4. Future structure:
   - Given your knowledge of MEASURE Evaluation III and other centrally-funded projects, what are the strengths and weaknesses of the mechanism and what would you like to see changed in a future project?

USAID FIELD MISSION STAFF

1. Satisfaction
   - What in your view have been the key achievements of MEASURE Evaluation III in your country thus far; i.e. what would not have happened, or have happened as quickly, without MEASURE Evaluation III?
   - Do you plan to use MEASURE Evaluation III in the future? Why or why not?
   - What are areas where MEASURE Evaluation III could do better, in terms of quality of interactions, processes that the project uses, or technical work? Please give examples.
   - To what extent is MEASURE Evaluation III's work aligned with the key priorities of USAID, the country, and the international health community? Please give examples.
   - *Please comment on communications between the field, USAID/W and Measure Evaluation staff.
2. Collaboration and partnering:
   - *Is MEASURE Evaluation III doing enough to work collaboratively with other USAID projects and CAs? Are there important connections that are not being made, why not, and how could this be improved?
   - *In what ways is MEASURE Evaluation III contributing to international and multi-donor/partner fora? (Please be specific.) To what extent is MEASURE Evaluation III collaborating with the organizations, and on the issues, that are of highest priority to USAID?
3. Knowledge management:
   - *Which of MEASURE Evaluation III's KM products (e.g., tools and methodologies, publications, website) do you use in your work? How timely and useful are its products? How could they be improved?
   - How do you find out about MEASURE Evaluation III innovations and activities that occur across elements or in other countries? In your view, how well are products developed for one element or for one country getting transferred to others? Could this be improved?
   - Are you a member of a Community of Practice? If so, please comment on its usefulness and how it could be improved.
4. Data demand and use:
   - *Among MEASURE Evaluation III data-informed, decision-making products that have been used in your country, which have been most and least effective?

5. Capacity building and training:
   - How well are MEASURE Evaluation III's activities in your country meeting capacity building and training needs?
   - To what extent do you think current MEASURE Evaluation III clients will be able to use what they have learned without further support by the end of MEASURE Evaluation III? Can you give examples of people or organizations that can now apply MEASURE Evaluation III products without further technical support from MEASURE Evaluation III – including individuals trained by the project?
6. Future directions:
   - Given your experience with MEASURE Evaluation III and other centrally-funded projects, what are the strengths and weaknesses of the mechanism? What would you like to see changed in a future project?
   - *What are the technical gaps, emerging priorities and innovations that need to be addressed, either in the remainder of MEASURE Evaluation III or in a follow-on?

MEASURE EVALUATION-3 STAFF

1. Role /Overview
   - Describe your role in this project?
   - In what ways do you interact with the MEASURE Evaluation sub-partners on activities (if there are multiple sub-partners in country)? Do you have suggestions for improving the way sub-partners work together in this country?
   - Are you getting what you need from headquarters in the US to do your job? If not, what suggestions do you have for improvements?
2. Satisfaction
   - What have been your most successful activities/products? In what ways have they been successful?
   - What have been your least successful activities/products? Why?
   - Who (audience) uses the MEASURE Evaluation III tools, training, services the most? Who needs to use them but is not? Why do you think they are not using MEASURE Evaluation III products/services?
3. External Partners
   - Who (external to MEASURE Evaluation III) do you partner or collaborate with? How do you partner with them? What are you achieving with this partnership?
   - Who do you wish you could partner with? What could they bring to your work? Why have you not partnered with this group/organization?
4. KM/DDU
   - What has been the most effective strategy for getting organizations to more effectively/efficiently collect and use health data?
   - What has been the most effective method for letting people know about tools, training and other MEASURE Evaluation III services?
   - How do you involve others in the development of products or in the redesign of products/services? (input/feedback)
   - What sources of information do you use for your work? How do you learn new knowledge or skills?

- Have you ever benefited from working with or learning from MEASURE Evaluation III employees in other countries? How? Why not?
- Do you participate in a Community of Practice? If yes, what are the benefits of participation?

5. Capacity Building
   - Where have you seen the greatest growth in capacity in this country; in the abilities to collect, analyze, or use data? Is this sectorwide success, such as HIV, maternal and child health, nutrition? Give examples.
   - At what system level have you been most successful in building capacity— individual, organizational or national?
   - What activities are being lead or implemented by MEASURE Evaluation III staff now that will be independently lead/implemented by in-country organizations?
   - Do you have CB goals for the next two years? What are they? Are you are on track to meet these goals?
   - If MEASURE Evaluation III no longer existed, what would be the impact? How much longer does MEASURE Evaluation III need to work in this country before this work can be done independently? What needs to happen to get to this point?
6. Future
   - What gaps are there in the services or products you offer in this country?
   - Do you have suggestions for what might be done in the next two years to strengthen your efforts to build capacity in this country?

DONORS

1. Strategic partnerships
   - In which areas have you been collaborating/partnering with MEASURE Evaluation III?
   - At what level are you partnering with MEASURE Evaluation III?
     - Strategic
     - Technical
   - How have you been collaborating with MEASURE Evaluation III (pooled resources)?
2. Satisfaction
   - What have you been able to do through this partnership that you not have been able to do otherwise?
   - Is there anything you would like to see improved?
   - Is in your opinion MEASURE Evaluation III assistance aligned with the needs of the country?
3. Knowledge management (KM)
   - Are you familiar with MEASURE Evaluation III website, CoP, and Newsletter?
   - What do you find useful? What benefits are you getting from them?
4. Data Demand and Use (DDU)
   - Are you familiar with data informed decision making, tools, training, and guidance?
   - Are you seeing evidence that more data is being used in decision-making?

5. Capacity Building (CB)
   - In what ways is MEASURE Evaluation III improving M&E capacity in national entities?
   - In your opinion, do these activities lead to more national ownership in terms of planning and managing M&E activities?
   - How well is gender being addressed?
6. Existing gaps and future technical directions or issues
   - Which gaps and technical directions do you feel need to be better addressed?
   - Are there innovation approaches that you know about that MEASURE Evaluation III should use?

HOST COUNTRY ORGANIZATIONS AND IPS

1. Satisfaction
   - What have you been able to do with MEASURE Evaluation III assistance that you would not have been able to do otherwise and how did you apply that?
   - Was there anything you were dissatisfied with (interactions, technical, process, knowledge)?
   - Would you use MEASURE Evaluation III again? Why or why not?
2. Partnerships
   - With what other people/project/groups should the project have been partnering but was not, and what were the obstacles?
   - How does MEASURE Evaluation III collaborate to make the national health strategy work strategically in the area of evaluation in health; and do they sit in a working group to monitor the implementation of evaluation in the country?
   - How does MEASURE Evaluation III contribute to monitoring for multisector collaboration?
3. Gaps and future technical directions
   - What are the gaps and future technical directions that need to be addressed?
   - Are there areas of innovation that should be given more emphasis, and which are these?
   - Are there emerging priorities including gender?
4. Knowledge Management (KM)
   - What sources do you use for information you need to do your work?
   - How do you make use of MEASURE Evaluation III's website and newsletter?
   - How are you learning about activities across the MEASURE Evaluation III project?
   - How did you apply the project's KM products/methods/tools you received?
   - Are you a member of a CoP, and what are the benefits?
5. Data Demand and Use (DDU)
   - What DDU products/methods/tools do you use? Note: list them
   - Could you give an example?
   - What do you like and dislike about them?
   - What other DDU products/ methods/tools do you need to do your work?
   - Could you give an example?
   - Have they changed the way you do your work?
   - Did you find DDU TA activities useful and timely?

- Have they changed the way you do your work?

6. Capacity Building (CB)
   - What activities now being carried out by MEASURE Evaluation III (on a technical level and on an organizational level) would you expect to/want to be able to do on your own by the end of MEASURE Evaluation III?
   - To what extent have CBT activities resulted in changes in your organization?
   - Why or why not? (barriers and facilitators)
   - Are these activities meeting your needs in capacity building and training and what more is needed?

EMAIL QUESTIONNAIRE TO USAIDS WHO DO NOT USE THE PROJECT.

Dear Colleagues,

With only two years left of MEASURE Evaluation Phase III, we are in the midst of a midterm evaluation aimed at reviewing the project's progress toward its overall objectives to date, identifying changes that may improve its effectiveness over the remainder of the project, and suggesting future directions and project structure of any potential follow-on.

Because MEASURE Evaluation Phase III is primarily aimed at supporting the field, the midterm evaluation team wishes to have inputs from both users and non-users of the project. Your mission has not used field support to obtain the services of MEASURE Evaluation, but it is important to us to have your views on the project, if you have any, and to understand why you have not used the services of the project.

I would greatly appreciate your taking a few minutes to respond to the questions below. **Please send your response to Vikka Molldrem**, the midterm evaluation team leader, who is copied on this email. If you prefer not to put anything in writing, then please contact Vikka within the next week with a date and time (including phone number) when she can call you for an oral interview. We would like all interviews to be completed by June 17. The best times for a call are this week (June 1-3) or, if after that, early in the morning between 6:00 and 9:00 AM EDT, prior to June 17.

Your responses to the questions will be confidential—no one but the evaluation team will be able to identify your responses, and none of your comments will be attributed to you directly, though the team may want to use a quote from your response anonymously, unless you direct them not to do so.

We fully understand the busy lives of Mission staff, but we do highly value your response and do hope you will be able to find time to provide your important input. **If there is someone else on your staff who you think is more appropriate to provide this input, please pass this email to them.**

I would like to thank you in advance for taking the time to help us on this effort. A good response from the field will help in making this project and any follow-on as useful to the field as possible.

Sincerely,
Krista Stewart, PhD
AOTR, MEASURE Evaluation Phase III
202-712-0808

1. The focus of MEASURE Evaluation Phase III is on capacity building and helping host countries move toward sustainability in all aspects of data collection, monitoring and evaluation, and further analysis of data for optimal use in program planning. What is the reason that you have not invested in the MEASURE Evaluation Phase III Project? (Please circle all that apply and provide details)
   a. Unaware of the services this project provides
   b. Services of MEASURE Evaluation are not needed in this country
   c. Receive support from another source
   d. Not happy with the quality of MEASURE Evaluation's services in the past
   e. Currently using MEASURE Evaluation's services
   f. Plan to use MEASURE Evaluations services within next two years
   g. Other reason: _____

Please elaborate briefly on your reason(s):

2. If there have been any activities from MEASURE Evaluation Phase III that have been carried out in your country, please comment on how useful these have been.

3. Have you used any of MEASURE Evaluation's knowledge management tools, such as its website, publications, or communities of practice? If so, please comment on their usefulness.

4. Have you used any of the other tools or methodologies developed through MEASURE Evaluation in your work—for example, Routine Data Quality Assessment Tool (RDQA) or Data Quality Assessment Tool (DQA), Performance of Routine Information System Management (PRISM), Priorities for Local AIDS Control Efforts (PLACE), etc.?

5. What are the key technical gaps in your country limiting data-driven decision-making, and what suggestions do you have for future directions in a follow-on project to address these needs?

6. Other comments:

EMAIL QUESTIONNAIRE TO USAIDS WHO USE THE PROJECT:

Dear Colleagues,

With only two years left of MEASURE Evaluation Phase III, we are in the midst of a mid-term evaluation aimed at reviewing the project's progress toward its overall objectives to date, identifying changes that may improve its effectiveness over the remainder of the project, and suggesting future directions and project structure of any potential follow-on. Vikka Molldrem, consultant, is the team lead for this evaluation.

Because you, as the field, are the primary users of this project, your inputs are critical. Thus, we would like to get your input on the series of questions **listed below**. Either (1) **you may ask that Vikka contact you by phone** to arrange for an interview; or if you would prefer, (2) **you may respond to the questions below with responses inserted in an email and**

forward them to Vikka.. If you would like Vikka to call you, please contact her to arrange a time for the call and let her know at what number you can be reached. Because she is also managing a Washington-based interview schedule, the best times for a call are this week (June 1 – 3) or, if after that, early morning between 6:00 and 9:00 AM EDT but prior to June 17. If necessary, though, Vikka will try to schedule you at other times you may suggest.

Your responses to the questions will be confidential—no one but the evaluation team will be able to identify your responses, and none of your comments will be attributed to you directly, though the team may want to use a quote from your response anonymously, unless you direct them not to do so.

Because the evaluation team is on a bit of a tight timeline and because we have many people from whom we would like input, we would appreciate your response as soon as possible. **Please respond no later than June 17, 2011**. We fully understand the busy lives of Mission staff, but we do highly value your response and do hope you will be able to find time to provide your important input.

If there is someone else on your staff who you think is more appropriate to provide this input, please pass this email to them.

I would like to thank you in advance for taking the time to help us on this effort. A good response from the field will help in making this project and any follow-on as useful to the field as possible.

Sincerely,
Krista Stewart, PhD
AOTR, MEASURE Evaluation Phase III
202-712-0808

* *

1. Satisfaction

   What in your view have been the key achievements of MEASURE Evaluation Phase III in your country thus far, that is, what would not have happened or happened as quickly without assistance from MEASURE Evaluation?

   Do you plan to use MEASURE Evaluation Phase III in the future? Why or why not?

   Please comment on your satisfaction with MEASURE Evaluation staff and with the USAID/W MEASURE Evaluation management team.

2. Collaboration and partnering

   What efforts, if any, is MEASURE Evaluation Phase III making in your country to work collaboratively with other USAID projects or implementing partners? Are there connections that are not being made that should be, and if so, how could this be improved?

   In what ways is MEASURE Evaluation Phase III contributing to international and multidonor fora in your country? Please be as specific as possible. Please give particular note to the

extent to which MEASURE Evaluation is collaborating with organizations and on the issues that are of the highest priority to USAID?

3. Capacity building

   How are MEASURE Evaluation's activities in your country contributing to capacity building needs at the individual, institutional and systems levels?

4. Data demand and use

   How is MEASURE Evaluation contributing to demand for data and use of data in your country?

   Are there particular tools or products that MEASURE Evaluation is using that have made these efforts more or less effective?

5. Knowledge management

   Which MEASURE Evaluation Phase III knowledge management products—e.g., tools and methodologies, publications, website—do you or others you know use in your work? Please provide any comments you have on the usefulness of any of the products with which you are familiar and on how they could be improved.

6. Gaps and future directions

   What are the technical gaps, emerging priorities and innovations that need to be addressed, either during the remainder of MEASURE Evaluation Phase III or in a follow-on?

7. Other Comments

COMMUNITY OF PRACTICE SURVEY INSTRUMENT:

1. How do you participate in this community? (circle all that apply)
   - Ask others questions
   - Respond to others' questions,
   - Mostly read what others post
   - Email other members off-line
   - Attend community meetings
   - Participate in week-long forums/discussions
   - Read documents the facilitator sends out
   - Send in documents to post for others to use
   - Other _____

2. What benefits do you receive from your participation in the community? (circle all that apply)
   - Learn about similar projects others are doing so I can contact them
   - Get advice from others on technical
   - Locate resources such as articles, studies, reports that are useful to me
   - Work on project activities with others
   - Lessons learned from others
   - Access to best practices others have learned from doing the work
   - Other _____

3. How many community members from another country or region do you talk to off-line on a regular basis?
   - None
   - 1-2
   - 3-4
   - more than four

   List some of the topics that you talk about _____

4. What would make the community more useful for you? (circle all that apply)
   - More or different ways to interact
     - Teleconferences
     - Webinars
     - Face-to-face meetings
     - Direct contact with other members
     - Knowing where others are traveling so you could meet with them
     - Other _____
   - More or different features
     - Being able to post directly rather than going through the moderator
     - Yellow pages of member that would provide more info about others such as projects they have worked on, expertise, pictures, language
     - Being able to set up a small community on my own
     - Ability to post document on my own
     - Other _____
   - Change in Type of Community
     - Moving from a Listserv to a collaborative space
     - Communities based on other topics for example _____
     - Other _____
5. What role would you like to play in communities in the future? _____

6. In addition to the community, what other sources of information do you use to get your work done effectively? (number in terms of frequency with 1 being the lowest)
   - TA's
   - Measure Website
   - Websites of other organizations such as -_____
   - Training
   - Conferences
   - Other _____

APPENDIX E. CODING AND NAMING CONVENTION

INTERVIEW CODING CATEGORIES

Primary-level codes	Secondary-level codes	Tertiary-level codes
Global Health Bureau/GHI		
Management	Management - Tools	
	Management - Staffing	
	Management - Finance	
	Management - Communication	
Project Results	Project Results - Best practice	
	Project Results- Lessons learned	
Current Technical Gaps	Current Technical Gaps - Producing what people need	
Collaboration	Collaboration - Working group	
	Collaboration - Partnership	
Country ownership	Country ownership - Money	
	Country ownership - Alignment	
	Country ownership - Agenda with national and international priorities	
CB	CB - Training	CB - Training - Change
		CB - Training - Virtual
	CB - Technical Assistance	
	CB - University	
	CB - Individual	
	CB - Organizational	
	CB - Country	
KM	KM - CoPs	
	KM - Website	
	KM - Publications	
	KM - Journal Articles	
	KM Accessibility	KM - Accessibility - Data
		KM - Accessibility - Tools
DDU	DDU - Data demand	
	DDU- Data use	
	DDU - Rapid assessment	
	DDU - Capacity building	
	DDU - Institutional support	
Constraints		
Strengths		
Innovation		

Primary-level codes	Secondary-level codes	Tertiary-level codes
Rwanda		
Tanzania		
Senegal		
Mozambique		
Nigeria		
Other countries		
Future	Future - Technical need	
	Future - Project structure	
	Future - Next steps	

FILE NAMING CONVENTIONS

Main Name	Extension	Tertiary
MEASURE Evaluation staff	HQ	Title
	Field	Title
USAID	Washington	Name
	Mission	Name
Donors	HQ	Organization
Donors	Country	Organization
Cooperating Agencies	HQ	Organization
Cooperating Agencies	Country	Organization
Implementing Partners	HQ	Organization
Implementing Partners	Country	Organization
Host Country	Country	Organization
Host Country	Country	Organization
Host Country	Country	Organization
Host Country	Country	Organization
Host Country	Country	Organization
Other	Country	Organization
Training Participant	Country	Organization
CoP Member	Country	Organization

APPENDIX F. TABLES RELATED TO SECTION IV, KNOWLEDGE MANAGEMENT

Table 1: End of Year 3 Results and Indicator Summary for Task 3, Increased Collaboration and Coordination in Efforts to Obtain and Communicate Health, Population, and Nutrition Data in Areas of Mutual Interest

3.1	Outputs by CoPs in which MEASURE Evaluation had a leadership role	9
3.2	CoPs in which MEASURE Evaluation had a high level of participation	39
3.3	Members in CoPs moderated by MEASURE Evaluation	3520
3.4	Members who posted to a CoP in Year 3	63
3.5	New threads (discussions) started on a CoP in Year 3	29
3.6	Fora in Year 3	5
3.7	People who registered for an online CoP in Year 3	225

Table 2: End of Year 3 Results and Indicator Summary for Task 5, Increased Availability of Population, Health and Nutrition Data, Analyses, Methods and Tools

5.1	Research findings, experiences and/or lessons learned from data analysis, methods, or tools that are available to decision-makers or stakeholders	29
5.3	Electronic and print publications produced	37
5.4	Articles published in peer reviewed journals	13
5.5	Print publications distributed in response to requests through the website	1196
5.6	Digital publications downloaded from the website by non-MEASURE Evaluation users	295,361
5.7	Presentations given by MEASURE Evaluation staff	39
5.8	Organizations posting MEASURE Evaluation publications	54
5.10	Number of computers visiting MEASURE Evaluation website	125,954
5.11	Number of new subscribers to Monitor e-newsletter in Year 3	4658

Table 3: Response rate and number of responses to the CoP survey for each Network

Network	Percent of responses	Number of responses
Child Status Network (ChildStatusNet)	20.7	19
Routine Health Information Network (RHINO)	56.5	52
M&E of Malaria Listserv	29.3	27
The Global Health M&E Network	53.3	8

Table 4: Responses to CoP Survey question by percentage and number of responses

ONLINE CoPS, MEETINGS, NO ONLINE

Ways in Which Respondents Currently Participate	Percent of responses	Number of responses	Percent of responses GH M&E	Number of responses GH M&E
Email other members 0ff-line	13	12	25	2
Attend community meetings	8.7	8	75	6
Meet one-on-one with members of the community	NA	NA	12.5	1
Participate online			**25**	2
Ask others questions	17.4	16	**NA**	NA
Respond to others' questions	22.8	21	NA	NA
Mostly read what others post	79.3	73	NA	NA
Send in documents to post for others to use	12.4	16	NA	NA
Benefits Received from Participation in the CoP				
Learn about what others are doing	64.4	58	80	8
Get advice from others on technical issues	33.3	30	40	4
Locate resources such as articles, studies, reports	80	72	30	3
Work on project activities with others	11.1	10	0	0
Access to best practices others have learned from doing the work	66.7	60	NA	NA
What Would Make M&E Networks More Useful for You?				
Teleconferences	46.7	35		
Webinars	49.3	37	50	4
Face-to-face meetings	45.3	34	NA	NA
Direct contact with other members	45.3	34	12.5	1
Knowing where others are traveling so you could meet with them	32.0	24	0	0
What Features Would Make the Networks More Useful to You				
Being able to post directly	36.5	23	12	1

Ways in Which Respondents Currently Participate	Percent of responses	Number of responses	Percent of responses GH M&E	Number of responses GH M&E
rather than going through the moderator				
Yellow pages of members	57.1	36	62.5	5
Being able to set up a small community on my own	31.7	20	NA	NA
Ability to post document on my own	44.4	28	12.5	1
Change From a Listserv to a Collaborative Space Platform	84.9	45	37.5	3

Table 5: Responses to KM questions from phone and email interviews conducted from Washington

Group N=70	WEBSITE	MONITOR	COP
USAID/Washington	10	7	10
OGAC			1
CDC	2	1	1
UNICEF			1
USAID Missions	1		
PATH		1	1

Table 6: Responses to KM questions from interviews conducted during site visits to five countries.

Group N=124	WEBSITE	MONITOR	COP
Field Staff	2	1	3
Mission	3		1
Implementing Partners	10	4	9
Trainees		1	1

Table 7: Responses to KM questions about how knowledge about M&E is obtained other than the M&E website, Monitor, or COPS from interviews conducted during site visits to five countries.

Group N=124	LOCAL WEBSITE	FACE TO FACE	TA
Field Staff	5	2	3
Mission	1		
Implementing Partners			
Trainees		5	

APPENDIX G. BACK-UP TABLE ON BUREAU-WIDE AGENDA

Bureau-wide, Field, and Field plus Core Obligations through Year 3 by Office/Element : FY 08–FY 10

Office/ Element	Bureau-wide Obliga-tions	Field Obliga-tions	Core Element-specific Obliga-tions	Field Plus Core Element Specific	Percent of Bureau-wide	Percent of Field Support	Percent of Field Plus Core
FP/RH	3,250,000	4,153,000	n.a.		35.0	7.5	5.6
HIV/AIDS	2,403,300	39,460,034	12,364,790	51,824,824	25.9	71.1	70.3
HIDN Of which:	3,631,400				39.1	21.4	24.1
MCH		6,140,000	902,000	7,042,000		11.1	9.6
Malaria		4,335,800	3,825,600	8,161,400		7.8	11.1
TB		567,000	450,000	1,017,000		1.1	1.4
Avian Inf			625,000	625,000			0.8
Nutrition & Water/ Sanitation		800,000	50,000	850,000		1.4	1.2
					100%	100%	100%

APPENDIX H. COUNTRY VISIT SUMMARIES

MOZAMBIQUE

Context

- MEASURE Evaluation is not working with the Ministry of Health In Mozambique.
- MEASURE Evaluation is accountable to USAID and indirectly to DOD.
- National response for HIV/AIDS is coordinated by CNCS (National AIDS Council), which lost funding from the World Bank and the Global Fund.
- There is a drive to national ownership and desired transparency of donor support.
- National response to HIV/AIDS is donor driven.

MEASURE Evaluation Approach

- MEASURE Evaluation focuses on capacity building through training, TA, and mentoring.
- MEASURE Evaluation is strengthening the capacity of the national AIDS authority in developing one national M&E system.
- MEASURE is conducting DQA in all USAID partners and strengthening their systems for reporting to PEPFAR.
- The project works with non-health sector such as Ministry of Women's Affairs, Ministry of National Defense.
- The project fosters partnerships in the national response to HIV/AIDS.

Successes

- There is good collaboration between MEASURE and UNAIDS and other donors.
- The project has gained respect from other stakeholders for providing training for DQA.
- It is developing a health facility coding system and patient tracking system in the Ministry of National Defense (MND).

Data Demand and Use

- The project's focus is on improving data quality.
- MEASURE Evaluation does DQAs and reporting to the Mission.
- It did a rapid assessment at the start of the Ministry of National Defense project.

Knowledge Management

- Knowledge management is an area that needs improvement.
- MEASURE Evaluation is not successful in marketing the website.

Capacity Building and Training

- MEASURE Evaluation does individual training of M&E managers and mentoring of key persons.
- It sponsors attendance at international training and courses and meetings.
- It carries out DQA training.

Constraints/Challenges

- MEASURE EVALUATION is creating parallel systems, such as the MIS in the MND, which was going to be developed as a stand-alone system; however, there is a need to link with the drugs logistics system and with the existing lab system (for HIV/AIDS) in order to be useful in addressing the needs of the military health system for proper tracking of patients and to analyze trends in health outcomes.
- The project's Mozambique office has a narrow human resources base.
- Costs for database and e-system development are high.
- There is poor infrastructure for community data-gathering, especially in the remote areas.
- The relationship between the project and national entities needs improvement.

Current Gaps and Future Needs

- A more competitive environment which leaves room for regional and local contractors.
- Evidence of value for money for different interventions.
- Improved management and oversight of the project (at the level of the Mission) and establishment of a steering committee.
- More focus on evaluation research.
- Virtual leadership and management training, though Mission not interested in funding this.
- Institutionalizing M&E in the University in Maputo.

NIGERIA

Context

- Health sector reform (Joint Financing Agreement/JFA).
- Efforts to align federal policies/strategies with States and local government administrations
- Attempts to harmonize vertical M&E systems within the health system at all levels.
- Drive towards one national M&E system for HIV/AIDS, but rivalry between NASCP (National AIDS and STD Control Program) and NACA (National AIDS Commission).
- Efforts to establish positive synergy between HMIS and M&E unit in the Department of Planning, Research and Statistics in the Federal Ministry of Health (FMoH).
- Need for community system strengthening; the role of civil society in this regard has been recognized.
- Establishing public/private partnership in the national health strategy; 70% health expenditure through private sector.

MEASURE Evaluation Approach

- The project does capacity building through system strengthening, organizational development (VLDP), training and long-term TA.
- It works mostly with government at the federal level.
- Efforts at the State level are being piloted (3 resident advisers for HIV/AIDS, either at Dept of Health or States Agency for Control of AIDS—SACA).
- The project is strengthening one national M&E system for HIV/AIDS, working both with the FMoH and the NACA.

- Much emphasis is placed on strengthening one national authority for the coordination for HIV/AIDS.
- The project contributes to fostering partnership in the national response in line with the international partnership (Monitoring and Evaluation Reference Group/MERG).
- It uses evidence-based planning.

Successes

- There is good collaboration between MEASURE Evaluation and UNAIDS and other partners.
- In line with the Paris declaration there is discussion among the donors and the country and alignment with government priorities.
- The project is institutionalizing M&E in 2 universities (short- and long-term).
- It has gained trust of both government and the Mission.
- MEASURE Evaluation's focus on CB and generating strategic information is well appreciated, as is its responsiveness to training needs of different stakeholders.
- It has a national team in place of committed professionals that are familiar with the respective sectors.
- It has demystified social statistics and other data and enhancing their utilization by taking people step by step through the process of data collection, analysis, and dissemination.
- It fosters more national ownership.

Data Demand and Use

- Project's focus is on improving data quality.
- DQA and reporting to the Mission is done by Monitoring and Evaluation Management Service Project (MEMS). USAID wants MEASURE to focus on government.
- MEASURE Evaluation makes use of organizing framework for functional national HIV and AIDS M&E system (12 components).
- Demand for quality data is clearly on the agenda, including the non-health sector such as the Ministry of Women and Social Affairs.
- Role of civil society is recognized and strengthening their capacity for quality assurance and standardized operations is needed.
- The project has worked on Data Inventory and Documentation Initiative (DIDI) of the National Health Documentation Centre in the Department of Planning Research and Statistics (document and archive health facility and population based surveys and other information to improve data accessibility and feed-back strategies).

Knowledge Management

- Knowledge management is an area that needs improvement. There is a lot of information, but the skills to bring it together and to use it for decision-making are not always there.

Capacity Building and Training

- The project employs individual training of M&E managers and mentoring of key persons.
- It has embedded TA, such as with the Ministry of Women's Affairs.
- It supports stand-alone M&E short courses at the universities, and M&E is integrated in MPH courses.
- It sponsors participants attending international training and courses and meetings.

- It has used VLDP (NGO network, NACA, NACSP).
- It provides DQA training.
- OVC program is now evidence-based with changed focus of system strengthening.

Constraints/Challenges

- Nigeria has a high human resources turnover.
- There are parallel vertical M&E systems.
- There is rivalry for national oversight and coordination of the national HIV response.
- There are large differences among the States in strength of their health systems.

Current Gaps and Future Needs

- More focus on health systems strengthening.
- Need for community systems strengthening.
- Need for rigorous evaluation of capacity-building progress.
- Weak monitoring and oversight of the private sector.
- Strategic leadership.
- Evidence of value for money of different interventions.

RWANDA

Context

- Government wants country ownership. Everyone is aware of this desire and there are observable actions that are leading to this such as embedded MEASURE Evaluation employees in national organizations.
- Governmental organizations use performance-based financing.
- There is a move towards an integrated health system—where all health issues are integrated and important versus just a focus on HIV/AIDS. The country is forming a new over-arching health organization (similar to the CDC) called the Rwanda Biomedical Center.
- Government wants rapid change; they seem to be changing faster than donor organizations.
- MDG 2015—Donors are focused on these goals, and they are leading to discussions about the types of data collected.
- Some interviewees mentioned the need for management and leadership training.

MEASURE Evaluation's Approach

- MEASURE Evaluation works mostly at the national level.
- MEASURE Evaluation embeds staff in national organizations—to model the way and mentor key organizational partners.
- They are doing some work at the district level and want to do more, but must respond to Mission demand; they have trained the District AIDS Control Committees (CDLS) M&E Specialists.
- Majority of the focus is on HIV/AIDS data; but health integration is a priority.
- MEASURE Evaluation's country staff's main contact is with Country Focal person; otherwise, they have limited contact with Headquarters (UNC).
- MEASURE Evaluation is highly quantitative in its approach.

- Individual training is mostly on M&E; some GIS (using core funding for this).

Successes

- MEASURE Evaluation team assisted country counterparts with the National Strategic Plan; consequently, Rwanda was the only country to win a $400 million dollar grant from the Global Fund.
- Developing Master Trainers approach is successful, but high levels of turnover make this a work in progress.
- The project has developed Standards of Practice.
- It has developed definitions of indicators and reduced the list of indicators.
- MEASURE Evaluation is well respected; its staff are seen as experts. MEASURE Evaluation staff seem to have relationship building/collaboration skills/soft skills.

Data Demand and Use

- Project's focus is on improving data quality.
- It needs to move towards data use.
- It works on HIV/AIDS, with some work on child status – but will need to collect and use data in other health areas as well.
- Country counterparts seem to place less value on collecting and using data at the local/community level; yet, they are the ones who actually collect health data.

Knowledge Management

- MEASURE Evaluation staff members in Rwanda are not as aware of what is going on across MEASURE Evaluation-supported countries as they would like to be.

Capacity Building and Training

- At individual level focus is on training (M&E or GIS) of people in M&E positions; mentoring of key people within national organizations (guided support; on-the-job training); it takes advantage of CESAG and University of Pretoria training.
- Skills/knowledge focus on M&E includes what is it, why is it important, quality data collection, GIS mapping – how, why; what tools to use; and M&E planning.
- At the organizational level, it has used VLDP (one organizational team); works by being embedded within the organization; provides funds for resources (like modems); provides TA, e.g., edits papers and proposals
- At national level, it helped develop National Strategic Plan, standards of practice, national indicators; provides funds for supporting conferences; sits on national committees; provides TA, e.g., edits papers and proposals; looks at developing an academic course of study at the School of Public Health. Also expat Resident Advisor has transferred leadership to two local RAs and another RA from the region. MEASURE Evaluation is helping to harmonize HIV data. They are training Master Trainers.
- At the community level, the project trains district M&E officers.

Constraints/Challenges

- Rwanda has high employee turnover.
- The government has access to many tools and instruments. This may be confusing to them.
- The government keeps changing priorities.

- This is a poor country with limited resources.
- There is poor quality internet, but government has installed internet throughout health facilities.
- The health workers at the community level are less likely to see the value of collecting data and are less likely to use data for decision-making. Data collection is more likely see as a requirement of someone else.

Current Gaps and Future Needs

- Insufficient focus on building capacity to do "E" in the M&E.
- Insufficient emphasis on data use.
- Need for organizational leadership/management development.
- Training linked more closely to real-work and longer term follow-up (action learning teams might be helpful).
- Absence of link between VLDP Rwanda team and MEASURE Evaluation-Rwanda.
- Need for research agenda.
- Master Trainers are not yet independent due to need to train additional people after first group trained left positions.

SENEGAL

MEASURE Evaluation's partnership with the Institute Superieur de Management de la Santé (CESAG) in Dakar

CESAG offers M&E training, provides TA in M&E and carries out evaluation research. It is recognized as regional leader in management and training related to health programs in francophone Africa.

Context

- Health systems in the region are generally weak, especially at the subnational levels.
- National monitoring systems for HIV/AIDS (multi-sector) are usually not well functioning.
- Infrastructure for M&E training in the region is insufficient.
- CESAG receives support mainly from West African Economic and Monetary Union countries (UEMOA) and the World Bank.

MEASURE Evaluation Approach

- Participants come from francophone countries, mostly from UEMOA countries, but also from North and East Africa and even from countries outside Africa (Haiti, Moldavia and there was a Chinese participant).
- Project focuses on strengthening technical and organizational capacity of CESAG to contribute to increased management capacity in the region.
- Focus has evolved over time. In the first phase the focus was on M&E of PHN programs; in phase II M&E of HIV/AIDS programs was added and more recently RHIS and district health information workshops took place.
- VLDP is going to be introduced to support CESAG leadership and organizational capacity.
- Support is through core funding (field support is not involved except for providing scholarships for individual trainees).

Successes

- Mentoring of faculty members has been sustained throughout the partnership, including presentation of emerging issues during training of trainers (ToT) sessions and pairing MEASURE staff and local facilitators as co-trainers during the workshops.
- There has been quick transfer of competencies over time and mutual trust between facilitators.
- Data demand and use is pivotal in the training programs.
- Creation of ownership through remote ToT appears a success.

Knowledge Management

- Knowledge management is an area that needs improvement.
- Follow-up on training participants is a challenge.
- MEASURE Evaluation is in process of creating a Community of Practice for former trainees, which should facilitate follow up of trainees.

Capacity Building and Training

- The level of support from MEASURE Evaluation has changed over time. The initial 2 courses (PHN and M&E of HIV) received much TA and there was also some support to fund participants coming from the region.
- In the RHIS training course, MEASURE Evaluation provided TA only for one week. The project assisted the design of curricula and training materials and provided instructional support in the workshops, and logistical and administrative support to the workshops.
- CESAG holds regular ToTs, supplemented by using Team Viewer and Skype applications to provide remote ToT.
- The GIS module is well appreciated.

Constraints/Challenges

- The main challenge is financial sustainability; demand is twice the current capacity to finance the course. Dakar is expensive, and CESAG is reluctant to increase the cost of training.
- There is limited core staff. Salaries are unattractive and trained staff easily find better payment in the NGO sector.
- Back in their own countries, trainees often have unfavorable environments to fully use the acquired skills.

Current Gaps and Future Needs

- Improved organizational management VLDP.
- Participation in regional fora to harmonize health information systems (such as WAHO).
- Better value for money.
- More focus on evaluation research.
- More elaborated GIS.
- More attention to gender.

TANZANIA

Context

- PEPFAR /HIV funds have influenced the system: there is an increase in the collection of data for reporting to donors, there has been an increase in the types of health services offered (such as services for orphaned children and other HIV/AIDS services); the data collection requirements have occasionally led organizations to reporting what appears to be "fake data."
- Management and leadership training is needed.
- District hospitals and health facilities are not under the Ministry of Health; they report directly to the local governments and up through to the Prime Minister's Office.
- Collection and reporting of data are not harmonized.
- Because of division of responsibilities for PEPFAR by U.S. Government agencies at post, MEASURE Evaluation works less with the government than with USAID implementing partners. This seems like a missed opportunity.
- High levels of employee turnover exist at all levels of the health sector.
- MEASURE Evaluation receives direction primarily from USAID Mission and not from the country government. The project's scope of work is based on USAID's needs for data reporting among their implementing partners (IPs).

MEASURE Evaluation's Approach

- MEASURE Evaluation works primarily with U.S. Government IPs.
- It works with DSW by collaborating with the embedded M&E Specialist, supported by CDC, and USAID.
- Most work is with the IPs on the DQA process (organizational assessment, individual training—2 people per agency, mentoring, capacity building plan following assessment).
- MEASURE Evaluation's focus is on the ability to collect and report quantitative data.
- USAID Mission asked MEASURE to focus on how to better respond to PEPFAR requirements; DQA process collects health data on numerous health issues and system needs.
- Individual training is provided mostly on M&E; some GIS (using core funding for this)

Successes

- DQA process has resulted in the hiring of M&E Officers in many organizations; staffing for M&E is improving.
- Culture of using data is changing.
- US Department of Defense wants to buy into MEASURE Evaluation to conduct DQAs for their IPs.
- The DQA tool used by the Ministry of Health is a MEASURE Evaluation tool.
- MEASURE Evaluation has used GIS to help map the coverage areas of local health facilities.

Data Demand and Use

- Project focus is on improving data quality; the data accessibility and data quality work is primarily in conducting DQAs for USAID's IPs.

- The project provides M&E training to two individuals per organization prior to the DQA process.
- There is need to move towards greater focus on data *use*.
- The project focuses on quantitative data versus qualitative data.
- Volunteers frequently collect health data, but they often don't understand or appreciate why they are collecting the data; they may be uneducated and have no incentives for collecting good quality data.

Knowledge Management

- MEASURE Evaluation and country counterpart stakeholders/customers are not as aware as they want to be of what is going on across MEASURE Evaluation's global program (although a few mentioned communities of practice and online courses).
- Some stakeholders/customers have accessed MEASURE Evaluation website.
- MEASURE Evaluation All-Staff meeting was beneficial to new employees but not as useful for older employees.

Capacity Building and Training

- At individual level, MEASURE Evaluation conducts training (M&E) of key organizational people including program directors and people hired in M&E positions. MEASURE Evaluation mentors/provides TA to key people within IP organizations (guided support; on-the-job training); trainees benefit from CESAG and University of Pretoria training.
- Training focuses on skills and knowledge in M&E: what is it, why is it important, quality data collection, how, why; what tools to use; M&E planning.
- At organizational level, the project has provided VLDP (one organizational team); offers long term TA as part of the DQA process; provides training as part of the DQA process to two members of each organization. (This may not be enough people per organization to build sustainability given the high turnover rate.) MEASURE Evaluation is building the capacity of one local consulting firm to conduct DQAs and support organizations in responding to the DQA capacity building recommendations.
- At the national level, MEASURE Evaluation works with the DSW in the area of identification and support of most vulnerable children. They developed a tool and have worked with local NGOs to do spot checks of the most vulnerable children. The tool was piloted in collaboration with local consulting firm and will be rolled out soon. GIS mapping has been done but the work has only been done by MEASURE Evaluation; there has been no transfer of knowledge in training at this point. There is a hope that the work will generate interest in using GIS mapping.
- At the community level, the project primarily works with IPs.

Constraints/Challenges

- The country has high employee turnover.
- Many organizations are in the country doing capacity building related to M&E, which could cause confusion.
- Division of responsibilities between U.S. Government agencies is not always clear and may work against a greater role for MEASURE Evaluation.
- This is a poor country with limited resources.
- There is poor quality internet.

- The health workers at the community level are less likely to see the value of collecting data and are less likely to use data for decision making. Data collection is more likely see as a requirement of someone else.

Current Gaps and Future Needs

- Need for more focus on building capacity to do "E" in the M&E;
- Need for more emphasis on data *use*.
- Organizational Leadership/Management Development lacking.
- Training not sufficiently linked to real-work and lacking in longer term follow-up (action learning teams might be helpful).
- No academic M&E program at present, although there are courses at the University of Dar es Salaam in the Engineering Department.

Observations

- Perception of MEASURE Evaluation by others: U.S. Government IPs are very happy with DQA process and TA/Mentoring. Others do not see MEASURE Evaluation staff as leaders of M&E.
- Perception of training: high quality, useful, and immediately applicable.
- MEASURE Evaluation perceived as tardy in providing organizations their final DQA reports. MEASURE Evaluation says that the bulk of the recommendations are timely, i.e., delivered immediately after the fieldwork, and that this is followed with a full report that is provided within three months of fieldwork completion.

For more information, please visit
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